Birth@Internet.ca: A narrative analysis of Internet-based birth stories from Canadian women

by

Kimberley Mae Nuernberger
B.A., Carleton University, 1992

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF ARTS

In the Department of Sociology

Supervisor: Dr. C. Benoit

Birth@Internet.ca: A narrative analysis of Internet-based birth stories from Canadian women

Abstract

This study presents a sociological analysis of Internet-based birth stories. Sixteen narratives describing a recent childbirth experience were collected from Canadian women from a variety of websites featuring first-person accounts of childbirth or "birth stories". The writers of these stories provided information on their demographic and previous birth experience profile through an e-mail questionnaire. In addition, they considered the importance of Internet birth stories and assessed their motivations for posting personal stories online. The stories were analysed using a narrative approach to better understand the ways that women created meaning from their experience through story. Discussed are the ways women construct their stories to position themselves and their birth experiences in relation to cultural narratives of birth, including dominant medical narratives. Particular attention was paid to the ways in which narrative elements, and medical and broader cultural narrative resources were used in the construction of agency, and authoritative knowledge. The importance and value of the Internet as a method of data collection and a contributing element to the stories is also explored.

Examiners:

Acknowledgements

I am deeply indebted to so many people who have assisted me over the course of writing this thesis that I could not begin to include all of their names in this brief section. Those of you whose names do not appear here, you know who you are and thank you. I do, however, want to take this opportunity to single out a few whose support and encouragement has been instrumental to the process of completing this work. First of all, my deepest thanks are extended to the women who have posted their stories online and permitted me to include their stories in my work. These women not only provided me with a starting point, but their stories were a continual source of inspiration. Their commitment to sharing their birth experiences and themselves online renewed my own commitment to completing this thesis. I extend my gratitude to each member of my committee. Thank you for your advice, your guidance, and especially your support throughout the entire process. I am especially indebted to my supervisor, Cecilia Benoit. I thank you for believing in this project, believing in me, and giving me the freedom to explore and challenge the boundaries of my own sociological imagination. Thank you to my long-time friend Denise. Being present at the birth of your son was an event that changed my life and gave me memories that I will hold close to my heart forever. Thank you to my family. I know that this has seemed like a long and arduous process at times, but I also know that you have always been by my side. Last, but by no means least, thank you to Michael. Over the course of this degree you have made the transition from my long-term partner to my husband. I thank you for your unending support on every step of this journey and I look forward to every future step we share together.

Table of Contents

Chapter 1

Introduction: Writing Stories About Birth

Almost six years ago, I was invited to be a support person at the midwife-attended homebirth of a friend. I had explored the implementation of midwifery within the Ontario health care system during my years as an undergraduate student; I had spoken with several midwives about their practice and their philosophy; and I had read volumes of feminist literature investigating the ways that medicine has affected the role and status of midwives, and influenced the childbirth experience for women in many Western industrialized nations.

Despite all of this, my personal experience of childbirth had, until this time, been limited to the time I made my own way into the world. The moment when my friend's son was born in the early evening hours on a windy November day is one that I will never forget. I held my friend's hand in my own and a flashlight in the other to enable the midwives to see, as it was the only source of light in the room. Turning on the light was something that I never thought to do and it seemed somehow so much more intimate and cosier in the near darkness. We watched in silence after the baby crowned, hair waving gently in the blood-tinged water. We knew that the birth was imminent and we all cried out with my friend as the tiny body emerged from hers under the water and into the plastic inflatable pool that she had special ordered from Canadian Tire a few weeks before. In one swift motion the midwives scooped the baby out of the water and onto my friend's chest as we covered the two of them in blankets and began to fuss over the little one. "She's so beautiful," we exclaimed as we crowded in. I remember laying my hand on the back of this newborn infant. The blanket, surprisingly warm to the touch, was already soaked through with the water from the pool and the fluids that covered the tiny body. I remember the waxy vernix that clung to the skin and the way the ears were squished tight to the head, having not yet had the freedom to spring into the proper position. "It's a girl?" my friend looked up at us questioningly. "We don't know," we laughed with tears streaming down our faces. Nobody thought to check. I cut the cord, which felt as though I was cutting through rubber with safety scissors, and my

friend's partner took the baby into the living room to discover if he had a daughter or a son. I assisted the midwives and was helping my friend out of the pool to prepare for the arrival of the placenta, when her partner reappeared in the doorway. And that is how their son arrived to greet the world.

My friend has asked me to write my perspective on her son's birth and, truthfully, this is the closest I have come to putting these details in writing – although I have certainly shared these details in conversation with anyone who may have questions about midwives or homebirth. To put this story in writing and share the details of this incredible event had seemed to me to be such a personal experience. The search for just the right words to describe the scene and how I felt being a part of it I knew would be a challenging process. In each retelling of the story I perform the story once again; recreating the intimacy, tone, and feel of the birth in the words that I choose to communicate this story to others. This is why, when I happened upon written birth stories that had been posted on the Internet, I knew that what I had uncovered was important. Through the stories that women told and through the words they selected to breathe life into their stories, I, as both a reader of these stories and a researcher, had been given a unique and intimate glimpse into the way in which women write about birth from their own personal perspectives.

My own discovery of Internet-based birth stories happened somewhat by chance. I was actually looking on the Internet for the website that promoted the Life Network's reality television program "Life's Birth Stories", and when I entered the keywords "birth stories" into the Google search engine I was quite surprised at what I found. Women from many countries were writing and posting the intimate details of their birth experiences online by the thousands. Their stories were rich in detail and captured a vast diversity of birth experiences. The women communicated their stories in written language that was frequently moving, often humorous, and occasionally expressed a deep-seated anger that women carried about how they were treated during childbirth.

Birth stories generally focus on the birth itself as the key component of the narrative, but their beginning and end points may or may not be fixed within the immediate context of the birth experience. Occasionally, these stories began with a description of the onset of labour, but

stories sometimes also commenced at the start of the pregnancy, or even originated with aspects of life before pregnancy. The stories may end shortly after the birth as the new infant is introduced or they may continue further, bringing the reader up to the present time in which the story was written. If the birth resulted in complications for the mother or if the infant experienced difficulties following birth, these were often incorporated into the narratives. These stories could be described more accurately as "childbearing stories", because the scope of the narratives frequently involves aspects of the entire experience of childbearing. I will, however, continue to use the phrase "birth stories" throughout this entire thesis as this was the phrase selected to describe this genre of personal stories on the websites on which they were found, and I used the same phrase during both the initial discovery of this collection and to continue my investigation.

These stories appeared on a variety of types of websites; some of these sites were commercial sites devoted to general parenting issues, while others were private homepages where women had posted the details of the births of their children for family, friends and others who may have been interested. Still other sites were devoted to particular types of birth and/or particular philosophies of birth. There were quite a number dedicated to birth attended by midwives or doulas (caregivers who define themselves as providing emotional and physical guidance to women and their support persons in labour and birth), while others focused on unassisted childbirth (a birth that occurs without either a physician or a midwife present, typically at home, and often with family members and/or friends standing by). Some of the sites were devoted to helping women heal after a birth by caesarean section, while others were promoting VBAC (vaginal birth after caesarean). One website focused exclusively on the specific issues faced by plus-sized women in pregnancy and birth, and many others were organized into forums that allowed women who had conceived within the same time period to connect with one another to share experiences and information regarding pregnancy and birth. As they reached the ends of their pregnancies each would post the story of the birth, and the other participants would post their congratulations in reply. In essence, the complexity and diversity of the birth stories that appear on the Internet is only limited by the complexity and diversity of women's personal birth experiences.

The vast majority of Internet birth stories are written from the first-person perspective, and, as such, they permit access from a personal vantage point to both the events of birth and the ways in which these events are given meaning as they are enclosed in a publicly accessible narrative account. Much as telling the story of my friend's birth above involves performing the birth, in which I, as writer, become performer and you, as reader, become audience, the stage for telling birth stories is often set prior to the performance. Pollock writes, "Understood as performance, birth stories dramatize the convergence of multiple stories on the birth experience" (1999: 8). In telling her birth story, a woman may draw from these multiple stories (stories that include all of those to which she has previously been exposed) as she attempts to make sense of her own birth experiences and communicate a coherent version of the events and their meanings to her audience. Exploring these stories, therefore, will not only provide information regarding the storyteller and the events that she encountered during her birth, but the multiple stories that form the backdrop for the current narrative can also be brought to the surface to provide important clues regarding the knowledge systems and social structures through which her birth has been understood and given significance.

As a young woman of childbearing age I had been privy to the multiple stories of friends and co-workers. I had attended baby showers where the stories were told in between the games and the unwrapping of presents. Fiona Nelson (2004) discusses the surprise that some pregnant women described at hearing stories, not only from friends and relatives, but also from complete strangers. Della Pollock (1999) shares her reaction when, given that her own pregnancy had become visibly obvious by that time, a stranger turned a chance encounter in the produce section of the grocery store into an opportunity to describe in vivid detail her own traumatic birth experience. Pollock reflects on the ways in which she accepted this story and the manner in which in the process of being told this story she was charged with the responsibility of carrying this story forward to share with others.

It can be established, therefore, that women share birth stories. Additionally, the stories that are shared are shaped by those stories that women have been told in the past. According to research on birth stories, even strangers may be interested in

exchanging personal stories. Yet this still does not explain why women have recently turned to the Internet not only to share their stories with others, but also to construct a single written account of the birth available to anyone with access to the Internet. These Internet stories may be seen as an extension of the ways stories have been shared in the past. At the same time, however, they represent a diversion from both the intimacy of stories shared verbally between pairs or small groups of (primarily) women, and the versions of written accounts that have been told within the confines of a journal or scrapbook, or edited for inclusion in published volumes. These Internet stories provide us with not only important access to the ways that birth is lived and given context in the form of a written narrative account, but because these stories were located online, the Internet itself plays an important role in both the content and variety of these stories.

The Internet as a medium for instant global exchange has made vast inroads into changing the ways in which we communicate with others on a day-to-day basis in a very short period of time. Internet birth stories can be seen as part of a larger body of online communication that includes weblogs (sometimes called blogs these are personal journals that can be found online), forums, and online communities. (See Markham (1998) for an examination of virtual communities and the implications of life online.) In their analysis of weblogs, Langellier and Peterson explore the value of Internet storytelling. They state:

> Storytelling on the Internet provides a ready exemplar to question the changing relations of culture and technology as well as the tendency to privilege oral culture and 'orality' in the analysis of storytelling (2004: 160).

The presence of birth stories on the Internet, therefore, provides an opportunity to explore the ways that birth is experienced within our contemporary culture, and the ways that this experience connects and intersects with the technology of the Internet as a new medium to communicate and participate in storytelling. Investigating Internet birth stories will provide insight into why women have selected this technological forum in which to tell their stories and how the Internet itself is influencing the stories that are told.

The fact that these stories were written prior to any contact from the researcher means that the existence and content of these stories is unmediated by the research process. The typical process that involves the collection and construction of a narrative account within the context of a collaborative dialogue between participant and researcher (Mischler, 1986) has been avoided in this case. These stories exist independent of the research process and the content of these stories replicates precisely the content one would encounter on the original webpage. This in no way implies that ethical issues typically faced by the researcher when collecting personal qualitative data are avoided entirely. As I will explore in further detail in the methods section of this thesis (Chapter 3) I needed to be cognisant of other important ethical issues related generally to the use of unobtrusive methods, and specifically to the collection of narrative material from the Internet.

The intentions of this project were twofold. First, I wanted to explore in greater detail the construction of birth in narrative form, to examine how women put their stories into writing to give meaning to their experiences for themselves and those who would read them. Second, I wanted to illustrate how the Internet can be used to not only collect valuable qualitative information for the purposes of sociological inquiry, but also to explore the Internet as a forum for posting personal stories with an inherent value all its own. To post the story of one's birth experience is not the same as including it for submission in a book, writing it in a letter to a friend, or writing it down to be included in a scrapbook of infant memorabilia. Although there may definitely be similarities in these written versions, I contend that to post one's story on the Internet has a meaning and a significance all its own that must be explored within the context of the technology that was used to create it.

As I have established in the literature review section of this thesis (Chapter 2), much of the sociological literature regarding childbirth has examined the relevant issues within the context of two competing ideological models (the medical or technocratic model and the midwifery, holistic or natural model). However, according to the women in

my study who posted their personal stories on the Internet, childbirth is not lived from within the constraints of two competing ideological models; it is lived and experienced from within the context of these women's lives. Although some of the recent literature has begun to study childbirth from the woman's perspective, and there is a growing body of literature exploring narratives of birth specifically, there is no research that I am aware of that has taken as its starting point the stories that women tell over the Internet. These stories provide a unique vantage point from which the ways women communicate their experiences of birth can be viewed. How do women structure their narratives in this context? What narrative resources do women borrow from to create meaning in their experiences? How are these narrative resources employed and how do they reflect the knowledge systems and social structures that have the power to shape birth in a contemporary context? Additionally, what role does the Internet play in shaping the stories that are told, both on the level of the individual story and from the perspective of the stories as a collective? These are some of the questions on which this project will focus.

Following this introduction, the literature review section (Chapter 2) will examine in greater detail the relevant sociological work regarding childbirth from both an historical and a contemporary perspective. An overview of the medical and midwifery models as ideological approaches to understanding childbirth has been presented, as well as a review of research into women's perspectives on the childbirth experience and the narrative construction of the birth story. Chapter 3 (methods) presents an in-depth look at both Internet-based methods and narrative analysis as the methodological approaches that were used in this research. This is followed by a detailed examination of the specific procedures that were undertaken to select and analyze the final sample of 16 birth stories from Canadian women. Within the analysis section (Chapter 4), I have presented an examination of the results of the survey that was distributed via e-mail, and a narrative analysis of a selection of four stories from my participants. Chapter 5 presents a thematic discussion of the findings of this study that highlights the importance of the medical

narrative for understanding and telling stories about birth, the ways in which women create and enact agency and authoritative knowledge in their stories, and the role of the Internet in the content and context of the stories that were told. Finally, in the conclusion to this thesis (Chapter 6), I provide a summary of this work and highlight future directions for research involving women's personal experiences of pregnancy, labour and birth, and online narrative materials.

Chapter 2

A Review of the Childbirth Literature

Before I discuss the specific details of this study, it is first necessary to ground this project within the context of past work conducted in the areas of childbirth generally, and birth stories specifically. This review of the childbirth literature begins by presenting an historical overview of the processes that have occurred to bring childbirth under the scope of medical control. Feminist writers have been critical of the ways this process, referred to as the medicalization of childbirth, has substantially altered women's experiences and control over childbirth, and have labelled the ideological approach through which medicine perceives childbirth as the medical or 'technocratic' model. The principles of this model and the effects that this approach has on women's understanding and experience of childbirth are introduced, and followed by a description of recent challenges to medical authority and control, in particular as they are encapsulated in the movement to legislate and incorporate midwifery services. Because this research concerns the experiences of Canadian women, the focus of this review will concentrate on the implementation of midwifery and the responses to medical control in Canada. Next I present research that has investigated women's childbirth experiences from women's perspectives, and explore a growing body of recent work focussed specifically on birth narratives, their content, and structure. Finally, I conclude this section with a brief introduction to some of the work that has been conducted on the importance of Internet-based research and the ways in which the Internet may be a site well positioned to examine women's childbirth narratives.

A Historical Perspective on the Social Understanding of Childbirth

The biological processes of birth have not changed since the very beginning of human history. However, the ways in which birth is enacted as a human social event differs substantially between cultures and through time. In high-income nations, such as Canada, considerable changes have taken place within the last century, with the rise in power of the medical profession being at the core of these changes. The vast majority of births in our country today take place in

hospital under the direction of a medical professional, meaning that normative birthing practices are strongly influenced by hospital policies and medical ideology. However, this was not always the case. Up until the early 1900s, most women laboured at home with the assistance of midwives, relatives and other members of the local community. It is important, therefore, to briefly explore the historical process through which this transition took place and illustrate the features and implications of medically defined childbirth.

There is a substantial amount of literature that is devoted to exploring the "medicalization of childbirth" (See for example Arms, 1975; Oakley, 1984; Rich, 1986; and Wolf, 2001). Sociologists, in particular, have devoted a great deal of attention to understanding the process through which a biological condition falls under the scope of medical management in an attempt to explore the implications of medicalization on the social understanding of that condition. Peter Conrad offers the following definition: "*[m]edicalization* describes a process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (1992: 209 italics in original). Conrad points out that medicalization may occur on conceptual, institutional, or interactional levels, and that others, such as members of the public or other institutions (for example, government, legal, or corporate institutions) can be involved at the conceptual and institutional levels. Physicians, however, are most deeply involved in the interactional level and play substantial roles in contributing to medicalization at the other two levels. Sociological critiques, therefore, are often aimed at medical professionals, and the institution of medicine in general, for subjecting increasing portions of human life to medical control. Childbirth presents one example where this can clearly be shown.

Ann Oakley (1984) identifies two main stages vital to the medicalization of childbirth, both of which centre upon its inclusion into the domain of medicine and the resultant definition of childbirth as a medical problem subject to medical solutions. The first stage had its roots in the seventeenth century and involved the creation of a medical discourse surrounding pregnancy. Up to this point, pregnancy was viewed as a natural state and a healthy event in a woman's life, but the events and occurrences of prenatal development became increasingly subject to medical description through the use of medical terminology. Developments in anatomical and biological

knowledge of women's bodies in pregnancy and birth, as well as technological advancements in areas such as fetal assessment, characterized the second stage and led to changes in the ideology guiding medical definitions of human reproduction. Increasingly, the pregnant body became viewed as pathologic, and the doctor's gaze shifted from one of observation and identification to the assessment of deviations from normal development (Oakley, 1984: 12).

These stages of medicalization identified by Oakley, roughly equate to the two periods of obstetric specialization described by Mitchinson (2002). Originally, the role of these medical specialists in childbirth was to observe and intervene only when deemed necessary. However, the lack of a strong active role in a process still viewed as natural meant that other physicians questioned the appropriateness of obstetrics within the scope of scientific medicine. The increasing ability to establish normative patterns within labour and childbirth and assess deviations from these patterns was viewed as a means through which obstetricians could solidify their claim to an area of specialty, and take a more active role in ensuring that labour stayed on course. In order to strengthen the argument made by obstetricians that their actions were necessary, the obstetric literature increasingly borrowed from evolutionary arguments to distinguish the frailties of modern women incapable of birth without assistance from their less modern and more 'savage' sisters. Obstetric practice increasingly viewed pregnancy and childbirth as possibly pathologic in which technological advances and expert knowledge were necessary (Mitchinson, 2002: 52-4).

The development of the forceps is often cited as one of the crucial technological developments that advanced the power of medicine in the area of obstetrics. Adrienne Rich (1986) provides an historical overview of the incorporation of forceps into medical practice, demonstrating that the use and development of this technology often had little to do with the needs of women during labour. Forceps, invented in the late sixteenth century, were kept secret for almost 100 years by several generations of male midwives in the Chamberlen family of France before the secret was sold to obstetrical practitioners. They were employed at particularly difficult births, but their implementation was also tinged with aspects of medical monopoly and commercial gain (1986: 142-5).

After knowledge of forceps became public, Rich (1986) points out that their use was characterized by different trajectories for men and women providing birthing assistance in the 1700s. Some women of the time were openly critical of the use of forceps by male surgeons, and accused them of "using forceps to force labour prematurely and to shorten the time of normal deliveries, for their own convenience or for experimental purposes" (1986: 147). Despite the fact that access to forceps was not consistently divided along professional and gender lines in all high-income nations (for example, midwives in Sweden and Finland were trained in their use and employed them in cases of emergencies (See Benoit, 2000: 129-30), forceps continued to be used primarily by male surgeons, while female midwives remained less likely to rely on technological interventions.

Mary Lay (2000) notes that the appropriate use of forceps continued to spark debate amongst members of the American medical community into the early 1900s. The debate pitted physicians who believed that forceps should be employed only in extreme cases against those who thought their use could be beneficial to expedite all labours. What was not questioned, however, was that the use of forceps was exclusively reserved for physicians and the decision to rely on this technology was solely in the hands of medically trained professionals (2000: 56-7). Forceps became more commonly associated with a medical approach to childbirth and their usage indicated a growing belief among both medical personnel and the general public that birth required the skills, knowledge, and technology held exclusively by medically trained professionals.

Carr (1998) also identified that men's control of the use of forceps was one of the critical points establishing a greater role and power for men in childbirth practices, but demonstrates that male monopoly in medical training further barred women's participation in the growing profession of obstetrics. Strong patriarchal views, prevented women from apprenticing with trained physicians and attending university programs. These restrictions would begin to see some initial changes in the late 1800s and early 1900s, but women's enrolment in medical training did not show significant increases until the mid part of the 1900s. The first woman to practice medicine in

Canada was qualified in 1867, but was prevented from practicing legally until she was granted a license in 1880 (Carr, 1998; Library and Archives Canada, 2000).

Leavitt (1987) explores the increase in decision-making power gained by physicians attending women in childbirth in the United States during the period between 1880 and 1920. Early in this period, medical expertise was only called on to assess and intervene in cases of particularly difficult births. In extreme cases two surgical techniques were available to physicians of the day. The craniotomy, or surgical removal of the fetus through the vaginal canal, was by far the safer of the two for the mother, but was most certainly fatal for the fetus. On the other hand, a caesarean section could be performed at much higher risk to the mother. Although medical advice was respected on the grounds of scientific authority, moral and social factors (in which religious beliefs played a significant role), as well as the surgical skills and preferences of the physician, were key factors influencing the decision of the appropriate course of action. The authority of the physician was enacted and solidified by the ability to define the situation according to the moral and social values he held in the highest regard. The final result, therefore, was an increase in the role and status of the physician in the birthplace owing to this ability to make these life and death decisions.

Although Leavitt's (1987) study is based in the historical specificities of the late-1800s and early-1900s in the United States, the increase of physicians' power and authority in decision-making in childbirth was by no means unique to the US. Physicians' control over childbirth decisions increased during this same historical period in Canada. The power of members of the Canadian medical profession was one of the contributing factors that led to the virtual elimination of midwives as primary care attendants to women in childbirth during the late-1800s and early-1900s in this country (Bourgeault, 2000).

The specialized knowledge and skill set of physicians was gradually broadened permitting their role to change from one in which their services were requested only at difficult births to greater decision-making power during uncomplicated pregnancies and births as well. Oakley (1984) illustrates the development of prenatal care services in Britain that emerged in response to a perceived need to increase the overall health of the general population following

World War I. Although initial efforts were aimed generally at nutrition and health care provision, there was a gradual shift toward prenatal monitoring and diagnosis under the care of a physician with the use of technological interventions. The overall effect of this was to further solidify the power of physicians as the knowledgeable experts on pregnancy and, given that a prenatal relationship with the patient had already been established, it became a natural extension to provide continued care during labour and delivery. Mitchinson (2002) has shown that a movement to prenatal care in Canada occurred within a similar time frame as that of Britain and had similar results. She states, "[w]omen under the prenatal care of a physician had probably never gone to one so frequently. This could not help but deliver the message that they were somehow fragile, in need of care, and sick" (2002: 130).

Alongside increases in the perceived need for specialized knowledge and technological advancements, change was taking place in the location of childbirth. The hospital provided a central location and concentration of both medical personnel and technological implements. Since it was viewed as far easier to move the labouring woman into the hospital than to move all the amenities of the hospital into the woman's home, the hospital became the location of choice for the physician. The 1930s was the first decade in the US in which childbirth took place more frequently in a hospital than at home (Leavitt, 1987: 248). The Canadian situation, like that in the US, occurred within a similar time period, although under the direction of different policies. Powerful physician groups engaged in campaigns to ensure that midwives were virtually eliminated across much of the country, although the presence of midwives still persisted owing in large part to the vastness of the Canadian people and geography. Hawkins and Knox (2003) note that increased access to vehicles and improved road systems permitted physicians to extend the boundaries of their practices, and women to travel more quickly and comfortably to the growing numbers of hospitals. Public policy, such as the Hospital Insurance and Diagnostic Act of 1957 and the Medical Care Act of 1968, provided government funding to cover all hospitalization and physician fees and secured the dominance of physicians and the hospital setting as the appropriate caregivers and location for childbirth in Canada (Wrede, Benoit, and Sandall, 2001).

Although the process occurred at different rates, in varying degrees, and under the direction of differing policies (See Declerzq, DeVries, Viisainen, Salvessen, and Wrede, 2001 for a detailed look at these changes and the policies directing them in the US, UK, Finland and the Netherlands), the trend toward the increasing hospitalization of birth would occur in all Western industrialized nations over the course of subsequent decades. Midwife-attended homebirth would be virtually eliminated resulting in significant changes to the ways in which women experience childbirth.

The Foundations of the Medical Model

The medical approach to childbirth has been widely criticized by both academic feminists and those involved with the alternative childbirth movement. Academic literature on childbirth refers to the ideological approach underlying medical practice as the medical, biomedical or technocratic model (Cosslett, 1994; Davis-Floyd, 1994; Fox and Worts, 1999; Viisainen, 2001; Young, 1984;). The medical model, as an ideological approach to childbirth, contains several fundamental principles: a) it is rooted in patriarchal society; b) pregnancy and birth are seen in terms of pathology or illness rife with potential hazards and risks; c) technological interventions are required to diagnose and monitor these potential hazards and risks; d) pregnancy and birth are objectified, separated, and isolated from a woman's knowledge of her unpregnant self; and e) physicians' knowledge and authority are paramount and professional dominance exhibited by medical professionals is enforced in a way that creates the self-serving and cyclical power of the medical model itself. Given that the medical profession, and by association the ideological model from which members of the medical community draw their knowledge and techniques, plays a large role in defining women's experience of childbirth, it becomes important to explore the many ways that this model can influence women's experiences.

Mary O'Brien (1981) has posited that the core of patriarchal society is to be found in women's ability to birth and men's separation from their true knowledge of paternity, a difference that O'Brien refers to as differences in "reproductive consciousness". Women's intimate bodily connection to birth removed all doubt regarding their participation in the historical continuity of the

species, while men's exclusion from childbearing meant that there was a need for a system that permitted men to create their own legacy and ensure their place in history. The modern political system developed out of this need for men to stake their claim through the production of knowledge. The production of new ideas transcended in importance the production of future generations. O'Brien suggests that this emphasis on idea-production over biological reproduction is the basis for the creation of a dichotomy in which mind was valued over body and science over nature. Women's reproductive abilities tied them to nature and separated them from the world of science and technology. Men dominate in the non-natural sphere of science and technology where the primary aim is knowledge through the discovery of objective and empirically-verifiable truth, and ultimately control over nature.

Through this perspective, medicine, and the ideological approach of the medical model of childbirth, can be seen as a scientific specialty with foundational roots in patriarchal society. As O'Brien acknowledges, the obstetrician is a key player in this process.

> Men have brought to obstetrics the sense of their own alienated parental experience of reproduction, and have translated this into the forms and language of an "objective" science. Thus the process [of pregnancy] appears as a neat unilinear affair going on in women's bodies in a rather mechanistic way. (1981: 46)

Feminists have argued that the medical model is founded upon an understanding of health based in men's experience. Young points out that there is an "implicit male bias in medicine's conception of health. The dominant model of health assumes that the normal, healthy body is unchanging. Health is associated with stability, equilibrium, a steady state" (1984: 56). For women, on the other hand, good health is strongly connected to cycles of change. For a woman who is pregnant, these changes become more pronounced as monthly menstrual cycles are replaced with patterns of development that escalate into changes that can be noted by the hours and minutes up to and following birth. Young explains that even if their body is telling them that they are strong and healthy, the application of medical definitions of pregnancy may alienate the pregnant woman from her own understanding of her pregnant body. Incorporating these definitions into her sense of self may cause her to interpret the normal occurrences of pregnancy, such as nausea, shortness of breath, and discomfort, as complications indicating weakness.

One of the primary impediments to a medical understanding of pregnancy and prenatal development had been that the only visual cue to the existence and growth of the fetus was the mother's protruding abdomen. As a result medicine has developed a series of technological implements to assist in the process that Barbara Duden (1993) has referred to as the "skinning" of the pregnant body. From dissections, through x-rays and into the current days of ultrasound, medicine has been able to create visual reproductions of pregnancy that bring into view that which had only previously existed for each woman at the sensory level. The pregnant woman's field of reference shifts from what Duden (1993:91) refers to as a haptic state (existence through the sense of touch) to an optic state (existence through visual representation). She argues that pregnancy itself is transformed, such that what was previously accessible only to the pregnant woman, is now standardized through the use of visual cues accessible to all in the same way. Duden writes:

> The screen was so arranged that the pregnant woman could join her physician in real time to view the inside of her belly. She no longer had to rely on word of mouth or medical judgement to interiorize the emblem on the screen. With her own eyes, she could now pretend to see reality in the cloudy image derived from her insides. And in the luminescence, her exposed innards throw a shadow over the future. She takes a further step – a giant leap – toward becoming a participant in her own skinning, in the historical frontier between inside and outside. (1993:77)

Balsamo expands on the ramifications of ultrasound and other monitoring technology stating that "[t]he introduction of new monitoring technologies has the consequence of bringing both the obstetrician and the pregnant woman into a system of normative surveillance..." (1996: 90). She points out that not only does this technology significantly alter the role and experience for the pregnant woman, but it has implications for the power of the medical professional as well. Since it is the medical practitioner who holds the keys to interpreting the readouts on the machines and the photographs taken by the sonogram, it is increasingly the role of physicians and technicians to interpret the results and educate pregnant women of the processes that are occurring within their own bodies.

Technological advancements to assess and interpret the chemical transitions of pregnancy were also important contributors to the standardization of the experience of pregnancy and the removal of this experience from the unique vantage point of the pregnant

woman. Oakley concludes "it was the new understanding of reproductive hormones that most of all set the scene for the technological revolution" (1984: 95-6) and that "however imperfect and expensive, the A-Z test [early hormone-based pregnancy test] launched the modern era in which obstetricians would eventually be able to claim knowledge superior to that possessed by the owners of the wombs themselves, as to the presence, invited or uninvited, within" (1984:98).

In her historical exploration of the changes in subjective understanding of pregnancy, Duden notes that the quickening, or the first occasion that a woman feels her unborn child move within her, was originally taken as the first indication of pregnancy (1993: 80). Modern medical technology is thus credited with changing the experience of confirming the existence of a pregnancy. The internal sensations accessible and interpretable only to the pregnant woman were transformed to an external process interpretable through medical understanding. Mitchell and Georges (1997) in their cross-cultural exploration of ultrasound, further note that viewing the ultrasonic images has replaced the sensations of the quickening as "what makes the pregnancy feel 'real'" (1997: 398). They add that these images are not merely presented as a means through which the unborn fetus can be visually revealed, but rather that the fetus is embedded in its unveiling within the cultural and historical scripts employed to describe what the fetus is and what it means in its local specificities.

In short, through medical understanding and the use of medical technology, scholars argue that pregnancy and childbirth are separated and isolated from women's subjective experience in multiple ways. Usage of ultrasound and early pregnancy tests that can return a positive pregnancy test soon after conception are only two such methods. In labour, pain relief medication has also been criticized for removing women further from the realities of birth:

> As the epidural numbs the birthing woman, eliminating the pain of childbirth, it also graphically demonstrates to her through lived experience the truth of the Cartesian maxim that mind and body are separate, that the biological realm can be completely cut off from the realm of the intellect and the emotions. (Davis-Floyd, 1994: 1137)

Marshal and Woollett note, "the pregnant body is rendered as isolated from women's previous knowledge or interest in their bodies, and pregnancy is decontextualized – separate and distinct from women's prior histories and experiences" (2000: 357).

The assessment of risk, another key component of the medical model, has been described as "essential to the maintenance of an orientation to birth as a medical problem" (Riessman and Nathanson, 1986: 265). In part, this is because the concept of risk, as it is invoked in a medical understanding of childbirth, furthers the separation of the birth experience from a normal state of healthy living. All physical states are assessed to determine the likelihood that they indicate a deviation from normal. A pregnant woman is advised that certain activities, the consumption of certain foods, and a wide assortment of other aspects of daily life, to which one would likely give little thought outside of pregnancy, are now subject to additional scrutiny due to the possibility that they may involve an increased level of risk. All pregnancies are determined to be either high or low-risk, and the woman is reminded that her pregnant self is now different and subject to a system of classification that did not exist for her before conception. Risk becomes a tool of standardization against which all pregnancies can be measured and assessed (Riessman and Nathanson, 1986).

Lane (1995) adds to this critique by highlighting some of the key issues with regards to a risk orientation in the medical management of childbirth. First, a medical perspective on the assessment of risk has a tendency to overlook or under-represent the occasions in which the actions of medical practitioners or the introduction of medical technology increase the level of risk (iatrogenic causes). Second, the uniform application of risk categories to all women, despite the knowledge that most women will be low-risk, is a form of social control. There are no circumstances under which a birth will be classified "no risk" and women are acclimatized to the belief that their bodies are capable of failure. Third, medical criteria exclusively are used to establish the level of risk and other factors, and thus a woman's knowledge of her social, physical, and emotional states are devalued. Finally, an emphasis

on risk has the potential to undermine the importance of other factors, such as a woman's satisfaction and agency in her birth experience. Szurek points out that an emphasis on the concept of risk connects to broader themes within society concerning safety and moral responsibility and thus permits the self-perpetuation of the medical model by ensuring that medical definitions of birth stand despite critique from groups opposed to medicalization (1997: 292).

In her study of birth in the US, Jordan (1997) observes a hospital birth to illustrate the ways in which the lived experience of childbirth is separated from the medical experience of childbirth. In this hospital birth, readings from medical equipment are translated for the labouring woman and used to provide her with concrete evidence of the sensations that she should be feeling. The actual bodily sensations that she feels can be dismissed as the machines have provided all relevant information necessary for the medical personnel to define and assess the situation. The woman's subjective experience of contractions and sensations is separated, declared irrelevant, and replaced by the results of the monitors to which she is attached.

In discussing the use of fetal monitoring equipment in medically managed birth Cartwright concludes:

> The tempo and the rhythm of birth are completely embedded in the sight and sound of the monitoring equipment. The monitor is more than an uncomfortable belt around the woman's waist. It is the biomedical birth practitioner's most relied-upon tool of assessment, favorite security blanket, and crystal ball, all rolled up into one. (1998: 245)

The core problem, therefore, of separation and isolation in pregnancy and childbirth is that medical technology can remove women's subjective experience of pregnancy and replace it with its own ideology of empirically-verifiable realities:

> In ways that she cannot fathom, expert professionals claim to know something about her future child, much more, in fact, than she could ever find out by herself. Long before she actually becomes a mother she is habituated to the idea that others know better and that she is dependent upon being told. (Duden, 1993: 29)

Thus, at a point in her life when the potential for the transformation of her social identity is most poignant, the medical model of childbirth has been charged with the potential to

remove a pregnant woman's sense of agency and transform her unique connection with her own bodily experience.

Challenges to Medical Authority: Contemporary midwifery in Canada

The medical model has recently been faced with challenges from a variety of directions. In Canada, as in other high-income nations, users and practitioners of alternative health care have begun to challenge the very boundaries of medical definitions of disease and treatment. Critics of medical dominance in childbirth, in particular, have challenged exclusive medical control in all aspects of pregnancy. Both Tyson (2001) and Bourgeault (1999) point out that, although the medical profession had until recently been successful in virtually eliminating midwives in Canada (as evidenced by the fact that Canada had been the only high-income Western nation in which midwives had no formal legal standing), challenges to medical dominance have resulted in a consumer movement that has successfully lobbied for the inclusion of midwifery services in this country.

In 1994, Ontario became the first of five Canadian provinces to legally recognize midwives' right to practice as autonomous maternity care providers. British Columbia, Alberta, Manitoba and Quebec have enacted legislation since that time and other provinces are set to follow suit shortly. It should be noted that although legislation to regulate midwifery services was passed in Saskatchewan in 1999, the act was never proclaimed or implemented (ASAC, 2001; CAM, 2004; Hawkins and Knox, 2003;Tyson, 2001). Currently, there are over 400 midwives registered to practice in Canada (CMBC, 2001). Five of these provinces, the exception being Quebec, allow midwives to practice in either home or hospital in response to the needs and requests of their clients (ASAC, 2001). Quebec midwives currently practice in self-contained birthing centres, but there is a possibility that their range of practice may be extended to include home and hospital in the near future. Both Ontario and Quebec currently offer four-year baccalaureate training programs for midwives, and training facilities for aboriginal midwives exist in Northern Quebec (CAM, 2004). British Columbia began training new midwives in September 2002, through a program based on that offered in Ontario, and will undoubtedly see an increase

in the numbers of practicing midwives in the province in the near future as new recruits complete their formal training in 2005 (CMBC, 2004; UBC Department of Family Practice Division of Midwifery, 2002). A future baccalaureate program is currently being planned for the University of Manitoba to meet a growing demand for midwives in that province (CAM, 2004).

However, access to midwifery services is certainly not universal across the country, and in those provinces where regulations are in place, midwives tend to be concentrated in urban areas. For example, in British Columbia, of the eighty midwives registered with the College of Midwives in this province, fifty of them practice within either the Capital Regional District surrounding Victoria or in the Lower Mainland. One half of the remaining midwives practice in other areas on Vancouver Island or the Gulf Islands, while the final fifteen provide services in the interior, coastal and northern regions of the province (CMBC, 2004). Different funding models established within provincial health care systems also limit access to midwifery services. Currently, only Ontario, Quebec, British Columbia and Manitoba fund midwifery services through provincial health care plans, while the majority of women who seek midwifery in Alberta pay for these services out of their own pockets. Limited public funding is available through a hospital program established in Stonyplain, Alberta (CAM, 2004).

Despite issues related to access, midwifery offers new options for care in pregnancy and birth for Canadian women. In British Columbia, midwives attended 2.35% of all births during the period between 1998 and 2003. Although the hospital is still the primary location of birth, the proportion of midwife attended home births in BC has been steadily increasing in recent years. In 1998, midwives attended 178 home births, but by 2003 this number had increased to 289. Within this same time period the total number of midwife attended births climbed from 373 to 1012 (BC Vital Statistics Agency, personal communication, June 21, 2004). Although, midwifery services are certainly not available to all Canadian women, the rapid pace of expansion within the profession, new training programs, and pushes for legislative change in other provinces all seem to indicate that access to midwifery will only increase in the future. Indeed, in Ontario and British Columbia the demand for midwifery services currently outpaces the supply (CAM, 2004; Hawkins and Knox, 2003; Tyson, 2001).

Doulas have also seen a similar increase in numbers over the past few years. Hired and paid exclusively by the pregnant woman and/or her family, a doula's role is to provide the labouring woman with support, advice, and guidance independent of any professional primary health care provider. Although, their philosophy is similar in many ways to midwives, doulas are not trained to provide primary maternity care services. Their professional association, DONA or Doulas of North America, reports that it now has representatives in most Canadian provinces and every state in the US. Their statistics also show that membership has increased over 500% in the seven years for which data is available, from 750 in 1995 to 4,550 in December of 2002. Over 465 of these doulas are practicing in Canada with 58 in British Columbia (DONA, 2003).

Midwives, and to a large extent doulas, profess to practice from within a model of care that differs significantly from the medical model. This model, alternately referred to as the midwifery, natural, holistic or alternative model, is centred on a revaluation of childbirth as a normal and natural process in a woman's life. Midwives generally promote a holistic view of childbirth "combining an understanding of the social, emotional, cultural, spiritual, psychological and physical ramifications of a woman's reproductive health experience" (CMBC, 2001). As midwives are not licensed to perform a number of medical procedures and they practice according to a holistic philosophy that strongly objects to the routine implementation of many of these procedures, medical interventions and medical dominance in the childbirth experiences of midwives' birthing clients are likely to be limited. The overall extent of this limitation is, however, dependent upon both the approach and philosophy of the attending midwife, as well as the specific needs and interests of the woman who seeks her counsel and support. Also fundamental to the midwifery model of care is an emphasis on what is referred to as "woman-centred care" in which the needs of the woman are central, and a woman's right to make decisions regarding her pregnancy, labour and birth is respected. Appointments are scheduled to allow enough time to for midwives to listen to the concerns of the woman and provide her with advice and guidance that considers her wishes and needs (Hawkins and Knox, 2003). Since the role of a birth doula is to provide emotional and physical support to the woman, her partner, and other support persons during labour and birth, the presence of a doula contributes to a holistic approach to birth.

The medical profession has also responded internally to the challenges posed by public demands for more respectful care. Although many of these changes predate the implementation of midwifery services in Canada, consumer movements driving the acceptance of midwifery have also been important in fostering changes in the ways that doctors approach care in pregnancy, labour, and birth. Individual physicians and hospital policies have been prompted to include practices that reflect a profession more responsive to the needs of women in labour. A recent paper appearing in the *British Medical Journal* on the management of normal labour suggests the use of birth attendants to provide both physical and emotional support in labour, encourages physicians to be more accepting of different positions in labour, and to provide women with various implements to ensure their comfort (i.e. birthing pools, cushions and mats) (Steer, 1999). However, Fox and Worts caution that "hospitals' responses to the critique – the provision of birthing rooms and allowing newborns to room-in with their mothers – encourage women to assume more responsibility for the birth and care of their babies, while at the same time failing to challenge medicine's control" (1999: 330).

Despite the cautions raised by Fox and Worts (1999) that medical control itself is not being challenged, the information above illustrates that the *medicalization* of childbirth is possibly being challenged. As discussed earlier, medicalization hinges on the ability to create and successfully invoke medical definitions and to produce and reproduce what Brigitte Jordan (1997) has termed authoritative knowledge. According to Jordan, authoritative knowledge refers to the "knowledge that participants agree counts in a particular situation that they see as consequential, on the basis of which they make decisions and provide justifications for courses of action" (1997: 58). What these possible challenges to the medicalization of childbirth speak to is ways in which these definitions can be opened up and alternate forms of authoritative knowledge introduced. In this way it is possible to view the midwifery model as embodying its own unique knowledge system encapsulating alternative beliefs about childbirth. However, as discussed below, the contemporary situation is not simply a matter of two oppositional knowledge systems. When the two models are viewed from the perspective of processes involved in legislating and legitimating midwifery services, the relationship between them becomes much more complicated.

It is important to recognize that despite the challenges to the medical model (specifically those posed by the integration of midwifery services), medicine maintains a dominant position in negotiating the space and boundaries between the two ideological models or approaches to childbirth. Ivy Lynn Bourgeault (2000) points out that this unequal negotiation process still presents very real challenges to midwives in their attempts to provide care to their clients. In fact, it was the ability of medicine to define childbirth under its scope of practice and, thereby, eliminate others from the domain with legal threats of practicing medicine without a license that initially provided the impetus for some lay-midwives to begin to seek legal recognition of their status. Bourgeault argues that medicine has been a dominant force in determining the form and focus of midwifery practice every step of the way. In order for midwives to gain professional status they must seek training that differs in significant ways from their original apprenticeship approach and moves towards an education system similar to that faced by students entering the medical profession. To provide complete care to all women and honour the choices of women, it is important that they be able to provide care in both home and hospital. Physicians play a strong role in determining, first, if midwives can even have access to the hospital and, second, the form and administrative procedures midwives face once they arrive. In addition, each province has different administrative structures in place that guide the role, remuneration and access of the public to midwifery services (ASAC, 2001). The end result is that midwives may have to make major concessions in the face of the power of the medical profession in order to establish their status as professional autonomous providers of pregnancy and birth services.

Mary Lay (2000) examined the negotiations that took place within the boards and committees established to determine the conditions necessary for licensing midwifery services in the state of Minnesota. The committees, which included participation from both midwives and medical personnel, engaged in rhetorical debates that centred on the appropriate scope of midwifery practice. Frequently, Lay identified, the crux of the debate was centred upon the definition of "normal birth" and highlighted the differential knowledge systems of the medical and midwifery systems. Lay acknowledges the "uneasy relationship between the hegemonic, technology based knowledge system of medicine and the marginalized, experientially based

knowledge system of midwifery" (2000: 171). The challenge for the midwives became one in which they needed to demonstrate proficiency in the medical knowledge system, while establishing themselves as distinct autonomous care providers within a separate ideological system. Through this analysis, Lay clearly identifies the fundamental power of the medical profession to determine not only who can practice as a midwife, but the essence of what defines midwifery practice.

Lay (2000) also contends that much of the debate as to the appropriate scope of midwifery practice took place between differing factions of the midwifery proponents. In determining what knowledge counts, it was also necessary to establish the ways in which it was appropriate to acquire knowledge and understand the influence that different knowledge systems would have on the ways in which midwives interacted with their clients. Gloria LeMay, a midwife who has been "catching babies" for almost 20 years, provides a local illustrative example for this point. In BC, the professional status of midwife may only be granted to persons who successfully meet all criteria according to the College of Midwives of BC. LeMay has refused to participate in licensing exams that would permit her access to professional status. In her view, licensing procedures themselves run contrary to midwifery philosophy, and abiding by the regulations necessary to maintain professional status, she believes, will hinder her ability to serve the needs of her clients. The College has successfully sought an injunction against LeMay to prevent her from performing as a midwife in the province, but LeMay continues to challenge the authority of both the court and the College in determining who has the right to assist in care during childbirth. She is currently in the process of raising funds for an appeal to this decision (Vancouver Sun, 2002; www.glorialemay.com, 2003).

Davis-Floyd and Davis (1997) use the term "postmodern midwives" to describe the position and practices of contemporary midwives. These are midwives "who are educated, articulate, organized, political, and highly conscious of both their cultural uniqueness and their global importance" (1997: 320). They contend that midwives have had "to become almost hypereducated in the science of obstetrics" (1997: 319) to ensure their own authority in the face

of a powerful medical profession, and protect themselves from actions taken within a legal system that recognizes medical knowledge as paramount in establishing due diligence.

Foley and Faircloth (2003) build on Davis-Floyd and Davis's concept to examine how midwives employ medical discourse in their work narratives. Foley and Faircloth show that midwives are familiar with medical language and use this discourse to legitimate their own practice. They determine that the ability to draw from medicine was not considered participating in an oppositional belief system; rather it was used as a professional resource through which midwives were able distinguish themselves from medical practitioners while simultaneously establishing themselves as professional caregivers on an equal footing with physicians. Annandale's (1988) research on birth centre midwives also indicated that their practice involved finding a balance between obstetrically defined risk factors and women's expectations of natural birth. She states, "in trying to counter medical dominance, these center midwives had to 'engage' the professional medical model, using its very definitions to maintain the independence and alternatives they sought" (1988: 108). The final picture of contemporary midwifery is one in which the postmodern midwife must be able to engage with the medical model and blend it appropriately within her own practice to communicate her own competence in normative medical practices, procedures, and terminology, while still positioning herself ideologically as a unique and separate care provider focused on the individual needs of her birthing client.

In her study of midwives practicing at a birth centre, Paaige Turner (2004) has also arrived at similar conclusions with regard to the use of medical terminology among the midwives in her study. She adds that the midwives she studied were actively engaged in a process of negotiating definitions of what midwifery practice included and what it did not. Specifically, with the use of technology, she noted that birthing supplies closely connected with alternative birthing practices (i.e. birthing pools and herbal remedies) were prominently displayed, while those devices more commonly associated with allopathic care were kept out of immediate view. This is, however, similar to the manner in which hospitals keep medical equipment closely available, but out of view in cupboards and cabinets (Kerr, 2002). Additionally, Turner states that "[m]idwives discursively create a hierarchy of technology..." (2004: 657) to accomplish a number of interrelated

objectives. A hierarchy of technology permits midwives to make distinctions between low technology and high technology interventions. Adhering to practices that focus on low technology permits them access to technical devices and technical knowledge on behalf of their clients, while still laying claim to a low intervention approach. In effect, the (post)modern midwife is still able to claim specialized knowledge, while again blurring the boundaries between medicine and midwifery. Midwives who claim a low intervention approach preserve adherence to the midwifery model, but one has to question if this represents an underlying challenge to an overall belief system that emphasizes women's ability to birth without any intervention.

Although the recent incorporation of midwifery services in several provinces has introduced options for some birthing women in Canada, it remains to be seen whether this represents a real challenge to medical control and the medicalization of childbirth. What the growing number of midwives and doulas do represent is an increased interest in a model of care that professes to provide woman-centred care, recognizing the importance of social, emotional, cultural, spiritual, and physical aspects of a woman's birthing experience, with limited use of medical interventions. However, recent studies into the practice of midwifery have shown that legislating, regulating, and legitimating midwifery services may influence the ability of midwives to define a system of knowledge that is unique from that practiced within the medical model. Medical practitioners have played key roles in developing licensing standards and training programs for new midwives, and members of the midwifery profession have themselves engaged in rhetorical debates within the ideology of the medical model to determine the scope of midwifery practice and criteria for membership in professional associations. The "post-modern" midwife represents the new midwife who struggles to achieve balance between the pervasive strength of the medical profession and the medical model, and her own desire to claim professional status and represent the needs of her birthing clients. This debate, although crucial to understanding the contemporary context in which Canadian women give birth, does not illuminate how these issues are actually played out within a woman's childbirth experience. In order to see the effect of these possible challenges to medical dominance and the medicalization of childbirth, it is necessary to explore childbirth from

within the context in which it is lived. The collection of literature presented below has done just that, exploring childbirth from women's own perspectives.

From Birth Experience to Birth Story: Research into childbirth from women's perspectives

The preceding discussion has established several fundamental points critical to our understanding of the personal birth stories Canadian women have told over the Internet. First, much of the literature has split the cultural analysis of childbirth into two primary competing ideological models. While this has been crucial in highlighting the multiple ways in which the medical model can subjugate and change women's personal experience in childbirth, some would argue that it is a false dichotomy. Women who give birth do so from within the context of their own lives, within their own personal and cultural histories. Dorothy Smith proposes that expressing the social construction of people's lives in terms of competing ideological models in effect creates an ordered discourse that exists outside of the everyday/everynight experience of women, which "is a procedure that privileges the order of the discourse over the order of the actual" (1999: 61).

Second, although medicine maintains a prominent position, the body of work that explores contemporary midwifery in particular, has established that midwives use a blend of medical discourse and medical knowledge, while still adhering to an ideology that is specific to midwifery. The need for training, licensing, and professional legitimation requires that the postmodern midwife be able to move smoothly between ideological models. The boundaries between the two models are negotiated in a fluid process in which it is not always clear where one model begins and the other ends. The personal stories of women are likely to contain elements of the same process of negotiation in their narratives. If primacy were given to two competing ideological models, not only would the actual lived experiences of women be confined within these models, but the two models would also be positioned in binary opposition to one another creating what is likely to be a false sense of universal polarity. Differences between the two are highlighted, while similarities between and differences within are negated.

Some scholars maintain that there is no single definition of childbirth, even within the confines of either the medical or midwifery models. Rayna Rapp states that women who are pregnant are involved in an ongoing process of negotiation "...in which a woman reveals and embeds herself and her perceptions of her fetus in a language shot through with medical, personal, and communal resources" (1990: 31). Examining women's experiences of childbirth from within a framework that creates room for only two competing ideological models would deny the existence of any other meanings or definitions of childbirth that may be articulated in women's birth stories. Treichler (1990) also supports this view stating that:

> The crux of the problem is that childbirth is not a uniform event whose true meaning and real nature are universal and potentially accessible to everyone. Childbirth *is* what it means, and its meanings are so diverse as to be virtually infinite. (Treichler, 1990: 116, italics in original)

It is, therefore, critical that any examination of the experience of childbirth takes as its focal point the voices of the women for whom these experiences are most salient. Only from this central location will it be possible to explore women's experience of childbirth from the perspective in which it has been lived, and to explore the many ways in which women may interpret and understand their own birthing experiences.

In several recent studies that have taken as their core the voices of women expressing their own unique experiences of childbirth, the multiple definitions from which women can draw have been shown to be important in understanding what women value in their own birth experience. Davis-Floyd (1994) interviewed forty women on their experiences of childbirth, thirty-two of whom had hospital-based births and eight of whom opted for homebirth. In her research, Davis-Floyd shows that different women can employ medical definitions of childbirth toward different ends. Believing, on the one hand, in the power of medical control, and yet resisting the power of medical control can act to provide women with a sense of increased agency in their own birth experiences.

In their work, Fox and Worts (1999) conducted research with forty women who had recently given birth in hospitals in Toronto. Their results also show that, for these women, the concept of control varied considerably depending on each woman and the level of social

support that was available to her. Control could mean anything from controlling the interventions that were used to controlling her own ability to manage pain and anxiety. It is interesting to note, however, that anxiety in birth was often attributed to the concerns women felt over the application of various medical interventions. Viisainen (2001) spoke with Finnish women and couples who had planned homebirths and found that the meaning of control was again problematic. In this study, women distinguished between two types of control, control of external environment and conditions, and control of self.

Emily Martin (1987) conducted interviews with women to explore their use of language and imagery pertaining to their experience of menstruation, childbirth, and menopause. She found that medicine was a dominant resource used to describe these experiences and women's depictions borrowed extensively from images conjured through medical terminology and metaphors – images which focus on the body as machine and labour as productivity. The women in her research frequently told about their individual personal experiences in terms that accentuated elements of fragmentation and alienation of self from body, highlighting a core precept of the medical model that "your self is separate from your body" (1987: 77) Martin does note, however, that there were class differences in the use of medical descriptions and that, although far less common, women's descriptions also referred to non-medical imagery and metaphors.

By contrast, Pamela Klassen (2001) focussed specifically on the ways in which women who have chosen to birth their babies at home rely on discourses of religion and spirituality to make meaning out of their experiences. Whether it is specifically on the meaning of pain and power, or more generally on the meaning of birth itself, these discourses function as resources from which these women may draw to reach personal understandings. For example, on the subject of the creation of life, Klassen explains:

> [T]hese women are asserting on the basis of knowledge gained from their bodies that creating life is a powerful force. To make sense of this power they sought a diversity of religious languages and tools that have allowed them to 'procreate religion' – to make religious meaning out of the embodied memories of human connections forged in the process of childbirth. (2001: 64)

These studies have been fundamental in highlighting the multi-layered meanings that emerge when women describe their own experience of childbirth. In many ways this research is part of a larger movement within childbirth that parallels the resurgence in the women-centred approach of midwifery. Hand-in-hand with this resurgence and the challenge to medical authority have been feminist and consumer-based movements, which refocus on the importance of the experience of childbirth. It is not surprising, therefore, that an increased emphasis on personal experience of childbirth and a need to give voice to and share these experiences with others has resulted in a recent proliferation of birth stories of all kinds and varieties in a number of venues.

Stories about childbirth still persist at any occasion where women gather and the conversation turns to topics surrounding pregnancy and childbirth, but new locations for these stories to be told to new audiences are taking shape. Feminist texts written to educate women about modern medical childbirth used these stories to expose the medical model to critique. Examples of this include, Suzanne Arms classic work *Immaculate Deception* (1978), Margaret Atwood's (1977) "fictional" account that appears as "Giving Birth" in *Dancing Girls and Other Stories*, and more recently in the popular feminist writer Naomi Wolf's *Misconceptions* (2001) where she discusses her own emergency caesarean section. Mary Lay discusses the value of birth stories as educational devices within the lay midwifery movement in the US in the 1970s (2000: 68). Ann Marie Giglio compiled thirty-five birth narratives in her instructional guide to educate soon-to-be mothers about the "symphony of possibilities" that exist in modern birth (1999: xiii). Written birth stories have also found a special place among texts emphasizing the midwifery model of care. Ina May Gaskin (2003), a pioneering midwife in the United States childbirth movement, has recently published a *Guide to Childbirth* that begins with a substantial collection of birth stories of children born at the Tennessee farm on which she practices. Hawkins and Knox (2003) use snippets from birth stories to emphasize and illustrate their points on the value of midwifery care from a Canadian perspective. At one point they discuss the importance of written birth stories to midwives and their clients as a means to write and envision the ideal birth and to reinforce among birthing women a sense of accomplishment around the actual events of the birth (2003: 163-4).

Della Pollock explores performative aspects of birth stories stating that birth stories put the maternal body – in all its carnal, social, and political plenitude – center stage" (1999: 8). She presents a complex analysis of birth stories that examines what is revealed and what is hidden about birth and, in turn, what these stories say about who we are and the world that we create and recreate around us. On the nature of birth stories generally, she writes, "[b]irth stories migrate. They move in and through history, among tellers and listeners. They are mobile cultural fragments, renewed in affective alliance with other cultural parts" (1999: 22).

Tess Cosslett (1994) places fictional accounts of childbirth written by women at the centre of her inquiry into the ways in which women negotiate the space between the two competing models of childbirth. Although some of the literature presented refutes the belief that the models she identifies as the medical and natural models of childbirth are truly in competition with one another, her arguments lend support for those who contend that women in childbirth are involved in a process of negotiation:

> Thus, the consciousness of a birthing woman, whether constituted in an autobiographical account, or as a 'character' in a fiction, involves a process of negotiation with prevailing ideologies, whose aim it is, I would argue, power: in terms of writing, the power to take over the story, in terms of childbirth the power to control the experience; or, in both cases, the power to protest or celebrate lack of control. (1994: 3)

Tina Miller likewise conducted longitudinal research to investigate the ways that women construct narrative accounts of their childbearing experiences that allow them to "maintain unity in their lives" (2000: 309). Her work studies the metanarrative (from culturally embedded expectations), public (from professional or medical sources) and individual (from informal or lay sources) narratives of childbirth that women face as they create meaning from their own personal experiences. Her results show that women's "narratives are multilayered and complex and composed of public, lay, and sometimes personal narrative (and counternarrative) threads" (2000: 316). All of these threads must then be woven back together into a unified account of the events and the experiences that permit women to maintain a continuous identity as social actors in their own stories with the final version incorporating shifts from one sphere or ideological model to the next.

Jane-Maree Maher's (2002) work is also important in this respect, although she takes a different position than Miller and many other writers examining birth narratives. Maher argues "that narratives of birth in Western Culture are subject to the same degree of restraint as the women's legs in obstetric stirrups" (2002: 207). Central to this argument is the idea that stories of birth are produced in concert with social and cultural pressures that favour some narrative forms over others. Dominant themes and structures in birth narratives are proliferated in a process that permits prominent narratives to persist while the themes and structures of narratives of others are subjugated. The final result is that "the distance between the physiological act of giving birth and the cultural narrations of this act is maintained through structures that privilege certain epistemological models" (2002: 207).

As a partial validation of Maher's (2002) argument, reality programming has picked up on the stories of birth and packaged them for a television audience. Canadian television offers weekly birth stories on the Life Network on a program called "Life's Birth Stories". The Learning Channel in the US produces and broadcasts "A Baby Story", while British television offers "Birthday Girls". All of these programs follow women through the later stages of their pregnancies, throughout the births of their children, and as they adjust to life with a new baby. Carole Stabile (2001) has examined a few of these programs and warns that these television docu-dramas should be viewed with trepidation. She suggests that these "stories" are constructed and presented in a framework that serves more to reify than to challenge the dominant medical understanding of modern childbirth. Their increasing use for pedagogical purposes should be noted with caution as they function to educate women about medical procedures as normative and raise the profile of medical personnel to heroes who can do no wrong when it comes to matters surrounding childbirth.

Throughout the preceding discussion emphasis has been placed on the multiple definitions and multiple meanings that can be observed when childbirth is researched from the perspective of women's lived experience. The use of medical definitions, and imagery shaped by medical understanding were important elements in these experiences, but women also employed medical definitions toward different ends, and extracted meaning from their experiences based on

spirituality and other non-medical resources. Research into the topic of birth narratives specifically has also been an important means of exploring women's experience as it is constructed in story form. These stories are proliferating in many different mediums, including textual (both fiction and non-fiction) and televisions versions, but there have been no previous efforts to explore the construction and content of narratives located on the Internet. There is some evidence that stories told in text or on television are constraining these narratives such that they serve to replicate dominant ideologies, but analyzing Internet narratives may provide a different perspective. In the final section of this review, research on the Internet as a potential site for the distribution of personal narratives will be examined.

Birth Stories on the Internet

Another medium in which birth stories have found a niche, and the medium that forms the basis for this research, is the Internet. Birth stories on the Internet exist in considerable numbers and on a growing and changing selection of websites. These stories can be seen as part of a larger body of personal writings on the Internet that also includes stories of a wide variety of individual experiences and personal diaries and journals, known online as blogs. According to Mitra and Cohen, "the strength of the www [world wide web] stems from the authors' being empowered to produce texts and 'publish' them without the need for any mediation of a centralized publication and circulation system" (1999: 196). The strength of the Internet can also be located in the empowerment experienced by the reader of these personal stories. Reading stories of personal experience is a means of connecting with others, others who may have had similar experiences or others who may educate or enlighten the reader about alternative experiences.

McLellan (1998), in her review of the uses of the Internet for health-related reasons, has identified two general areas in which the Internet has the potential to change the ways in which health information specifically is gathered and disseminated. First, she points out that the Internet is widely used as a site of education about health and illness information. This increased access to information in both volume and scope, she believes, will influence the relationship between

care-provider and "patient", such that the overall effect will be an increase in the level of responsibility for health matters on the part of the "patient" and a more "patient-centred" approach necessary on the part of the care-provider. Second, she adds that ready access to personal experiences in the form of first-person narratives represents a unique power on the part of the patient to publicize information not previously widely available outside of edited volumes.

As Gillian Youngs also points out, the Internet may be especially well suited to the study of women's personal narratives: "The Internet era may be new but it builds on what has already been achieved by women in overcoming their social segregation to share and talk to one another and to work individually and collectively for social change" (1999, p. 64). Building on this, we can see that the Internet can serve several purposes for women in general, and women who have recently given birth in particular. Women who have recently given birth may be faced with a sense of social segregation that may be felt more acutely than in other periods of their lives. At home, and often alone, they face the many demands of a new infant. Physical recovery from childbirth, as well as the challenges involved in venturing outside of the home with an assortment of baby paraphernalia and the uncertainty of adjusting to the feeding and sleeping routines of a new baby may isolate them structurally within the home. A separation from previous co-workers and friends without children may isolate them socially from others whom they feel may be unable to relate to the changes that have taken place in their lives. The woman herself must make significant adjustments as she takes on the role of mother in an emotional, physical and social sense and may be faced with elements of that role in which she feels uncomfortable or unfamiliar. The Internet, then, can be seen as a vehicle through which some women may be able to connect with others who find themselves in similar situations and connect with the information they require to assist them in adjusting to their new role as care provider for a new infant. All of this can be done from the comfort of their own homes, and at times that permit them to work around the needs of their child and responsibilities in other areas of their lives.

It must be emphasized, however, that the Internet is not available to all and that the lines upon which accessibility to the Internet are drawn are strongly influenced by socio-economic indicators, such as income, education, urban/rural living, and age. In addition, the Internet is a

very public domain and not all women will feel comfortable opening up to a global audience to share such an intimate experience. In conducting this research, I want to be certain to recognize that my aim is not to explore how all Canadian women experience childbirth, but rather to examine the experience for those select, but influential, few who have chosen to make their experiences public by participating in an online environment to connect with others and share their story.

Summary

This literature review has provided an overview of the historical circumstances through which medicine gained dominance and the medical model became the fundamental ideology through which childbirth is understood. This medical model, however, has received extensive criticism from feminists both within and outside of academia for the ways in which childbirth is ideologically created as an illness, objectified and isolated from a woman's knowledge of her own body and her own health, and subjected to technological control and medical dominance. As a result medicine has responded by instituting changes in policy and procedure, and midwives have gained recognition as professionals who offer care that is respectful and responsive to the needs of women. There is still debate, however, as to whether these changes truly reflect a challenge to medical dominance and the medicalization of pregnancy, labour and birth.

In order to explore this debate and examine the extent of medicalization and medical control on a woman's understanding and experience, researchers have made a movement to view childbirth from the perspective in which it is lived. In this context, research can explore not only the scope of medical control, but also alternative non-medical means through which women understand their own births. An additional perspective that has been studied more recently is to interpret the ways in which birth is written in narrative form. Birth stories have been shared for generations, but new versions have appeared in texts for educating midwives and women about birth from a lived perspective. Fictional and non-fictional stories have appeared in written form, and the reality television craze has even picked up on these stories to provide audiences with depictions of "real" birth complete with commercial breaks and voice-overs. The Internet has also

become a distinctive space in which written stories can be told and exchanged, and it is these stories that form the basis for this project.

What these Internet narratives present us with is the opportunity to explore multiple meanings of childbirth as they are communicated in all of the complexity that is available to a woman who gives birth in a contemporary Canadian context. It may be the case that these stories serve to illustrate the pervasiveness of the medical model, or they may illustrate other ways in which women can create and contextualize their own personal understanding of their childbirth experience. Given that these stories have been written and exist on the Internet outside of the context of a research interview or other more typical sociological data collection method the opportunity presented is not only unique, but it also allows us insight into the narrative devices that women may use to communicate their experiences to others who are not involved in the research enterprise. It is to the collection of these stories and the implications of data collection on the Internet to which I will now turn.

Chapter 3

Methods

This research project has taken two distinct directions in the areas of data collection and interpretation. Before I begin to examine the specific tasks that were undertaken to collect and analyze the materials from my participants, it is first necessary to provide context into the use of Internet-based and narrative research methods. The first section of this chapter will provide additional information on the collection of materials from the Internet, including the advantages and disadvantages of Internet methods, conducting qualitative research online, and ethical considerations specific to Internet methods. This is followed by an overview of narrative analysis and narrative theory. Within this section I have explored the "turn to narrative" as it represents a shift in terms of not only a methodological approach, but also a means of interpreting how our lives are lived and given meaning within the context of story.

After establishing a basis for the methodological approaches used in this study, I detail the steps that were taken to collect the narrative materials from the Internet, administer the e-mail survey to potential participants, and apply a narrative approach to the analysis of the birth stories. Although ethical issues are woven into other sections of this discussion, I have included a specific section outlining the ethical considerations that were incorporated into this study. Finally, I end this chapter with a reflexive account including my own personal reflections on the process and implications of writing up narrative analysis.

Internet-Based Research Methods

The use of the Internet as a communication medium has exploded over recent years. Statistics Canada reports that 62% of Canadian households used the Internet regularly in 2002, representing a 4% increase from the previous year. This is part of a continuous year-over-year increase that seems to be levelling out due only to saturation among groups with high Internet usage (Statistics Canada, 2003). Such groups include persons with higher than average levels of education and income, and households with children living at home. According to a study of American Internet users, although women spend less time and visit fewer websites than men,

they are more likely to use the Internet at home. Additionally, rates of participation on the Internet by women are growing at a faster than average rate, with women's participation increasing 9% compared to an overall average increase of 6% (CyberAtlas, 2002). Canadian trends are likely to be similar to those reported in the US.

Not surprisingly, therefore, the power of the Internet to reach and be reached by multitudes of individuals is a factor that is gaining recognition among those collecting and interpreting data for social research. Much of the research of the past has focussed on the collection of quantitative materials through e-mail and online web survey forms. Best, Krueger, Hubbard and Smith (2001), Hewson (2003) and Smith (1997) are just a few of the many researchers that have employed Internet technology to collect data in survey form. Through this work several advantages of collecting data from the Internet have been identified, such as minimal cost with maximum reach, as well as the ability to transcend geographic borders and conduct non-intrusive research that might not be feasible if one were using face-to-face or other more conventional methods of data collection. The ability to conceal the identity of both researcher and participant has been suggested as an advantage with the potential to redistribute any imbalances in power that may exist within a face-to-face research relationship. Participants in the research can contribute their responses to questionnaires at any time of the day and night and from any location that is convenient for them. The textual-based nature of online communication means that time-consuming transcription and data-entry tasks are eliminated, however it must be cautioned that typographical errors, errors of omission, and difficulties clarifying the information collected in an electronic survey form may offset some of the advantages gained by the ease of access to data already in textual form.

Researchers using Internet methods are also quick to establish that the Internet exhibits its own unique set of methodological issues, particularly in the area of data collection. First and foremost among these issues is a need to understand that the subset of the population with access to computers and computer-mediated communication technology is demographically different than that of the general population and, therefore, the generalizability of Internet samples to broader offline populations may be limited (Best et al, 2001; Selwyn & Robson, 1998).

Although these demographic differences are likely diminishing with the increased distribution of the technology among the population over time (Hewson, 2003), the use of Internet-based methods may be best suited to researching specific online populations or populations which are otherwise difficult or impossible to access offline.

Both Selwyn and Robson (1998) and Smith (1997) caution that the increased use of electronic communication in our daily lives threatens to undermine the use of the Internet for research purposes, as potential participants venture toward becoming "overloaded" or increasingly suspect of unsolicited communication from a person not known to them. Surveys distributed via e-mail are easily deleted by the final recipient or blocked before they are even read by automatic spam filters designed to eliminate or isolate unwanted e-mail. Smith adds that in her research a number of the surveys that were distributed were "bounced" back as a result of incorrect or otherwise invalid e-mail addresses. Although occasionally there is an automatic message to inform the sender that the message could not be delivered, this is not always the case, and as a result, it becomes problematic for a researcher to determine precisely who or how many of the original requests for participation actually reached their intended recipient.

More recently, qualitative researchers have begun to explore the Internet environment to conduct interviews, focus groups, and analyze textual information posted online. Annette Markham (1998) has explored not only the lives of those who spend considerable amounts of time online, but also the process required by a researcher to begin to explore the web. She demonstrates in her work that there is a definite learning curve for those who choose to explore the Internet, but that once a certain familiarity is gained the Internet reveals a depth and breadth that is of value to explore in its own right. "[C]yberspace is not simply a collection of texts to analyze; rather it is an evolving cultural context of immense magnitude and complex scope" (Markham, 1998: 25).

Barbara Sharf (1997) has based her Internet research on a discussion forum for those whose lives have been touched by breast cancer. Her work shows that the Internet can be used by individuals not only for sharing information, but also as a source of social support and personal empowerment. Katherine Morton Robinson (2001) has used the Internet to collect caregiver

narratives and has also demonstrated that the Internet can be a valuable means and method for collecting meaningful textual data. Illingworth (2001) used an online method to examine women's lived experiences of infertility, and although she contends that the Internet offers many decided advantages over face-to-face methods, the medium itself should not be viewed as an "easy option". It is her belief that methodological challenges experienced through other approaches to data collection may be experienced more acutely online, including problems related to the representation of underprivileged populations and establishing the validity of a participants' contribution (Illingworth, 2001: para 7.2). Mitra and Cohen (1999) propose a critical approach to analyzing web-based textual material. They argue that there not only needs to be a focus on the text itself, but on the interrelations between individual texts, between writers and readers of texts, and on the multiple ways in which the text is mediated by the technological environment in which the text is created and exists.

Mann and Stewart (2000) have considered the multiple issues and challenges that may face the potential online researcher and produced a handbook to guide the qualitative researcher through the process of employing an Internet method. Many of the advantages to online approaches they have recognized are similar to those listed above, including the ability to extend access to participants across geographic borders and within closed communities, the potential to research sensitive topics, and the ability to collect resistance accounts or stories that counter the status quo. They argue that the ability of participants to access the research site from their choice of computer locations means that they are more likely to feel safe in a familiar environment and that this informal and anonymous forum may be more conducive to testing new thoughts and ideas. The specific challenges of Internet methods that they identify include the necessity for the research population to be computer literate, and difficulties in making contact and recruiting potential participants. Once e-mail addresses have been located for these potential participants the difficulty remains as to whether the address is valid, whether the potential participants check their e-mail regularly, or if they even read the e-mail at all.

One of the issues that many of these qualitative researchers have highlighted is the importance of ethics in collecting and interpreting online materials. Mann and Stewart (2000)

identify that the inclusion of web addresses in the research report may have the unintended effect of increasing web traffic to that particular site and that this increased traffic may in turn compromise any efforts made at protecting the identity of the participants. The researcher must, therefore, determine where to cross the line between providing adequate reference information and honouring the confidentiality of their participants. Sharf's work also identifies the importance of issues related to "privacy, confidentiality, informed consent, and the appropriation of others' personal stories" (1999: 245).

These issues are particularly salient when the content of the material to be analyzed exists online outside of the privileged confines of an e-mail, for example, information posted to a web forum, discussion list, or contained on a webpage. In many cases, these texts exist in a publicly accessible domain available to anyone with the technology and knowledge to retrieve and review them. Therefore, one could presume that their use for the purposes of research would be protected only by copyright regulations, much as any material viewed on television, read in a newspaper, or heard over the radio. Yet, there needs to be recognition on the part of the researcher that the material collected was never posted online with the intention of being included in a research project, and may contain content that individuals may be wary of sharing in another location or context. Although, opinions certainly differ on the reasonable expectation of privacy held by one who posts a personal opinion or story on the Internet, it is my belief that as researchers we are bound into a special relationship of respect not only with potential participants, but also with others in the research community who may wish to explore similar means of data collection. To act unethically or in ways that do not attempt to honour these relationships as completely as possible, we risk damaging the already fragile relationship between researcher and participant and "muddying the field" (Illingworth, 2001: para 16.2) for those researchers who follow in our footsteps.

It is within this context that Sharf (1999) and Robinson (2001) have developed a series of guiding ethical principles for those who choose to explore the Internet as a site for the collection of personal narrative data. The researcher should always ensure that the purposes of the research are not in conflict with or could not be potentially harmful to the author of any piece that

is to be used in the research. In this instance, Sharf maintains that the researcher can be critical, but should not provoke or embarrass the participant in her or his analytical work (p. 253-4). The researcher should also be sure to provide information to all potential participants that introduces the researcher, his or her role, the intention of the research, and, wherever possible, every attempt should be made to contact those individuals whose words will be collected as part of the research. This will likely involve contact via e-mail and, due to the concerns raised above with regard to e-mails that remain unanswered, a researcher can never assume that a non-response implies consent to participate. As with any other personal data collected in the name of research, all names and identifying information should not be included in the final report. In addition, the researcher should maintain an open and approachable relationship with potential participants, while demonstrating respect and sensitivity. Robinson adds, "If there is any doubt as to the appropriateness of including the data in a research report, the researcher should err on the side of justice, beneficence, respect for persons, and autonomy" (2001: 712).

Keeping in mind all of these cautions and guiding principles, I maintain that the Internet is both a valuable and important site of information for understanding social interaction. This is especially true when one considers the ever-growing role the Internet plays in our day-to-day lives. Tasks such as managing personal finances, reading a newspaper, and finding out information on entertainment choices have all been adapted to an electronic environment and are being utilized on a growing basis. We communicate with friends, relatives, co-workers, and online pen-pals (whom we may never anticipate meeting offline) through e-mail, web-forums, and list-serves. Digital technology allows us to take a photograph and send it via e-mail or post it to a webpage for others to view without the image ever being printed on paper. As the Internet expands it brings with it the increasing ability to bring us in closer contact with others around the corner or across the globe without our ever having to leave the confines established by our desks, computer and keyboard. We are thus ever occupying a place in which we are united with others on some levels, while maintaining distance in many other respects. On the impact of this technological conundrum, Markham states:

> As much as technology connects us, it also isolates us, with or without online forms of communication. This has serious implications for traditional notions of community, family, and the environment, but it isn't the technology that does it to us. We engage it. We live it. We choose it. (1998: 230)

It is vital, therefore, that as social researchers we continue to engage with the Internet to explore the ways in which it is shaping our lives (or, as above, we choose to allow it to shape our lives), and to work through the challenges and pitfalls of collecting and interpreting information from this medium to develop methods to employ to investigate it. This may not be true of all topics, but it may be especially true of those topics where the Internet itself is a fundamental component of the topic to be investigated. In the case of Internet birth stories, I maintain that this is certainly the case. These are stories that have taken on new shapes and have found a new niche on this medium. Although accounts detailing the births of children have been exchanged for generations, these versions are novel in the sense that they have not existed in this form or on this forum for more than a few short years. The Internet itself is, therefore, a fundamental component and exploring these stories further will give us a better understanding of how birth is experienced and communicated in a contemporary context. Later in this chapter, I expand in detail on the Internet method that I employed, as well as the revelations and the pitfalls that I encountered as I completed this investigation. Before I do so, however, it is first necessary to provide information on the narrative approach that was used to conduct this research.

Narrative Analysis

The use of narrative as a method within the social sciences has grown substantially in recent years. Through a review of the PsychINFO database, Hevern (2003) concluded that the number of studies using this method increased rapidly in recent years, a trend that is particularly evident in the most recent decade. Employing this same method to the Sociological Abstracts I was able to witness a similar pattern in literature specific to sociology. Roughly 68% of the total records in the database containing the keyword "narrative" were found in works published since 1995. Within the five year period between 1995 to 1999 an average of 270 articles with this keyword were published per annum, while for the period 2000 through 2003 this number jumped to 333. This increased usage of narrative as a means of collecting and interpreting data on

personal experiences and the assumptions that underpin this trend have frequently been referred to as the "turn to narrative" (see for example, Hevern, 2003 and Riessman, 2001).

Turning to narrative implies exploring "narrative as the organizing principle for human action" (Riessman, 2001: para 1). We may live our lives as a series of events experienced in day-to-day activities, but we give meaning to our lives as we construct them, order them, and represent them in the stories we tell to others. Bochner states:

> We narrate to make sense of ourselves and our experiences over the course of time. Thus, narrative is our means of recollecting the meanings of past experiences, turning life into language, and disclosing to us the truth in our experiences. (2001:154)

Hevern (2004) notes that the narrative perspective is founded in the interpretive traditions of sociology. These interpretive traditions can be traced back to the symbolic interactionist paradigm, which focuses on the significance of social interaction for the creation and interpretation of meaning. Social interaction, in large part, is characterized by communication, and communication, in turn, is highly dependent on the use of language as a symbolic system (Schwandt, 1998). A narrative, therefore, can be seen as a structured form of communication mediated through language expressed in the context of social interaction. Within a narrative we relate the events of our lives in storied form and, in so doing, arrive at a meaningful understanding of these events both for ourselves and for others.

Any given narrative is both formed of and given form through discourse. A discourse, broadly defined, involves the use of language in spoken, written, or unwritten forms, as is the case with symbolic exchange. According to Kahn, discourse incorporates "language domains" (1995: 6) that may be constructed within and evocative of ideological approaches. A narrative itself represents a distinct discursive structure. It is a recognizable construct of language that we learn to both interpret and produce in our relations with others. When we are told stories we anticipate a logical sequence of events that are meaningfully tied together and will unfold to reveal a final point. When we hear a story that seemingly has no conclusion, we ask, "what's the point?" When we tell stories we relate events in order and create a cohesive structure by means of a plot.

According to Polkinghorne, "[p]lot is the narrative structure through which people understand and describe the relationship among the events and choices of their lives" (1995: 5). Plot, therefore, forms the basis upon which the audience is able to interpret individual events and actors in the story as they contribute to the movement of the story toward the final point. Polkinghorne adds that plot serves several essential functions in narrative. A plot places boundaries on the narrative by signifying both the beginning and the end of a story. For the teller, a cohesive plot permits the selection of those events relevant to the story, and thus included within the confines of the narrative. Those events determined to be extraneous, hence falling outside of the scope of the story, are eliminated. The events remaining are presented in the narrative in temporal order. Finally, a plot identifies the meaning of each event as a contributing element to the story as a whole.

In interpreting narrative, it is important, therefore, to pay particular attention not only to the way in which a story is constructed, but also to the context in which it is created. Gubrium and Holstein write, "[a]s texts of experience, stories are not complete prior to their telling but are assembled to meet situated interpretive demands" (1998: 166). Josselson adds, "[n]arratives select the elements of the telling to confer meaning on prior events – events that may not have had such meaning at the time... In understanding ourselves, we choose those facets of our experience that lead us to the present and render our life story coherent" (1995: 35). Storytelling, therefore, is an active practice that we engage in to produce an account (or a story). The story is the interpretive site in and through which we communicate and give meaning to the events in our lives, and the stories that we tell are situationally dependent on the time, place, and person in whose presence they are created. Our stories are permeated with discourse, at the same time as they represent a unique discursive construction that is meaningful unto itself.

As personal accounts of meaning based on individual experience, one might ask the question: "how is this sociologically relevant?" Much as personal experience does not occur in a social vacuum, neither does storytelling. The stories of our lives are inextricably tied to the social structures, social actors, and cultural themes that weave their way into and throughout the stories we tell. When we tell a story we can see explicitly the social structures and actors that emerge in

the content of the narrative. "In what context does the story take place", and "who or what is directing the action" become important questions in assessing the meaning of a narrative. Implicitly, we can explore the stories more subtly to examine the ways in which the stories explore cultural themes and through which the teller of the story places her or himself in relation to these cultural themes. Riessman explains "[t]o the sociologically oriented investigator, studying narratives is additionally useful for what they reveal about social life --- culture 'speaks itself' through an individual's story" (2001: para 12).

When an individual creates a narrative account, he or she enters into a reflective process in which sense is made from the particular event by placing it in relation to that which is known from the past, anticipated of the future, and acknowledged from others (Miller, 2000). Additionally, storytelling is a social activity in its own right. A story is co-created within a specific context between teller and audience. Narrative construction, therefore, is an individual action that is socially mediated in several ways. For instance, how one creates an account of a life event is a process that incorporates the teller as a socially interactive agent, the context in which the story is told as a socially constructed forum, and the audience as a socially significant recipient and interpreter of meaning. As researchers we collect these stories in order to analyze the immediate content of the narrative, and the interpretive meaning contained within the story. In narrative analysis, therefore, we move from understanding the particulars of individual lived experience at the micro level to the general social processes and social world of the storyteller that is embedded in their story at the macro level (Chase, 1995).

Polkinghorne (1995) distinguishes between two related approaches that fall under the broad definition of narrative analysis. The first, the most common of the two, he labels analysis of narratives. This form is involved in collecting narratives from research participants and analyzing them in an attempt to discover similarities or themes between stories. The result is a thematic analysis of what is most likely an experience that is common to all of the participants. The second approach, retains the label narrative analysis, and refers specifically to those projects that construct a single unified story synthesized from the information gathered from several individuals. The research may be presented in the form of a novel, play, or some other form in

which one blended account is created from each individual's contribution. It is the former approach, analysis of narratives, which was used in this project. Polkinghorne's distinction, although certainly valid, is not widely applied by the research community engaged in work with narratives and the label narrative analysis is generally used as a broad descriptor of a variety of methods that use narratives as the primary component of investigation. Nonetheless, I believe it is valid to include his definitions to clarify the specific approach employed in this project.

Perhaps in support of Polkinghorne's argument regarding the need for specification among different ways of doing narrative analysis, Riessman, the author of a fundamental instructional text for narrative analysis, is quick to point out that "there is no single method of narrative analysis, but a spectrum of approaches to texts that take narrative form" (1993: 25). This knowledge can be perplexing to the researcher making an initial foray into narrative methods. When an investigator begins to question the appropriate analytical procedure to apply to the narrative materials collected, she or he is likely to receive a different answer for each source consulted. The key component, therefore, is that the initial research material, the final research project, or both must take the form of a narrative.

Narrative materials can be collected through several methodological approaches. Although interview methods (both group and individual) represent the most common means of gathering material in storied form, Coffey and Atkinson (1996) point out that participant observation and other ethnographic methods can also produce narrative accounts. Much of the work on conducting narrative analysis, however, relates to issues inherent in identifying narrative responses generated in the context of research interviews and focus groups. Mischler (1986) argues that typical interviewing practices involving structured interview schedules have emerged within the context of a stimulus-response paradigm, such as that used in experimental methods. In this manner the interview process itself becomes "a behavioural rather than a linguistic event" (1986: 10). When we place individuals in the position of participants/informants/respondents, they take cues and frame their responses within the context of a discursively created role. They play a part in the production of research by responding with answers that are tied to the questions that have been posed, and, hence not from the context of their experience as it is lived.

Chase (1995) has tested Mischler's ideas by examining three different sociological studies to compare standard research interviewing to narrative methods. For each of the studies, she shows how responses to questions framed in sociological terms (i.e. with the use of the variables that the researcher is interested in), even if the language used is common language, elicits responses from participants that take the form of sociological responses and thus are more closely connected to the researcher's own interests and distanced from the ways in which the experience is embedded and understood in the participant's own life. She writes "sociological questions fail to invite the other's story because they orient the interviewee to the researcher's interests ... [and] direct the other to the researcher's concerns and away from her own life experiences" (1995: 11). This provides support for Mischler's recommendation that an interview should be conducted in a way that provides participants with sufficient time and space to construct their responses in narrative form. Although this interview process may be extremely lengthy and require the researcher to develop thorough listening skills, he concludes that, "interviewing practices that empower respondents also produce narrative accounts" (1986: 119).

Outside of the context of the research interview, there is very little information related specifically to the analysis of materials already in narrative form. Riessman (1993) does, however, provide a few guiding principles for analyzing narrative materials. First, the narrative must remain intact. She writes:

> Precisely because they are essential meaning-making structures, narratives must be preserved, not fractured, by investigators, who must respect respondents' ways of constructing meaning and analyze how it is accomplished. (1993: 4)

The interpretive analysis of narrative material then turns to the form, content, and context of the story. How is the story constructed? What narrative resources or discourses are used in the telling of the story? In what context is the story told and how does this context influence the story that is told? If the story appears in written form, what elements are used in the text to construct the story and how do these elements illustrate the interpretive process of meaning construction that the teller has engaged in? How does the teller use his or her story to engage with an audience and what is implied in the relationship between teller and audience based on what is included in the story and what is excluded? These are some of the questions that a narrative

analysis will attempt to explore and these are all aspects of the narrative analysis I have conducted with the Internet-based birth stories.

Narrative analysis has been criticized by its reliance on individual accounts and its unsuitability to large samples. Riessman contends that "[t]he approach is slow and painstaking, requiring attention to subtlety" (2000). Certainly it is not a method that would be appropriate for all topics or all researchers, but it does offer unique insight into the significance of lived experience and the multitude of ways that lived experience is socially constructed and communicated. Paying attention to the subtle ways in which meaning is communicated in storied form will direct the researcher to common elements that enter the narratives, similar structural patterns in the ways the narratives are constructed, and cultural aspects of the stories that influence the process of meaning-making for each storyteller. For the researcher, stories also have the advantage of being accessible in many forms and through many means. They are written, as in the case of this project, but they may also be told in the context of an individual or group interview, captured in the field as part of an ethnographic study, or extracted from diaries, audio, and video journals. Narrative analysis, therefore, is a multi-layered approach that involves multiple possible means of data collection and diversity in the ways that this data can be analyzed.

According to Freeman (2004), narrative analysis, as a methodological approach for exploring the significance of lived experience as told in story, may be better suited to exploring human social interaction than other methods simply because the construction of narratives is a process that extends outside of the context of the research enterprise and into the ways in which we communicate with one another. Storytelling as a discursive device is cross-cultural and is probably as close to universal as any construction of language is apt to be. We are human, therefore we tell stories. In order to explore the significance of personal events and to illustrate how these events and tales describing these events locate us biographically, socially, and historically (Riessman, 2001:5), what would be more illuminating than to explore the stories that we tell.

Collecting Narrative Material from Online Sources

The following section presents an overview of the procedures that I followed to collect my final sample of 16 Internet-based birth stories. Throughout this overview I have contextualized the choices that I made and the actions that I took. As with any research there are virtually as many unique approaches to a project as there are researchers to investigate it. The procedures that have been explicated represent neither the only way, nor (as I discovered during the process of collecting the stories) the most efficient way to collect these materials. This discussion, therefore, addresses the issues related to collecting narrative materials from the Internet through the perspective of one who has chosen this path.

The process of selecting stories for inclusion in this research involved a multi-stage search process that started with a general search for websites featuring first-person birth narratives. The logical first step, therefore, was to begin with a selection of search engines. All search engines filter through vast quantities of material on the Internet and return matches or hits on a single or a group of keyword(s) resulting in a list of websites. Each search engine, however, begins its exploration of the Internet with a slightly different set of available websites and performs its search with slightly different parameters. In order to perform a comprehensive survey of the Internet to determine the scope and prevalence of Internet birth stories, I selected five independent search engines (Alta Vista, Excite, Google, MSN, and Yahoo) and performed a keyword search on the phrase "birth stories" on each one. My original intention was to include Northern Light, a Canadian search engine, to maximize Canadian content among the results returned, but it was no longer operational at the time this aspect of the data collection phase began and Excite was substituted in its place.

The five search engines each retrieved a different selection of sites, but with a substantial amount of overlap among the individual results. Yahoo and Google resulted in the greatest number of matches (121,000 and 119,000, respectively), while the other engines produced far fewer results (Alta Vista – 26,678, MSN – 21,353, and Excite – 94). It is important to note, however, that there is a continual ebb and flow in the material accessible through the Internet and the way the results are displayed by any search engine. Typically, those webpages that are

accessed the most frequently are returned at the top of the search. Therefore, while the material on the list is changing in subtle ways on a day-to-day basis, so also is the order of the list itself. There was no conceivable way for me to proceed through all of the webpages that were returned, so I employed a systematic approach that involved reviewing the list of websites returned by each search engine and adding every unique URL (Universal Resource Locator) to an alphabetical list. As I proceeded through the search results, I was able to easily identify duplicate sites. I halted the process of searching on each search engine when it became apparent that the majority of sites were duplicates of ones that had already been captured on the list. The majority of this work was completed between April and June of 2003, although some searching was done earlier to ensure that enough suitable material could be located for this project.

The final list included 542 websites of which 356 were checked for content and 233 were found to contain first-person authored birth stories. The remainder of the sites that were not checked were determined to be additional duplicate sites (i.e. different URL's that pointed to the same webpage), sites that were no longer active or valid, or sites that ended with an extension indicating that the page originated in a country other than Canada, and hence was unlikely to contain Canadian material. This would be an important component of the selection of individual stories as outlined below.

In part, the purpose of this research was to explore the Internet as a site for telling and sharing personal narratives, but in order to complete a manageable piece of work that also permitted me to explore the personal experiences of birth for women in a contemporary Canadian context, it was necessary to place limits on the selection of stories by establishing clearly defined criteria for inclusion. The criteria required that the stories be written in English by Canadian women describing births that took place between 1995 and present-day. Additionally, once the final sample was located it was necessary to choose a subset of stories to complete the narrative analysis. Four stories were selected to represent different birth experiences, both in terms of place of birth and practitioner present at the birth. More detail on the selection of this subset has been provided in the following section, entitled "Applying a Narrative Approach to the Birth Stories", on pages 59-62.

Geographic restrictions were placed on this study to limit the differences that would have resulted from international variation in health care management and policy. Although it is the case that there is a considerable amount of difference provincially in the provision of maternity services, it is not so great as the differences that are seen across international boundaries. The inclusion of a language component to story selection was unfortunate, as it meant that French stories written by French-Canadian women and stories by Canadian women written in other languages would be eliminated from the analysis. This is simply a matter of my own linguistic abilities, however it has been shown that English is the dominant language of the Internet. According to the Internet Society (quoted in Uimonen, 1998) approximately 80% of all Internet material is in English. Although it falls far outside the scope of this paper, the restriction of the majority of the world's peoples from Internet communication technology as a result of language barriers is undoubtedly a factor that deserves future attention. The criteria limiting the time in which the births took place was introduced to ensure that the births described all took place within a recent time period. The births that were selected took place within a time frame that has seen significant changes in the providers of prenatal and labour care, particularly the introduction of provincially registered and funded midwifery services, the decrease in family physicians attending births (CIHI, 2004), and the increase of doula services. In addition, this time period captures the majority of the relatively short span of the Internet, and it was rare to find a story that described a birth that took place prior to 1995.

Two final criteria involved selecting stories that described live births and included valid e-mail addresses. There are a substantial number of websites devoted to stories that describe stillbirths and miscarriages and, while these stories represent an important area for future research, the women (and occasionally men) who have written these stories have come to meaning in this experience through a divergent path. While I am cognizant of the critique of Della Pollock (1999) who argues that these stories are frequently silenced, my reasons for excluding these stories were not meant to continue to silence an already underrepresented population in research pertaining to childbirth and women's reproductive health, but rather to acknowledge that these stories are important in their own right. They require exploration that is far beyond the

scope of this project, and I simply cannot do justice to the complexity of these stories here. The requirement of e-mail addresses made it possible for me to initiate e-mail contact with the women who posted their stories online. By e-mailing these women I was able to inform them of the purpose of the research, solicit their informed consent to use their stories in my research, and gather additional information in the form of an e-mail questionnaire.

With a complete list of all of the websites from which the final stories were to be selected and clearly defined criteria to guide the selection process, I then began the time consuming task of searching through the sites to identify those stories that were eligible for inclusion in the project. At this early stage of the search process I relaxed the necessity for an e-mail address in an attempt to identify all Canadian women who had posted stories online among the final list of websites. Of the remaining search criteria, the one that proved to be the most limiting was the requirement of Canadian authorship. Canadian women frequently posted stories on sites that originated in other countries (particularly those from the US), the number of sites originating in Canada was limited (for example www.CanadianParents.com), and participation on sites of Canadian origin was not verifiably restricted to those from Canada. It was thus necessary to search through all of the sites to identify stories that contained geographic parameters indicating that the author was from Canada. These parameters included references to Canadian cities and towns, a profile of the author that included a Canadian address, an e-mail address that indicated that the author of the story was Canadian (i.e. an address ending with a .ca extension), and references to Canadian holidays (Thanksgiving in October) and Canadian restaurant chains (Tim Horton's). This second phase of the search process resulted in 43 websites that contained a total of 143 stories written by Canadian women. Because webpages can change and disappear without warning, once a story was located it was immediately copied into a text-based file and printed for future reference.

Of the 143 stories identified, 70 of them contained e-mail addresses from unique potential participants. There were several participants who had written more than one story, and I decided to include only the most recent birth story from each participant. The women who authored these stories were all sent e-mails between August and December of 2003. The e-mails contained

information to introduce the research and the researcher, and allowed potential participants to provide informed consent to participate in the project. This was done according to the guidelines indicated above by Sharf (1997) and Robinson (2001). In keeping with this ethical approach, it was not appropriate to assume that I had the right to use their narrative material in my research simply because it was publicly accessible. In addition, e-mail contact with potential participants permitted me to invite these women to include further thoughts and clarification on the stories that were located online and to complete a brief questionnaire to provide me with more information on themselves and their birth experiences. According to McLellan (1998), persons who make personal contributions to the Internet may regret the communication at a later date and the ability to recall or recant their words may not always be available. Providing informed consent to this research gave the women who posted their stories the ability to maintain control over the usage of their stories, as well as the opportunity to make alterations or additions to their stories if they chose. Interestingly, none of the final participants chose to make any changes and the stories that are included in this project are identical to the versions posted online.

Two weeks following the delivery of the initial e-mail a reminder was sent to all potential participants from whom I had not received any response. Each of the e-mails I sent were customized, such that the body of the e-mail contained both the name of the child whose birth was described and the website that the story was selected from. This was done for several reasons. First, women periodically posted the stories of the births of each of their children on the same website. I determined that only the birth story of the child born closest to present day would be included, as women's most recent birth experiences were likely influenced by their previous birth experiences. Occasionally, the birth story of the same child written by the same woman was located on different websites. Including the child's name and website information in the e-mail provided clarification as to which story and which version I was asking for permission to use. While it is certainly the case that the birth stories of different children born to the same woman will be different, it is also conceivable that stories appearing on different websites (even though they describe the same birth) might be quite different from one another. Customizing the e-mails also added a personal touch to each contact with a potential participant. I believed that if the women

knew that the request was not made as part of a large anonymous bulk mail-out, they may be more likely to read and respond to the request for participation. Finally, I felt that a customized e-mail would be less likely to be immediately deleted as unwanted spam from a stranger. One participant did admit that her automatic e-mail filter had quarantined my request, which resulted in a slight delay in her participation and provides an indication that, even though measures were taken, it was not possible to avoid the influence of all technological features for e-mail filtering.

Because I was uncertain as to whether women would prefer to respond to the questionnaire in the form of an attached Word document or in the body of the e-mail, I included and customized both in each e-mail. Although an attachment would be better to preserve the format of the survey, I was uncertain as to whether women would have access to the software required to read the attachment. Attachments are also frequently avoided because they are known contributors to computer viral infection. I felt it was best that my participants have the option of choosing the survey format that they preferred, and, indeed, participants used both. The added work was minimal when compared with the efforts required to locate the story in the first place, and I felt it was advantageous to make any and all possible efforts to maximize participation. Another possible method for survey delivery would have been to post the survey online at any one of several websites designed to collect survey information and include a link to the website in the body of the e-mail. This may have simplified the process of completing the survey and, hence, increased the participation rate. However, this would have added to the expense of the project, and may have compromised participant confidentiality. Also, the format would likely necessitate placing limitations on the character length of the responses. I am uncertain, therefore, as to whether this would have been a viable alternative for this project.

In total, 16 e-mails were received in response to my request for participation. All consented to have their stories used in the research and all completed the questionnaire providing substantial detail about themselves, their birth experiences, and their motivations for posting their personal narratives on the Internet. Thirty additional e-mails were returned immediately as a result of an e-mail address that was no longer current or valid. This is similar to the bounce-back problem experienced by Smith (1997) that was discussed above. Twenty-four e-

mails were sent into cyberspace and were never heard from again. I remain uncertain as to whether these e-mails were received and read and never responded to, or whether they never even reached their intended recipient. In sum, assuming that all of these unreturned e-mail addresses were valid, the final sample of 16 represents a 40% response rate, which is well within a respectable range for an unsolicited e-mail survey.

Reflecting back on the process that I chose to locate my final sample, I would contend that the key disadvantage to this approach was that it was extremely time consuming. My intentions upon starting out were to respond to concerns expressed early in the research that perhaps women would not post stories in numbers sufficient enough to complete my analysis. As the project developed this possibility grew more and more unlikely. The approach that I used was successful in capturing a snapshot of the Internet in its full complexity, but perhaps this was unnecessary. As Robinson (2001) points out, narratives on the Internet are ephemeral. New stories reappear on a daily basis and computer memory and access to web-space means that other stories will disappear without warning. The snapshot of the Internet that I attempted to capture, therefore, only represented the slice of time that existed between the moments pinpointing the start of data collection and its completion. As I moved progressively through my lists the ground that lay behind me was slowly shifting and reshaping itself, and thus the entire conceptual plan to capture an Internet snapshot becomes seemingly irrelevant. I can definitively state, however, that although the specific content of the Internet stories that I located in my research would have been different had the data collection period been altered, the overall content of the Internet is unlikely to shift far from its own centre within a relatively short span of time. A more efficient approach may have been to purposively select a number of websites to represent a range of different types of Internet sites. For example, one could select a purposive sample of stories located on personal homepages, commercial public interest pages, and pages promoting or supporting given choices in birth (such as pages dedicated to vaginal birth after caesarean or VBAC, unassisted birth, or birth in water).

The questionnaire data collected were used to provide a demographic overview of the participants, contextualize the information that was contained in their stories, present the women

with a forum to discuss their motivations for placing their stories online, and permit them to clarify or add to the narratives if they wished. The information they provided in the questionnaires was extremely detailed and at times went on at length about their past birth experiences and personal philosophies surrounding birth. For the women whose stories are highlighted in the analysis section of this thesis (Chapter 4), I have used their individual questionnaire results to provide a brief introduction to the story and the woman who wrote it, including demographics and a profile of her birth history. I have included a complete version of the survey questionnaire, as well as the letter of consent in the appendix to this document.

Applying a Narrative Approach to the Birth Stories

The narrative material collected also proved to be rich in detail and description. Each woman's story was undeniably unique, but there were common threads that wove their way through all of the stories. The process of analyzing the narrative material, therefore, focused on what was unique about each story while paying particular attention to those aspects of the stories that crossed from one to the next. The analysis concentrated on broad narrative elements, including plot (the events included within the stories), context (the location in which the stories were told), and structure (the form the stories took), as well as specific narrative elements, such as pronouns, voice, and metaphor. In conducting the analysis it was necessary to read through each of the stories multiple times. Through the first readings of the stories I became increasingly familiar with the events of each story and the language used to construct these events in narrative. Following this I proceeded through each narrative line-by-line, systematically processing the stories by placing my analytical comments and reflective notes in the margins.

Typically, narrative analysis involves the creation of a cohesive narrative from interview materials. This may involve an interactive process in which the researcher returns to the participants with the storied form of the interview transcripts for clarification, and researcher and participant work together to construct a unified story (for a description of this process see Leja, 2001). One of the key advantages to this project was that the materials collected were already in storied form. It was not necessary to return time and again to the participants to construct a narrative, because the narrative version of the events of their births already existed in its final

written form. Yet there remained a process of co-construction in the final analysis of the narrative material. Rather than returning to the participants, I returned to their stories. Upon each read through I reflected on their stories from my own shifting position relative to my interpretative readings of other material and other stories. Concurrently with this process, I began reflecting upon the best way to present, in analytical form, both the original birth narratives and my reflections on these narratives – my story on their stories.

There simply is not space in this project to include an analysis of each of the 16 stories. The final analysis, therefore, is a presentation of four complete birth stories followed by my analysis of each story. Following the advice of Riessman (1993) presented above, these four stories will appear in their entirety and, as much as possible, the original formatting choices of the author will be preserved. Since a narrative is an interpretive composition in which an individual makes meaning from life experience by constructing it in story form, fracturing their stories into analytic chunks for the purposes of presentation would disrupt the meanings and identities they have constructed in the process of creating and telling their story.

In addition, I envision this work as a collaborative project. For me to break their story into segments that have meaning for my purposes would privilege my analytical framework and voice over that of the women who wrote the stories. I am aware that my role as analyst and writer places my voice in a privileged position. I have selected the words to inform you about this research, I have selected the method through which to perform the analysis, and I have selected the stories to present in the body of the text. What I cannot do is tell you how these women experienced childbirth. That is their story to tell and I will leave intact the words and (as much as possible) the format in which they chose to do so. I acknowledge that there remain issues with removing these stories from the web-based format in which they originally appeared, but I believe that this method of presentation is best suited to creating a final document in which my participants' stories are honoured as they co-contribute to the final document.

The four stories that I have chosen to include in the analysis section of this thesis (Chapter 4) were purposively selected to embody a cross-section of different birth experiences. These stories have been highlighted because they reflect both the diversity in my sample and a

range of some of the possible birth experiences and birth attendants available to women in a contemporary Canadian perspective. Each of the stories displayed a significant amount of variation in how the events of birth were perceived and how perception of the events was communicated. These differences can be seen in the narratives in two distinct layers. The surface layer includes the content of the narrative, including the events that transpired, differences in practices and procedures used, as well as the range of practitioners and others present at the birth. The second layer involves subtle differences in the usage of language. It is within this layer that I have explored specific narrative elements, such as the use of pronouns, metaphors, and Internet specific textual conventions. The analysis of each story moves through these layers to illustrate how each woman presents and projects her own understanding of childbirth.

For each story included, there are three more that were excluded. Unfortunately, time and space do not permit an extensive examination of each of the stories. This is not to say that each participant did not contribute to the final analysis. All of the stories told a different tale and all of the stories touched me and/or caused me to reflect on the sociology of birth in a new way, including reflecting on the stories that are included in the analysis. I have decided, therefore, to present the remaining stories in the appendix of this document. They are there for you to review, engage with, and enjoy, and although they will not contain the analytical detail added to the others (*my story about their story*), they are *nonetheless a key part of this project and have* unquestionably woven their own thread into the overall discussion.

After the full birth story is presented, my story/analysis will follow. Just as space does not permit me to include all of the stories, neither does it permit me to expand upon all of the material that is present in each story. What I have chosen, therefore, is to select a number of elements from each story that are key to the development of a broader understanding of the process through which each woman negotiates her own course between her own experience and the social structures and cultural themes in which her personal experience is embedded and explored.

I also want to emphasize that my analysis of their stories represents my personal reflections on their stories as they were told and in the context in which I read them. I have used a

change in font to indicate a shift between their story and my own, and visually create a distinct space in which my voice is presented separate from my participants'. Just as the women have written their stories about their own birth experiences and that is their story to tell, I have my own story to tell. My story reflects the content of their stories as I see it. As a reader, I bring my own interpretive framework into creating meaning from what I read. My framework is a reflection of what I bring into their story as a reader, and may include who I am, my own personal experiences, my purpose and intent as a writer of a Master's thesis, and all of the perspectives of others with whom I have engaged at some level. What I have tried to provide for my readers is a deeper understanding of the process that I participate in as I engage with their stories. What I hope that I have accomplished is to open up the process through which a new text is created, a text, which is itself, an engagement with the texts of others.

Ethical Considerations

I have already expanded on some of the procedures that I implemented to ensure that my participants were informed of the purposes of the research and given the opportunity to provide informed consent to participate. Participants were encouraged to make alterations to their stories as they appeared on the Internet if they wished. They were informed that they were not required to complete the survey questionnaire or that they could leave any question on the survey blank if they chose. All participants were thanked for their participation and encouraged to contact me via e-mail if they had any future questions or concerns.

With regard to the narrative materials, I have removed all personal identifying information from the stories. All names of the participants, their families, friends, and attendants have been removed from their stories and replaced with initials (not necessarily the original initials of the participant). I have placed the relationship of each individual mentioned in the story to the author following the first inclusion of their initial. Where the same initials represent different individuals in the same story, the relationship has been included after each occurrence for clarity.

This project has received ethical approval by the University of Victoria Ethics Review Committee on Research and other Activities on Human Subjects.

Reflexive Account

Much of this project has seemed to unfold before me in a series of logical steps. I chose to explore issues related to the sociology of childbirth because they have always fascinated me. The first time I read Suzanne Arm's classic, *Immaculate Deception* (1975) I knew I was hooked. In 1991, I wrote my first academic paper on midwifery for an undergraduate course on mothering. This naturally extended into my undergraduate thesis work in which I interviewed Ontario midwives about their views on the incorporation of midwifery into the Ontario health care system. Faced with the prospect of a large independent research project for my MA degree it was not surprising that I again decided to explore issues related to childbirth. I quite literally stumbled onto Internet birth stories when I searched the Internet for information related to "Life's Birth Stories", a Canadian television program devoted to exploring the "real" experiences of women giving birth. When I discovered that typing the phrase "birth stories" into the computer opened up a world of first-person narratives describing personal experiences of childbirth, I immediately realized that I had located my thesis topic. Even the method I selected to analyze the stories seemed to be the logical next step. I was collecting narratives; therefore a narrative inquiry approach seemed a natural fit.

I set out on the journey and eventually began the process of systematically processing a mountain of information on the Internet to locate my final sample. Flash-forward several labour intensive months and I now had 16 women willing to participate, 16 questionnaires filled in with tremendous detail, and 16 vivid first-person accounts of birth to use in my research. I will admit that at this stage I was stymied. "Now what?" I pondered. I had read the work of Riessman (1993) in which she explicitly states that narrative material should be left intact and not picked apart for the purposes of analytical review, but how was I to create a single unified analysis of 16 very different narratives from 16 very different women.

The dilemma, as I saw it, was that either I abandon Riessman's guidelines and filter through all 16 narratives to select only those elements pertinent to the analysis, or I present the narratives in their entirety and create what could possibly be a very cumbersome and unfocused document. My solution, as I have detailed above, was to limit the sample size and focus on four

of the stories in their entirety, providing them as case studies. In order to create a final project in which women's voices were honoured and women's experiences valued, I felt it would be best if these four women were given the space in which to tell their own complete story. Unfortunately, this necessitated that twelve women's stories wouldn't be incorporated in the analysis section at all, but I knew that I simply could not present all of the stories and believed that this was the best way to resolve my dilemma. The analytical component that follows each narrative then becomes my story on their story. The final result is a document, which is in many ways unconventional. It contains large sections of uninterrupted "dialogue" from my participants, and font changes to indicate shifts between my analytical voice and my participants' narratives. Even within the stories themselves, textual changes appear in which my participants have changed fonts and included bold-face type for emphasis and to differentiate their own voice in the narrative present from their voice narrating the events of the past – what appears as their own personal reflections on their story.

In many ways, however, I would argue that narrative methods encourage the development of unconventional means of thinking about and writing up sociological research. In May 2004, I attended a workshop at the Narrative Matters conference in Fredericton, New Brunswick in which one of the participants stood up and asked a question regarding establishing validity through narrative methods. I remember thinking to myself how out of place this question seemed. Yet just a few short years before this question had seemed perfectly acceptable when sitting in a class discussing qualitative methods in general. The narrative approach to data analysis is certainly a method that falls well within the confines of qualitative inquiry, so why then would this question strike me as strange. This was a point, which I believe was pivotal in my own understanding of narrative methods.

In the time between my undergraduate years and my graduate education, I have witnessed what seems to be a deepening chasm between quantitative methods on the one side and qualitative methods on the other. In my initial exposure to research methods as an undergraduate student both approaches were presented in the same course without a need to differentiate between the two. Sometime between then and now, the two approaches have

become separated, and even though researchers may employ methods from both camps, the distinctions between the two seem to me to be increasingly solidified. While in some instances this may seem divisive, it has also highlighted the strengths and weaknesses of each approach. If one chooses to engage with the broad spectrum of methods included within the domain of qualitative methods, one must inevitably question some of the assumptions established within the quantitative tradition. Concepts such as reliability, validity, and generalizability are put to the test and replaced with notions that include (among others) transparency, and reflexivity. The grand purpose in qualitative methods seems to involve working towards a better richer understanding of the social world through an investigation that not only explores the complexity of the phenomena under study, but also the role and position of the researcher within the project.

Much as qualitative methods have pushed at the boundaries of quantitative assumptions, I would argue that narrative methods have begun to experience some limited success in extending the peripheral boundaries of qualitative inquiry. Concepts such as transparency and reflexivity become not just principles to work towards, but rather underlying assumptions of the entire activity. When our participants tell us a story in the course of a research project, the context through which we analyze their story necessitates that we consider our position not only as a researcher, but also as the intended audience for the narrative. Within our research we must make our position transparent and reflect on the role of our position in the creation of the story itself, simply because our placement as audience is a fundamental component to the activity of storytelling.

Perhaps this is why the question of my fellow conference participant struck me in the way that it did. Each time an individual tells a story it will be a different account. Changes in language will undoubtedly occur from one version to the next, and more substantial changes in the events included in the story will occur in light of when the story is being told, to whom, and for what purpose. Questions of validity and reliability become somewhat alien concepts in this context, as there is no possible way to replicate the process of storytelling from one instance to another and arrive at the same product. Even if the story itself did not change – for instance if we were watching a film version or reading a written account, our interpretation of this account will change

as we reflect on it from our own continually changing subjective positions. This is certainly the case with the Internet birth stories I have collected. Even though the stories that are presented here have not changed in their textual form from my initial contact with them, I have changed as the reader during the course of this project. It is imperative, therefore, that I make my own position transparent and that I reflect on my contribution, because who I am, the location from which I read these stories, and the purpose for which I read them are all significant contributing elements to the process of storytelling.

To view the products and the process of research in this way involves turning the entire enterprise on its side. As I have become more deeply engaged in the process of analyzing the stories of others, I have come to the realization that what I am participating in as I write up this project is an act of storytelling. My thesis, therefore, can be viewed as a story. It is a story in which I communicate to you, my reader, why my research has meaning, what I did to accomplish my research, and what I found when my research was complete. As I have engaged you (hopefully) with the story of my research, I have endeavoured to make my position within this research as transparent as possible. Although this specific section of the thesis is reserved for critical self-reflection on the process of the research and the role of the researcher, I have attempted to maintain a reflexive perspective throughout this entire document. As any given story is as much a reflection of the events that have occurred to the individual teller as it is of the ways in which they have interpreted and made sense of those events from within the context of their own lives, so too this thesis is a reflection not only of my own contribution to the understanding of Internet birth stories, but it is also a reflection of me.

This thesis as story is, however, not merely a reflection of me, it is also a refraction of me. I have been permitted a space in which to tell the story of my research, but I have been given limited liberty with the overall structure of this story. If narrative lends itself to unconventional texts, the thesis is a textual structure that hinges upon conventionality. The structure of the sociological thesis has emerged directly from a framework with foundational roots in the scientific method. When I participate in the process of reviewing past literature, collecting materials for analysis, and writing up my findings I am invariably engaging with these foundational roots. I set

out to illustrate my own unique contribution to understanding on my topic, but I must frame my discussion within a very specific discursive structure. The story of my thesis cannot unfold in a manner through which I create my own interpretive meaning from the events, but rather I must adhere to the structure and communicate meaning from within this predetermined framework.

In many ways this structure is not foreign to me. I have learned to participate with this structure through many years of university education. I have learned to structure my arguments so that they (and I) can be evaluated, and so that others trained in the same process can readily extract my meanings. In writing this thesis, I have turned to my colleagues to establish how they have implemented the structure within their own work and determine how I should employ the same structure to engage my own materials.

The disconnect that I have experienced in this process occurred when I was faced with incorporating the stories of others within my own work. Upon coming to the realization that I could not disturb the integrity of my participants' stories, I felt a keen sense of uncertainty with the next logical step. The challenge that I experienced seemed to be related to the necessity to blend the conventionality of the thesis structure with the unconventionality of the stories of my participants; to make one type of story fit within the confines of another. This fit did not seem to be natural and at points it felt as though I was trying to place a round peg in a square hole. The decision that I eventually reached to limit my sample size and present only a few of the stories in their entirety was a compromise that involved reshaping the collection of stories, while at the same time rounding out the holes into which they would fit within the body of the analysis section. The result of this process in no way represents the only way to solve this dilemma, but it does represent the way which I deemed to be the best fit at this time.

What I have offered in this account are my reflections not only on the process in which I participated while conducting and writing up this thesis, but also on the process of writing up sociological research in general. This, I believe is one of the key advantages to the narrative approach. It allows us to consider in a new light not only what we write up, but also how we write things and why we do so. Recognizing that the thesis is a structured story, whose structure has emerged from a long-standing tradition within the academic community allows us to accept that

these structures in which we discuss the social construction of the world around us are themselves structures embedded in the same social world we describe. If one of the goals of sociology is to explore the workings of our social world in an effort to mobilize social change, then perhaps one of the changes that we can entertain is the incorporation of unconventional approaches to writing up research. At this point I am not suggesting radical immediate change, but perhaps we could begin the process of pushing the peripheries one story at a time.

Summary

The preceding chapter has provided an overview of both Internet-based research methods and narrative analysis to contextualize both the location in which women's birth stories were found, and the analytical approaches that were used to interpret and explore them.

Internet methods represent a diverse, rapidly growing, and shifting field, but one that is vital for sociological evaluation. The Internet is changing the ways that we communicate with one another, and in the process it is changing the ways that sociologists can reflect on and research modern communication and interaction. The technology of the Internet allows research projects access to unprecedented speed and reach, and permits investigation in many different forms on a multitude of different topics. Researchers who decide to pursue Internet-based methods need to be aware, however, that the attributes of the technology can also make it potentially challenging. Access to the Internet is not evenly distributed amongst the general population, rapidly expanding instances for Internet-based communication may threaten to overload the population, and investigators need to pay particular attention to ethical issues specific to this forum.

Narrative analysis also represents a diverse emergent method and area of investigation. Narrative data can be collected through a variety of means and have the potential to be empowering to research participants. On a simple level narrative analysis involves the study of stories, but researchers in a variety of fields have explored the intricacies of story as meaning making structures in which and through which we embed ourselves and our audiences personally, socially, historically, and culturally. By exploring the stories that we tell, we reflect on who has told the story, the context in which the story was told, how the story was created, what purpose it serves, and what it tells us about the interaction between storyteller and audience.

Studying a story involves the researcher in an interpretive process of exploring the ways in which meaning is created and expressed in the content and context of a narrative.

I have brought these two methodological approaches together as I have collected and interpreted women's birth experiences and the stories they have told about these experiences on the Internet. The methods that I employed to gather the stories and survey responses from my participants were time consuming, but they were successful in bringing together a variety of different stories from different women across Canada. Without the complexity of the stories that these women told and the details they shared with me in their thoughtful survey responses, the analysis would not be nearly as comprehensive. The following chapter provides a detailed exploration of the survey and narrative materials.

Chapter 4

Analysis

The following analysis explores three different but interrelated aspects of this project. In the first section, I have presented selected results from the e-mail survey to provide information on the demographic and birth experience profile of the women who participated in this project. This section of the analysis contextualizes the narrative information that will follow and demonstrates the ways in which this sample of women selected from the Internet is both similar to and different from the general population of women who give birth in Canada.

The second section is focused on the online stories that form the core of this project. The Internet birth stories were all extremely rich in detail and offered unique insights into the birth experiences and choices of the women who shared their stories through this forum. A sub-sample of four of the stories are presented in their entirety to illustrate the ways in which women who post such stories represent themselves and their personal birth experiences in Internet narrative form. The stories that are included were chosen to reflect a broad cross-section of different birth experiences and were written by women who reside in four different Canadian provinces. Each of the stories is followed by my own analytical reflections on the ways in which their experience has been captured in writing. The remaining twelve stories will appear in full in the appendix.

The final section of this analysis explores the results of the e-mail questionnaire pertaining to the women's motivations for placing their personal stories of birth on the Internet, and the meanings that these stories held for this group of women. This section examines the value of Internet communication about birth and demonstrates the ways this form of communication contributed to a feeling of connectedness and community among the women who shared their stories online.

Overview of the Study Participants

The 16 women who permitted me to use their Internet stories reside in 7 Canadian provinces (BC – 1, AB – 4, MB – 2, ON – 4, PQ – 1, NS – 2, NL – 2). The women ranged in age between 23 and 36 at the time of the birth that they described, with a mean age of 28.9 years. On

average, these women had experienced 3.3 pregnancies up to the time of the research, with a minimum of one pregnancy and a maximum of six. One participant did not respond to this question and explained that due to fertility problems that resulted in several early miscarriages and the emotional aspects of repeated pregnancy loss, she stopped counting after four miscarriages. The minimum number of children born to these women was one and the maximum was five with a mean of 2.4. (Figure 4.1 contains frequency distributions for total number of pregnancies and number of children for all participants.) It is noteworthy that the fertility among this group is considerably higher than the Canadian average, which for 2001 was estimated at 1.51 children per woman over the course of her lifetime (Statistics Canada, 2003), and may indicate a difference between this sample of women and the overall Canadian population.

Figure 4.1: Number of pregnancies and number of children for each woman in the sample

Number of Pregnancies	Frequency	Number of Children	Frequency
1	1	1	4
2	5	2	5
3	3	3	4
4	2	4	2
5	2	5	1
6	2	6	0
Total	**15**	**Total**	**16**

All of the women who participated in this project were in heterosexual relationships at the time of the birth that they wrote about, with 15 of them being married and 1 living common-law with her partner. Their annual household incomes ranged from under $20,000 to between $60,000 and $80,000 at the time of the birth, with a median income between $40,000 and $60,000 (figure 4.2 describes household income for all participants). Participant's level of education at the time of the birth was bimodal, with some college or trade school and college or trade school completion selected most frequently. They reported that their partners had most often finished college or trade school. (See figure 4.3 for a complete description of the education levels of the participants and their partners.)

Figure 4.2: Reported total annual household income for all women in the sample

Total Annual Household Income	Frequency
Under $20,000	1
$20,000 – 40,000	5
$40,000 – 60,000	5
$60,000 – 80,000	3
No response	2
Total	**16**

Figure 4.3: Reported highest level of education for all women in the sample and their partners

Level of Education	Participant	Partner
High school completion	2	1
Some college / trade school	4	1
College / trade school completion	4	7
Some university	0	2
Completed university	3	5
Master's or PhD	1	0
Other	2	0
Total	**16**	**16**

Participants also reported a range of personal occupations that included: account manager, computer technician, cosmetologist and decorator/designer, dental assistant, homemaker/mother, medical laboratory assistant, personal care worker, nanny, PhD student, and receptionist secretary. Perhaps most interesting was that there were a number of women who reported that their primary employment at the time of the birth of their child was directly related to providing services and support to others in childbirth. Two women reported that they were employed as doulas (professionals trained to give physical and emotional support to women in labour and childbirth), and one additional woman indicated that she was self-employed as a birth counsellor and prenatal educator. A fourth woman listed her occupation as the owner of an Internet-based company that supplied childbirth equipment and support services. This emphasis on professions that centre on childbirth provides an interesting perspective into the lives of these four participants. For these women providing assistance and education to other women in childbirth was a role through which they earned a living and likely formed an ongoing and central role in their personal and professional identities. Issues and concerns related to childbirth were

undoubtedly a part of their day-to-day lives that extended beyond the scope of their own pregnancy and birth experiences.

The e-mail survey also asked participants to provide specific information regarding the birth experiences of their first, second, and third-born children. One woman copied, pasted and edited the survey questions to permit her to include information about her fourth-born child. In total, information about 36 personal birth experiences was collected through the survey. Of these births, 25 took place in hospital in a labour and delivery room, an additional 6 took place in a hospital operating room, and the remaining 5 took place at home. When asked about birth attendants, 11 indicated a GP or family doctor was present, 20 specified an obstetrician/ gynecologist, 5 reported using midwifery services, while 1 relied on the assistance of a doula. A further 2 participants indicated birth experiences with no professional health care provider present or what is more commonly known as unattended childbirth. (Totals exceed the number of births on which information was reported due to multiple birth attendants present at some births. This included situations where an obstetrician shared care with a family physician, and instances in which midwives and physicians both participated as birth attendants.)

In some ways this range of birth experiences parallels the birth experiences of Canadian women. The majority of the births took place in hospital with a trained allopathic medical professional in attendance. The description of the techniques or procedures used at these births indicates a high prevalence of medical interventions (19 of the births included the use of a fetal monitor; 16 indicated that the amniotic sac had been artificially ruptured; and 15 included an induction or augmentation of labour). Six of the 36 births (19.4% of all hospital births) were via caesarean section indicating a highly medicalized surgical birth. The rates of birth by c-section were only slightly lower than Canadian statistics, which place delivery by c-section at an all time high of 22.5% of all hospital deliveries during the period 2001 to 2002 (CIHI, 2004). Eleven of the women in my sample (35.5% of all hospital births) reported having epidural anesthesia during labour. This is comparable to the figures collected by the Canadian Anesthesiologists' Society, which state that 35% of all women in labour have an epidural administered by an anesthesiologist (as quoted in CIHI, 2004).

However, this sample does differ in significant ways from recent statistics describing birth in Canada in general. Of the total 36 births on which women reported information, 86.1% took place in hospital, and midwives were in attendance for 13.9% of all births in the sample. This is a considerably different picture than among the Canadian population in general. In British Columbia, the province with the highest percentage of midwife usage in Canada (ASAC, 2001), 96.6% of all live births that occurred in BC during the period 1998 to 2003 took place in hospital, with midwives attending only 2.35% of the births within this same time period (BC Vital Statistics Agency, personal communication, June 21, 2004).

Perhaps most interesting and most telling of the ways this Internet-based sample differs from the broader picture of birth in Canada, is the presence of two unattended births in this sample. Even though these two births represent a minority of the births for which information was collected, their presence in a sample of this size is noteworthy. There are two possible contributing reasons that would account for the presence of these births in this sample. First, it is decidedly possible that current statistics on the place and practitioner present at the birth do not adequately reflect the frequency with which these types of births are occurring in the population. In data collected by the province of British Columbia, information that describes the practitioner present at the birth is classified into the categories of physician, midwife, or non-registered attendant. Since those who give birth at home unassisted have the option of either registering the birth themselves (non-registered attendant), or with either a physician or a midwife, the unassisted numbers would be blended with the other categories. Even if the parent registered the official record of the birth the number would be subsumed into the category that contains all other non-registered midwife attendants. In either case, the number of non-registered attendant births accounts for only a tiny percentage of the total number of births (0.07% of all BC births between 1998-2003). Unassisted birth, therefore, is likely to represent only a fraction of all births, although it is difficult to pinpoint the exact number.

The other possible contributing reason to the presence of two unassisted births in this sample is linked to the fact that this sample was located through the Internet. With over 96% of women giving birth in a hospital under the care of a physician (BC Vital Statistics Agency,

personal communication, June 21, 2004), the decision to reject not only physician-attended birth, but assistance from any professional caregiver may mean that women could face strong opposition if they chose to make their decision known to anyone other than those in whom they had a great deal of trust. The Internet provides a space that offers safety through its anonymity and can accommodate diversity simply through its sheer magnitude. Within the webpages of the Internet, persons who subscribe to a non-normative belief system regarding childbirth (or possibly other topics) may feel more comfortable sharing their experiences and opinions, and also more likely to seek out and locate others with whom to share their viewpoints. Indeed, if one wanted to conduct research on women who had decided to pursue unassisted childbirth by choice the task would likely prove quite challenging offline, not only because of the small population from which to select, but also because women who choose this as a viable option may feel unwilling to disclose this information.

From a sociological perspective, unassisted childbirth presents us with other unique opportunities to explore the ways in which women who ascribe to non-normative beliefs about childbirth create meaning in their personal birth experiences. The assumptions of normative birth are evident even in the language that is most commonly used to describe this situation. Unassisted childbirth would suggest that women give birth completely unaided, but from the reports of the women who selected this option we can see this is not true of their experiences of birth. In both cases, their husbands were present to provide support and assistance and the women took advantage of the pain relieving properties of hot water as they gave birth in the tub. For one woman the primary information relied on during the birth came from her baby and herself, but the support of her partner and information she received from a midwife who was telephoned during the labour were also important. The other woman reporting an unassisted childbirth mentioned using a pregnancy reference book, as well as the Internet and childbirth classes for information and drew support from both her partner and other participants in an Internet support or chat group. To label these births as "unassisted" is to define them only in reference to the lack of a trained health care professional in attendance at the birth and, as such, contains an implicit assumption that the only acceptable form of assistance in birth is that provided by these

professionals. For lack of alternate terminology I will continue to use the term unassisted to refer to those births that took place without a professional caregiver present, but I maintain that it is important to clarify that unassisted does not mean without information, support, and resources.

Of the 36 births for which information was collected, the 5 involving midwives as primary attendants, 2 unassisted births, and 1 including traditional birth attendants (birth attendants who believe in a woman's ability to birth naturally without the interference of drugs or technology, but who are not recognized as midwives in mainstream health care systems) all took place at home, and collectively represent 22.2% of the total sample. As I have demonstrated above, this is a pattern that is markedly different from that of the general Canadian population and is especially relevant insofar as it leans toward an alternative or holistic understanding of birth. Again, there are two possible contributing reasons for this particular sample distribution. The first possible explanation would be that the sample is in part a result of a self-selection bias in which women who were more active and interested in issues pertaining to birth were more likely to respond to a request to participate in a project that explores women's childbirth experiences. In particular, those women who practice as doulas and childbirth educators would be more likely to both have a personal and professional interest in a project designed to explore birth experiences and to view birth holistically and limit medical personnel and interventions in their own birth experiences. For those women not practicing as doulas and childbirth educators, a greater degree of interest and activity in issues related to childbirth would mean an increased likelihood that they would be exposed to literature and organizations promoting midwifery and other holistic birth practices, and, therefore, more likely to choose a birth setting or practitioner that supported their holistic views. A self-selection bias may also draw these women to my project in greater numbers than others with a lesser degree of interest or participation in birth issues. The second possible contributing reason relates again to the fact that this sample was collected from the Internet. For the reasons discussed above, it is possible that the Internet may appeal more to those women who follow an alternative or holistic belief system about birth. In this way, the birth experiences collected in this sample are less a reflection of the distribution of birth experiences among the Canadian population in general and more a reflection of the distribution of birth experiences that

are located and discussed online. Indeed, considering the rigor through which the sample selection procedure was carried out and the method through which the requests for participation were delivered (discussed in Chapter 3) it is quite likely that both of these factors contributed to the final sample distribution.

Despite the fact that this particular distribution of birth experiences may not resemble the broader picture of birth among Canadian women in general, I believe it allows us to move forward in this analysis with two important pieces of information. First, the Internet itself is an important contributor to women's ability to share and be exposed to a wide range of birthing options and opinions. Second, the sample covers a range of possibilities in birth and will allow us to explore how women create meaning and understanding through their descriptions of a diversity of birth experiences.

When women were asked on the survey what sources they relied on the most for information about pregnancy and birth, responses were varied. The most commonly selected response to this question was a pregnancy reference book, cited by 13 of the 16 participants. The next most commonly selected response was the Internet selected by 12 participants, followed by childbirth classes selected by 8 participants. Physicians, friends, and magazines were also frequently cited sources of information (7 participants for each). In terms of the support that they received during this pregnancy and birth experience, the most prominent response by far was that their husband or partner was a source of support (14 participants). This was followed by friends (9 participants), and members of an Internet support or chat group (8 participants).

These results show that pregnancy and birth information was solicited primarily from written sources and formal authorities – physicians and childbirth educators. The only notable exception to this was information from friends, which most likely represents a body of knowledge based on personal experience and passed on through personal connections within social networks. Sources of support, on the other hand, represent a system of connections and relationships to other individuals through which women mobilize a network that provides them with not only physical support, but also emotional support and care. The Internet, for this group of women, has the ability to fill both roles. It is both a source of textual information on a wide variety

of issues and topics related to pregnancy and birth, and a site through which women can connect with networks of other individuals for emotional support, including sharing their own pregnancy-related questions and concerns. It is likely that since this sample was selected from among a group of individuals who may be more Internet savvy than others, the Internet appears more frequently as a source of information and support than it would if the sample was selected through other means. Nevertheless the considerable presence of the Internet among the responses is testament to its ability to fill different roles and serve different purposes to different people.

The diversity of birth experiences is also captured in the Internet birth stories collected from this group of women. Of the 16 stories that were collected, 11 described hospital births attended by a physician, including 10 vaginal births and one scheduled caesarean section. The remaining 5 births were homebirths, two of which were attended by certified midwives, one attended by traditional birth attendants, and 2 unassisted by a professional or apprentice-trained attendant. These stories described the birth of a first child for nine of the participants, a second, third and fourth birth for six participants (two at each level), and a fifth for the final participant. It is the content of these stories that I will focus on next.

The Internet Birth Stories

Each of the 16 stories I collected is unique and every one provides a different perspective on how each woman negotiated her own path through the social structures, relationships, and knowledge systems that are woven through her own narrative. However, there are also a number of commonalities between the stories. All of the stories describe the events of the birth of a child and as such they share common elements and the order of the events is unwavering throughout all of the stories.

Generally, the stories engage the reader in an introduction to provide context, through to a description of the pregnancy, and the recognition of the onset of labour and labour itself. This section is followed by a description of the birth and the events that took place following the birth before the reader is returned to the narrative present with a reflection on the birth and the creation of a new or redefined family at the conclusion of the story. This consecutive ordering of timed

events can be understood as a necessary property of narrative construction, described at length by Labov and Waletzky (as cited in Mischler, 1986). Also, undeniably part of this presentation of sequentially ordered events is a basic understanding of the process of birth itself. The biological imperatives of vaginal birth mean that contractions are necessary for dilation and that dilation must occur before the baby moves through the birth canal.

For the reasons that I have detailed in the methods section of this thesis (Chapter 3), this section of the analysis will include the complete stories of four of my participants. I have specifically chosen these stories because they display a broad spectrum of birth settings and birth options available to Canadian women today. The women who wrote these stories have provided unique insights into their own personal birth experience and have shown, through narrative, how they have engaged with the social structures and cultural themes that shape birth in a contemporary context. In stating this, I do not mean to dismiss the birth stories of those women whose stories are not presented here. Even if their narratives were not presented in this section, the remaining twelve women and their stories are undeniably a part of this analysis. As I read through the stories over and over again, each one offered insight into the interpretation of not only the story I was reading, but also the other stories in the collection. It is for this reason that I have decided to include the remaining twelve stories in their entirety in the appendix. In addition, I have incorporated relevant elements from the other participants' stories into the thematic discussion section of this thesis (Chapter 5).

The stories that are presented include those written by K, L, S, and H. These four stories describe a caesarean birth that took place in hospital in Quebec, a hospital birth with a general practitioner in Ontario, a homebirth with a midwife in Alberta, and a homebirth with only the mother and her partner present that took place in Manitoba in 2002. A brief profile of each woman/author/mother will be presented first followed by the narrative as it appeared on the website on which it was found. The stories are presented in a different font to distinguish them from my analytical segments and all names have been replaced with initials to preserve the confidentiality of the participants.

K's Story

At the time that this birth took place, K was employed as a dental assistant and her partner, A, was a car mechanic. K had a completed college or trade school education, while A had some university education. They had a total combined annual income of between $20-40,000. K's birth story describes the caesarean birth of her second child, which took place in a Quebec hospital in 2002 when she was 27 years of age. Her first birth experience was also a caesarean birth that took place after 40 hours of labour and was followed by an infection that resulted in an extended hospital stay of seven days. Throughout much of her story the events and emotions from her first birth experience play a strong role in the decision-making process that transpires in this second birth. K describes that she is somewhat satisfied with this birth experience largely because she knew what to expect given that this c-section was planned and because her recovery from this surgical birth was quicker than her previous experience. To prepare for this birth she drew information and support from a number of difference sources. She relied on information provided to her by a physician, a nurse, her mother, her sister, a pregnancy reference book, and the Internet. She gathered support from her partner, her mother, her sister, her friends, and members of an Internet support or chat group. Here is her story:

Cesarean Birth

Seven days before my due date on Thursday evening, I began having contractions that were six to eight minutes apart. This lasted for two hours or so, and then they petered out. Then the next few nights seem to be carbon copies of Thursday night, and I was getting excited because I figured it would be any time now that they would, instead of stopping, start getting stronger. It never happened.

At 39 weeks, I was told I was not dilated at all and that the baby was staying very high. I was so discouraged by the news, which was two days before my contractions started, so I was

anxious for my next appointment on the following Monday. Sunday morning, I lost my mucous plug and continued to have a bloody show all day.

In the afternoon, I felt two small gushes and wondered if I had broken my water. I called the hospital, and they said to come in and check to be on the safe side. So off I went. They used a small piece of litmus paper to determine if there was any amniotic fluid, and although it had changed color in places, the nurse said it was not enough to say my water had broken. So I came home and was able to sleep since I was no longer wondering if it had or had not broken.

Monday morning arrived, and I was off to the doctor, feeling confident that with all the contractions and large amounts of bloody discharge the baby would have finally engaged, and I would be a few centimeters dilated. Upon internal examination, I was found to be almost 1 centimeter, but Baby was still floating very high, not at all engaged, not even any lower. Dr. R was quite surprised at how high he was and told me she thought he would be at least 4 kilos, and maybe these were signs that there was a disproportion, as with my first pregnancy.

I really wanted to try for a vaginal birth after having A (first child) by Cesarean section after 40 hours of labor not progressing and her not dropping. But the situation seemed to be pointing to the same sort of problems arising. She asked if I wanted a C-section, and I asked her what she would do. She said she would probably go with the surgery, and that we could do it on Wednesday, one day before my due date. So I agreed.

When I got home, I was crying because I wasn't sure if I made the right decision. I was trying to balance my wanting a vaginal birth against wanting a safe, healthy baby. So it was done, Wednesday would be the day. Everyone around me seemed to think it was the right thing to do, but it bugged me a bit that they felt that way more out of convenience.

Wednesday morning we arrived at the hospital at 6:15 a.m., and I was prepped for the surgery. The nurse removed nail polish from my toes, did blood tests, checked my vital signs and then we just had to wait for the operating room to be ready for us. I didn't feel nervous at all, it was strange.

Then at 8:30 a.m., they came to wheel me down. They took A (partner) to get him changed into hospital garb while they brought me into the operating room and got started. First they started the IV, and then it was time to do the spinal. I was nervous about this since last time it took four tries before it worked. Lucky for me, it went well. I was sitting up curled over, and I didn't really feel pain, just a prick and then weird sensations in my back. It is difficult for me to describe, but I could feel them in my spine. I was also quite sick last time from the block and told them this so they would be prepared. I began feeling nauseous and told the anesthesiologist right away. They gave me a shot in the IV to regain my blood pressure, as it had dropped a bit. Within seconds, I felt fine.

They then inserted a catheter, which I did not feel since I was already going numb from the spinal. They put up the curtain, and the doctor asked how was I feeling. I said, "I feel like I am camping," and that I felt fine. I was worried that I was not frozen enough though, since my legs felt like pins and needles. I didn't remember feeling them at all last time. Now was A's time to come in. They had already started the first incision, and I did not feel it so I was reassured and happy to finally have him in the room with me. I asked Dr. R that no one say the sex of the baby, that I wanted A to peek and tell me. She agreed.

Then the pressure started. I could feel them pulling and tugging, and I was moving around on the table from them pushing me around, which A asked if I felt. I told him yes, I felt lots of pressure and movement, but no pain. They really had to push to get the baby out; he did

not want to come. The doctor even commented on how high he was. They were pushing so hard on my ribs that I felt like I couldn't breathe, but I knew baby would be here soon. Finally, I heard a gurgled cry, followed by a second one, not too loud but good enough to make me cry! Then they said to A to go ahead and look, so he stood up, and they immediately told him to sit down and to just look around the side of the curtain. He then looked at me with an amazing expression on his face and said, "It's a boy!" It was a surprise for us, as we chose to keep the sex a secret until delivery day. Baby boy stayed in Daddy's arms while they stitched me up.

We then all three went to the recovery room, and I was able to nurse the baby, who took to it like a pro. He had already been eating his blanket and fingers in the operating room, so he was ready! He nursed a good 10 minutes and then he went upstairs with Daddy to be weighed and measured and checked out by the pediatrician. He was 7 pounds, 13 ounces and 22 inches long, and he scored all 10s on his Apgar! Once the feeling started coming back to my legs, it was time to bring me back up to my room where I saw Grandma, Nanny and my friend, M, and her hubby looking into the nursery at my new baby boy!

We were planning on calling him M, but in the operating room I said to A that he didn't look like a M, that he looked like an A, but his reaction was not too great to that name. Over the next day we narrowed it down to T, I and B. Then A told me it was my choice from those names, so I chose I since I thought it suited the baby the most. T was nice, but living in Quebec, it would sound weird in French so that turned me off, and I really like B, but I thought people liked I more.

Then when we got home, the blues hit, but the strange thing was that the only time I really got upset was thinking about the name I. A said it was not a good sign, and I agreed. I was disappointed by people's reactions to I. Anyone French was calling him ---, which I hate, so

this is how it came to be B. It is still a bit strange, since it feels like we had to name him fast, unlike A (first child) who we knew way before delivery. I seem to be much more comfortable with the name B. There were one or two names I liked more, but A and I have really different tastes, and I find it harder to name a boy somehow!

Recovery has been painful, but now 11 days later, I am feeling more comfortable and able to move around without wincing. I cannot lift for another two weeks, so I am anxious to be able to be a normal mom again to A (first child) and just get back to life! She is taking very well to her new brother, and hasn't shown any signs of jealousy – yet.

The beginning of K's birth story is, for her, the beginning of what she anticipates will be the contractions that will eventually strengthen, turn into labour and result in the birth of her child. Through the words that she chooses to begin her story, she sets the foundation for her understanding of "normal" birth and how the narrative of a "normal" birth should unfold. "Normal" birth begins on or around the due date and progresses through regularly timed contractions that continue and increase in strength. The sentence that closes her first paragraph lets her readers know that the birth story that they are about to read will deviate from this "normal" path.

These normative patterns of the early stages of labour are strongly influenced by biological components of labour and birth and defined through medical parameters and medical discourse. Not surprisingly, therefore, it is the medical personnel who are primarily responsible for the distribution of authoritative knowledge through the early parts of her story. According to Jordan (1997), authoritative knowledge is that knowledge which participants agree counts in a situation and on the basis of which decisions are made. K refers to the due date and the dating of her pregnancy in weeks. These are key aspects of a medical discourse of pregnancy, which establishes individual timelines based on normative curves of gestational age and provides the basis for fundamental decision making criteria in late pregnancy. She also receives other authoritative information about her pregnancy and her pregnant body from a number of different

medical practitioners. Following each of these encounters she provides for her readers a description of her emotional response to each piece of information to illustrate the significance of this information insofar as it confirms or denies her individual placement within these normative patterns. When her contractions begin and continue in a seemingly regular pattern for a number of nights, she is excited because her individual bodily experience is confirming the knowledge that she already has about normative patterns of progression in late pregnancy. At the 39-week appointment she is told that she has not dilated and that the baby is staying high. She reacts to this information with discouragement and anxiety, since this information does not conform to the normative script and her own expectation about what should be happening at this point. After tests at the hospital fail to conclude that her water has definitively broken she is reassured and able to sleep. In this instance it is not a specific answer that provided her with this reassurance, but rather that she has received information that resolves her feelings of uncertainty.

In terms of the water breaking, there is no accepted normative pattern (less than 20% of all labours begin with the water breaking [Hawkins and Knox, 2003: 177]). Indeed, it would seem from her description in this paragraph that there remains uncertainty within the medical test to determine if her water had broken. She feels sensations that might be consistent with her water breaking and on the advice of the hospital staff she undergoes a litmus paper test. Although the test does confirm the presence of amniotic fluid, the fluid was not present in quantities sufficient to produce a definitive result. K receives reassurance not from the result of the test, but rather from engaging with the process of testing itself. She is no longer wondering, "if it had or had not broken", but rather her uncertainty is transferred to the results of the test which will provide her with the certainty of a response one way or the other. The results of the test are dichotomous; framed as either yes or no, positive or negative, or more accurately, positive or not positive with the lack of a definitive positive result permitting the assumption of a negative result. This is analogous to any scientific testing in which the null hypothesis (no change has occurred) is assumed unless there is definitive proof to allow for the acceptance of the alternate hypothesis (a change has occurred). Any uncertainty in the testing procedure itself is not considered valid because the result of the test is the only piece of information that is considered authoritative.

Authoritative knowledge, as used by Jordan and others (See Davis-Floyd and Sargent, 1996), is undeniably linked to power. It is the person or system, which displays this power through the ability to invoke authoritative knowledge to make binding decisions and influence what counts as important in a situation. In a scheduled caesarean birth, such as the one described by K, we would expect that this highly medicalized birth would result in a complete transfer of authoritative knowledge to the physicians and medical personnel performing the surgery and, consequently, a removal of the power of the woman who is undergoing the surgery. While it is certainly possible and likely that the medical establishment maintains a considerable amount of power in surgical birth in general and in K's story specifically, we also see several locations during K's birth story where she reclaims power – the power to decide the course of action that is to be followed and to decide on what counts in the situation – by shifting the location of the authoritative knowledge.

K describes how she was "feeling confident" that the sensations she was experiencing were an indication that she would have made progress toward the birth of the baby. She anticipates that the head will have by this point engaged in her pelvis and her cervix begun the process of dilation. Instead she is given information from her doctor that although her cervix has dilated to one centimetre, the baby is still quite high. The doctor begins to suspect that the baby might be too large for her to deliver vaginally as was determined to be the case with her last birth – a c-section after 40 hours of labour. K's reaction to this information is to solicit information from the doctor to decide what she would do. (There is some ambiguity around this statement and I am uncertain as to whether she asked the doctor what she would recommend in K's situation or what she would do if it were the doctor in K's position. These are very different questions with significantly different interpretations.) The doctor advises K that her choice would be with the surgery and K agrees with the doctor's opinion. It is at this point that K's narrative shifts.

K enters into a segment in her narrative where she reflects on her decision to proceed with the c-section. She mentions being upset and consults with others to gather their thoughts about the decision. The options available to her are weighed against one another. On one side of the balance is the vaginal birth that she wanted; while on the other is the safety and health of the baby. Here she engages in rhetoric that has been found its way into the critique of the medical

model of birth (Davis-Floyd, 1994) in which mother and baby are presented as separate and distinct with oppositional interests. K's desire is for a vaginal birth, but to decide on this route would, in this oppositional sense, compromise the health and safety of her baby. The only option for K, therefore, is to act in the best interests of the baby and proceed with the c-section. She receives support from those around her who agree with the decision, but nevertheless she still experiences apprehension as to their motivation. She is concerned that "they felt that way more out of convenience" alluding to the possibility that others may be more willing to opt for the caesarean since a scheduled birth will negate the uncertainty that comes with a vaginal birth or, alternately, that it is easier (or more convenient) to agree with K than to challenge this decision. Once again the reference here is not entirely clear and could be interpreted in more than one way.

Upon arriving in the hospital, K and her partner, A, are subsumed into the hospital routine. They are prepped for the surgery with K undergoing testing and having nail polish removed from her toes and A being changed into hospital scrubs. K has been through a c-section birth before, and although the circumstances were different she is familiar with this routine and the procedures that will take place. It is her previous knowledge of the experience that she is able to draw from in order to enact some limited authority in this situation. She knows that last time she experienced nausea from the anaesthetic and she is able to communicate this information to alert the anesthesiologist. When she does begin to experience nausea, she quickly informs the anesthesiologist who administers medication resolving the situation. This description follows precisely the definition of authoritative knowledge. She is privy to information based on her previous experience that the others do not have. She communicates this information and is able to influence the actions that take place as a result of her privileged knowledge.

In her narrative she constructs and maintains a role for herself as an active decision maker and an active participant in her c-section birth. Her narrative contains several verbal exchanges with her physician, as well as one instance in which she is able to respond to the physician's request for information on how she is feeling with light humour. When Dr. R asks her how she was feeling she responds by relating her surgical experience to camping. Her

comparison of being covered with sterile surgical drapes to tenting can only be taken as an attempt to add a touch of lightness to the situation. I would have to assume that the number of similarities between surgical birth in a sterile operating room and camping in the great outdoors would likely be limited. It does, however, attest to her ability to continue to remind the reader of her continual bodily presence throughout the procedure. She is awake and speaks to the anesthesiologist and the physician while including in her description repeated references to bodily sensations; "I did not feel since I was already going numb", "my legs felt like pins and needles", "I could feel them pulling and tugging", and "I felt lots of pressure and movement".

Throughout her narrative she is actively engaged in and aware of the sensations of her body, and although the sensations she experiences as birth are undoubtedly very different from that experienced in vaginal birth, she is nonetheless not removed from the experience. Body and mind are connected as she participates in and communicates these sensations not only to those present at the birth (such as when she describes the "pressure and movement" she is feeling to A), but also through her narrative she communicates her own personal experience of surgical birth to her readers. Through the words that she has chosen and the descriptive detail that she includes, she writes what surgical birth feels like from the mother's perspective. From her description, however, we can see subtle elements of how her role in the birth experience is altered from the script of "normal" birth. The anaesthetic that has numbed her from the chest down means that her experience is of "pulling and tugging". The role of pushing, that which is typically used to describe the actions of mothers giving birth vaginally, is an action that in her story has been confined to the physicians. She states, "They really had to push" and "They were pushing so hard on my ribs".

One other verbal exchange with the medical staff that K incorporates into her narrative is one in which she requests that the physician and others present not announce the sex of the baby after the birth. She would like to reserve this role for her partner. By making this request, K has created a specific role and space for her partner within the birth of their child. His ability to be the first to speak the sex of the baby aloud and to inform the mother allows him to actively engage in the birth in his new role as father and simultaneously solidifies and enacts his

relationship to both K and the baby. Immediately after the birth of the child the father proclaims that, "It's a boy!" and A, who was previously referred to in the narrative only by name, now takes on the mantle of "Daddy". His relational role to the child and within the family is identified, named and strengthened.

After the birth and after K is stitched up from the surgery, she makes a first attempt to breastfeed. Here she uses the phrase "took to it like a pro" to describe her baby's natural inclination and aptitude at breastfeeding. This was a phrase or a sentiment that was expressed in several of the stories that I located. It was not uncommon to find descriptions that involved "nursing like a pro" or "like a champ" to describe those infants who immediately latch onto the breast and suckle successfully on the first occasion. While I certainly do not want to discount the importance of this experience for those whose children do not experience difficulties with breastfeeding, the ease with which this phrase entered the narrative and was incorporated with very little other description would seem to counter the experience of those who experienced difficulties establishing and maintaining breastfeeding. According to Leja (2001) women may experience feelings of inadequacy and frustration when their children do not take to "nursing like a pro". The ready acceptance and usage of phrases such as the ones that appear in this story (and others) without similar catchphrases or tags that could be adopted by those with less than positive initial experiences of breastfeeding may serve to further isolate women from the realities of what can often be a challenging task for both mother and baby. The implication that babies are natural/professional/champion nursers who take to breastfeeding on an instinctual level may not correspond with the experiences of others who find that they need assistance and that developing an effective nursing relationship with an infant may take a considerable amount of time, effort, and patience.

Returning to the closing paragraph of K's story she has constructed a segment that brings us, as the reader, back to her narrative present – 11 days after the birth. She talks about the pain of her recovery, and the increasing level of comfort she is experiencing over time. She also mentions that the surgery has left her temporarily unable to lift for a period of almost one month. For her, the significance of this limited mobility has meant that she is unable to pick up her

oldest child and provide her with the type of care associated with being a "normal mom". In several ways this reference to normalcy is a return to the discussion that was started at the beginning of this analysis. Much as her birth did not follow the course that she had anticipated by adhering to a cultural script that outlines the events incorporated in "normal" birth, the surgical birth that she did experience is interfering with her ability to be a "normal mom". Surgical birth necessitates a recovery period in which the abdominal muscles need to heal and strengthen. Any stress on these muscles may result in further injury and lengthen the time required to heal. However, during this healing time she is unable to participate in activities that she ascribes to a "normal mom", such as picking up or carrying her child. This restriction on activity provides for K a reminder that her own experience differed from the "norm" and her awareness of this difference results in feelings of anxiousness to return to this role. For K the role of mother is so closely associated with the duties that a mother performs that the inability to perform these duties results in a perceptual and lived distance that prevents her from fully claiming the role of mom in the normative sense.

One final attribute in this story that I wanted to focus on is the appearance of hyperlinks. In the text above the hyperlinks appear as underlined words or phrases. In the online text these phrases are interactive markers, which allow the reader through a click of the mouse to open a link to a separate web page containing a glossary of terms. The terms that are hyperlinked in K's story include items such as, mucous plug, amniotic fluid, cesarean section, catheter, and Apgar. If one were to click on amniotic fluid a page containing the following description would open: "This protective liquid, consisting mostly of water, fills in the sac surrounding the fetus" (iParenting, 2004). Hyperlinks are certainly not contained within all Internet-based birth stories, but they are a relatively frequent feature of stories that are located on some of the more commonly accessed pages. This includes those stories originating from www.birthstories.com, one of the most prolific websites with over 3,900 stories at last count. The function of the hyperlinks is to connect the two aspects of the Internet discussed above, the ability to provide both information and a space to connect with others on a personal level. Through their stories women connect with others by sharing their own personal experience of birth with their readers. Through the hyperlinks the

stories provide readers with information on pregnancy and birth terminology and procedures. The vast majority of the terminology and procedures that are described through the hyperlinks contain references using medical language or to procedures that would be more likely to be found in a medicalized birth. These include the names and acronyms for testing procedures, medications, complications, and medical terminology to describe common occurrences in pregnancy and birth. Through the stories, therefore, readers are exposed to and absorb information that educates them and normalizes medical definitions and understandings of childbirth. To connect these two aspects of the Internet through the hyperlinks is to make very tangible (in a virtual forum) the connection between actual personal lived experiences of childbirth and the ways in which medicine permeates those experiences, insofar as they permeate the text.

L's Story

L's story describes the birth of her first child, which took place in a hospital in Ontario when she was 30 years old. At the time of this birth, both L and her partner D had completed college or trade school. L was employed as a secretary, while D was an employee of the provincial government in the Ministry of Transportation. Their combined annual income was between $60-80,000. D was present at the birth, as well as L's mother and father, and what L described as an "awesome nursing staff". When asked about her level of satisfaction with this birth experience, L indicates that she is extremely satisfied largely because she was able to avoid using pain relief and mentioned that she was more frightened of the epidural than she was of the pain of childbirth. Her responses to the survey specified that her primary sources of information for this birth were from physicians, pregnancy reference books, the Internet, magazines, childbirth classes, and a support group for mothers whose children were born in the same year. She mobilized support for this birth through this same group of friends that she found through the support group. Here is her story:

Well, after nine long months of waiting, we did it!

Pregnancy was pretty good for me -- the only problems were a bit of morning sickness and a total aversion to hamburger meat in the beginning, gestational diabetes (which was controlled strictly by diet), and really big swollen feet in the last month and a half.
Here's my story!

Sunday January 28, my husband D made Chili for dinner. It was delicious. About 3:00 a.m. I awoke with really bad pains in my lower abdomen -- and I had to keep going to the bathroom. I blamed this on the Chili! At around 4:00 a.m. my husband got up with me (after me getting in and out of the bed for the past hour so many times, it was impossible to remember how many).

We went downstairs to our rec-room and I sat on the couch with the heating pad on my lower back. Finally around 4:30/5:00 or so the pain started to occur throughout my entire uterus -- so I realized I was finally in labour! The contractions kept progressing and around 8:00 a.m. they were five to six minutes apart and lasting for about a minute or so. We called the hospital, and they said -- you sound still pretty far off, so wait a while. Just after that I placed a call to my doctors office. She returned the call at 8:30 and we described the situation to her -- she said "Go upstairs, get a shower and get to the hospital".
Well, by the time I was finally ready, showered and changed, it was around 10:00 and we were in the midst of a full-blown winter storm. We got to the hospital around 10:20 a.m. and went to admissions, then they wheeled me up to Labour and Delivery. They put me into the assessment room, and had me lie down and strapped me into the monitors. Well, needless to say, the only way I could deal with my contractions was to sit up. After 10 minutes of monitoring, I was so uncomfortable, I said to the nurse I have to sit up, I can't stand the pain! She said, OK, I guess I'll have to check you, but I don't think you're ready yet! Well she checked, and she said I was at 8 cm and my water was bulging.

They quickly walked me down the hall to the Labour and Delivery room. I got in there at about 11:00 a.m. My husband had called my mother who was to come into the delivery room with us as an "assistant" coach. Due to the fact that my brother and I are adopted, she had never been through this in her life, so I thought it would be pretty special to her. When our nurse J listened to the baby's heartbeat, she quickly turned to us and said "I think it's a boy". Well time went by pretty quickly and suddenly it was 1:00 and time to start pushing. Once this started, I felt like I was in a dream-world. It was hard to believe that it was really happening. I was pushing, and pushing, and pushing, for what seemed like a relatively short period of time, when the doctor said that they were having trouble getting the baby's head past my pelvic bones. They changed my position, and made me go even more spread-eagle in the delivery bed. The doctor then decided that they had to do an episiotomy and that they were going to use vacuum extraction to help get the baby out. Boy did I ever do some major pushing when I heard what they were going to do! They worked on the vacuum a few times, and a couple of times it came off, but finally, the baby's head was out and I had to stop pushing right away, because the cord was around his neck. Boy was that ever hard, but when they said I could go again, it felt like a whoosh and out popped the baby, and I heard the doctor say it was a boy, and I could hardly believe it!

He was born at 2:35 p.m. C J H -- our Baby Boy!

They assessed him, and said that he had a rash on his face, so they would have to take him to Observation for four hours or so. Around 4:00 I was taken from L&D to my room, and as I was wheeled by the nurses station, they all said what a great job I had done! The nurse who was pushing me said that they never say that unless you did a really great job. I got to my room, and my husband and I sat there together until my dinner came, and once I was finished, they brought C in to us!

WOW!!!!

Our hospital here has a policy that you go home in 24 hours after delivery. So at 4:00 Tuesday, we were home and meeting my husband's parents. C is their 13th grandchild, and believe it or not, the first one to carry on the family name!

Two days after we arrived home from the hospital, I was sitting with C, and I noticed that the whites of his eyes were a bit yellow, so I called the doctors office, and we had to bring him in. We had to go for a blood test that the doctor had rushed through, to check the levels for jaundice. If they were too high, he would have to go back to the hospital. The feeling of having to take him back there left me in tears -- I guess this is part of the post-partum blues, as well as all the worries of parenthood. The doctor phoned us at around 8:00 that evening and told us his levels were high, but not high enough to go in to the hospital. Our prayers were answered. We had to go back again the next day to have his blood tested again, and again, his levels were not high enough to warrant hospitalization.

My doctor said that she is so angry at the hospitals for sending new mothers and babies home from the hospital so quickly. She said that jaundice usually shows up on day three, and if they kept us in a bit longer, this whole ordeal could have been avoided.

This past Saturday our local paper, the Toronto Star, had an article stating that hospitals are sending mothers home too early, and this often causes unneeded hospital/doctors visits for newborns.

Anyway, motherhood is wonderful, worries and all! C is finally getting the hang of breastfeeding with me. Unfortunately, due to the fact that I am self-employed, I don't get an extended maternity leave, so my husband is taking the parental leave. I plan to continue to breastfeed by pumping off milk when I'm at work. Hopefully C will be happy going from

breast to bottle and vice-versa. I have a friend who was successful at this, so hopefully we'll be lucky too!

Well, sorry about babbling on, take care all!

WOW, I still can't believe it, I'M A MOTHER!!!!

Born January 29, 1996 at 2:35 p.m.

Peel Memorial Hospital

Brampton, Ontario, Canada

Weight 8 lb. 9 oz.

L begins her narrative with a statement that invokes her feelings of triumph surrounding the birth. In this statement she uses the collective first person pronoun "we", thereby introducing a theme that will carry throughout her story. Pronouns are of particular importance because they function in a story to indicate the originator of an action or the claim of an active position within the sentence. This first collective pronoun within her story is a reference to an active claim on the accomplishment of her birth. "We" is most likely a reference to herself and her partner, D, who played an important part in the birth of their child and the creation of new roles for themselves as parents. "We" could, however, be a considered as a collective pronoun that also incorporates an assortment of other characters in her story, including her own parents, her physician, other hospital staff, and even her own child. Notable is that her choice of pronoun does not indicate a solitary sense of accomplishment as would be implied with the use of the pronoun "I". In some ways this could be seen as a detractor from the mother's unique role in pregnancy and birth and a sense in which the ownership of the birth is removed from the mother's exclusive domain and transferred and shared with others who are present in differing capacities. Although this is certainly a viable interpretation, it may also be understood as an indication of the importance of others to L and recognition that these others were important participants in the accomplishment of

birth. Either way, the use of the collective pronoun "we" is significant in our understanding of this story because it implies a collective accomplishment of birth.

After providing her readers with a brief overview of her experience of pregnancy, L formally introduces the beginning of her story. Her story starts on what would seem an unusual note for a story of birth; the chilli that her husband made for dinner the night before. It is this chilli that is blamed for the stomach cramps that woke her up and kept her up in the early morning hours. She is in pain and experiencing stomach discomfort that keeps her running to the bathroom, but it is not until, as she puts it, "the pain started to occur throughout my entire uterus" that she makes the realization that what she is experiencing is labour. It is this recognition that what she is feeling can be localized to central parts of her reproductive anatomy that she can then make the connection between her individual bodily sensations and her expectations of what she should be experiencing in labour. Once she can attribute the sensations to her uterus and label her experience as labour, she can then begin to invoke a medical script for understanding and interpreting her own experience. Her story becomes intertwined with a cultural narrative of labour and birth that is closely tied to medical protocol. Having knowledge of this script means for her that she can make a transition between the experience of stomach upset caused by a food that does not sit well, to a system in which the events of labour unfold as a progression of logically sequenced ordered events. Immediately following the introduction of her uterus into her narrative, pains are referred to as contractions, which are subject to timing to discover their duration and frequency.

L places a phone call to the hospital to inform them that she is in labour – the next logical step in the medical script for understanding labour - and she is told that it is likely too early and she should wait. Immediately following this phone call she places a call to her own physician who responds with information that counters the advice of the hospital. L decides to follow the doctor's advice and begin making preparations to head into the hospital. Within her narrative the hospital staff that received the initial phone call and L's physician are both medical personnel, and both of their advice brings with it the weight of the authority of the medical model. However, in this instance L chooses to respect the authority of her own physician to initiate the next steps in her

labour rather than the authority of the hospital staff. In the face of this conflicting information, both from authoritative sources, L exhibits her own display of power in her ability to choose from amongst several possible courses of action as she negotiates her own path through this process pitting the authority of her own physician against that of the hospital. Her decision is likely based partly on the increased assessment of the authority of her personal physician over the unknown person at the hospital who provided her with advice over the telephone, and partly on the medical script in which she is participating. The next logical step after realizing that labour has begun and timing of contractions indicates a sufficient duration and frequency is to head for the hospital and thus the individual who would provide her with the information that best reflected her interpretation of the medical script would be the one whose advice would be given the greatest respect.

Upon arriving at the hospital we can once again see the importance of pronouns enter her narrative. In the description of events preceding her arrival at the hospital she consistently uses first person pronouns to describe both the actions that she engages in and the sensations that she is experiencing. After being admitted to the hospital there is a distinct pronoun shift with a large number of the actions described in the third person. This shift indicates a movement in L's relative position within her own story from being the subject of the sentence and a primary agent in the events that took place, to being the object of the sentence and thus the one who is acted upon. The ability of the medical model to objectify women in childbirth is nothing new and has been thoroughly explored in the feminist critique of medicine. In L's story we see that this objectification has been so complete that her description of her own role in her birth experience changes from the first person to the third person as soon as she enters into the hospital routine. Although it is not absolute, in large part she becomes not the actor, but the passive recipient of action. "They wheeled me...", "They put me...had me lie down and strapped me...". The only locations at which she maintains her position as subject in the sentence and actor in her story is when she is providing her readers with descriptions of the personal physical sensations of her labour.

As the time of the birth nears, the importance of personal pronouns and their relation to agency within the story becomes even more pronounced. L uses the first person pronoun "I" to describe those moments in the birth when her active role is most prominent, specifically when she is pushing. The physician, in this segment of the narrative, plays a very active role in the birth to the extent that she begins to take a dominant position in aspects of the birth that allow her to supplant the mother's abilities and remove a fair degree of L's agency. After pushing for a period of time that seemed quite short to L, her narrative states that, "the doctor said that they were having trouble getting the baby's head past my pelvic bones". This statement enters the narrative at a time preceding the introduction of any instruments to assist in the delivery and has the effect of transferring the role of the mother's body to that of the physician. In birth it is the mother's body and the mother's active attempts to push the baby from her body that move the baby down through the birth canal. However, in the statement above the mother's body is removed and it is the medical staff (included in the pronoun they) that are taking responsibility for moving the baby's head around L's pelvic bones. This increased role in the birth allows the medical personnel to continue to play a dominant role in the birth. "They changed my position, and made me go even more spread-eagle in the bed. The doctor then decided that they had to do an episiotomy and that they were going to use vacuum extraction to help get the baby out." L has become the subject in her own sentences and is subjected to the increased role of the physician in her birth to make decisions and control the situation according to her own increased sense of authority in the situation. L, however, is not stripped of her own power in this situation. Although she does not challenge the doctor's decision to perform the episiotomy and use vacuum extraction, she does respond to this information by directing all of her efforts to the role that she has been assigned in this birth, to push the baby out. She states, "Boy did I ever do some major pushing when I heard what they were going to do!"

L's role as pusher and the physician's role as puller are positioned in the narrative as two oppositional actions working toward the same end. It is a struggle that is taking place within L's own body, but interestingly, what is virtually missing from this description of the birth is L's body itself. From the very beginning of this segment the pushing begins not with an urge to push or any

other signal that would have originated from within her own body, but rather the pushing stage of her labour begins, according to L, when the time is appropriate. "Suddenly it was 1:00 and time to start pushing." Even the birth itself is described in a word that connotes movement and not sensation and the baby emerges with a pop without any indication of the location from where he emerged. "[I]t felt like a whoosh and out popped the baby". The implication is that the role of the physician has been strengthened and that the work that her body would typically engage in has been replaced by the labour of the physician. The use of the word "pop" strengthens the metaphor of body as passive machine, similar perhaps to the manner in which toast would pop from a toaster. This is reminiscent of the work conducted by Martin (1987) whose interviews revealed that women frequently used metaphors that evoked a sense of labour as productivity and body as machine.

According to hospital policy, L and her son were discharged from the hospital 24 hours after the birth. This is a policy that both L and her physician question after the baby develops jaundice two days after returning home. The blood tests that are required and the possibility that the baby might have to be hospitalized is something that moves L to tears. Within this discussion there is a display of circular logic. It is the opinion of the doctor (strengthened by the newspaper article) that hospital policies regarding release after 24 hours are the cause of unnecessary hospital visits. The solution to this dilemma is to keep mothers and their infants in the hospital longer. Ergo, to avoid the hospital, one should stay in the hospital. The fundamental principle within this argument seems to be to solidify the role of the hospital and medical practitioners, as not only the appropriate place for birth, but also the location in which new mothers and infants should be kept for observation. Under these circumstances the post-partum period would be increasingly subject to the scrutiny of the medical gaze and the normalization of the medical script.

S's Story

S's story describes the midwife-attended homebirth of her fifth child that took place in Alberta when she was 32 years old. S and her partner K had both completed college or trade school at the time of this birth, and had a combined annual household income of between $40-60,000. S's

primary occupation at the time of the birth was as a doula, while K worked as a mechanic. This story describes the first child to be born at home and represents a significant change for S from previous birth experiences that had, for the most part, involved an induction of labour and taken place with an obstetrician present. S has received training to practice as a doula and her background and education, as well as information from her midwife, other doulas, pregnancy books, the Internet and magazines formed the foundation of the information that she relied upon for this birth experience. Her primary sources of support for this birth experience were from a niece who had recently experienced a homebirth in water, as well as her midwife and doula friends. S's story is quite long and the original version contains numerous photographs, which have been deleted here to protect her confidentiality. The photo captions have however been preserved in this version as they are thoroughly interwoven as part of her narrative. Also abundant in this story is a substantial cast of characters that includes family, midwives, doulas, and friends. Here's her story:

On Thursday January 13th I was exactly 1 week past my due date and was anxiously awaiting labour to start so that I could have the homebirth that I had dreamed of for the past 9 months. I had seen my midwife on Tuesday and she wasn't even able to reach my still very posterior cervix to check and see how dilated I was so she gave me some alternatives to think about to try to induce me if I wanted. She told me about blue/black cohosh and also gave me the recipe for taking Castor Oil. She told me that I could (and probably should) go in for a biophysical profile the next Monday if nothing had happened before then, but warned that they might find my fluid to be on the low side because of being "over due" and it might ruin my chances of having the homebirth that I so wanted. I really felt like I was in a bind. This was my 5th baby and I really wanted to "get it right" this time and trust my body to go into labour on it's own..., completely naturally. I had been induced with 3 out of my 4 other pregnancies and just wanted to be able to let my body do it's job this time. But on the other hand I really wanted to have this baby at home with my midwives and decided that if

nothing had happened by Friday morning I was going to try taking the castor oil cocktail they recommended. My friend and doula trainer E had just told me a few days earlier that she had had great success with a bottle of castor oil that had put 3 women into labour and it still remained unopened in her bathroom cabinet. She explained that all these women had to do was visualize the horrible stomach pains that would ensue after taking the cocktail and it had put every one of them into labour just imagining it! I thought I'd give it a try so on Thursday night I sat here at my computer with my bottle of castor oil sitting menacingly in front of me and read my email while thinking about what lay ahead tomorrow. I also came across a link to the most beautiful natural birth story that I had EVER read in my entire life at http://pages.ivillage.com/misc/coatlicue/index.html, so I was REALLY in the mood to have this baby. I went to bed thinking positive thoughts and drifted off to a peaceful sleep.

January 14th, 2000

7:30 AM - I woke up this morning feeling tiny twinges but figured it was mostly in my head. My husband K had already started the truck to warm up as he was on his way to the grocery store to fetch me another bottle of castor oil to make up the 4 ounces that I was supposed to take to start labour. (the first bottle only contained a little less than 2 ounces) I told him to hold off for just a bit because I was feeling "something". I decided that I'd better get up and see if things were going to progress or if I was really going to have to take the dreaded castor oil. Time was of the essence because my husband had to decide whether or not he was going to go to work, and whether or not we were going to take the kids to school. (we wanted them present for the birth) I got out of bed and went to the bathroom and when I went to get up off the toilet I had a little dribble down my leg. I thought "hmmmm..... maybe my water leaking?", but dismissed it as probably just loss of bladder control. I got into the shower with my youngest daughter L and shampooed both of our heads all the while

thinking "come on baby!" When I got out of the shower I noticed a little droplet of "pee" on my black tile floor in the bathroom and upon closer inspection I noticed that it had little white flecks in it so I really became suspicious of whether or not this was really amniotic fluid that I was losing. I sat down on my bed to put on my panties and when I got up - GUSH!! This really *was* it!! I was so excited! I called down to K to shut off the truck and call the school to tell them the kids wouldn't be coming today! I had a bit of tidying and preparing to do so I went about my business of getting ready for the day.

8:30 AM - I started feeling crampy and decided that since I really didn't know how long my labour would be (my previous labours had been fairly quick, but mostly induced, so I really had no idea how long it would be until baby would be here!) I decided to let my midwives know that something was happening. I got a call back from J (midwife) and told her that I was leaking and she said to just carry on with my daily activities and let them know if contractions got any stronger. She told me to keep checking my temperature every 4 hours to make sure I wasn't getting an infection.

J (midwife) lives in Cochrane, which is about an hour from my house, so I was a little anxious about her being so far away, but knew it would still be awhile until the baby would be here. I also paged my two doulas, F and S to put them on alert. F was on her way to one of the local hospitals to do a volunteer shift with E (friend and doula trainer), and I left a message on S's (doula) answering machine to let her know that today would be the day!

K (partner) left to run and get some groceries to feed everybody lunch and to have some fruit, snacks and drinks on hand for everybody.

I shuffled around the house keeping myself busy, still in my pink robe. I prepared my bed by turning down the feather comforter and putting my vinyl sheet on top of my good sheets, with an old sheet on top. This is where I would be delivering the placenta after having a

water birth so I didn't want the mattress to get ruined. I was so excited to finally be doing these chores that I had envisioned a million times in my head while anticipating my labour!

9:00 AM - My sister L called to tell me that she had an interview to do but would be over just as soon as she could to start the homemade soup that I had requested as part of my birth plan. (I wanted something to make the house smell wonderful, and to keep people busy so that I wouldn't be a "watched pot" while I laboured. I thought chopping vegetables and preparing soup would be the perfect job!)

10:00 AM - F (doula) called me back to let me know she was at home and would wait for me to call her to come when I was ready for some labour support. S (doula) called to let me know that she had received my message and that she would get her husband to drop her off at about noon. My sister gave her instructions on how to get to our house. I puttered around the house doing laundry and making sure that all of my birth stuff was ready. I was a little surprised at how difficult it was to keep my mind on some of these tasks. I was really starting to have a dull aching feeling in my lower back and although I was able to talk through it, it really did bother me. K (partner) and the kids mulled around the house and kept checking in on me every once in awhile.

10:30 AM - I decided to call F (doula) and tell her to come on over if she felt like it because I was afraid that things might pick up too quickly and I wouldn't get a chance to call her to come later. She sounded excited to be coming, even if it meant that we would just "hang out" together until things got more difficult. I was grateful for the company! L (sister) arrived a bit before this and started to boil some beef to start the soup, which didn't have the wonderful aroma that I thought it would, but I thought it might have had more to do with my labour than anything. (it must have been, because it sure smelled wonderful and tasted great afterwards!)

11:00 AM – S (doula) arrived and we all sat and visited in the kitchen and living room and had raspberry leaf tea while my contractions continued to increase. I was having pretty bad back labour so I was sure this baby was still posterior. I wanted to do some chest/knees exercises to try to get him to turn but I was afraid that with my membranes ruptured that I was at a higher risk of cord prolapse, so I was hesitant to do that. I told my doulas that I was afraid to "let go" and let myself get into labour mode without my midwives here in case baby came too fast and they wouldn't make it. J (midwife) called and asked what was happening and I told her that I was having back labour and she said to go ahead and do hands and knees.

I tried to palpate the baby's position and was sure I could feel his back along the right side of my body so I couldn't figure out why I was having all of this back labour. (posterior position is when baby's back is against the mother's back, not in front the way it should be)

12:00 PM

K (partner) started laying out the cold meat etc. for lunch. I didn't feel much like eating a sandwich so I headed upstairs to my bedroom ensuite to change my pad and have some privacy for a few minutes. Sitting on the toilet the contractions felt very strong. I was still having problems "letting go" with them. I wasn't allowing my body to open up.

J and K (friends) arrived around this time and J (friend) came upstairs to check and make sure I was okay. Other than my aching back I was still doing fine!

When I got back downstairs I complained a bit about my back so S (doula) suggested they try using the rolling pin on me. She filled her Tupperware rolling pin with boiling water and I leaned over my birth ball while they took turns running the hot rolling pin over my lower back and bottom. They were afraid it was too hot but it felt *wonderful*! (I still had my robe on, so it didn't feel too hot at all through the fabric)

Every so often I would go upstairs and the contractions would intensify on the toilet. I was having some pink show now too. F (doula) tried doing some figure 8's with my hips while I did hands and knees.... a technique we learned at the DONA conference in Toronto last August that is supposed to help turn posterior babies. Nothing really seemed to alleviate the pain, but it really felt good to have two caring doulas fussing over me!

I also liked laying my face against the cold granite tile on the island in our kitchen. Hot and cold are certainly nice distractions for a labouring woman! This is my husband K watching over me while I take advantage of the cool granite.

1:00 PM

1:00 PM - I decided to call J (midwife) and let her know that my contractions were about 4 minutes apart. I was still able to talk through them, but the discomfort in my back was telling me that things were definitely progressing. I explained that the contractions I had on the toilet were very strong and that I just didn't know where I was progress wise, and that concerned me. She said that it didn't matter as much how far apart the contractions were, but what did matter was the intensity of my labour. The roads were quite icy and I was a little concerned that it might take her a bit longer than usual to get to our house too. I think she could hear the hesitation in my voice, and in hindsight I wish I had just told her that I wasn't able to let myself go without them being here, but she said to keep them informed with my progress and they would be out just as soon as I needed them.

2:00 PM - J (midwife) called back and said that she had a meeting at 3:00 and couldn't decide whether she should go ahead to the meeting, or to come to our house first and check and see how things were going. She wanted to know what was happening. I told her that things had increased in intensity, but that I didn't know if it was too early for them to come or not. I had a contraction while on the phone with her, and was able to talk through it, but I tend

to be a quiet labourer so it was really fooling everybody that I didn't seem to be close at all. J (midwife) decided that she would come to the house and see where I was at and then decide about her meeting once she had a take on things. She was leaving right away.

I hung up the phone and said "Okay girls! Let's have a baby!" I could finally let myself go and get things going now that I knew she was on her way. I started doing some deep squats to bring this baby right down on my cervix with every contraction to help myself dilate. I turned inward during my contractions and stopped being as chatty with everyone. I was allowing the pain I was experiencing to go directly to my cervix to do it's work. I wasn't letting fear make the pain worse. I let the contractions go through me, opening me.

I went upstairs for another break alone and lit the candles around my Jacuzzi in the ensuite. I laboured a bit on the toilet and let my head lay against the wall beside me while I endured the pains without tensing up my body. I thought about laying out the tarp that would cover the carpet going from the tub to my bed, but decided that my birth team could do that closer to the birth. I was having more difficulty carrying out simple tasks while dealing with these stronger contractions.

2:30 PM - I went back downstairs and S and F (doulas) filled up the rolling pin with some more boiling water and continued to roll my back. I tried to move my legs further apart to make more room for the baby's head to turn. S (doula) mentioned that she thought my labour had really changed all of a sudden. I was definitely getting into labour land.

2:45 PM - I remembered that I had forgotten to tape up the emergency drain in the Jacuzzi to enable us to fill the tub even deeper so I sent K (partner) and J (friend) up to find the duct tape to do it for me. They couldn't find it (how irritating! I was starting to get irritated with things... a good sign for a labouring woman! It means progress!) so they got some electrical tape instead.

I asked them to fill the tub with hot water so that when J (midwife) arrived I could get right into the water if I was dilated enough. I didn't want to get into the tub too soon because it can really slow down labour if you haven't progressed enough. I thought I would get in if she said I was at least 5 cm dilated. The thought of being in the tub sounded soooooo good at this point!

3:00 PM - All of a sudden it was like I was so hot that I wanted to throw my robe off and I had the doulas stop doing the rolling pin thing immediately! I felt all hot and sweaty and wondered if this might be transition. I heard J (midwife) at the door and was relieved that I would soon know my progress.

J (midwife) and I headed upstairs after a few minutes and she had K (partner) go out to her car to get the things she would need out of her trunk. She started to get things ready on the bed to check my cervix etc. She listened to baby's heartbeat and it was just fine... 150's. Nice variables. She checked my blood pressure and said it was excellent. She had a peek into the ensuite and said that it was perfect for birthing! We have a double wide shower with a bench in it and she said that it would be excellent to use in labour. Our ensuite is really long so there would be lots of room for everybody too. The Jacuzzi isn't all that big, but she said it would be plenty big enough to birth in.

When J (midwife) checked my cervix she found that I was 5 - 6 cm dilated and she said that the reason that I was experiencing back labour wasn't because the baby was posterior, but that he had his head tilted up, instead of chin down, and that the larger part of his head was trying to navigate down through my pelvic bones instead of the narrower, crown part and that was why I was having such pain.

She suggested that I get into the tub and try squatting to get him to tilt his head down. I was thrilled to be able to get into the water!

This is a picture of J (midwife) and I chatting right after I got in the water. Boy it felt nice! As you can see I was still smiling at this stage.

On the left is my 7 year old daughter K.

The tub was just amazing! Getting into the water felt incredible. Instant back relief!! J (midwife) and I chatted and soon S and F (doulas) came up. (M (son) and F (doula) In Left Pic)

I would rock my hips back and forth during a contraction. They were more intense when I was squatting. I had someone turn on the CD player with my "sounds by the sea" playing. J (midwife) commented that the second song was played by her children at her wedding. J (midwife) decided to call P, the other midwife, (it is required by law in Alberta that you have 2 midwives present) to come now because she didn't think it would be that long until we had a baby!

The kids and K (partner) would come in from time to time to check and see how I was doing. I was still very social between contractions. Nothing was distracting me and when I needed to turn inward and focus nobody minded. I tend to labour in silence and some people thought that I was only doing so because of my audience, but that's just the way I deal with the contractions. Every time I would have a strong one I would just focus on it going right to my cervix and doing it's work of opening opening opening.

This is K, M, L (children) and my doula S!

J (midwife) reminded me that I would be feeling pressure down below soon with the contractions and that would mean that baby was coming down further into my birth canal. F (doula) would rub my hands and arms soothingly while I hung my head over the side of the tub to relax during contractions.

J (midwife) checked the fetal heart tones with the doppler every so often and they were always just perfect. So reassuring!

I loved her cold hands! She would hold my arms during contractions and they felt awesome. She said that that was the only time their clients appreciated her cold hands.... certainly not in clinic!

At about 4:50 J (midwife) checked me again because I said that I was feeling some pressure and she said that there was just a little lip left of the cervix. She pushed it out of the way while I gave some good pushes and she held it over the baby's head while we waited for another contraction to hit so that it wouldn't slip back over the head.

It took a few minutes for the contractions to come back afterwards.... the calm before the storm!

I really don't get the urge to push like most women do. In fact I hate pushing!! Stretching out really made the contractions ease up so J (midwife) made me get back into a squatting position.

Sometimes I would fake that I wasn't having a contraction so that I wouldn't have to push because I really hated that feeling.

(shhhhhhhh! Don't tell anyone!)

Once I started pushing the whole gang came in. My 4 kids, as seen here with their noses pressed up against the glass of our shower which is right at the end of the Jacuzzi, (Bird's Eye View or what??) my husband K, my sister L, my nieces (L's daughters) J and K, J's (niece) 10 month old daughter S, my two doulas S and F, my 2 midwives J and P and their student midwife C, my sister in law V who barely made it to the birth but videotaped for us once she got there!

Yes, there were lots of people and I was acutely aware of everything being said and what was going on around me, but I never once felt distracted. I could hear S's (niece's child) little peeps once in awhile, and the kids asking questions and people trying to shush them, but I really didn't mind.

M (son) - 8, at one point during crowning said to my sister "Yaya (that's what the kids call her), is the baby going to come out of that little crack???" That really cracked us all up and J (midwife) explained that yes, it would, but that little crack was going to stretch nice and wide for the baby to come through!

I also remember that one of the boys got the brilliant idea to run down to their bedroom and fetch the little pen-light flashlights that they had because it was beginning to get dark and they wanted to have a good look at what was going on. They thundered down the stairs to get them and I remember being amused. (imagine... amused at that point of labour!)

J (midwife) was my focal point during pushing, but everybody was very reassuring and encouraging. I remember hearing lots of "you're doing great S!", and "wonderful, that's the way"..., and it was just exactly what I needed to hear.

I was getting to that point of "I can't do this anymore!" here in this picture. I felt a humongous bulge down below and when the baby had passed by my hip bones I swear that I felt it!

I was having a hard time stretching my perineum on the bottom part where I had lots of scar tissue from having 4 previous episiotomies. J (midwife) said she wished she could get some olive oil on it to try to soften it more, and I offered to get out of the tub to try, but she said that we would just continue to try to do it by pushing little by little.

I remember asking if the head was out yet and my sister said "no, but just about!" and I knew she wasn't telling me the truth, but I didn't hold it against her! :) I really thought I

would enjoy touching the head and looking at the progress this time, but as with my others, I just found that it took too much away from my concentration and I couldn't do both.

I clenched my fists and pushed harder!! I had someone plug in the fan and direct it at me... this was hot work!! C (midwife) wiped my brow with a cool cloth and my doulas took turns getting cold cloths for my neck. I didn't want to be touched anymore at this point.

really had to get my mind around getting this kid out of me. It was hard painful work this pushing, and I decided that if I didn't want to do it all day then I'd better make up my mind to get it over with, and so I did! Finally I got that little head outta me!! What a relief!

Now, I have a question, I know I'm a doula and should know the answer to this question, but isn't the head facing the wrong way? Isn't it almost posterior? This didn't occur to me until later when I saw this picture.

J (midwife) had me bring my hands down to help lift my baby out of my body and up onto my chest. I'm grateful that she reminded me to do that because it's really distracting birthing a baby and you don't remember to do these things unless instructed!

Here J (midwife) and I had lifted my big baby onto my chest and I began to rub the back to stimulate that first breath. The baby cried almost immediately!! I knew that sometimes babies born in water take a few minutes to cry and to pink up but this baby just started right up and I was happy about that because I knew K (partner) would worry if there was a delay in crying or anything.

It didn't even occur to me to check whether it was a boy or a girl, because we were pretty sure we were having a boy and we had been calling him "Jack" for months now..., but someone said "Well... is it a boy or a girl???" so I thought I'd take a look just to appease everyone else...

and.....

Wow! Were we ever surprised. I opened a leg up and said, "oh my Gosh, it's a GIRL!!!!!!" Everyone cheered and laughed while I looked a little closer to make sure I hadn't missed anything. J (midwife) even checked!

Sure enough, she was a girl and we would now have 3 little girls and 2 little boys in our busy household!

It was the best surprise to think you are getting one thing (we had had ultrasound at 18 weeks and thought we saw "something"), and to get something else. It was better than not peeking at the ultrasound at all!

A tired but pleased mama!

I DID IT! I DID IT!

I spent a couple of minutes in the tub before the midwives helped me to get out to go to the bed to deliver the placenta. After having 5 kids I was at a higher risk of hemorrhage and it's easier to estimate blood loss when not in the water, so I didn't mind. We had set up a tarp going from the tub to the bed to catch any drips along the way.

A lot of people are curious about how "messy" a tub birth was, and let me tell you that there was barely any mess at all! The water wasn't even pink until after the baby arrived. There was just a bit of a puddle underneath me on the bed and that was it!

Daddy got to hold the little nameless one while the midwives checked everything over. He thinks she's pretty sweet! Now if we could just come up with a name!!

(We finally did, 3 days later... and her name is....)

S G

I was given a shot of Syntocinon because my uterus wasn't clamping down as much as we would have liked, despite the gallons and gallons of Raspberry Leaf Tea I had during my pregnancy, and we even tried nipple stimulation with both the baby and manually. I was

taking Arnica so my after-pains weren't really all that bad despite having the artificial hormone flowing through my veins! If this was the only intervention that I needed then I think I got away pretty darn good!

Hi Mom!

Here is my sister L holding little S (baby) while I am having my second degree tear fixed up by the midwives. Once that was over with my doula S brought me some toast and milk. All that work made me pretty hungry!

Here is P the midwife checking the baby out to make sure everything's working perfectly, and it was!

K (daughter) was holding my hand on the left.

Here is another nice picture of P (midwife) looking over the baby while K (daughter) and C (midwife) are looking on.

See the baby sucking her hands?? She just wanted everybody to leave her alone for her first meal!

I was able to have a nice hot bubble bath with the baby after her checkup and my repair and then I got into the shower and washed my hair. I was a little weak when I got into the shower and had to sit down for a bit, but by the next day I felt great.

C (midwife) helped the kids dress the baby while I showered and then she finally she got to nurse.

K and M (children) watch as she was latching. She's a great nurser and I didn't even get sore initially as I had with the others.

And Now Our Family is Complete!

(I think.... never say never!)

I want to thank so many people for helping me to achieve such a wonderful birth! Thanks to J and C (friends) for helping me to believe that I could really do this! Thank you to my two wonderful Doulas F and S for their wonderful friendship and care throughout my pregnancy and during the birth. Thank you to my sister L for her love and support, not to mention all of her help on the day of the birth (she kept everybody fed and happy, helped take care of the kids, and made the best homemade soup ever!). Thank you to K and J, my two nieces for being there with us for S's (baby) birth and for allowing me to be a part of the birth of their children which inspired me to pursue having a homebirth. Thank you to my sister in law V for coming and videotaping S's (baby) waterbirth. Thank you to E (friend and doula trainer) for your trust in birth and in life. I have learned many lessons from our visits together. I am sorry you weren't able to come to S's birth, but felt you there with me spiritually (and thanks for the tip about castor oil!).

Thank you to the rest of our family and friends for not discouraging us in our decision to have our baby at home, even though I know it made some of you nervous because you didn't initially understand how safe it really was.

And last but absolutely not least, thank you to my 3 midwives P, J and M and their assistant C for helping to make my pregnancy the best ever with their loving care of our whole family during our prenatals, and especially during S's birth. I will dearly miss our visits and I hope that our paths keep crossing in our birth work so that we are able to keep in contact, you are all wonderful women!!

I hope that funding of midwifery in Alberta will happen soon so that any woman who wants to experience birth like this will be able to.

From the very start of S's story we can see evidence in her narrative of the negotiations she enters into to chart her own path through and between medically managed birth and natural birth at home. Her dream birth is a midwife-attended homebirth that begins without any artificial forms of induction, but she realizes that she may have to make certain sacrifices to her ideal birth in order to avoid more significant alterations to her plan, most notably the move of her birth from home to hospital. She accepts the information conveyed by her due date and notes that she is one week past, yet she doesn't fully accept the definition of overdue as applied to her own situation. She introduces the phrase "overdue" in quotation marks as a way of differentiating and setting this medically defined term apart from her own narrative and her own understanding of pregnancy.

She is given the option (and the recommendation) from her midwife to undergo medical testing to confirm the baby's health status (biophysical profile), but is warned that she may receive results from this test that would negate her ability to give birth at home. The other option that is presented to her is to try a selection of alternative methods of induction, including blue/black cohosh and castor oil, but S accepts that even though these methods of induction may be defined as natural they still represent an induction and as such are a movement away from the natural birth she envisions.

S describes her reaction to these options as feeling "caught in a bind". The bind in which she is caught represents her own discomfort at occupying the space between a medical and a natural understanding of her own birth. She is aware of the medical limitations on her midwife's ability to attend to her in a homebirth and knows that if the pregnancy continues too far into that period defined as "overdue" she faces losing the ability to have a midwife-attended homebirth. On the other side of this bind she could accept alternative methods of induction, but in doing so acknowledges that she has once again been induced and is faced with confronting the belief that her body was not able to "go into labour on it's (sic) own". She recognizes that by choosing to give birth at home she has chosen a birth that in many ways does not follow the dominant cultural narrative of birth, but nevertheless medicine maintains a dominant presence. She attempts, through the use of quotation marks around terminology such as "overdue" and "getting it right", to

set the medical paradigm apart from her own voice, but in many ways this segment of her narrative highlights the strength of the medical script for understanding birth even in a scenario in which medical personnel are not present. She must be aware of and negotiate with the boundaries that medicine has created around midwifery practice and through this process she solidifies and illuminates the shifting spaces in between. For S the biophysical profile represents the medical model and is carried out by individuals referred to as "they" who have the power to "ruin" her chances of achieving her dream homebirth. The alternative approaches to induction such as blue/black cohosh and castor oil represent a more acceptable method of induction than she had experienced in past pregnancies, but S acknowledges that these approaches are still a deviation from that which she defines as natural. For S, therefore, to birth naturally is to allow the body to enter into labour without any outside interference or assistance and this is the route she views as "get[ting] it right". To negotiate her way out of the bind, S permits herself to employ the measure that most closely conforms (or deviates the least) to her view of natural by deciding to use the castor oil if she is not showing signs of labour by Friday.

One technique to prompt her body to begin the labour process is to attempt to connect to her body through her mind. She uses the castor oil, initially not as a substance to be taken internally, but rather as a visualization aid. She also reads the online birth stories of others to enhance positive thoughts and get "in the mood" to have the baby. Later in the shower she begins to communicate messages directly to her baby in an effort to persuade the child to hurry along. Through each of these methods she is recognizing a belief system in which the mind is distinct from body, but a connection between the two can be established. Visualization and positive thoughts have the ability to play a definitive role in preparing the body for labour. Likened to the adage "mind over matter" there is an acknowledgement that at some level the will of the mind can influence the actions of the body. For S, however, this connection can also foster a sense of overcompensation in that the mind has the capability of playing tricks on the body. Upon waking with "tiny twinges", S dismisses them as being "mostly in [her] head". For S, she has concentrated so completely on convincing her body to go into labour that when small contractions

are initially perceived they are dismissed as illusions, as a figment existing in her mind rather than an actuality in her body.

The mention of the Internet birth story is particularly significant. In this occasion we see evidence that women who post their own birth stories not only write their story for others to read, but they also read the stories of others and look to these stories for inspiration and motivation. Internet birth stories are not, therefore, created and distributed in isolation, but rather they exist as part of an ongoing exchange and dialogue. S was inspired by the story written by another woman, a woman whom she most likely will never meet face-to-face, but yet a woman whose words are so meaningful to S that a mention and a link to this woman's story appears in her own birth story. The implication is that a reader of S's story *now* has access to both of these stories and, just as S has incorporated the other woman's narrative into her own, it is possible that this future reader could also incorporate S's story into either a future birth experience or an interpretation of a past experience. Collectively, therefore, we can begin to see some initial evidence of the power of these Internet birth stories to weave their own thread through this contemporary collection of birth stories. Women who write of their own personal experiences of birth are influenced by and have the power to influence others who may encounter their stories.

Throughout much of her story S uses a timeline approach to structure her narrative. As explored in the work of Simonds (2002) time is a key component of the medical model, which breaks the prenatal period into months and weeks and the labour into periods in which contractions are measured and each stage of the labour takes place within an optimum time period. In this case, S has written a story which occurs outside of the confines of the hospital and thus outside of the scope of a typical medically managed birth, but yet we still see the importance of time as a structural element to her narrative. The introduction of the timeline approach begins as S wakes up in the morning with the early sensations of labour. Times are presented in increments that range from one hour to 15 minutes and appear as headings or subtitles ending at 3:00pm with the arrival of the midwife. This leads to two different questions. First, what is the purpose of the timeline structure to this non-medicalized birth story? Second, why does this structure disappear with the arrival of the midwife? I postulate that one possible answer to both of

these questions concerns S's ongoing struggle with and negotiation against the medical model and the authoritative knowledge this model represents and signifies. Time is an important structural element, not only in birth, but also in most of our daily activities. We wake with alarm clocks that signal to our body that our allotted amount of sleep has ended and it is time to begin our day. Breakfast, precedes lunch, which precedes dinner such that we begin to make connections between our experience of hunger and the appropriateness of scheduled mealtimes. We watch the clock, and count the hours as part of a larger cultural script that structures our lives in segments of time. Medical use of standard timelines is a way of establishing benchmarks according to this larger cultural script. Time is an objective measure, a yardstick that can be borrowed to provide structure to a lived experience, such as labour and childbirth. When S uses a timeline to structure her narrative she is hinging her story on elements that we can all comprehend, the passage of time in measured increments. Time, therefore, is a way of introducing objectivity and externally verifiable reality to her story. I would argue that as medicine divides pregnancy and labour into chunks for the purposes of references and establishing truth through the passage of time, so to does S divide her story into segments to allow us to view the passage of time through her perspective. Time in this case passes and provides her readers with an objective measure of the progression of her labour. The timeline disappears from her story when the midwife arrives, because S no longer needs to be involved in objectively measuring and monitoring her own progress, because this role has been transferred to the midwife. The passage of time as an indication of progress in labour has been replaced by a description that includes the number of centimetres dilation measured by the midwife and a personal account of the experience of and S's efforts to "deal with the contractions".

Early in her labour S's body is the primary source of authoritative knowledge about this labour experience. There is, however, a thread of uncertainty that continues throughout much of the initial part of her story. Because most of her past labours involved inductions, she is unable to make comparisons between this labour experience and those that came before. She would typically look to her body to inform her of what to expect, but the discrepancy between this

unmedicated experience and her previous medicated births prevent her from making comparisons. She states:

> I started feeling crampy and decided that since I really didn't know how long my labour would be (my previous labours had been fairly quick, but mostly induced, so I really had no idea how long it would be until baby would be here!)

S recognizes past experience as a valid source of authoritative knowledge, but the conceptual distance that has been created between this experience and others means that she is unable to effectively invoke authoritative knowledge in this situation.

She does, however, have other sources of authoritative knowledge from which to draw, such as her training as a doula, and her own experiential knowledge of this birth, but the distance that she recognizes between this birth experience and the others means that there are limitations on the situations in which she feels comfortable making decisions. She attempts at several locations to negotiate through this uncertainty by relying on the technical knowledge of birth (textbook knowledge), but is held back from fully incorporating this information because she is unable to access information on her progress in labour that would provide her with all of the information needed to make a definitive conclusion. In the segment that appears below she is aware that employing a course of action based on technical knowledge may alleviate her pain, but it may also expose her baby to significant risk. Without a full claim to authoritative knowledge in this situation she cannot make a decision without first receiving advice from her midwife. Partway through her story, she explains:

> I was having pretty bad back labour so I was sure this baby was still posterior. I wanted to do some chest/knees exercises to try to get him to turn but I was afraid that with my membranes ruptured that I was at a higher risk of cord prolapse, so I was hesitant to do that. I told my doulas that I was afraid to "let go" and let myself get into labour mode without my midwives here in case baby came too fast and they wouldn't make it. J called and asked what was happening and I told her that I was having back labour and she said to go ahead and do hands and knees.

Through this passage S illustrates for her reader the decision making process in which she participated to determine an appropriate course of action. She interprets what she is feeling (back labour) and makes an assessment based on her knowledge of labour that the baby's position was posterior. (The baby's spine is in alignment with the mother's spine. This is a position that is more likely to result in painful labour experienced in the mother's back.) She determines an activity that

could alleviate this pain by changing the position of the baby, but she also acknowledges that changing her position could result in increased risk to the baby. She has all of this knowledge in order to make a decision, but she lacks the authority on which to base the decision. The midwife provides her with the authority required to implement her course of action.

S also demonstrates in this segment both her comfort level and acceptance of terminology that has its origins in the medical model. She talks about "membranes ruptured" instead of using more common language such as broken waters. She discusses cord prolapse without any mention of what this refers to and why this is a risk to the baby. She is making assumptions about her audience that they will be as comfortable and familiar with the terminology as she is knowing that this situation refers to the possibility that the umbilical cord has looped through the cervix and into the vagina with the possibility of disturbing the baby's oxygen supply. In order to describe this situation, S invokes aspects of the medical discourse, which focus on risk, acknowledging the "higher risk" state that she was disposed to since the waters had broken.

Several past researchers have focused on the way in which midwives participate in medical discourse in an effort to "maintain independence and alternatives" (Annandale, 1988: 108) and gain legitimation (Foley and Faircloth, 2003). This blend of the medical and the natural used by midwives has resulted in the label, used by Robbie Davis-Floyd and Elizabeth Davis (1997), post-modern midwives. In much the same way that midwives may use medical language and discourse in their own narrative descriptions of birth, we see medical terminology weaving its way through S's story. S has been trained as a doula and the use of medical terminology in her story can be viewed as a result of her professional exposure in much the same way as that of midwives. Much as Foley and Faircloth argue, we can see through this story that the discourses of midwifery and medicine are not polar opposites, instead they blend together and serve different purposes in S's story to provide her audience with information pertaining to her understanding of her own birth experience. S uses medical discourse at first (through her initial discussion of being "overdue" and her dream of having a homebirth) to distinguish between her views on birth and medical understanding, but in this later passage she uses specific medical terminology to communicate to her audience her comprehension of the biological processes of labour. S

represents, in many ways, a post-modern mother; she easily mobilizes this discourse to both explain her understanding of this birth and position herself and her own understanding of birth in relation to medical birth. The placement of this language within her narrative without any explanation at this point is an indication not only of S's comfort and familiarity with this terminology, but also reflects an assumption that the readers of this story will also exhibit a similar amount of familiarity with the medical language of birth.

Through her use of terminology and her ability to assess the situation and propose a possible course of action, S displays a significant amount of knowledge about birth in general and provides a specific assessment of this birth. Interestingly, despite her knowledge of birth, S does not rely on this knowledge to make an authoritative decision in this situation. The primary source of authority in this story is the midwife and it is the authority of the midwife that holds sufficient weight to enable S to proceed with the course of action that she had initially believed would be helpful.

S states that without her midwife present she is unable to "let go". This is the first instance in her narrative that this phrase will appear, but it will resurface on several occasions. For S, "letting go" is a reference to the mental control that she maintains on her labour. She is unable to "let go" or release her mental control over her labour because the midwife, or the source of authoritative knowledge on this birth, has not yet arrived. S is very knowledgeable about this birth and draws information from a wide variety of sources, including her own body, her professional training, and past birth experiences, but without the presence of the midwife she lacks the authority to engage fully in the decision making process. In addition, she is missing what she believes to be a key piece of information about her body (her body's reaction to a non-medically induced labour) that would allow her to be able to relinquish mental control over the labour. She is uncertain about how long her labour will be in this case and is fearful that releasing mental control over her labour will speed up the process and the midwife will not arrive in time.

Like the research done by others (Fox and Worts, 1999; Viisainen, 2001; Davis-Floyd, 1994) control is a key element in this narrative. What is slightly different in this story is that S is acknowledging that she is in control of the birth, but what she awaits is the time when the midwife

arrives and she can surrender some of this control to the authority of the midwife. Essentially, S is in control of the entire experience. First by maintaining mental control and next by being able to determine when she can relinquish control.

This struggle to maintain control and this desire to release control can be paralleled to the differential spheres of mind and body that are deeply embedded in the medical/natural dichotomy. She acknowledges throughout her story that mind and body are connected and by using the phrase "letting go" further acknowledges the control of mind over body. At the same time she also communicates her underlying belief that in order for labour to progress she must loosen her hold on the mental aspects and release her body to the process of the labour. She needs to be able to "let go" to "get into labour mode".

As the story progresses, however, we can see that this differentiation between mind and body becomes more complicated. As her labour progresses and once S knows that the midwife is on her way she may release some elements of mental control, but she maintains a strong mental presence as she allows her mind to focus on the processes of her body. In the initial parts of her story she maintains a strong rational presence processing information, assessing the situation, and deciding on a course of action. Following the arrival of her midwife, she is able to transfer some of this rational process to the midwife and focus instead on developing a deeper connection with her birthing body. She states: "I turned inward during my contractions and stopped being as chatty with everyone", and "Nothing was distracting me and when I needed to turn inward and focus nobody minded". Finally, as the birth draws closer she states that she "really has to get my mind around getting this kid out of me" and "I decided that if I didn't want to do it all day then I'd better make up my mind to get it over with, and so I did!" Through each of these statements S emphasizes both the mental and physical work required to birth her baby. There is still a distinction between mind and body, but she is able to mentally connect with her body in a way that allows her to focus on the work that her body was doing. For S, it was not about releasing mental control, but rather strengthening the connection between mind and body. Mind and body enter into a dialogue in which she listens to her body and communicates back sending messages of encouragement.

When S describes the scene of the birth the entire cast of characters in her narrative is brought together, the number of people far exceeds the average number of non-professional attendees at the other births for which women provided information (typically one or two other people). S's birth includes her four children, her husband, her sister, her three nieces, the child of one of her nieces, and her sister-in-law, as well as two doulas, two midwives and a student midwife. Not including the mother and baby this is a total of 16 people present at the birth. While this birth scene may not be typical, it is likely more characteristic of home births than hospital births and definitely represents a departure from the hospital birth experiences of women who gave birth at a time when even partners were not permitted into the labour and delivery room. What this does show is a refocus on the importance of family and friends at birth and an effort to normalize the birth experience, particularly to children who are more likely to be excluded from birth by hospital policy and by those who feel that the experience of birth could be traumatic. Homebirth literature generally acknowledges that parents should judge if witnessing the birth would be appropriate for their children (See Hawkins and Knox, 2003), and in several of the homebirth stories I collected, mention was made of the importance of children at the birth and the value of educating children about the actualities of birth by not restricting them from attending the birth.

S completes her story by providing an acknowledgements section, set apart from the rest of the text by a bold font. In addition to acknowledging the various participants and their contribution to the birth, S adds a comment to her narrative about her desires for the continuation of funding for midwifery services in Alberta. This statement contains recognition of the political significance of both the events that she describes and the act of storytelling itself. To tell this story, therefore, not only demonstrates an ability to make this personal experience visible, to perform this story in a publicly accessible forum, but it is also an opportunity to communicate a message. The personal is made visibly political through this story and its ability to educate and inform women about midwife-attended homebirth as an option is opened to others to consider as a viable option.

H's Story

H's narrative describes the story, or as she titles it the "secret", of the birth of her third child. This birth took place in 2002 at home in Manitoba with the assistance of her partner D when H was 36 years old. At the time of the birth, H had completed university, while D had some university education, and the couple had a combined annual income of between $20-40,000. H was self-employed as a birth counsellor and prenatal educator and D worked for a courier company. H's first birth occurred at home with a midwife in attendance and her second birth was an attempted homebirth that resulted in a transfer to hospital and a caesarean birth under a general anesthetic. Information for this birth experience was sought from a midwife who was called during the labour, but H indicated that she and her baby were the primary sources of information about the pregnancy and birth. Her partner was a fundamental source of support for this birth. H rates her level of satisfaction with this birth as extremely positive noting that it was "the most powerful and yet completely normal thing" she had ever done in her life. Here's her story:

My Secret :

Or the birth of J R C

June 23, 2002

I had a baby. Now anyone who knows me realizes that this isn't the secret. We have proudly told everyone we know about our son. He is amazing! We all adore him. As well, pretty much everyone knows by now that he was born at home, his birth attended by his daddy.

The secret is his birth story. I have been asked many times about his birth and various people know tidbits of our shared experience, but I have yet to tell anyone the whole thing. I have sat down several times to write about his birth, but haven't been able to bring myself to committing it to paper... I finally understood this morning that this is because his birth experience was so personal and so intimate that to share it feels invasive. Then I realized

that I don't have to share it with anyone simply because it has been written. I can hold the secret as long as I need to and when the time feels right – then I can tell the whole world.

On Friday June 21, I began to suspect that perhaps I wouldn't be pregnant forever. I had been having BH contractions for months, so the sensation wasn't completely new to me. It did feel a bit "different" though. I mentioned to my mom that day that I thought my body was beginning ever so slowly to prepare itself for birth.

Saturday morning about 6:30 I got up to pee. I noticed that I was still having the usual tightenings in my uterus. They were more frequent although they were still quite spaced apart. I stood and walked back to the bedroom and when I got there I began to leak. I momentarily wondered if I was peeing again, although I didn't see how that could be the case... Of course it was my waters leaking. I got dried off and climbed back into bed. Something was definitely happening! I drifted off to sleep again, happy but determined not to get too excited too early with this birth. I was going to sleep because it was early and I would need my strength later. We got up around 10:30 and began a fairly normal day. I told D (partner) that something was happening and that I was in early labor. I spent the day napping and reading, eating when I felt like it and relaxing. D was great for making sure my glass of fluids followed me around the house – and I drank quite a bit RRL tea with chlorophyll. I spoke to J (friend) on the phone a few times and managed even through contractions not to let on that anything was different than usual. For some reason I did not want anyone to know. I didn't want anyone clock watching for me or worrying if it took a long time. I just wanted this birth to happen.

We ate supper that night and eventually E (daughter) went to bed. A (son) was away camping for the weekend – he would be home on Sunday evening. It was the perfect time to have a baby if we wanted it to be just D and me. I found myself struggling somewhat

with what "should" I be doing. Was it appropriate to be watching tv when perhaps I should be going out for a walk? Maybe I should go to bed and get some sleep if I could. If I actually ate supper that evening could I really be in labor? Questions flooded my mind. I had an insatiable need to know how far along I was and when would this baby be born. Was I in early labor or was something actually happening? Could I get into the pool any time soon? Was this going to be another 3-day birth?

D gave me a dose of Sulfur, the homeopathic remedy that seems to be able to make my life better, at about 11 p.m. He doesn't ask anymore. He just prepares it and I take it. It was nice to have someone else thinking at a time when that would have just been one more question for me to obsess about. Should I take Sulfur – or do I need another remedy this time?

D and I spent some deliciously intimate moments together during the evening. It was so nice to be close to him and to feel his support. It was great to spend time with him and not have anyone observing us. We snuggled and talked. He was so positive that things were happening – that I the labor was progressing, as it should.

Some time after midnight we went upstairs. I didn't have a recollection of time by this point. It was all just floating by us at a "Twilight Zone" pace. I labored in our darkened room for a while in various positions depending on what felt right at the time, the midwife in my mind warring with the mother giving birth in my body. Sometimes I was on my hands and knees, sometimes standing. I spent time on the toilet. We set up the birthing pool (a plastic children's pool) and filled it. Eventually I allowed myself to get into it. The water felt great. It was so much easier to get comfortable. I had finally found a position that eased the ever-present ache in my back. I spent quite a bit of time in the water. After a while I started to feel "pushy." Part of my mind was saying, "This is way too early to be

pushing!" The other part realized that if it was time to push and I did, the baby would be born soon.

After a few pushes in the water D suggested a change of position. Perhaps getting up and out of the water would move things along. I think he realized instinctively that something needed to change. When I was upright the contractions intensified. I went through several on the bed on hands and knees, rushing to the toilet regularly to pee (thanks to the RRL tea and watermelon I had no problem keeping my bladder empty!) Before long the contractions were getting the better of me. I was beginning to hear the blathering in my mind, "I attend birth very well – but I don't give birth well at all!" being the most prevalent sound track. I realized that I was comparing myself in birth with others who I knew, women I had attended and the unassisted birth stories I had heard. The midwife within was holding up a measuring stick and I was seeing myself falling short. It took some work to come to the conclusion that no one else's birth had anything to do with me. No other birth I had ever attended had anything to do with this birth. My previous two births were irrelevant right here right now. That was one hurdle cleared. I naively thought I was now on my way to birthing this baby. I got up to go to the bathroom once more and was hit with a succession of nasty contractions. I was pushing, had been for some time now but the baby wasn't moving down. I began to panic. I remember sitting on the toilet wondering what on earth I was going to do. I needed someone to save me. I really needed someone there who could make it all better and help me through it. Could I transport to the hospital for another Cesarean Birth? Was that an option for me? Not really, although I can completely understand the epidural rage in hospitals today. If I had been somewhere where someone could have offered me that kind of release, a way out of the pain, I would have taken it in a heartbeat. I did think about it – quite seriously, very quickly perhaps, but seriously. I decided that I

couldn't transport again. I knew that the only way through this for me was through it, but how was I realistically going to get there? I was intermittently crying and calling for help. I didn't know where to go…

At about 4:30 a.m., I asked D (partner) to phone D (midwife). She is one of the most amazing women I know. She has attended many births and has been the inspiration for numerous UC births. She is a traditional midwife. D (partner) talked to D (midwife) for a bit and then handed the phone to me. I was still in the "someone needs to save me" mindset. What I wanted to hear her say was that she was on her way over to make it all better. She lives over 2 hours from me! She very quietly asked where I was feeling the pressure/contraction. I told her it was largely in my back. She listened to me as another wave rocked my body and then suggested that it sounded like the baby was very low applying a lot of pressure to the cervix, but that I was not fully dilated. Therefore, I was having the urge to push without any progress. This resonated with what I "knew." The midwife within stood back, arms crossed nodding her head. The mother in labor groaned and whined in disbelief at the suggestion that she could try blowing off the contractions for a time. As the next swell hit I met it head on with a breath. While I was blowing out it was barely manageable. When I had to break to inhale, I felt myself drowning. Right there beside me I heard D (midwife) praising me, supporting me, validating what I was doing. She listened to me blow through two contractions and said that I should probably aim for an hour at least. As I heard her I wondered how on earth I could do that? How could anyone ever ask a woman in labor to blow away that kind of intensity? I told her I would try and hung up feeling still somewhat lost because she wasn't coming to my aid. D (partner) lit the candles on my birth alter which represented the most amazing group of women I know. He knew that I needed support and saw that this was a way to help me.

For a time – 20 mins – 3 hours who knows – I laid on my side in bed beside D as he tried to get some much-needed sleep – blowing off contractions. I would look at the candle lit wall and the flickering lights. It was helpful to have the women represented by the candles present with me and to connect with other women birthing in the world. I was thankful for my experience with toning because I would moan/tone through each contraction and rock back and forth frantically until it was over. At the end of each one I would blow it away and remind myself that I needn't go there ever again. I got up to pee one more time and was bowled over by the intensity. I sat on the toilet crying wondering how D could possibly ignore my plea for help.

When I came back into the bedroom I told him that I wanted to get back into the pool. Something in me made a connection with the water and I understood that I needed whatever it was the water had to offer. I got in and D turned on the hot water to warm up the pool. It felt wonderful. The warm water rushing toward my belly as I leaned back helped immensely. The pain in my back was beginning to subside.

For the next hour and a half or so I found my zone. It was an amazing place to be. For the first time I fully understood what Pam England meant by the term "Birthing From Within." It was the strangest place to be. Today I get only a soft edged glimpse of that place and it continues to fade with time. It was quiet and warm and ever so calm. During contractions I would tone or blow (breath awareness being another HUGE blessing to me during this birth.) Between contractions, I floated away. It was almost like during those times in between I didn't exist. Time was completely irrelevant and one sensation was in no way related to the next. Occasionally I would look up and see D sitting at the edge of the pool. I think he was napping on and off – although not soundly I'm sure. At one point I looked up and he looked a bit concerned – but he simply smiled and said nothing. His trust and belief

in me were overwhelming. When I failed to see the strength in myself he never lost that sight.

Some part of me was vaguely aware that after a time my uterus was pushing without my conscious effort. I continued to blow through contractions for a time and observed my body doing it's own work. It was an interesting place to be.

Suddenly something within me shifted. Laying and blowing off contractions was no longer the right thing to do. There was a slight catch in my breath/tone during the contraction and that ever present midwife smiled within me. I thought perhaps I would get up to pee again. I got as far as an upright on my knees position when another one came over me. After that contraction I checked within and the baby's head was right there. I could feel it less than one inch inside me. I told D and he was hit with a burst of energy. It was fun to watch because the tension he was feeling lifted as we were once again in a moving forward kind of place.

I was on my knees leaning forward against the back of the birth pool which we had supported with two bean bag chairs. I could feel the baby move down during contractions and slide back up between. After a couple contractions, I began to plead with him. "Come on baby! Come on baby!" That wise woman within understood what the baby was doing – gently preparing his path into the world, but the mother bear within had had enough. She wanted a baby to hold and to nurse and she had been waiting long enough! When I began to understand that the fullness in my bowels was causing the delay I experienced a moment of embarrassment. I made some mention to D about needing to have a poop. He thought I'd said the baby pooped. I said, "No, I am going to!" In his most complete moment of assistance he said to me "You do what you need to do." It was in that instant I understood the perfection of unassisted birth. There was no one present who would judge me. There

was no one wondering what I was doing or why. No once was concerned about the well being of the baby because I knew he was fine. No one suggested that perhaps I should do this or that. The only other person present loved me and believed in me and trusted me. He knew that I knew what I needed to do!

I pushed and pushed and pushed! I wasn't waiting much longer to see this wee one. I could feel him wiggling within me – squirming his way out. After a momentary "Is this a head? What is this? This feels weird!" I determined that yes he was coming head first. The head moved down steadily ever feeling larger and larger. My hands were over his head supporting myself from the outside. I could feel his hair waving in the water, tickling my palm. It began to burn and for an instant I thought, "I will NEVER give birth unassisted again! I will NEVER recommend unassisted birth again! I don't think I will EVER do this again!!" And then as I breathed, his head slipped through into my hands. I saw and felt him turning. Taking that last curve in the path to this world. With the next push his body was coming. His cord was looped around his neck and under one arm. I lifted it off and he swam out and grabbed hold of my leg. D and I both reached down for him and as he was brought to my body D said quietly "Whatcha got mama?" I looked although we both already knew, and confirmed that yes indeed we had a boy!

Crying I marveled at how adorable he was and how incredibly much he looked like his sister. I was overwhelmed with pure joy. He was here and I was cuddling him and all was right with the world. He cried quietly for a few seconds and then snuggled into my body.

D phoned his mom almost instantly. He was excited and needed to share the news. Gramma got to hear the first wee cries of her grandson. This served another purpose as it turned out; it gave us the birth time for our wee babe on our phone bill. He was born at 6:49 a.m.

D woke E (daughter) up. She came in looking a bit bleary but happy and excited. She marveled at the wee babe in my arms and asked questions about the baby and the blood in the water. We discussed again how women bleed after giving birth. How fortunate to begin to have an understanding of normal at 3!

While still in the birthing pool he latched onto the breast and nursed like a pro. D gave me some Arnica and I relaxed for a time with my baby in arms. The placenta detached and delivered about 20 minutes after the birth, although there were still membranes holding it in close to my body. After J (baby) nursed for a while I was starting to feel restless and wanted to get out of the water. I handed him to D and got more upright – pushing slightly while gently pulling the membranes. They released and I realized that they had only been held in place by a large blood clot inside a pocket of membrane.

I got up to pee and climbed into bed. Within an hour after the birth D, E and I were nestled into bed together with the baby in awe of this new being in our lives.

A (son) came home later in the evening. When he came in he seemed to know that the baby had been born. He asked D not to tell him if it was a boy or a girl and came up to our bedroom. When he came in he said to me "Don't tell me, I want to see if I can tell." He looked at the baby and his face lit up as he exclaimed, "It's a boy!! Right??" He was thrilled, having already decided that little sisters are brats he desperately wanted a brother. He climbed into bed beside him and lay looking at his brother for some time.

That's my secret. I finished writing about it this morning. I held it secure for almost 6 weeks and now feel ready to share it. There was a real advantage to waiting. J R's birth was so intensely private and intimate that to share it sooner would have disrupted something for me. It has also taken this time to simply find the words to describe the birth. I acknowledge now that I could write about his birth daily for the rest of my life and the mere words would

still fall desperately short of really sharing the experience. That knowledge is something for my heart and my soul and cannot be shared in any real way, but I hope this tale may spark that passion in others who have their own stories.

H begins her story reflecting not on the birth, but on the process of writing the birth story. The words that she uses to introduce her story provide us with an initial understanding of the importance of these stories for the women who write them. For her, the process of writing birth is an act of intimacy. Viewed through the work of Della Pollock (1999) a birth story is a performance of the birth itself. The intimacy of the process of writing the birth story is derived in part from the intimacy experienced by H in this birth experience, such that to write the story is to reenact the intimacy of the birth in language. To preserve and respect this intimacy, her written birth story is presented as a secret. For H, it is not merely a detailed written account of the events of the birth, but rather a private performance of the intimacy of this personal experience. This performance becomes public when the story is released and the secret shared with others. H maintains the control over the shared intimacy of the secret by choosing both the time and the place where this story can be told, and once she determines that the time is right then she "can tell the whole world". In many ways by choosing to share her story on the Internet this is precisely what she has done.

The story of her birth begins with the early sensations of labour. H mentions, "I had been having BH contractions for months". BH contractions refer to Braxton Hicks contractions, named after the physician John Braxton-Hicks who practiced in the mid to late 1800s. The contractions were originally associated with the recognition of the existence of a pregnancy, but now have come to signify "practice contractions" in which the uterus is conditioned for the upcoming labour (Oakley,1984: 25). The appearance of the abbreviation BH is indicative of two distinct elements in this narrative. First, Braxton Hicks is a term that is historically situated within a medical model of childbirth. The ease with which this language enters the narrative illustrates a level of comfort and familiarity with this medical terminology. Indeed, it appears as an abbreviation without explanation

indicating an assumption on the part of the writer that the audience will also be equally comfortable and familiar with the term, even in its shortened form. This is comparable to some of the terminology that was employed in S's story and serves to illustrate the ways in which the use of medical language in childbirth has become so dominant and pervasive that it permeates even stories in which no medical personnel are represented. Also, as in the previous story, this is an indication of the blurring of the boundaries between the ideologies of natural and medical childbirth. Boundaries which are typically presented in the literature as mutually exclusive oppositional categories, but don't appear to be lived or experienced as such.

The second element that the inclusion of this abbreviation could be seen to represent is an indication of the ease with which abbreviations themselves have become part of an Internet specific lexicon. As a form of interpersonal communication the Internet is peppered with short forms, emoticons (symbols or key strokes that stand-in for displays of emotion or an emotional response to a statement), and other specific textual conventions, such as the use of font changes to indicate an aside and all caps for emphasis or to indicate yelling. The website www.allaboutmoms.com contains both birth stories and a reference page containing a number of the more commonly used Internet acronyms in online birth stories. This reference tool contains both medical terminology expressed in acronym form (including CF for cervical fluid, PROM for premature rupture of membranes, and LAP for laparoscopy) and Internet language for everyday usage (such as LOL for laughing out loud or lots of luck, DH for dear or darling husband, and VBG for very big grin). The stories that I collected included a wide range of these conventions. The extensive usage of these textual elements in these stories, as well as others online, serves to illustrate the many ways that the Internet itself is weaving its own discursive thread through these contemporary narratives of birth.

The story that H describes is a story of an unattended childbirth. Other than H, who practices as a birth counselor and educator, no additional professionally trained caregivers are present in person at any time during this birth. As a result of this, the typical sites of authoritative knowledge are shifted slightly. The body, which has been seen as the site of authoritative knowledge in some of the other stories, becomes in this case a primary site of authoritative

knowledge. When H describes the early contractions she is feeling she mentions that these contractions are "different" than those she experienced before, she uses quotation marks to emphasize the experiential difference in sensation between these contractions and the BH contractions that she had experienced in the past. When speaking to her mom about these changes, she notes "I thought my body was beginning ever so slowly to prepare itself for birth." This statement alludes to the body as a separate and distinct entity. She does not say "I was preparing myself for birth", but rather uses the third person to describe her own body in terms of "itself". In this way the body is created as a separate and distinct entity; one capable of acting in its own interests and "preparing itself" independent of the occupant of the body.

As in some of the other stories that have been reviewed, time is an important element in this story. It is important, however, not in its presence, but rather in the vagueness through which it is deliberately constructed. While in early labour, H actively attempts to keep others outside the home from knowing that she is in labour. When speaking to a friend on the phone she does "not let on that anything was different than usual". She states that she does this because she "didn't want anyone clock watching". She knows that there are normative increments of time, particularly evident in the medical model of birth, by which certain events in labour are typically measured or certain benchmarks should be met. By not letting others know that she is in labour, she is preventing them from being able to apply these standards of time and thus resisting this element of the dominant cultural narrative of birth by preventing others from "clock watching".

Time does enter the narrative briefly at certain points within her story, but it is always hedged with terms indicating uncertainty. H precedes the introduction of specific times within her story with words and phrases such as "around 10:30", "about 11 pm", "about 4:30am", and "some time after midnight". When time increments are introduced it is with the same uncertainty as in, "for a time – 20 mins – 3 hours who knows". At one point, H specifically mentions that she didn't have a "recollection of time" and indicates that time was "floating by us at a 'Twilight Zone' pace". Each of these instances gives the reader a vague idea of the passage of time, but it is effectively communicated that time is not an element of importance to H in constructing this story. The only

time marker that is included with precision is the time the baby was born, 6:49am, a time that coincided with the long-distance phone call to announce the birth.

If time is one element of the dominant cultural narrative of birth that H resists, many other dominant elements of this narrative are present. Throughout the narrative there is evidence of this dominant script continually running in the background. H states, "I found myself struggling somewhat with what 'should' I be doing." Should she be sleeping? Should she be walking? Should she be eating? These are all everyday activities in which most of us engage on a regular basis, but in this situation they become questions that she poses to herself that give the reader an indication of her engagement with a broader cultural script implicated in labour. When we consider actions in which we should be partaking or events that should be occurring, whether in labour or not, we enter into a negotiation in which we evaluate ourselves within a realm of expectations. Whether these are expectations we have of ourselves or expectations that others place on us, it is all evidence of our ability to position ourselves in relation to an external knowledge or belief system. When she asks should I be sleeping/walking/eating, she is negotiating from within a cultural script or a belief system that espouses what activities women in labour should do and what activities they should not. If one were birthing in a hospital restrictions may be made on fluid intake or the consumption of food. Walking may be encouraged to speed up a slower labour or it may be discouraged or made impossible by hospital equipment or policy. Confinement to bed eases the opportunity to rest by connecting the place in which women labour with the location in which one would typically sleep. In a midwife-attended homebirth, one may be encouraged to eat or drink to keep up ones energy, and walking or resting may be encouraged based on the midwife's assessment of progress in labour and the mother's energy reserves. These day-to-day activities become ones that implicate the advice or direction of others. Given the birth plan on which H has decided, there are no restrictions on her activity, nor are there any persons present who would encourage her to engage in any activities or restrict her from engaging in others. H becomes the sole decision maker on which activities are deemed appropriate, yet she maintains her engagement with the cultural script that determines that these types of activities have implications that a woman in labour should consider.

As discussed previously, much of the literature in the sociology of childbirth has been divided along two different ideological streams, medicine/technocratic and midwifery/natural. The choice that H has made to have her child at home with neither a physician nor a midwife present is a choice that is well positioned to open this dichotomous ideological pattern to scrutiny. This is a birth that, although most closely related to the midwifery model in its belief in women's ability to birth without the interference of technological assistance, challenges the boundaries of these models by creating and inhabiting a new dimension to the space that exists between and beyond them. In many ways because the chosen location of this birth is at home, this experience can be seen as presenting the greatest challenge to the boundaries of the midwifery model. The logical extension of the midwifery argument seems to be that if women can birth naturally without interference, then is the presence of even a midwife truly necessary. For some this certainly seems to be the case, however, for H, the midwife, although not present in body, plays a strong role in this birth experience. H resists and reshapes the midwifery model by recreating a dichotomy within her narrative of midwife and mother through a distinction between a "virtual' midwife who exists in the narrative in spirit only and herself as mother.

The first appearance of this "virtual" midwife occurs in H's story while she is in labour in the middle of the night. She states, "I laboured in our darkened room for a while in various positions depending on what felt right at the time, the midwife in my mind warring with the mother giving birth in my body." By creating these two oppositional entities, H turns the traditional dichotomy of medicine/midwife on its side by exploring the dimensions of related dichotomies, those of mind and body, science and nature. The midwife, who by definition is seen as with woman, is now outside of and against woman. The midwife in this story is representative of the mental sphere, the rational voice of reason. The mother, on the other hand, is in the body and is irrevocably tied to the natural sphere. Later in H's story when she expresses doubts about her ability to birth, it is "the midwife within [that] was holding up a measuring stick". The role of the midwife is thus to act as a source of objective measurement, to apply standards to the birth to determine if H's birth is within acceptable standards. This is a role, which the feminist critique of the medical model has charged physicians with, but in this case it is the midwife who has the

ability to determine progress through measurement. The mother is judged by the standards upheld by the midwife and she was "seeing [her]self fall short".

Soon after this segment the presence of the "virtual" midwife is strengthened by a phone call placed to a traditional midwife. This midwife listens over the phone to the vocalizations H is making as she experiences a contraction and makes an assessment as a result of the information that she interprets from the sounds that she hears. The actual midwife collects and interprets information and provides an assessment and a course of action based on this information. In so doing she strengthens the role of the midwife. The vision of the "virtual" midwife in H's story is transformed from a presence or a voice, into a full visual image that performs specific actions as she "watches" over the birth. "The midwife within stood back, arms crossed nodding her head". With the traditional midwife on the phone and the "virtual" midwife in agreement, H is provided with a source of authoritative knowledge with the power to influence the choice of action to take. Even though this is information that H states she "knew" previously, she could not act on this knowledge without the input of the midwife.

The final appearance of the midwife/mother split immediately precedes the description of the birth. She states, "That wise woman within understood what the baby was doing – gently preparing his path into the world, but the mother bear within had had enough." In this instance, H strengthens the mother side of the dichotomy by providing a visual image that connects the mother within to nature in the form of a bear. The bear is provided as a creature of instinct, strength, and power and represents the strength that H mobilizes within herself to birth this baby. In addition, the image of the bear is strongly tied to elements of motherhood that emphasize protection and devotion. The mother bear will challenge all who come between her and her cubs. For me, this image is reinforced by a personal close encounter with a mother bear. Upon discovering a black bear cub scurrying up a tree, my own mother hurried us away knowing that the mother bear would not be far away and would represent a much greater danger if she interpreted our actions as interfering with her young. The midwife in this section is transformed from midwife to wise-woman. Reminiscent of the French translation of midwife, sage-femme,

which literally means wise woman, the emphasis is once again placed on the role of the midwife as the source of rationality and reason.

Although the birth is unassisted, there are many others that are present at this birth. The midwife is phoned during the birth for advice. H's partner, D, maintains a strong presence throughout the birth acting as a caregiver, overseeing tasks surrounding the birth (placing phone calls, refilling the birth pool, etc.), and providing H with strength and encouragement. H also alludes to the importance of other women within her narrative. At first, other birthing women are implicated in the story as a source of comparison between what H is feeling and how she is faring through her recollections of the coping abilities of others whom she has attended in the past. H comes to the realization that these comparisons are hindering her ability to focus. She makes an active choice, stating that "it took some work to come to the conclusion", to disregard the importance of any other birth experience. For her, this includes not only those births she attended, but also her own previous birth experiences. In so doing, H is actively rejecting past birth experience as a source of authoritative knowledge. Her justification for this is based in her belief that these past experiences were so different that they could not serve as a point of comparison from which any value could be drawn, and therefore, they needed to be distanced from her understanding of this birth.

This realization that she could not compare her current experience to her past is extremely different from decision-making models typical in medical birth. Within a medical birth a woman's birth history is a key piece of information used to evaluate the current birth. We have seen this in K's story in which a previous caesarean birth led to a subsequent caesarean after the initial indications were similar to those of the first birth. Within S's story we see evidence that the lack of information on how her labour would proceed without induction was, for her, a source of uncertainty in the current birth. Within this understanding, previous knowledge of a woman's birth experiences can be important pieces of information used to evaluate present birth experiences and influence decisions within the context of the current birth. Medical guidelines on what actions to take and what events to anticipate are founded upon normative curves based on projections from women in the past. When H arrives at the conclusion that "[n]o other birth I had ever

attended had anything to do with this birth. My previous two births were irrelevant right here right now", she permits herself to discount past experience as a form of authoritative knowledge.

Her conscious decision to disregard past experience as authoritative does not mean, however, that other women's births are not important in her narrative. Later in the labour H's partner, D lights candles on a birth alter. The candles on the birth alter represent the spirits of "other women birthing in the world". In this way H can connect with this collective spirit and draw support from this group. There is an acknowledgement in this practice that connecting with other birth experiences is important, not as a point for comparison, but rather in a spiritual sense as a source of empowerment, support, and strength. H is able to negotiate her own boundaries surrounding the birth experiences of others to draw from them what she needs while disregarding those aspects she finds disempowering. There is also within this statement an indication of the importance of spirituality to this birth. This was something that Pamela Klassen (2001) identified in her study of religion among women choosing homebirth. For Klassen the spirituality exhibited in birth is one way through which women can understand the power of their ability to birth and hence to create life. By tapping into this power women discover an embodied connection with others who have experienced childbirth down through generations.

The description of the birth itself is substantially different from that described in K's story. This birth is described in detail and is replete with the sensations of birth. H's body is ever-present as she describes the feelings of "the head mov[ing] down", the baby's hair tickling her palm as she supports herself, and the burning sensation of crowning. The connection between mind and body permeates her description with sentences describing the sensations of birth blended thoroughly with the mother's thoughts during birth. Both mother and baby are active participants; mother breathes, the baby turns, mother lifts off the cord, and the baby swims out. Throughout this description there is a blurring of dichotomous boundaries between self and other, body and mind. Each remains distinct, but overlapping and interweaving with one another.

After the description of the birth, family connections are made. The baby is likened to his sister, the grandmother is called and informed of the birth, the sister is introduced to her new brother while her questions about birth are answered. The oldest son is introduced later that day

as he returns home, and H returns the reader to the narrative present by returning to the very start of her narrative reflecting on the intimacy of writing the story. She also describes for the reader one of her motivations for telling this story, stating a hope that "this tale may spark that passion in others who have their own stories." Through this statement, she acknowledges the power her story has to inspire others to tell their stories. There is a recognition that these stories do not exist in a vacuum, but rather the story itself permits an engagement and interaction with others. The stories are part of an ongoing dialogue in which one individual shares her story in an effort to move others to do the same. This aspect of Internet birth stories was something that women discussed and developed further in the survey portion of this research and this is the topic to which I now turn.

Why Share Stories Online: The women reflect on Internet-based birth stories

The e-mail survey permitted participants to comment on their own motivations for including their story online, whether they would recommend the Internet as a site for others to tell their story, and for general comments on Internet-based birth stories. In their responses women acknowledged the role that birth stories played to allow them to connect with and share their experiences with other women. For them posting their story appears to have been an empowering experience, to the extent that they were able to contribute to and participate in an online community made up of other new mothers, and other women who share similar views on pregnancy and childbirth. Through their participation, these women have received information and support, and have posted their stories as a means of giving back to the community by providing information and support to others. Some of the women they communicated with became friends and the bonds that they shared appear to hold firm irrespective of the fact that they have never met (nor likely will ever meet) in person.

Their comments included:

> Initially I posted my birth story on the internet in order to relay it to some of my online friends and colleagues. I've left it up though, because I've had so many positive responses to my birth story from strangers all over the world. Many women have told me what a positive and empowering story it has been for them to read during their own pregnancies. (S)

> I posted my birth story as a means of sharing with others who I connect with through the Internet. During [baby]'s pregnancy I was involved with several online women's networks and wanted a way to share his story. I also sent the link to family and friends who were waiting to hear his birth story. I believe that we learn much through shared stories and know that I have learned a great deal through others who have chosen to make their birth stories accessible. This was my way of passing that on. (H)

> I have a large group of online friends, other mothers, whom I have met over the years from various message boards during my process of trying to conceive. I had unfortunately suffered 2 ectopic pregnancies which was very difficult and I found support online – over the years I have developed many dear friends with mothers all over the world, whom I have never met in real life. It is mostly for these friends that I post the details of my life, including my birth story... (P)

> On the Internet, the sense of community among women involved with childbearing and parenting is immense. It's a tremendous source of support and a good outlet for the feelings of women who would otherwise feel alone if their partner is working and their family is geographically or emotionally unavailable. (R)

For others the process of posting birth stories online was a way of working through their own feelings of anger and trauma at the events that transpired during the birth of their child. For B, a participant with a negative experience the process of writing the story was "a way to vent my anger and frustration with the experience." For K the process of writing was found to be a release for her conflicted feelings: "I enjoyed reading birth stories while I was expecting. I also found it to be therapeutic, since I had struggled with the decision to have a c-section or not. Writing down my feelings helped take a load off my shoulders."

Through all of this, women were aware that the words that they wrote and the experiences that they shared had the power to influence the decisions of others, or reassure others that they were not alone. One participant stated,

> I believe birth is a magical experience and not one birth is the same. All pregnancies, labour and deliveries seem to vary so much. There was much that happened to me that I wanted to share to let someone else reading know that either they aren't alone or what could happen. (V)

For N, "I just thought that maybe a first time mom out there in my situation may have some comfort to know that it can happen and that all can come out okay." L simply stated, "if a persons personal story can help someone get through a challenge, then it is worth every character typed to help."

Although the women emphatically stated the importance contributing their own online story had been for them, when they were asked if they would recommend the Internet as a site for others to post their birth stories many of them felt this was a personal choice. In their responses several women acknowledged that participating in this way in a very public forum might not be comfortable for all women. S stated, "I think it's definitely an individual thing... It does open you up to the world and you have to be ready to accept that."

Some participants also acknowledged the importance of their stories as "real" experiences, as opposed to images that one may encounter in the media. This was of particular importance to those women whose opinions about birth conveyed alternative belief systems. One of the participants who experienced an unassisted birth wrote:

> It is a personal choice I think, not everyone is up to sharing themselves in that way. But I think that the more info from real actual births there is out there to even out the TV and movie births we see that gives us false images of what birth really is about will give women a better change (sic) at a healthy non drugged birth. (D)

The responses of women who wrote about alternative births allude to the importance of telling stories to counter negative birth narratives. According to Fiona Nelson (2004) one of the primary themes that emerged in her study of birth stories was the importance of telling stories that emphasized the pain and suffering women had endured during labour and birth. She stated, "women who have experienced, without medication, relatively easy, painfree and enjoyable births can feel marginalized and even rejected in the circles of birth-story-sharing" (p. 15). The Internet, therefore, may offer a space for women to convey their positive birth stories, free from the judgement of others. One participant recognized this aspect of birth storytelling and responded:

> I loved sharing my story because it's not all that often that women get to read positive birth stories. As a rule it's the drama of things gone wrong and excruciating pain that women love to share among each other. I have a different opinion about birth and love to share it with others who are willing to listen and my hope is that it can change some of our society's misconstrued views on birth. (S)

In general, the women surveyed believed that the Internet was a valuable site in which to both read and share birth stories. They were grateful for the knowledge that they gained and the empowerment they felt as a result of being able to connect with other women and contribute their own story. Their responses pointed to the power of the Internet to provide a unique forum in which women's voices can be heard, and women's experiences supported. The final word on this topic, I would like to leave to two of my participants.

> The WWW has opened up publication to people everywhere – the vanity press is no more the privilege of the rich and well-connected. Even more so now than in 1997, the WWW is full of people's personal writings in the form of blogs and personal web pages. If women can use this medium to help and support each other then it's a blessing! (M)

> I am very thankful to the women who choose to share the stories of this most intimate of experiences. I have read hundreds of birth stories that were posted to various lists and websites and I learn something from each of them. Sometimes it reinforces something I already knew – like BIRTH WORKS – other times the story causes me to stop and acknowledge some judgement I was holding about a particular birth scenario. I think the internet is an amazing tool and when used for communication and sharing wonderful things happen. Many women have no one close to them who would appreciate their birth stories (amazing or traumatic) and to have people respond in ways that are completely appropriate and supportive is wonderful. (H)

Summary

The stories and survey material presented in this chapter have illustrated the diversity of Internet birth stories and the importance of these stories to the women who write and exchange them. The group of women who participated in this project may be differentiated from the general population of Canadian women in several important ways. The information provided on the survey indicated these women had more children than the Canadian average, and the occupations they listed were highly concentrated in areas related to childbirth. These factors seem to indicate that childbearing was an important aspect of these women's lives, in terms of both their roles as mothers and their employment. This certainly may be attributable to a self-selection bias in which women with more childbirth experience have responded to my request for participation in greater numbers. It may also be the case, however, that the Internet has provided a unique space in which women who share an interest in topics related to birth are more likely to share their birth stories online. Given the small sample size, however, it is possible only to speculate at this time.

When women provided details regarding the births of all of their children, there were similarities to birth experiences among Canadian women in general. The births they described typically took place in hospital under the care of a medical professional. Among the hospital births included on the survey, the rates of caesarean section and epidural anesthesia were very similar to national statistics. What was substantially different was that the birth experiences of this group of women were more likely to include non-medical birth locations and practitioners. These births were more characteristic of holistic belief systems and took place at home under the care of midwives, traditional birth attendants, or unassisted by either midwives or physicians. Again, although this sample is too small to draw definitive conclusions, it is possible that the Internet itself played an important role in providing these women a space to share stories of alternative birth.

The Internet is also source of both information and support for these women, perhaps more so than would be found in a sample selected from offline sources. For this group of women, however, the Internet permitted them to connect with one another and share their experiences. They found that it was empowering to be able to contribute to these web-based environments, and frequently posted their personal stories as part of their participation in online communities. These communities were founded on systems of exchange in which one participant would post her story in response to others, and these communities were kept active through ongoing acts of storytelling. Through their participation women were able to forge friendships, and connect with others who held opinions on childbearing similar to their own. Stories were occasionally told to work through a traumatic experience, or to vent about an experience that left them angry, but more often these stories were told to share the triumph and joy experienced in giving birth. Participants acknowledged that posting their stories was a personal decision, but they knew that by doing so they had the power to influence and educate other women by informing them about "real" birth. Particularly for those who had experienced alternative births, telling their story was a way of countering negative images contained in stories in the media or heard from other women.

The influence of the Internet is also invariably an important contributor to the collection of stories at the core of this study. The four stories that were presented in this chapter represent a

diverse group of birth experiences. K's story described the birth of her second child, a repeat caesarean section at a Quebec hospital. L's story concerned the birth of her first child in an Ontario hospital. S has described the birth of her fifth child that took place at home with her team of midwives and an assortment of friends and family. Finally, H's story described the birth of her second child, born in water with her partner in attendance. These stories are considerably different in many ways, but they also allude to similarities in the ways that women understand and create meaning when representing the details of their births in narrative. Women frequently drew from medical knowledge and used medical terminology in the context of their narratives. In doing so they acknowledge that the medical model and medical ideology surrounding childbirth is a fundamental system of knowledge through which childbirth can be understood and communicated to others. Medical knowledge was often a source of authoritative knowledge through which actions were understood and decisions made, and when applied it frequently (although not exclusively) resulted in a loss of agency and power for the women. Their stories, however, also indicate many ways that women can claim power in their births. Often they can do this by recognizing other sites and sources of authoritative knowledge, such as previous experience, the professional knowledge of midwives or doulas, spirituality, and the importance of their bodies as sites of information. In the next chapter, I explore these key themes in more detail as they appear in the full collection of stories.

Chapter 5

Thematic Discussion

During the time that a woman is pregnant, her thoughts inevitably turn to the upcoming labour and birth of her child. She may have a detailed birth plan, or she may have visualized the birth, but she will not know for certain what events will transpire and how she will respond until the birth is over. All of the birth stories I collected were written after the birth took place. Women's stories, therefore, permit an opportunity to examine the process through which women come to understand and create meaning in their birth experience retrospectively. The narratives present a single comprehensive account of the birth, and the events that women chose to incorporate into their stories, the ways these events are introduced and described, and the language that was used to communicate meaning are all important means through which the reader can understand how birth is understood from women's personal perspectives.

This chapter contains a thematic discussion of some of the ways the women in the study created meaning in the birth stories they told over the Internet. In the previous chapter, I provided an in-depth narrative exploration of the stories of four women who had each chosen very different paths through their own birth experience. Among these four stories there were both similarities and differences in the ways these women's stories were constructed and the ways the women portrayed themselves and their birth experiences, both in response and in opposition to dominant ways of understanding childbirth. This chapter takes a deeper look at some of the main themes that emerged from within the context of the entire selection of stories in my sample. These themes include an exploration of the position of medicine as a key narrative resource, with specific regard to the ways women negotiated with due dates, the passage of time in labour, the assessment of dilation, medical procedures, and medical terminology. The ways women claimed power and agency in their narratives is explored with regard to women's interactions with and against the medical narrative. Occasionally, women's participation in the medical narrative or script resulted in a loss of agency, but women were also able to negotiate a claim for power within the confines of the medical script, or resist the medical narrative altogether in an effort to assert

their own agency. Further, women's stories indicated that the medical model was an important source of authoritative knowledge, but other sources were also considered authoritative. Other sources of authoritative knowledge employed within the stories included knowledge held by midwives, gained through previous experience, and exhibited within the context of belief systems that incorporated spirituality and intuition. Finally, I have examined the role of the Internet as it relates specifically to women's claims of agency.

Metanarratives and Medical Narratives: The intersection of narrative resources

As noted in the literature review (Chapter 2), Tina Miller (2000) argues that women draw from three key narrative types to describe their experiences of childbirth: metanarratives (those narrative elements which develop from culturally embedded expectations), public narratives (that which is publicly accessible through professionally defined discourses), and individual narratives (those narratives characterized by lay or informal experience) (2000: 312). In combination, these three provide narrative resources from which women can create a coherent account, not only of the events that occurred during childbirth, but also of a unified identity for themselves as narrators and social actors.

However, looking specifically at the collection of women's stories in this study, Miller's core narrative types became problematic insofar as there seemed to be a blending of what she refers to as metanarratives and public narratives. Metanarratives appear to be the broadest of the three types and are characterized by that which is culturally embedded. However, modern medical care is culturally constructed and, as Conrad (1992) illustrates medicalization hinges on the ability to culturally create and recreate medical definitions surrounding aspects of our daily lives. Medically embedded expectations, therefore, cannot readily be separated from the culture in which they exist.

Miller's definition of public narratives specifically concerns the use of medicine as an independent narrative resource, but as I will illustrate further, many of the women's stories depicted the connections between medical expectations and cultural expectations. That being said, medicine did represent a distinct and dominant narrative resource from which women could

draw as they constructed their own account of the events of their births. Often medicine appeared to provide the women with an underlying normative script that ran in the background and paralleled many of their stories. This script was used to compare a woman's unique story and individual experience with medically defined expectations and outcomes. When the women presented detailed accounts of the processes they engaged with to determine, for example, that they were nearing the end of their pregnancies or to communicate an understanding that the birth was getting closer, they routinely negotiated from within the context of a medical script to draw information for their judgements.

Within the stories, some of the most common elements of this normative medical narrative included the introduction of due dates, the assessment of progress through timing and measuring contractions and dilation, the use of medical procedures, and the inclusion of medical terminology. The extent to which each of the stories incorporated these elements varied, depending on the specific circumstances of the birth, but each of the stories included at least some of these elements. What did differ, however, was the manner in which women incorporated these elements in their stories and, related to this, the ways in which the medical narrative was used by each woman as she created meaning from her birth experience, either within and through the dominant medical understanding or ideology or in resistance to it.

Doing Due Dates: Negotiating definitions of gestational age

Typically, the first element of the medical script included in the stories was a mention of the "due date". In her review of how time is portrayed in pregnancy and childbirth, Simonds (2002) has turned to *Williams Obstetrics* to illustrate how the due date is constructed as a fundamental element not only to date gestational age, but also to assess the pregnancy against medically established normative curves. She argues that medical dating of the pregnancy does not consider a woman's own knowledge of conception, and variation in her individual menstrual cycles is considered only insofar as it establishes a date for the last menstrual period. Additionally, she contends, the procedure through which the due date is calculated is counter-intuitive since it involves a process of counting backward subtracting three months to a corresponding date in the previous year to approximate the gestational period of nine months,

rather than counting forward to a date that estimates the date in the actual year of the birth. In this way pregnancy is calculated in the past and due date appears as though it precedes the time of the actual conception.

When the women whose stories I collected incorporated due dates in their narratives it was frequently done to provide their readers with a fixed point in time, and to establish that they either were or were not conforming to normative patterns. In K's story (presented in Chapter 4), the due date was introduced and positioned relative to the onset of the initial contractions. In part, this was done to communicate that what she experienced in early labour conformed to medically defined expectations, even though the actual birth that she described differs from "normal" birth. In her story, T used the phrase "Right on time, the day I was due..." to communicate that her labour also conformed to the normative expectations established by the due date, while G titled her story "J Arrives 2 Days Early", establishing the date of the actual birth in relation to the due date.

Other women, however, entered into a process of negotiation with the criteria on which this date was based and the meaning of the date itself. J's story, which describes a homebirth with traditional birth attendants, includes a discussion of the elements that were considered when the due date was established. For her the "typical calculations" were taken into consideration, but her menstrual patterns were also considered important in establishing a date. She admitted that the chosen due date was selected for "no particular reason", and in the end they settled on a date merely because it seemed to be "likely". In addition, she enclosed the phrase "due date" in quotation marks, reminiscent of the manner used in other stories to differentiate a personal understanding of the concept from its significance in medical understanding. Through this discussion, we, as readers, are given a sense of the arbitrariness of the actual date, yet later in her story she acknowledged becoming "impatient" when the date passed and labour had not yet begun. She wavered with this impatience, on the one hand appreciating the continued experience of pregnancy, while on the other becoming increasingly bothered by concerned individuals calling to see if the baby had arrived. Despite this wavering, however, we can see that the date itself has important meaning and significance for her experience of late pregnancy.

Another woman, V, was given conflicting information about the due date from two different medical sources. Her physician established one date using the "typical calculations" referred to above, but the results of an ultrasound (used to measure fetal development) indicated that the physician's date was likely not accurate. V's decision was to date her pregnancy according to the physician's date, apparently because it more closely conformed to her own knowledge about the date of conception. What is missing from V's description, however, is any attempt to incorporate her own knowledge about the date of conception into the actual calculation of the original due date assessed by the physician. This would seem to be the one piece of definitive information that would be fundamental in determining the exact dating of the pregnancy, but as Simonds states "medicine does not recognize her knowledge as a reliable way to date gestation" (2002: 562).

Although some women's discussions of the processes used to determine due dates point to the inconsistencies and inaccuracies of medical procedures for establishing gestational age, what is not questioned in the stories is the necessity of establishing a date in the first place. Instead, many women made reference to this date, and as the date grew nearer they often experienced increased feelings of anxiety or anticipation. This is true even for those who resisted medical models for defining childbirth. For example, in S's story, although she questioned medical criteria for determining the appropriate length of pregnancy (as demonstrated by her use of quotation marks around the word overdue) the due date itself remained unchallenged. She entered into a process of negotiation between her beliefs surrounding childbirth and those contained in the medical model, and described her feelings regarding this situation as being caught "in a bind". The due date established a fixed point for estimating the duration of her pregnancy and she knew that her ability to realize her dream of a midwife-attended homebirth would be compromised if her pregnancy extended too far beyond the due date and she was classified "overdue".

Also emerging as important in the women's stories with regard to the due date was that it became a piece of information that could be shared and negotiated with others in a variety of social situations. J's story, described above, includes a mention of the impatience she felt when

her due date passed, and she admitted that a large component of her feelings were related to the phone calls that she received from others. She stated, "...other days I just had to lie down and cry because I couldn't field another phone call from someone asking if I'd had the baby yet". Additionally, D's story includes details of a conversation about her due date that she had with the election officer working at the voting booth she attended the day before her daughter was born.

In contemplating the reactions of others to her own visibly pregnant body, Pollock discusses that others "tended [her] with fascination" (1999: 2) and she was frequently asked the question "when are you due?" by casual acquaintances whom would not typically be privy to personal information about her body and her life. The question, "when are you due", has seemingly transcended the medical model from which it originated, to become part of a broader cultural lexicon of pregnancy; an exchange of information which connects pregnant women to others, both within and outside of their immediate social networks. However, when women are engaged in exchanging information about due dates, the concept itself and the medical protocol within which it is grounded remain largely invisible and unchallenged. The question "when are you due" begins to illustrate how culturally embedded assumptions become joined with medically defined normative patterns, and the medical narrative is blended with the metanarrative.

Clock Watching: Assessing the passage of time in labour

Once a woman is certain that her labour has started (the precise identification of which often frequently required women to negotiate with medical criteria) the birth story continued by communicating to the reader signs that the birth was getting closer. The stories focused on several ways of establishing progression. Typically the passage of time in labour, measuring dilation, and timing the duration and frequency of contractions were used by the women as important markers determining their progression towards the birth. Each of these markers has been constructed within a medical model of understanding childbirth that is hinged on the authority of normative standards established through means such as Friedman's curve. Friedman's curve was developed by studying and calculating patterns among childbearing women in the 1950s and is used to compare an individual woman's progress against the acceptable standard rate of dilation of approximately one centimetre per hour. Simonds states,

"[o]bstetrics reifies this particular time-keeping mechanism as an evaluative tool which determines how treatment should proceed" (2002: 565) Simonds continues by stating that the application of Friedman's curve necessitates intervention in the form of frequent routine checks for cervical dilation, and if the woman's labour does not conform to the normative standards further interventions will be applied. Recent studies, however, indicate that less than half of all women in labour conform to these normative guidelines (Taylor, 2002: 102).

As I have illustrated in my analysis of S's story (Chapter 4), her use of a timeline to structure her homebirth narrative can be seen as a way to demonstrate that her childbirth experience conformed to objectively definable external measurements, even though her progression in labour may not necessarily have matched medical guidelines. The element of time within S's story disappeared when her midwife arrived, and progress measured in time increments was substituted with cervical checks to assess dilation. The underlying theme that ties these two elements together is the importance of establishing criteria through which progress can be evaluated in intervals through the use and application of measurement criteria.

For many of the other women in my study, their stories also revealed that time was an important structural element, and the inclusion of a specific time in their narratives frequently corresponded with their interactions with medical personnel and procedures. For example, B included times at the following locations in her story: the date of her scheduled induction, the time she was given the cervical gel, the time her dilation was initially checked, when she initially asked for an epidural, the second occasion on which she asked for pain relief, the time pain relief was administered and, finally, the time of the birth itself. T, who also had a hospital birth, paired the passage of time in her narrative with a mention of the number of centimetres dilation she had reached. The women's inclusion of time increments presented alongside interactions with medical procedures served to reinforce the connection (both as it is lived and interpreted) between time as a common structural element that guides much of our lives and the medical model for understanding childbirth that incorporates linear measurement and standardization of all labour and birth experiences.

For the women who gave birth in the hospital, the time of day determined when medical personnel were available to check cervical dilation or administer pain relief, and, in cases where a woman's labour extended through changes in shift, which personnel were available to provide assistance. Other women laboured 'against the clock', as was the case for V whose physician provided her with a timed deadline. In her story she stated, "My Doctor was in at 5:00a.m. and said that since things weren't progressing and I was extremely fatigued...that I needed some relief so if I was not dilated by 7:00 a.m. we would have to perform a C-section." V explains that her fatigue likely resulted from the fact she had not eaten for over two days, and that she was upset by the doctor's decision regarding the caesarean. Further, she added that since her epidural had worn off, the caesarean would be performed under general anaesthetic, a procedure that would mean her partner would not be able to witness the birth.

Even women who gave birth outside of the hospital setting were aware of the ways time was used as a measurement to compare against normative standards. H, whose story was presented in Chapter 4, specified that she did not want others "clock watching" or using time as an element to judge her labour and childbirth experience. In order to prevent this she decided to hide from others her knowledge that labour had started. In doing so, she communicated both an awareness of medical standards regarding the passage of time in labour and a resistance to the control of these standards by denying others the information necessary to implement them.

Magic Words: Women's interpretations of cervical dilation

Coinciding with the passage of time was the measurement of dilation in centimetres. Women readily cited the progression of labour by centimetres in their narratives without ever including an explanation for their readers of either the significance of this measure or the manner in which it should be interpreted. This again can be seen as part of a widely understood lexicon of labour for which no explanation was offered because none was deemed necessary. Women's reaction to this measure alternately conveyed feelings of either disappointment if the number of centimetres was lower than they anticipated or triumph and inspiration if the number of centimetres could be interpreted as a sign of rapid progress. V stated, "My husband and my wonderful friend were at my side every step of the way and all of us were more than upset when I

found out that I hadn't dilated past 2 cm." M, on the other hand, commented, "Turning over on my back for the exam was hell, and I almost lost it again until the resident said the magic words: 'Seven centimetres.' I opened my eyes and said SEVEN? All right! I can do this!"

The measurement of progress through dilation in centimetres was an important element, even in stories where the birth took place at home and medical personnel were not present. In her story, S stated that she was relieved when the midwife showed up because it meant that she "would soon know [her] progress", while H admitted to having "an insatiable need to know how far along [she] was." For D, the other woman who chose to birth her baby at home with only her partner present, the responsibility for checking cervical dilation, typically reserved for medical staff, was transferred to her partner.

Once again, I would argue that these practices, employed to assess progress in labour, have made the transition from a measurement and standard developed within the medical model to part of a broader cultural narrative surrounding childbirth. They require no explanation because their significance has transcended the medical model and become part of an everyday understanding of childbirth. This, again, would seem to support the thesis of medicalization suggested by Conrad (1992) and illustrates the extent that certain aspects of childbirth have come to be understood within medical expectations. Upon making this move from specific medical narrative to broader cultural narrative (public narrative to metanarrative), these elements become not merely medically defined normative patterns, but widely acceptable terms through which labour and childbirth experience can be defined and interpreted. However, when standards of measurement developed within a medical model for understanding childbirth become universally applicable and interpretable guidelines, the medical origins and assumptions at the base of these measurements are shielded. In this way the underlying principles, which involve the need to measure and standardize the childbirth experiences of women, remain largely unquestioned.

Managing Medicine: Medical procedures and terminology in birth narratives

Descriptions of medical procedures, including the use of technology for assessment and assistance, were also regularly mentioned in the stories. Women whose stories involved births in

hospital were more likely to include medical procedures than those who chose to give birth at home. The simplest explanation for this can be found within the distinctions between the scope of practice differentiating physicians and midwives. The medical practice of physicians incorporates a vast range of technological tests and procedures and birth in the hospital means that these procedures are readily available. Midwives are typically both restricted from the use of many technological procedures and abide by a model of care that frequently questions their value. Providing women with care in their own homes means that if a technological procedure is deemed necessary during labour it will most likely require a transfer to hospital. Therefore, a woman who gives birth in hospital under the care of a physician is likely to have more exposure to medical tests and procedures, than a woman who chooses midwifery care. A woman who opts to birth at home without the assistance of either a physician or a registered midwife will be completely restricted from medical procedures during the birth unless she chooses to transfer herself to hospital during labour. She may, however, encounter medical procedures if she has chosen to receive prenatal care with a midwife or physician.

When women's narratives included medical procedures, they provided not only a description of the event, but also an interpretation of the ways in which these procedures were lived and given meaning within the context of their birth experiences. In K's story (presented in Chapter 4), the medical procedures included in her birth experience range from those that could be classified as low technology and low intervention, such as the litmus paper test used to determine the presence of amniotic fluid, to those at the high technology and high intervention level, such as catheters, epidurals, and caesarean birth. At each point in which a technological procedure entered her narrative, however, there was a subsequent influence on how her labour experience was changed and interpreted. Even low intervention techniques, such as the litmus paper test, provided her with reassurance not from the result of the test, but rather through the administration of the test itself, providing a specific result with a specific meaning. At the other end of the intervention spectrum, the caesarean birth that she experienced has distanced her from what she interpreted as a "normal" birth, and during her recovery from the surgery she found

herself unable to perform tasks, such as picking up her oldest child, and thus claiming the identity of a "normal" mom.

Perhaps one of the most interesting ways in which a woman's interaction with technology influenced her interpretation and experience of labour was included in a story from M, another woman with a hospital birth. She arrived at the hospital shortly after her waters had broken, but before she felt any contractions. A few hours after M was admitted to the hospital a fetal monitor was used. She stated:

> Lo and behold, the tocometer (pressure sensor) after a while started showing regular waves about 3-6 minutes apart. The nurse agreed that they might well be contractions, and left the monitor on. This was fascinating, that the machine could tell I was contracting when I couldn't! After some time watching the monitor strip, I identified a peculiar feeling in my abdomen, as if the baby were rolling very slowly from my left side to centre, with each wave from the tocometer. I played at anticipating them and got better at it as time went on...

This example closely parallels Jordan's (1997) study of birth in an American hospital in which the sensations of the labouring woman are fused with the monitoring equipment and the equipment becomes the primary source of information, not only on what is occurring in the woman's body, but also what she can expect from labour. In this case, the monitoring equipment itself was the first to perceive the contractions and M became aware of the sensations in her own body and learned to read and recognize the contractions through her interaction with the machinery. The equipment designed to monitor contractions in effect created the experience of contractions as it modified the sensations and made them perceptible in the form of a mechanical readout. Had the monitor not been applied, M may not have detected these sensations, or she may have attributed them to the movement of the baby. In both of these cases they simply may not have been considered relevant to the birth, resulting in their possible elimination from her narrative.

Although this experience was unique in terms of its extensive description of the interaction with the monitor, the meaning of the experience and women's reactions to medical technology and testing was not. Many of the women mentioned instances in which medical devices were applied to provide them with specific information related to the processes that were going on within their own bodies. In some cases, these medical devices were readily accepted and the results of the readouts and tests were incorporated unchallenged into their own

understanding of their pregnancy, labour and childbirth experience, while in other cases medical devices and tests were resisted.

Resistance took many forms and had many meanings for these women. For instance, in L's story, the physician decided that an episiotomy and vacuum extraction were required to move the baby past the pelvic bones, but when this information was communicated to L, she stated, "Boy did I ever do some major pushing when I heard what they were going to do!" Through her increased efforts L works in concert with the medical staff – she pushes as they pull, yet her statement can be read as an indication that her intention was not to assist the medical staff, but rather to challenge the need for the procedure in the first place. In making this statement at this location in her narrative, and in the context of a story in which the authority of the medical staff had been readily accepted to this point, her words serve to emphasize and reinforce her presence as an active participant in this birth and her ability to resist medical control.

In S's story, she resisted the biophysical profile suggested by her midwife based on her understanding that the results of this medical procedure could jeopardize her dream of a homebirth. Her final decision was to attempt an induction with castor oil if labour did not begin on its own within a specified time frame, acknowledging her commitment to a belief system in which a low technology intervention is preferred over a medical procedure. In addition, she would retain control of the use of the castor oil, whereas the biophysical profile could reveal results that would prompt a change in the location of birth and place further limitations on her control. This woman's experience with a herbal induction is in agreement with the findings of Westfall and Benoit (2004), who suggest that the use of induction by women committed to non-medicalized births is in part an acknowledgement of midwifery regulations which deny homebirths to those over 42 weeks gestation, and an expression of personal agency on the part of women who wish to limit technological interference in their births.

When women included in their stories descriptions of medical procedures, conditions, or assessments they do so with the use of specific medical terminology. Furthermore, although medical procedures are not universally mentioned, the inclusion of medical terminology was a feature in all the stories collected. Women's stories often contained definitions or explanations of

the terminology, and these definitions were either included directly in the text by the author or they appeared on a separate webpage linked to the story by the page administrator or creator.

In Chapter 4, I have already discussed the significance of hyperlinks, one form in which definitions of terminology were accessible through links to a separate webpage, but other webpages conveyed similar information through different means. For example, some webpages, such as www.allaboutmoms.com, provided a glossary of medical terms to enable women who read the birth stories contained on their pages to familiarize themselves with the language that they will encounter. These glossaries, however, are not an exclusive feature of Internet stories. Kitzinger (1977) and Giglio (1999) have both provided glossaries at the back of their childbirth reference books to prepare women for the terms they may encounter during pregnancy and birth.

Whether the woman who wrote the story or the page administrator provided the definitions, both were an indication that medical terminology was an important component of the Internet birth stories. In order for the writer to convey meaning in their story it needed to be included, and the reader needed to be able to interpret this language within the context that it was used in order to fully comprehend this meaning. Even in those cases where no explanation was provided, the presence of medical terminology was still important. With no definition present, the writer made an assumption that the ability to understand and interpret the terms was an aptitude she shared with her reader. Whether explanations are provided or not, including this terminology in the stories demonstrated both a proficiency in medically defined language concerning childbirth and a recognition that this linguistic proficiency is an important component to understanding and communicating stories about birth.

Before I consider the ways in which medical terminology was used within the stories, it is important first to consider what precisely is encapsulated in medical terminology. In some cases, the answer to this is clear. Medical terminology includes all of that language that is specific to medical practices and procedures and that has no meaning outside of its medical definition. For example, the terms epidural, episiotomy, and prostaglandin gel all have meaning that is unique to the medical context. There are no substitute everyday words that could be used to capture the same specificity. These words are deeply embedded within a medical understanding and women

have learned to use these words to effectively communicate their meaning and significance within their own experiences.

In other cases, words have one meaning within a medical context, but another meaning beyond their medical definitions. It is in these areas that there were subtle differences in the ways that women used or altered the terminology. For example, the majority of the stories used the word "contraction" to describe the muscle movements that are involved in opening the cervix and preparing the uterus for birth. Some women, however, substituted the word with alternatives such as "twinges" or "surges". This wording change is important for two reasons. First it moves beyond the medical definition recognizing the power inherent in language, and second it aims to describe the lived experience of labour from a woman's perspective, capturing how labour is felt from within, rather than described from outside. A comment on the significance of this wording change is provided by Ina May Gaskin as a note following one of the birth stories in her recent childbirth guide. She states:

> I have a master's degree in English and was aware of how language can condition our response to a physical/emotional/spiritual process such as labor. I began to use the word rush instead of contraction. Why use a word that suggests tightness and hard muscles when successful labor will require expansion of the cervix. (2003:33)

In some stories, particularly those involving a hospital birth, medical terminology was used as a descriptor to move the plot forward by illustrating what happened. It was a necessary component not only to describe the events of the birth, but also to communicate to the reader that the woman had the technical knowledge to understand what happened and the meaning of the events within the context of her own birth. From the time that women arrive in the hospital, their birth becomes subject to description by an assortment of medical personnel. They become immersed in the medical language that is a fundamental component of the institution, and learning to speak the language is an adaptive ability that will ensure that they can establish a more active involved role in the birth.

However, even those women whose births occurred at home demonstrated proficiency and an active use of medical terminology. S, whose story was contained in Chapter 4, used phrases such as "membranes ruptured" and "cord prolapse", she described the possible position

of the baby as "posterior", and after the birth she discussed her "higher risk of hemorrhage". At each of these occasions her story drew from and intersected with the medical narrative of birth as she borrowed medical terminology to describe her own birth experience. In doing so she was participating in a similar process to those whose births took place in hospital. She demonstrated both her knowledge of and comfort with medical language and, through her story we, her readers, are educated about these medical terms, not only what they mean but how they are lived. On occasion, women demonstrated an easy familiarity with medical language by using abbreviations in place of specific medical terms. In H's story, the term BH is used to refer to the Braxton Hicks contractions she experienced, while C, another woman who gave birth at home, used the abbreviation ROA for right occipital anterior to describe the position of the baby.

The prevalence of medical terminology within the stories once again demonstrated the dominance of the medical model and the medical narrative as a resource used by the women to communicate meaning. Since medicine maintained a dominant position in the birthplace, it is understandable that medical terms were used to describe events for which no other terminology was appropriate. Yet as women included this language in their stories they not only described the events, but also demonstrated their ability to participate in a knowledge system about birth that is tied to the medical model. As noted above, this knowledge was enacted not only by women who chose to birth in hospital, but also by those who chose to give birth at home, physically outside of the primary location of medical control. Incorporating medical language in their stories, and the explanations that women provided of the terminology, was also a means through which women educated their readers about medical knowledge, its importance and its usage. The act of passing this knowledge from writer to reader, in addition, solidifies the normalization of medical language as a language of birth.

Foley and Faircloth (2003) have demonstrated that midwives use medical language to negotiate and legitimate a claim to knowledge about birth. Women's use of medical terminology and medical descriptions can be seen in a similar light, as women attempt to demonstrate an understanding and a proficiency in medical means of describing birth. What is worthy of consideration, therefore, is the effect of medical knowledge on women's own understanding of

their personal birth experiences. It is undeniable that claiming knowledge is a claim for power. As Mitchinson (2002) argues, developing a language specific to medicine was one way in which physicians could claim power by emphasizing a specialized knowledge set and elevating their position above that of their patients. Women's use of medical language to describe their own births is a means of removing this language from the exclusive domain of medical control and gaining power through an increased understanding of the processes that are occurring within the body. Yet, claiming medical knowledge about birth places women in the position of understanding themselves and their bodies in ways that have been criticized for removing women's agency and replacing knowledge gained from women's subjective experience with an external knowledge base grounded in a system that emphasizes technology and the authoritative knowledge of the physician (Davis-Floyd, 1994; Duden, 1993; Marshal and Woollett, 2000; Oakley, 1984). It is important, therefore, to explore the ways in which women assert claims to agency and power in their birth stories, both from within the context of the medical model, and outside and against medical understanding.

Claiming Agency in the Birthplace: Power from women's perspectives

The stories that women told about their birth experiences provided important insights into the ways in which women's participation in a medically based knowledge system had an effect on their claims to agency and power. One particular means through which agency was established in a narrative is seen in the way that pronouns were used as signifiers of an active position. To speak from the first person is to claim agency in the story by letting the reader inside the writer's perspective. A statement that claims, "I did this" emphasizes the performance of the writer as the primary participant in the action. When a writer claims the object position in the sentence (as in the statement "they did this to me") the focus shifts, from the author as active participant, to the position of passive recipient of the action.

In L's birth story, which appeared in Chapter 4, we saw how her use of pronouns changed from the first person singular to the third person plural perspective to reflect a shift in her role upon her arrival in the hospital. Members of the hospital staff became positioned as the initiators of the action, and replaced L as active decision makers in her narrative. Of all the stories

that I collected, this pronoun shift is most evident in L's story. What is more common, but very similar in the manner in which it can be interpreted, was the tendency for women to use the passive tense to describe actions to which they were subjected. B, whose labour was induced, states, "I was sent for an ultrasound...", "I was scheduled for an induction..." and "I was given the prostaglandin gel...". P states, "I was checked and told that I was dilated 6cm", and from M, "I was put on the monitor again..."

Among those who chose to give birth at home, the use of the passive tense and third person in their sentences was rare. There were a couple of occasions in S's story that involved consultations with the midwife about alternative methods of induction. Here S stated, "she (midwife) gave me some alternatives" and "she (midwife) told me about blue/black cohosh". On both of these occasions the midwife was the active participant, but the exchange involved information only, and not the application of a medical procedure. The single occasion in which S used the passive tense was after the birth when she stated, "I was given a shot of Syntocinon". Interestingly, this was also the only occasion (according to her narrative) where a medical intervention was employed. Similarly, one of the only other occasions in a homebirth in which a woman positioned herself as the recipient of action occurred in D's story of an "unassisted" birth. On this occasion it was the partner, who had been assigned the responsibility for checking cervical dilation, who was credited with initiating action in the statement, "J got me to lie down and checked my cervix again...". In both of these stories the shift in tense and subject position in the women's statements corresponded to those instances in their narratives where a medical procedure or assessment was included.

Closely related to this were statements in which the women discussed decisions that were made regarding their births. While there were occasions where women who chose to birth in hospital took an active role in their narratives as decision makers, such as L's decision to proceed to the hospital on the advice of her physician and against the instructions of the hospital staff, and K's decision to pursue a surgical birth, these decisions were frequently mediated by medical professionals and concerned medical procedures. Indeed, hospital birth stories often included decisions that the women attributed exclusively to medical staff, with little or no acknowledgement

of their own role in the decision making process. In K's story she stated, "The doctor then decided that they had to do an episiotomy", and other stories included statements such as, "My doctor decided at this time to break my waters..." [and] "The OB/GYN told me that they wouldn't decide whether I needed a Cesarean or not until the baby started to come...", and "they decided to give me an epidural." The homebirth stories, by contrast, included statements such as, "I awoke at 3 am to strong surges and decided a bit later to go into the tub to relax", "J looked at me and asked me what I wanted to do and left the decision up to me. I then took 20 seconds to decide what to do", "I decided that if nothing had happened by Friday morning I was going to try taking the castor oil cocktail", and "I decided that if I didn't want to do it all day then I'd better make up my mind to get it over with, and so I did!"

Although this focus on agency and decision making power in birth is strongly divided between different locations of birth, I do not want to imply that the findings did not show that women who gave birth in a hospital did not exhibit agency and power in their birth narratives. However, I would contend that their stories indicated that women who chose to give birth in hospital negotiated from within a model in which their role, as a woman giving birth, is strongly defined before they even entered the hospital. Upon arriving in the hospital women stepped into a script that had been largely pre-determined by the normative standards to which women in labour were expected to conform. When they did take steps to assert their own agency, they were placed in the position of rewriting this role by challenging the standards that were automatically applied to them.

We see an indication of this in L's story when she is placed on the monitoring equipment, a procedure that required her to remain lying down. She complained to the nurse that the pain was too intense in this position and she needed to sit up. The nurse informed her that in order to permit her to sit up she would need to be checked for dilation. According to the nurse's initial assessment it was likely that L was not "ready yet"; however, the results of the cervical check revealed that she was indeed "ready". In this case, the nurse applied predetermined standards of dilation to L's personal situation and made a judgement according to her professional knowledge that L was likely not dilated enough. The results of the cervical check provided sufficient

information to redefine the situation, but in order for this information to be obtained L must assert her own needs in this situation and in this process she reasserted her own presence and the importance of her personal experience.

R, a woman whose story described an unmedicated hospital birth, claimed agency on several occasions during her description of labour. She arrived at the hospital still in doubt that she was in labour, but when she spoke with the hospital staff their exchange was depicted as follows:

> Our nurse, G, promptly turned to another nurse, stifling a laugh and said, "This is Mrs. R. She's at 35 weeks, and this is her first baby. She's been having lower abdominal cramps all day which became rhythmic around 6 p.m. The contractions are four minutes apart, and she thinks she's not in labor [sic]." The other laughed. "Put her in 74."

Here R's individual experience was neatly summed up and subsumed within the medical script, and her situation was apparently so typical as to be comical to the nurses on duty. In order to restore the importance of her personal experience in this narrative and exert her own agency, R must define a role that distinguishes her as unique from other patients. She stated: "It was becoming clear to them that I wasn't the kind of girl to be laying on my back biting a rag." At a point slightly further along in the narrative, she refused a medical procedure to break her water. When it broke spontaneously, she described the situation as follows:

> My water broke rather explosively about 10 minutes later, and I screamed like a banshee. When the nurse tried to shush me, I shot her the look of death as if to say, "Look lady, do you see a tube of piped-in pain reliever sticking out of my back? I didn't think so. Now sod off." I think she got the message actually. She was much more helpful after that.

The fact that this birth took place without medicinal pain relief is a key determinant in the way in which R was able to step beyond the boundaries of the medical script and create a distinct role for herself. She refused medical procedures and acted in ways that diminished the ability of the medical professionals to limit her active participation in this birth. When, immediately following the birth, one of the residents pointed out that this birth was "natural", or without pain relief medication, R was struck by this realization, stating that, "I have never felt so in touch with my big bad female self. Ever." She successfully negotiated the ability to legitimate her own unique

embodied experience, and this has left her feeling empowered and able to form a deeper connection with those aspects of herself she deems "her female self".

Multiple Sources of Authoritative Knowledge: Medical, midwifery, previous experience, spirituality and intuition

In the instance described above, R was able to make claims to authority by distinguishing herself within the medical script and claiming the significance of her own personal experience as a valid source of information for this birth. As discussed in Chapter 4, Jordan's (1997) concept of authoritative knowledge implies that knowledge is considered authoritative only when it is deemed consequential to all involved. Jordan further emphasizes that authoritative knowledge is not merely accepted as legitimate, but that the knowledge and its legitimacy are actively produced and reproduced amongst all who are involved. In considering the production of authoritative knowledge in these stories, it is possible to explore the processes that women engaged in to recognize and legitimate knowledge as authoritative, and also to actively produce and reproduce this knowledge through their ability to interpret what information is deemed important and in which circumstances this information was used to make decisions.

Authoritative knowledge is a primary component of the decision making structure within childbirth, and the most common form of authoritative knowledge displayed in these birth stories was that based on the authority of the medical model. Medical knowledge was instrumental in influencing decisions made during these women's pregnancy and labour experiences, especially as it pertained to establishing a due date and assessing progress in labour. Within the births that took place in hospital, medical personnel played a key role in making decisions and establishing appropriate courses of action based on the information gleaned from medical equipment and assessment procedures. The authority of medical staff was established within the context of a medical narrative in which events unfolded in logical sequential order according to predetermined standards. This can be interpreted as part of the cyclical nature of the medical model in which the application of the medical narrative is justified by the power of medical authority, and as this narrative is enacted and reproduced it serves to reinforce the power of the model itself, and hence solidify medical authority.

The medical procedures and technological devices that were included in women's birth stories represent some of the primary ways in which medical information was gathered and then employed in a knowledge system that compares women's individual experiences with normative patterns. When women's labour experiences matched with the normative patterns the value of the information was proven and maintained. When women's individual experiences deviated from the normative patterns, the information was used to justify a decision to intervene. Women's use of medical terminology was included to describe not only procedures and technology, but also bodily processes in medical language, and showed that women were actively engaged with medical knowledge. They reproduced both the knowledge and its legitimacy when they employed this language in their stories, and they created legitimacy for themselves and their knowledge of birth by participating with the language. Through their stories, women passed their knowledge on to their readers thereby replicating its value as an appropriate means of understanding and interpreting birth.

Even the women who chose to birth at home, outside of the immediate context of medicine, negotiated with the authority of the medical model. They frequently assessed the timing of their pregnancies according to medically defined due dates, interpreted their progress in labour through centimetres dilation, and incorporated medical terminology, and hence medical knowledge, in their descriptions of the processes that were occurring within their own bodies. Even if women's stories did not explicitly contain due dates or medical means of assessing progress in labour, it was still frequently necessary for homebirthing women to negotiate with medical means of understanding pregnancy and labour in order to distance themselves from the medical model. For instance, when S places the term overdue in quotations, or when H prevents others from "clock watching" by not telling anyone she is in labour.

Through their stories, women did mention several instances in which the application of specific medical information to their individual circumstances was challenged. However, challenging this information does not necessarily represent a challenge to the authority of the medical model itself. They may challenge the way a due date is assigned, but this did not challenge the need to assign a date and assess the overall length of the pregnancy according to

medically defined standards. When L challenged the episiotomy and vacuum extraction by increasing her efforts to push, she nevertheless did not challenge the authority of the physician to make the decision to employ these techniques. And when R refused to let the medical staff break her waters and challenged the nurse's attempts to quiet her, she did so from within a context in which she felt a need to differentiate herself and her experience from that of the typical birthing woman. By stating that she was not the type of "girl to be laying on [her] back biting a rag", she differentiated herself from this stereotypical image and claimed her own unique identity. However, she presents this image as a valid interpretation of women in birth, and preserves medical authority over those women whose birth experiences, she believes, more closely adhered to the normative medical script.

Those who chose to give birth at home, either "unassisted" or with the assistance of midwives or traditional birth attendants, posed the greatest challenge to medical authority. By giving birth outside of medical institutions and denying the presence of professionally trained attendants at their births, they challenged the claim to legitimacy for medicine (and in some ways midwifery) in childbirth. However, medical knowledge does not entirely disappear from their births. They often make extensive use of medical terminology and medically defined criteria for assessing progress in labour, and, in so doing they recognize the value of medical knowledge and legitimate certain aspects of the medical model. This parallels the work of Westfall and Benoit (2004), who found that women committed to "natural" childbirth were often reluctant to reject medical definitions regarding the duration of pregnancy, frequently taking steps to end their pregnancies through various means of induction. Their actions seem to indicate that medical definitions regarding gestational length were often incorporated into their own understanding of pregnancy, even if they professed to reject medical control. Monto (1997) also discusses the importance and "lingering presence" of medical definitions among women who espoused non-medical views on pregnancy and childbirth.

While medicine, as a system of knowledge, undoubtedly maintains a dominant position in the narratives, it is certainly not the only source of knowledge that is incorporated in these stories.

Women's narratives also relied upon authoritative knowledge based on midwifery, previous experience, and intuition, premonition, and spirituality.

As depicted in the women's stories, midwives could be important sources of authoritative knowledge for those births where they were in attendance. However, as the literature suggests, their stories highlighted the ways in which midwifery knowledge is often blended with medical knowledge making it difficult to identify a knowledge system that was unique to midwifery. As Foley and Faircloth (2003) and Annandale (1988) point out midwives use medical knowledge to both legitimate their own practices and establish their position as independent professional practitioners. From the content of the stories involving midwives, it became evident that the role of midwives at the birth was often dependent on their ability to perform those tasks that are typically attributed to medical professionals. In S's story, our initial introduction to the midwife was in the context of an exchange that involved the midwife checking cervical dilation, suggesting a biophysical profile to assess the health of the baby, and providing S with information regarding alternative methods of induction. Contained within each of these elements of S's interaction with her midwife were aspects of the medical model for understanding childbirth. For example, even though the methods suggested by the midwife were alternative methods that involved the use of herbs, and as such could be considered a more holistic approach than medical means of induction, there was still recognition of the need to impose a medically defined understanding of the appropriate timing for the duration of the pregnancy. This was likely closely related to the midwife's familiarity with medical protocol that limits her participation at a homebirth in a pregnancy that exceeds 42 weeks gestation (Westfall and Benoit, 2004). Later on in the story, S indicated that she was finally able to "let go" and release her body to the process of labour when she knew that the midwife was on her way. In this statement, S was acknowledging the authority the midwife would bring to her birth, in particular through the midwife's ability to assess S's progress. When the midwife arrived she immediately prepared to check dilation, monitor the baby's heart rate, and measure S's blood pressure.

One of the most interesting examples of the parallels that could be drawn between midwifery knowledge and medical knowledge occurred in a birth story in which neither a midwife

nor a member of the medical profession was present in person at the birth. H's story described an internal process of negotiation in which she invoked a mental image of a midwife to represent the authority of a member of that profession. In this case, the mental midwife was presented in opposition to the "mother giving birth in [the] body". This midwife was conjured to assess progress by means of a "measuring stick", and judged H according to the normative standards implied by this measurement. When an actual midwife was called to provide additional information, it served to strengthen the image and a new course of action was adopted based on the authority of the midwife. In this case it was the authoritative knowledge of the midwife that was respected, but the authority that was given to the midwife was of a variety similar to that of a medical professional who would typically be responsible for comparing individual progress against normative patterns and judging a woman's labour according to these standards.

What remains distinctive about the midwifery system of knowledge, as compared to that of the medical profession, was the ability to co-produce the legitimacy of the information upon which decisions were based by placing a greater emphasis on those aspects of the woman's experience that were not empirically measurable. Returning to S's birth story, when the midwife was telephoned S informed her about the frequency of the contractions, but stated that she was concerned about a lack of information regarding her progress. The midwife informed her that the timing of the contractions was not important, but rather their intensity. The intensity of the contractions represented information that was uniquely accessible to S, no one else present would be able to assess the contractions and provide this information, and thus the midwife established that S's knowledge of her own sensations was valuable information on which to assess progress and ultimately base decisions. For J, who gave birth at home with the assistance of traditional birth attendants, the collective pronoun "we" was used in her discussion of the due date, and provided an indication that establishing this piece of information involved a process of co-construction. Both the "typical calculations" made by the traditional birth attendants and the woman's personal knowledge of her individual menstrual cycles were incorporated in constructing this piece of authoritative information.

According to some of the women, previous birth experience was also a form of authoritative knowledge incorporated in their stories. As I have demonstrated with regards to the manner in which midwives relied on women's knowledge of their own bodies, previous experience also relied strongly upon information accessible only to the woman who was experiencing the birth. In K's story of the caesarean birth of her second child, previous experience was a key form of authoritative knowledge for her, and she was able to incorporate this knowledge to assert her own agency in this birth. Her previous experience with anesthesia in the past allowed her to claim authoritative knowledge regarding her possible reaction to the anesthetic during this second birth, and she was able to use this knowledge to influence the actions of the anesthesiologist. She alone was able to make the unique bodily connections between this caesarean experience and her previous one, and the repeated references in her story to the sensations of the birth and the conversational exchanges in which she engaged served to reinforce her active role and presence in this birth.

The ability to draw from previous experience as a source of authoritative knowledge appeared to be not simply a matter of having a previous experience, but rather it was contingent upon the specific circumstances of that experience. S's story described the homebirth of her fifth child and, as such, she should have plenty of previous experience from which to draw to make decisions regarding this birth. However, she appeared in her story to be unable to invoke this knowledge as authoritative, seemingly because of the difference in the way that labour had started for this birth as compared to her past births. On this occasion she went into labour spontaneously, whereas her previous birth experiences involved the use of medical procedures to induce labour. This difference prevented her from being able to draw comparisons that would allow her to estimate how fast she would progress through labour, and as a result she was faced with uncertainty as to the appropriate time to call her midwife and other support persons. For H, the differences between this labour experience and others resulted in her decision to dismiss the value of previous experience as a source of authoritative knowledge, stating, "It took some work to come to the conclusion that no one else's birth had anything to do with me... My previous two births were irrelevant right here right now."

From all of these stories, it was evident that previous experience could be a source of authoritative knowledge, but it was reliant upon the ability to connect the current birth experience with those that have gone before. Since previous experience is a source of information that is accessible and interpretable only by the woman in labour, in order to establish the information as authoritative it is important that a woman has confidence and trust in her body to provide her both with accurate information and the ability to interpret this information. In this manner, the body itself can become a fundamental site of information relevant to the birth and decisions that are made regarding the birth. However, the ability to establish confidence and trust in one's body may prove difficult, especially to women who have a deeper engagement with medical knowledge. According to Young, "The control over knowledge about the pregnancy and birth process that the physician has through instruments, moreover, devalues the privileged relation she has to the foetus and her pregnant body" (1984, 46). Medical means of understanding childbirth have been repeatedly criticized for undermining women's knowledge of their bodies in pregnancy and birth by separating and isolating women from the experiences of pregnancy and labour through the routine application of medical tests, procedures, and technology (Duden, 1993; Marshall and Woollett, 2000; Mitchell and Georges, 1997; Oakley, 1984). It is in this area where the midwife's emphasis on the co-production of authoritative knowledge through their reliance on information accessible only to the birthing woman might be of particular importance in reconnecting women to the bodily experiences of pregnancy and birth, and hence to a greater claim on agency and power in the birthplace.

One final aspect of authoritative knowledge that was evident in the stories involved the use of knowledge based on aspects of spirituality and intuition. As discussed by Klassen (2001) and Davis-Floyd and Davis (1997) spirituality and intuition can be important sources of guidance in decisions during childbirth, particularly at homebirths. Davis-Floyd and Davis examine the use of intuition from the midwives perspective, but the homebirth stories also indicated that women relied on their own sense of intuition to tell them what to do or to accept that the birth was proceeding well. In H's story, she used the word "something" to refer to an unnamed sense that guided her decisions regarding what actions were appropriate. When she decided to get into the

pool, she stated, "[s]omething in me made a connection with the water and understood that I needed whatever it was the water had to offer." D, who also experienced an "unassisted" birth explained, "[m]y intuition told me that everything was going to be fine." C, who chose a midwife-attended homebirth, credited her faith for guiding her through the birth experience, stating, "I want to thank God for His blessing of this amazing birth experience. I knew He wanted me to have this birth experience through answers to prayers." C also relied strongly on the premonitions that she experienced prior to this birth, which she credited as a "gift from God." Through her premonition she had a vivid depiction of the birth including what she would be seeing, where the birth would take place, and the exact position she was in at the time of the birth. She permitted this premonition to guide her and give her strength as the birth proceeded.

In much the same way that Davis-Floyd and Davis assert that the ability of homebirth midwives to rely on intuition is "a strong marker of their commitment to holism and its underlying principle of connection" (1997: 317), reliance on knowledge grounded in intuition, premonition, and spirituality suggested that these women were connected to their beliefs. In terms of intuition it is a belief in themselves and their own ability to know what is right when it involves giving birth, and in terms of spirituality it is a belief in a higher power and a trust in birth itself. In both of these circumstances the women's beliefs seem to permit them a greater claim to agency in their own births. A greater belief in themselves and their own ability to give birth would be consistent with a stronger claim to personal agency, while a belief in spirituality would bring them closer to their own faith through which they may experience a greater sense of strength and power. According to Klassen (2001) women's participation in discourses that focused on religion and spirituality allowed women to connect with the power entailed in the knowledge that their bodies were capable of creating life.

The Role of the Internet: A final note on agency in birth stories

Perhaps the greatest display of agency with regard to these stories is not contained within the stories, but rather can be located in the act of telling the story in the first place. All of these women took the initiative to write detailed accounts of the births of their children and post them for anyone with Internet access to read. As Mitra and Cohen have stated, the Internet

enables individuals to claim the power of publication outside of the typical means through which words are edited and reviewed by editors and publishers before they ever reach the public in written form (1999:196). Women have borrowed from the power of this global communication forum to let their voices be heard, and they are more than aware that their words can have an effect on those who read them.

Some women used their stories as a means of participating in a community of women with whom they held similar experiences or similar views. Others shared their stories as a way of celebrating triumph or venting anger. Some women also saw their stories as a means through which they could educate their readers about their own personal birth experiences, and assist others by preparing them for what to anticipate or avoid should they find themselves in comparable circumstances. Sometimes the stories incorporated more than one of these objectives, but ultimately all of the writers have made the decision to use the Internet to tell their stories because each believes that her story is important and her experience unique.

Women's stories also often incorporated the stories of others. In S's story, she acknowledged how reading the Internet birth story of another woman became a source of inspiration for her. Other women recognized that through sharing their stories with others they were contributing to the strength of their online communities. M begins her story in the form of a letter or an e-mail informally addressing her readers and connecting them. She wrote: "Hi folks, [w]ell it took four weeks to write, but here it is, in all its infinite detail. I love reading all your birth stories, so I promised myself I'd post ours."

As I have mentioned in the section on Internet-based research methods (Chapter 3) the Internet serves two functions. It not only is a forum for communication, but also a source of information. Women's stories and survey responses showed that they have tapped into the informational power of the Internet to provide them with increased knowledge and understanding of pregnancy and labour. R's story described the Google search she conducted on "false labour" to help her understand the sensations she was experiencing, while C used the Internet to communicate with the creator of "The Pink Kit" (described online at www.birthingbetter.com), an alternative childbirth preparation system that she incorporated into her birth experience. Much of

the information that women encounter on the Internet, however, is likely to be situated within a medical model for understanding childbirth, but as McLellan (1998) points out the use of the Internet as a source of health information has the potential to influence the relationship between a woman and her health-care provider and make the woman a more active participant and decision-maker. Given that the majority of women choose physicians as primary care-providers, and that midwives are also likely to employ medical definitions, the information that is accessible through the Internet has the capability to increase women's agency in childbirth by allowing them to make informed decisions on the care that they believe is best suited to their needs.

Summary

In the above discussion, I have attempted to offer a deeper understanding of how these women's experiences and these women's stories provided insight into some of the issues and concerns that have been raised in the sociological literature regarding issues of childbirth and the medicalization of women's reproductive health. Although, I can state with certainty that these stories demonstrated the power of the medical model in understanding contemporary Canadian childbirth, I also believe that these stories revealed that the overall issues are not as clear as much of the literature would lead us to believe. Women are not simply subjected to medical tests, procedures, and technology in the course of their pregnancies and births, but rather these elements of the medical model are constructed and lived within the context of a woman's life. I will now turn to the concluding chapter where I will attempt to provide additional insight into the overall value of this project and the application of Internet-based methods to explore narrative materials, as well as identify future directions for research involving women's birth experiences and online narratives.

Chapter 6

Conclusion

The sociological investigation of childbirth has been a fundamental area of interest for feminist theory and research. Sbisà explains that in her belief:

> ...the experience of childbirth deserves attention not because of its supposedly crucial place in women's lives, but because of the difficulties women encounter in constructing their own point of view about it – difficulties [she] attribute[s] partly to the influence of a perspective on childbirth external to the women and functional to the needs and interests of those actors on the scene who are (or count as) male ones. (1996: 374)

Although women's stories do show that perspectives external to women enter their birth narratives, they are most definitely able to construct their own points of view about childbirth, and have been in a variety of settings and with a variety of other women for quite some time. Birth stories have been exchanged between family, friends, co-workers, acquaintances, and sometimes even strangers (See Pollock, 1999). They have been passed from mother to daughter, aunt to niece, friend to friend and form an important means through which women learn about birth as it has been experienced. The Internet represents a unique and powerful setting in which these stories are shared around the globe, and women are writing these stories and contributing their individual experiences to an ever increasing collection of personal narratives that are accessible to anyone with Internet service.

Exploring women's personal narratives of birth can provide valuable insight into the ways these experiences are lived and given meaning as they are constructed within a single unified account of the events of childbirth from a woman's perspective. Most of the sociological literature on childbirth, however, has taken a different approach and studied the influence of medicine on women's experience of childbirth from a professional perspective. This has been important research that has examined the process through which childbirth has been medicalized, and the ways medicine has the potential to influence how childbirth is perceived and understood. This ideological approach to childbirth has been labelled the medical (or occasionally technocratic, or biomedical) model, and it is typically placed in opposition to the midwifery (or natural model) of childbirth practiced by midwives or advocated by those seeking alternatives to medical control in

childbirth. What is often lost in a discussion of the ideological belief systems through which childbirth practices are shaped, is the way in which childbirth, as a personal experience, is shaped and given meaning by women in the context of their own lives.

There have been contributions to this body of literature that have explored the unique birth experiences of women from their own perspectives, and there have been more recent pieces that have investigated the birth narratives that women create to communicate their birth experiences, however, to my knowledge this project represents the first occasion in which birth narratives written on the Internet by Canadian women have been the focus of sociological investigation. What these narratives have revealed is that a diverse group of women have used this technological forum to post their personal stories on the Internet. Their stories were often poignant, frequently entertaining, and always filled with the rich detail of personal experience. Women have breathed life into their stories by writing them with the full complexity that one would expect when creating in narrative the events surrounding such a life-altering event as the birth of a child. As women constructed written versions of their personal experiences of childbirth, the language that they used wove through the layers of complexity that have been identified in past research on childbirth to arrive at a location where this birth experience had meaning for them in the context of their own lives. The range of different experiences that their stories described provided a unique opportunity to explore the processes through which women created personal meaning in very different types of births.

While each story that I collected was undeniably unique, there were common structures and dominant themes within the stories. In each of the women's stories, the narrative structure followed sequentially the events of the birth. Although not all of the stories contained descriptions of each of these segments, generally the stories began with an introduction that included a description of the pregnancy, followed by a discussion of the onset of labour, and continued as the labour progressed. Women then provided a description of the birth of their child, which was followed by a concluding section that brought the reader back to the present time in which the story was written. The sequential ordering of narrative events is regarded as a fundamental element of narrative structure (Labov and Waletsky, cited in Mischler, 1986), and women's

adherence to this structure illustrated its importance for constructing birth in narrative form. This may lend some credence to Maher's (2002) argument that written birth narratives are constrained within forms that are deemed culturally and socially acceptable, such that prominent narrative structures persist, while alternate forms may be eliminated.

Exploring the content of the stories also illuminated common themes that wove their way through the stories. The women's stories demonstrated that medicine was a dominant narrative resource through which personal birth experiences could be given meaning and communicated to others over the Internet. Given the extent to which medicine was present in each of the stories, even in those that took place outside of the hospital and without medical professionals in attendance, it is important to question whether the power to publish personal stories on the Internet is leading to a greater overall understanding of childbirth through the opening of alternative perspectives, or whether the dominant ideology of childbirth (the medically defined narrative script) is being replicated in new ways through this new medium. What I would have to contend, and what the variety of the stories that I located seems to suggest, is that the Internet is large enough in scope and diverse enough in content to be able to accomplish both at the same time.

The majority of the stories that I located on the Internet described a birth that took place in hospital under the care of a physician, and this parallels the birthing situation for women in the general Canadian population. Women's stories included references to medical tests, procedures, technology, and terminology, and through their stories women participated in the dominant medical knowledge system and reproduced its authority by passing their personal knowledge of their engagement with this system to their readers. They learned to speak in medical terms and taught others that this knowledge system is the normative system through which childbirth is practiced and understood. The medical narrative formed a fundamental component of the narrative resources through which childbirth stories can be told, and its presence was strongly tied to the broader cultural narrative in which it is embedded. It was often difficult to ascertain where the public narrative of medicine ended and the metanarrative specific to cultural expectations began. The medicalization of certain aspects of pregnancy, labour, and childbirth

frequently appeared in the stories to be so complete and acceptable that the medical model at the base of these practices was often shielded in ways that would make them difficult to challenge and resistant to change.

But women's stories did show resistance. Although the medical script retained its position as a dominant narrative resource, women have claimed the ability to tell their stories from their perspective, to show not just how medicine influenced their experience of childbirth, but to demonstrate how medicine was lived in childbirth. They recreated cervical checks, fetal monitors, vacuum extractions, and caesarean sections not merely as aspects of modern medicine that women may face during childbirth, but they told us how these practices were lived in the context of personal experience. In telling us their stories they have demonstrated the ability to resist these techniques and illustrate the many forms that their resistance may take.

The Internet also permits a diversity that is wide enough to accommodate stories in which women's resistance to medical dominance took them outside of the hospital (the primary institution of medical control) as they chose to give birth to their children in their own homes. As I have discussed in the analysis section of this thesis (Chapter 4), these stories were represented in this sample in numbers that far exceeded their proportion in the general population. While this may be attributable to several factors, one factor is likely a result of the overall numbers of homebirth stories that are part of an active online homebirth community.

Through these homebirth stories women have shown the pervasiveness of medicine as it influences their experiences and medical language weaves its way into their narratives. Their stories also provide insight into the precarious position of modern midwifery in Canada as midwives attempt to define the boundaries of their own unique knowledge system. Often this knowledge system can be seen to intersect with the medical model as midwives face the medically determined limits of their practices and incorporate medical knowledge into their relations with their clients. But these stories also provide us with an important glimpse into the midwife client relationship as it is seen from the perspective of the birthing woman. Through these narratives the ways in which midwives co-produce knowledge by relying on information that is uniquely accessible and interpretable to women can be seen as one way in which midwives can

assist women to reassert agency in their births by reclaiming and revaluing the information that is derived from their own bodies.

The scope of birth stories that are present on the Internet is most clearly displayed in the selection of stories describing "unassisted" homebirths. It would be challenging to explore these birth experiences through other means, but the Internet offers a direct path to websites on which women have gathered to share these stories and educate other women about the issues and challenges they may face if they choose this route. Although women's "unassisted" stories did incorporate aspects of the medical narrative, they also presented the greatest challenge to medical authority. A birth that takes place at home without the immediate presence of either a physician or a midwife means that a woman has only herself and those she chooses to accompany her on which to make decisions and justify actions. As she wrestles with the questions that inevitably face all women in labour (Is this "it"? What should I do? What can I expect?), she relies the most on her own ability to know that the answers to these questions are ones that she will find as she learns to trust her own body and her own knowledge.

The range of birth stories located on the Internet has contributed greatly to the ability to take this project in many directions and to explore birth from a multitude of perspectives. Women's stories have shown that their experiences are too broad to be limited to exploration involving a dual system of oppositional ideologies. Indeed, their stories frequently illustrated that these ideologies were not necessarily opposites, but rather they were blended together allowing women to acknowledge the authority of either system, or move outside of these systems altogether, to understand and create meaning from their births in different ways. They demonstrated that they could claim agency by borrowing from the power of the medical model, resisting it, or finding some other means to assert the importance of their personal experience.

Methodologically the Internet also proved to be a beneficial and important means through which to undertake this research. Once potential participants were identified, they responded to the request for participation quickly, within typically about one week. They were able to complete the e-mail survey at their leisure, and the thoroughness of their responses seems to indicate that this permitted them the time and space to fully develop their answers. Of course, it would not be

possible to locate Internet birth stories through any other medium, but the fact that I was able to gather more than enough materials for this project is further proof that the Internet can be an important source of unsolicited first-person narratives, and a valuable site for qualitative investigation. The extent to which the Internet itself played a role in the context, and content of the stories, both individually and as a collection, is important in that it speaks to the power of this unique forum to shape the ways we communicate with one another and gather information about the world around us.

The sheer size of the Internet, however, meant that collecting the material was a time consuming process. I would suggest that others who decide to use the Internet for qualitative research employ a different method of sample selection. Although the approach that I used was certainly thorough, one has to question the need to select a sample through such rigorous methods when the ephemeral and fluid nature of the Internet means that the potential pool of narrative material is constantly changing and ever expanding. Targeting specific websites, either for their content or their scope, and then selecting stories from these sites would reduce the scale of the project and make it much more manageable.

Generally, I would not only recommend the Internet as a useful method through which rich narrative material can be collected, but I would state that it is an important site to explore simply because of the ways spaces have been created in which personal narrative material is being posted and exchanged. While conducting this research, I also came across many other types of personal stories in areas closely related to childbirth. Many sites existed through which women (and men) could express their personal experiences with pregnancy loss and stillbirth. Through these stories, individuals were able to work through their grief and connect with others who had shared similar experiences. Discussing the seeming invisibility of stories about stillbirth, Pollock states:

> Stories with dire consequences are often simply prohibited, either by doctors who warn prospective mothers off anecdotes and lore for fear of panic or noncompliance or by the generations of mothers who think they're doing newcomers a favor by not revealing the "secret". (1999: 5)

Yet on the Internet these stories are not silenced. They are given voice and the writers of these stories convey the meaning and complexity of pregnancy loss and stillbirth within the context of their own lives. Exploring these stories in future research, the ways in which their authors create meaning, and the manner in which these stories are structured and exchanged would be an important step in understanding a crucial aspect of women's reproductive experiences that is frequently silenced and misunderstood. Also appearing on the Internet were sites that were devoted to sharing TTC (trying to conceive) stories. Investigating these stories could also prove to be an important contribution in understanding another aspect of women's reproductive health that is more often understood from the perspective of medicalization and medical control, than from the perspective in which it is lived and experienced.

Expanding beyond the immediate context of women's reproductive experience, the Internet also offers possibilities for investigating a plenitude of personal stories and diaries (blogs) that involve a wide variety of topics. As Neimeyer states, "[a]s human beings we live our lives in stories" (2003: 3). We make sense out of the events of our lives and present ourselves to others in narrative form. Exploring the stories that we tell on the Internet, therefore, would open a window into a network of global communication in which we share the stories of our lives and present our multiple technologically mediated selves to the world. For the sociologist, the Internet represents tremendous potential to explore the stories in which we live our lives, and the stories that, in turn, shape the lives that we lead.

References

Annandale, E. 1988. "How Midwives Accomplish Natural Birth: Managing Risk and Balancing Expectations." *Social Problems* 35(2): 95-110.

Arms, S. 1975. *Immaculate Deception*. Boston, MA: Houghton Mifflin Company.

Association for Safe Alternatives in Childbirth (ASAC). 2001."Updates on Midwifery in Canada." Retrieved March 15, 2002 (http://www.asac.ab.ca/updatesMidwiferyCanada.html).

Atwood, M. 1977. "Giving Birth." Pp. 228-245 in *Dancing Girls and Other Stories*. Toronto, ON: McLelland and Stewart.

Balsamo, A. 1995. *Technologies of the Gendered Body: Reading Cyborg Women*. Durham, NC: Duke University Press.

Benoit, C. 2000. *Women, Work and Social Rights: Canada in Historical and Comparative Perspective*. Scarborough, ON: Prentice Hall Canada.

Best, S., B. Krueger, C. Hubbard and A. Smith. 2001. "An Assessment of the Generalizability of Internet Surveys." *Social Science Computer Review* 19(2): 131-145.

Bochner, A.P. 2001. "Narrative's Virtues." *Qualitative Inquiry* 7(2): 131-157.

Bourgeault, I.L. 1999. "Delivering Midwifery: The Integration of Midwifery into the Canadian Health Care System." *Canadian Women's Health Network* 2(3). Retrieved March 15, 2001 (http//www.cwhn.ca/network-reseau/2-3/midwifery.html).

Bourgeault, I.L. 2000. "Delivery the 'New' Canadian Midwifery: The Impact on Midwifery of Integration into the Ontario Health Care System." *Sociology of Health and Illness* 22(2):172-196.

Canadian Association of Midwives (CAM). 2004. "Across Canada." Retrieved September 11, 2004 (http://members.rogers.com/canadianmidwives/Canada.html).

Canadian Institute for Health Information (CIHI). 2004. "Giving Birth in Canada: Providers of Maternity and Infant Care." Ottawa, ON: Canadian Institute for Health Information, Retrieved May 8, 2004 (http://secure.cihi.ca/cihiweb/).

Carr, I. 1998. "Women in Healing and the Medical Profession." Winnipeg, MB: University of Manitoba Department of Obstetrics, Gynecology, and Reproductive Sciences, Retrieved September 10, 2004 (http://www.umanitoba.ca/outreach/Manitoba_womens_health/wominmed.htm).

Cartwright, E. 1998. "The Logic of Heartbeats: Electronic Fetal Monitoring and Biomedically Constructed Birth." Pp. 240-254 in *Cyborg Babies: From Techno-sex to Techno-tots*, edited by Robbie Davis-Floyd and Joseph Dumit. New York, NY: Routledge.

Chase, S. 1995. "Taking Narrative Seriously: Consequences for Method and Theory in Interview Studies." Pp. 1-26 in *Interpreting Experience: The Narrative Study of Lives, Volume 3*, edited by Ruthellen Josselson and Amia Lieblich. Thousand Oaks, CA: Sage Publications.

Coffey, A. and P. Atkinson. 1996. *Making Sense of Qualitative Data: Complementary research strategies*. Thousand Oaks, CA: Sage Publications.

College of Midwives of British Columbia (CMBC). 2001. "What is the College of Midwives?" & "Philosophy of Care." Retrieved April 5, 2001 (http://www.cmbc.ca/cmbcfram.htm).

College of Midwives of British Columbia (CMBC). 2004a. "Midwifery Education." Retrieved May 5, 2004 (http://www.cmbc.bc.ca/).

College of Midwives of British Columbia (CMBC). 2004b. "List of Registrants." Retrieved September 11, 2004 (http://www.cmbc.bc.ca/docs/list.htm).

Conrad, P. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18: 209-232.

Cosslett, T. 1994. *Women Writing Childbirth: Modern Discourses of Motherhood*. Manchester, England: Manchester University Press.

CyberAtlas. 2002. "Men Still Dominate Worldwide Internet Use." Retrieved May 30, 2003 (http://cyberatlas.internet.com/big_picture/demographics/print/o,,5901_959421,00.html).

Davis-Floyd, R.E. 1994. "The Technocratic Body: American Childbirth as Cultural Expression." *Social Science & Medicine* 38(8):1125-1140.

Davis-Floyd, R. and Davis, E. 1997. "Intuition as Authoritative Knowledge in Midwifery and Home Birth." Pp. 315-349 in *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives*,

edited by Robbie Davis-Floyd and Carolyn Sargent. Berkeley, CA: University of California Press.

Davis-Floyd, R.E and C.F.Sargent (eds). 1997. *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives*. Berkeley, CA: University of California Press.

Declercq, E., R. DeVries, K. Viisainen, H.B. Salvesen, and S. Wrede. 2001. "Where to Give Birth? Politics and the Place of Birth." Pp. 7-27 in *Birth By Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*, edited by R. DeVries, C. Benoit, E.R. Van Teijlingen and S. Wrede. New York, NY: Routledge.

Doulas of North America (DONA). 2003. "Doulas of North America Statistics." Retrieved March 15, 2003 (http://www.dona.org/statistics.htm).

Duden, B. 1993. *Disembodying Women: Perspectives on Pregnancy and the Unborn*. Translated by Lee Hoinacki. Cambridge, MA: Harvard University Press.

Foley, L. and C. Faircloth. 2003. "Medicine as Discursive Resource: Legitimation in the work narratives of midwives." *Sociology of Health & Illness* 25(2): 165-184.

Fox, B. and D. Worts. 1999. "Revisiting the Critique of Medicalized Childbirth: A Contribution to the Sociology of Birth." *Gender and Society* 13(3):326-346.

Freeman, M. 2004. "Life and Literature: Continuities and discontinuities." Keynote address at Narrative Matters 2004, Fredericton, NB, May 21, 2004.

Gaskin, I.M. 2003. *Ina May's Guide to Childbirth*. New York, NY: Bantam Dell.

Giglio, A.(Ed). 1999. *Labour Day: Shared Experiences from the Delivery Room*. New York, NY: Workman Publishing Company.

"Gloria LeMay." 2003. Retrieved September 11, 2004 (http://www.glorialemay.com/index.html).

Gubrium, J.F. and J.A. Holstein. 1998. "Narrative Practice and the Coherence of Personal Stories." *The Sociological Quarterly* 39(1): 163-187.

Hawkins, M. and S. Knox. 2003. *The Midwifery Option: A Canadian Guide to the Birth Experience*. Toronto, ON: HarperCollins Canada.

Hevern, V.W. 2003. "Introduction and General Overview. Narrative psychology: Internet and resource guide." Retrieved August 25, 2004 (http://maple.Lemoyne.edu/~hevern/nrintro.html).

Hevern, V.W. 2004. "Narrative in Other Disciplines: Sociology." Retrieved September 12, 2004 (http://web.Lemoyne.edu/~hevern/nr-soc.html).

Hewson, C. 2003. "Conducting Research on the Internet." *The Psychologist* 16(6):290-293.

Illingworth, N. 2001. "The Internet Matters: Exploring the Use of the Internet as a Research Tool." *Sociological Research Online* 6(2). Retrieved June 23, 2004 (http://www.socresonline.org.uk6/2/illingworth.html).

iParenting. 2004. "Glossary of Pregnancy & Labor Terms." Retrieved July 10, 2004 (http://pregnancytoday.com/reference/library/glossary.htm).

Jordan, B. 1997. "Authoritative Knowledge and Its Construction." Pp 55-79 in *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives* edited by Robbie Davis-Floyd and Carolyn Sargent. Berkeley, CA: University of California Press.

Josselson, R. 1995. "Imagining the Real: Empathy, Narrative, and the Dialogic Self." Pp. 27-44 in *Interpreting Experience: The Narrative Study of Lives, Volume 3*, edited by Ruthellen Josselson and Amia Lieblich. Thousand Oaks, CA: Sage Publications.

Kahn, R.P. 1995. *Bearing Meaning: The Language of Birth*. Chicago, IL: University of Illinois Press.

Kerr, H. 2002. "Rooms when you're due." *National Post* Birth Guide supplement, June 3, 2002, BG2.

Kitzinger, S. 1977. *Giving Birth: The Parents Emotions in Childbirth*. New York, NY: Schocken Books.

Klassen, P. 2001. *Blessed Events: Religion and Home Birth in America*. Princeton, NJ: Princeton University Press.

Lane, K. 1995. "The Medical Model of the Body as a Site of Risk: a case study of childbirth." Pp 53-72 in *Medicine Health and Risk: Sociological Approaches,* edited by Jonathan Gabe. Cambridge, MA: Blackwell Publishers Ltd.

Langellier, K.M and E.E. Peterson. 2004. *Storytelling in Daily Life: Performing Narrative*. Philadelphia, PA: Temple University Press.

Lay, M. 2000. *The Rhetoric of Midwifery: Gender, Knowledge and Power.* New Brunswick, NJ: Rutgers University Press.

Leavitt, J.W. 1987. "The Growth of Medical Authority: Technology and Morals in Turn-of-the Century Obstetrics." *Medical Anthropology Quarterly* 1(3):230-255.

Leja, G.M. 2001. "A Narrative Analysis of Breastfeeding Counselling." MN thesis, Department of Human and Social Development. University of Victoria, Victoria, BC.

Library and Archives Canada. 2000. "Emily Jennings Stowe Augusta Stowe Gullen: Pioneer Women Doctors." Retrieved September 10, 2004 (http://www.collectionscanada.ca/women/h12-207-e.html).

McLellan, F. 1998. "Like Hunger, Like Thirst: Patients, Journals and the Internet." *Lancet* 352(s2):12-17.

Maher, J.M. 2002. "Up in the Stirrups Again: Narratives of Birth and the Transition to Motherhood." Special Issue of *Meridian, The Fertile Imagination: Narratives of Reproduction* 18(2):207-226.

Mann, C. and F. Stewart. 2000. *Internet Communication and Qualitative Research: A Handbook for Researching Online.* Thousand Oaks, CA: Sage Publications.

Markham, A. 1998. *Life Online: Researching Real Experience in Virtual Space.* Walnut Creek, CA: Alta Mira Press.

Marshall, H. and A. Woollett. 2000. "Fit to Reproduce? The Regulative Role of Pregnancy Texts." *Feminism and Psychology* 10(3): 351-366.

Martin, E. 1987. *The Woman in the Body: A Cultural Analysis of Reproduction.* Boston, MA: Beacon Press.

Miller, T. 2000. "Losing the Plot: Narrative Construction and Longitudinal Childbirth Research." *Qualitative Health Research* 10(3):309-323.

Mischler, E. 1986. *Research Interviewing Context and Narrative.* Cambridge, MA: Harvard University Press.

Mitchell, L. and E. Georges. 1997. "Cross-Cultural Cyborgs: Greek and Canadian Women's Discourses on Fetal Ultrasound." *Feminist Studies* 23(2):373-402.

Mitchinson, W. 2002. *Giving Birth in Canada, 1900-1950*. Toronto, ON: University of Toronto Press.

Mitra, A. and E. Cohen. 1999. "Analyzing the Web Directions and Challenges." Pp. 179-202 in *Doing Internet Research: Critical Issues and Methods for Examining the Net* edited by Steve Jones. Thousand Oaks, CA: Sage Publications.

Monto, M. 1997. "The Lingering Presence of Medical Definitions Among Women Committed to Natural Childbirth." *Journal of Contemporary Ethnography* 26(3):293-316.

Neimeyer, R.A. 2003. "Community and Coherence: Narrative Contributions to the Psychology of Conflict and Loss." Pp. 166-191 in *Narrative and Consciousness: Literature, Psychology, and the Brain* edited by G. Fireman, T. McVay, and O. Flanagan. New York, NY: Oxford University Press.

Nelson, F. 2004. "Birth Stories and the Narrative Construction of Maternal Identities." A paper presented at Narrative Matters 2004. Fredericton, NB, May 23, 2004.

Oakley, A. 1984. *The Captured Womb: A History of the Medical Care of Pregnant Women*. New York, NY: Basil Blackwell, Inc.

O'Brien, M. 1981. *The Politics of Reproduction*. London, UK: Routledge & Kegan Paul.

Polkinghorne, D.E. 1995. "Narrative Configuration in Qualitative Analysis." *International Journal of Qualitative Studies in Education* 8(1):12-28.

Pollock, D. 1999. *Telling Bodies Performing Birth: everyday narratives of childbirth*. New York, NY: Columbia University Press.

Rapp, R. 1990. "Constructing Amniocentesis: Maternal and Medical Discourses." Pp. 28-42 in *Uncertain Terms: Negotiating Gender in American Culture*, edited by Faye Ginsburg and Anna Lowenhaupt Tsing. Boston, MA: Beacon Press.

Rich, A. 1986. *Of Woman Born: Motherhood as Experience and Institution, Tenth Anniversary Edition*. New York, NY: W.W. Norton and Company.

Riessman, C.K. 1993. *Narrative Analysis. Qualitative Research Methods Series, No. 30*. Newbury Park, CA: Sage Publications.

Riessman, C.K. 2000. "Analysis of Personal Narratives." Retrieved November 21, 2001 (http://www.uel.ac.uk/cnr/riess1.doc).

Riessman, C.K. 2001. "Narrative Analysis." Digilante.net, Retrieved April 23, 2004 (http://www.digilante.net/cgi-bin/teq.pl?%20%20Oddities%...).

Riessman, C.K and C.A. Nathanson. 1986. "The Management of Reproduction Social Construction of Risk and Responsibility." Pp. 251-281 In *Applications of Social Science to Clinical Medicine and Health Policy*, edited by Linda Aiken and David Mechanic. New Brunswick, NJ: Rutgers University Press.

Robinson, K.M. 2001. "Unsolicited Narratives From the Internet: A Rich Source of Qualitative Data." *Qualitative Health Research* 11(5):706-714.

Sbisà, M. 1996. "The Feminine Subject and Female Body in Discourse about Childbirth." *The European Journal of Women's Studies* 3:363-376.

Schwandt, T. 1998. "Constructivist, Interpretivist Approaches to Human Inquiry." Pp. 221-259 in *The Landscape of Qualitative Research: Theories and Issues*, edited by Norman K Denzin and Yvonna S Lincoln. Thousand Oaks, CA: Sage Publications.

Selwyn, N. and K. Robson. 1998. "Using E-Mail as a Research Tool." *Social Research Update*. Retrieved March 10, 2002 (http://www.soc.surrey.ac.uk/sru/SRU21.html).

Sharf, B.F. 1997. "Communicating Breast Cancer On-Line: Support and Empowerment on the Internet." *Women & Health* 26(1):65-84.

Sharf, B.F. 1999. "Beyond Netiquette The Ethics of Doing Naturalistic Discourse Research on the Internet." Pp. 243-256 in *Doing Internet Research: Critical Issues and Methods for Examining the Net*, edited by Steve Jones. Thousand Oaks, CA: Sage Publications.

Simonds, W. 2002. "Watching the Clock: Keeping time during pregnancy, birth, and postpartum experiences." *Social Science & Medicine* 55:559-570.

Smith, D. (1999). *Writing the Social: Critique, Theory and Investigations*. Toronto, ON: University of Toronto Press.

Smith, C.B. 1997. "Casting the Net: Surveying and Internet Population." *Journal of Computer-Mediated Communication* 3(1). Retrieved June 26, 2000 (http://www.ascusc.org/jcmc/vol3/issue1/smith.html).

Stabile, C. 2001. "Fetal Monitors: Labor and Birth on Daytime Television." Paper presented at Console-ing Passions Conference. University of Bristol, UK, July 2001.

Statistics Canada. 2003. "Household Internet Use Survey" *Statistics Canada Daily*, September 18, 2003. Retrieved September 18, 2003 (http://www.statcan.ca/Daily/English/030918/do30918b.htm).

Steer, P. 1999. "Physiology and Management of Normal Labour." *British Medical Journal* 318(7186):793-798.

Szurek, J. 1997. "Resistance to Technology-Enhanced Childbirth in Tuscany: The Political Economy of Italian Birth." Pp. 287-314 in *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives* edited by Robbie Davis-Floyd and Carolyn Sargent. Berkeley, CA: University of California Press.

Taylor, C. 2002. *Giving Birth: A Journey into the World of Mothers and Midwives*. New York, NY: The Berkley Publishing Group.

Treichler, P.A. 1990. "Feminism, Medicine and the Meaning of Childbirth." Pp. 113-138 in *Body/Politics: Women and the Discourses of Science*, edited by Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth. New York, NY: Routledge.

Turner, P. 2004. "Mainstreaming Alternative Medicine: Doing Midwifery at the Intersection." *Qualitative Health Research* 14(5):644-662.

Tyson, H. 2001. "The Re-Emergence of Canadian Midwifery – A New Profession Dedicated to Normal Birth". Retreived March 15, 2001 (http://www.acegraphics.com.au/resource/papers/holliday01.html).

Uimonen, P. 1998. "Cultural Encounters in Cyberspace." Paper presented in a virtual conference organized by the International Telecommunication Union (ITU) on "Internet in Asia: Cultural Diversity". Cyberspace, March 1998. Retrieved August 8, 2004 (http://www.i-connect.ch/uimonen/culture.htm).

University of British Columbia Department of Family Practice Division of Midwifery. 2002. "Midwifery: The Program." Retrieved April 28, 2002 (http://www.midwifery.ubc.ca/program.html).

Vancouver Sun. 2002. "Controversial B.C. Midwife Prohibited from Practising Now Faces Police Probe". Retrieved May 5, 2002. (http://ca.news.yahoo.com/020325/6/18gj.html).

Viisainen, K. 2001. "Negotiating Control and Meaning: Home Birth as a Self-Constructed Choice in Finland." *Social Science & Medicine* 52:1109-1121.

Westfall, R.E. and Benoit, C. 2004. "The Rhetoric of "Natural" in Childbirth: Childbearing women's perspectives on prolonged pregnancy and induction of labour." *Social Science & Medicine* 59:1397-1408.

Wolf, N. 2001. *Misconceptions: Truth, Lies, and the Unexpected on the Journey to Motherhood.* New York, NY: Doubleday.

Wrede, S., C. Benoit, and J. Sandall. 2001. "The State and Birth/The State of Birth: Maternal Health Policy in Three Countries." Pp. 28-50 in *Birth By Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*, edited by R. DeVries, C. Benoit, E.R. Van Teijlingen and S. Wrede. New York, NY: Routledge.

Young, I.M. 1984. "Pregnant Embodiment: Subjectivity and Alienation." *The Journal of Medicine and Philosophy* 9:45-62.

Youngs, G. 1999. "Virtual Voices; Real Lives." Pp. 55-68 in *Women @Internet: Creating New Cultures in Cyberspace*, edited by Wendy Harcourt. New York, NY: Zed Books.

Appendices

Appendix A: E-Mailed Letter of Informed Consent

Let me start this e-mail by introducing myself. My name is Kim Nuernberger and I am a student in the Master's program in sociology at the University of Victoria, Victoria, BC. As part of the requirements for the Master's program, I am conducting research that will explore birth stories posted by Canadian women on the Internet. The purpose of this research is to develop a better understanding of women's experience of birth and the meanings this experience has for them. In my research I hope to capture the richness of women's voices as they share stories covering a wide variety of childbirth experiences. Since I am only studying stories that have been posted on the Internet, understanding Internet birth stories is also an important part of this research.

I have read the birth story that you have posted on the Internet at _____concerning your child _____. I would very much like to incorporate your story into my research and am asking for your permission to do so. While you are under no obligation, your agreement to participate would be greatly appreciated.

Following this e-mail there are also a few questions that I would like you to answer. These questions should only take about 15 minutes of your time. The purpose of these questions is to gather some basic information from women who post stories on the Internet. Your responses would be appreciated, but again there is no obligation to answer. You may also leave blank any question(s) that you do not wish to answer.

If you wish to participate simply respond to this e-mail and let me know. If you decide to complete the question portion of this e-mail, please include this with your response. I have included the questions in the text below. The questionnaire has also been included as a Word attachment. If you experience any difficulties with this e-mail or simply if you prefer to use the attachment, please feel free to include your responses in the attached Word document. If you experience any further difficulties, please send me an e-mail to let me know.

I guarantee you that participation in this project will require no further commitment on your part and that there are no known or anticipated risks to you by participating in this research. I will also be taking several steps to ensure your privacy as well as that of your family. I will change all personal identifying information mentioned in the stories, web locations will never be connected with any of your story content in the final research project, and I will also be sure to keep all answers and contact information under lock and key at all times with this information only accessible to myself and my supervisor. All materials gathered in this project will be destroyed 2 years after the completion of this project (estimated completion date April 2004). This project has received approval from the Human Research Ethics Committee at the University of Victoria. If you wish to receive a copy of the approval form, please e-mail me and I will be happy to send you one. You may also contact the Associate Vice-President of Research at the University of Victoria at 250-472-4362 if you have any questions related to the ethical approval of this study.

If you have any further questions regarding this research please e-mail me at knuernbe@uvic.ca and I will be happy to answer them. If you wish you may also contact my supervisor, Dr. Cecilia Benoit at the University of Victoria at cbenoit@uvic.ca or 250-721-7586/7578. You may also use my e-mail address to contact me at a later time should you wish to make any changes or amendments to your participation or question responses.

Thank you for your time and input.

Sincerely,

Kim Nuernberger
Master's Candidate
Department of Sociology
University of Victoria
Victoria, BC

Appendix B: E-Mail Questionnaire

Please indicate your consent to participate in this research by marking a plus sign (+) next to the "Yes" response on the following question. If you indicate "No", your story will not be used.

I have read the attached e-mail and give my consent to include the birth story found at _____ concerning my child _____ in this research project.

___ Yes
___ No

If you answered "Yes" to the question above, please continue by answering the following questions to the best of your ability. Remember, there are no right or wrong answers as I am interested in your unique experiences of childbirth. Please feel free to use as much space as necessary for your responses. If you do not wish to provide an answer for any question, simply leave it blank. Thank you once again for your assistance.

Please answer the following questions with regard to the birth story that was told at _____ concerning your child _____.

1. What would you say was your primary motivation for placing this birth story on the Internet? (Please feel free to use as much space as necessary.)

2. Would you recommend that others post their birth stories on the Internet? Why or why not? (Please feel free to use as much space as necessary.)

3. In which province did this birth take place? _____

4. On what date (dd/mm/yy) did this birth take place? _____

5. How old were you at the time of this birth? _____

6. Does this story describe the birth of your first, second, third or subsequent child?
_____

7. In total, how many pregnancies have you ever experienced? _____

8. In total, to how many children have you ever given birth? _____

9. The following sections ask several questions about the births of your first, second and third children (if applicable). Please complete each applicable section by marking a plus sign (+) next

to the category or categories that best describe(s) your experience(s). If you would like to add more details about the births of any of your children, or provide information about the birth of a fourth or subsequent child, please feel free to add this information to question 19.

Concerning the birth of your first child:
Where did this birth take place?
___ Hospital - Labour and Delivery Room
___ Hospital - Operating Room
___ Hospital - Birthing Centre
___ Independent Birthing Centre
___ Home
___ Other (Please specify location on the line below)
_____

Which of the following birth attendants were present at the birth of your first child? (Select all that apply.)
___ General Practitioner or Family Doctor
___ Obstetrician / Gynecologist
___ Midwife
___ Doula
___ Other birth attendant (Please specify)_____
___ No birth attendant present (Unassisted childbirth)

Who else was present at the birth of your first child? (Select all that apply)
___ Husband/Partner
___ Mother
___ Husband/Partner's Mother
___ Father
___ Husband/Partner's Father
___ Sister(s)
___ Brother(s)
___ Friends
___ Other family member (Please specify) _____
___ Other non-family member (Please specify) _____

Which of the following were used or performed at the birth of your first child? (Select all that apply.)
___ Artificial rupture of membranes (Breaking the bag of waters)
___ Birthing tub
___ Caesarean
___ Epidural
___ Other pain relief medication
___ Episiotomy
___ Fetal monitor
___ Forceps / Vacuum delivery
___ Labour induction or augmentation (Pitocin or other labour enhancing drug)
___ Other birthing practice (Please specify as many as applicable in the space below. Feel free to use as much space as necessary.)

Overall, how satisfied were you with the birth experience of your first child?

___ Extremely satisfied
___ Very satisfied
___ Somewhat satisfied
___ Somewhat dissatisfied
___ Very dissatisfied
___ Extremely dissatisfied

Why would you say that you are satisfied or dissatisfied with this birth experience? (Please feel free to use as much space as necessary.)

(If you have given birth to a second child, please answer the following questions. If not, please skip ahead to question 10.)
Concerning the birth of your second child:
Where did this birth take place?
___ Hospital - Labour and Delivery Room
___ Hospital - Operating Room
___ Hospital - Birthing Centre
___ Independent Birthing Centre
___ Home
___ Other (Please specify location on the line below)
_____

Which of the following birth attendants were present at the birth of your second child? (Select all that apply)
___ General Practitioner or Family Doctor
___ Obstetrician / Gynecologist
___ Midwife
___ Doula
___ Other birth attendant (Please specify)_____
___ No birth attendant present (Unassisted childbirth)

Who else was present at the birth of your second child? (Select all that apply)
___ Husband/Partner
___ Mother
___ Husband/Partner's Mother
___ Father
___ Husband/Partner's Father
___ Sister(s)
___ Brother(s)
___ Friends
___ Other family member (Please specify) _____
___ Other non-family member (Please specify) _____

Which of the following were used or performed at the birth of your second child? (Select all that apply)
___ Artificial rupture of membranes (Breaking the bag of waters)
___ Birthing tub

___ Caesarean
___ Epidural
___ Other pain relief medication
___ Episiotomy
___ Fetal monitor
___ Forceps / Vacuum delivery
___ Labour induction or augmentation (Pitocin or other labour enhancing drug)
___ Other birthing practice (Please specify as many as applicable in the space below. Feel free to use as much space as necessary.)

Overall, how satisfied were you with the birth experience of your second child?
___ Extremely satisfied
___ Very satisfied
___ Somewhat satisfied
___ Somewhat dissatisfied
___ Very dissatisfied
___ Extremely dissatisfied

Why would you say that you are satisfied or dissatisfied with this birth experience? (Please feel free to use as much space as necessary.)

(If you have given birth to a third child, please answer the following questions. If not, please skip ahead to question 10.)
Concerning the birth of your third child:
Where did this birth take place?
___ Hospital - Labour and Delivery Room
___ Hospital - Operating Room
___ Hospital - Birthing Centre
___ Independent Birthing Centre
___ Home
___ Other (Please specify location on the line below)
_____

Which of the following birth attendants were present at the birth of your third child? (Select all that apply)
___ General Practitioner or Family Doctor
___ Obstetrician / Gynecologist
___ Midwife
___ Doula
___ Other birth attendant (Please specify)_____
___ No birth attendant present (Unassisted childbirth)

Who else was present at the birth of your third child? (Select all that apply)
___ Husband/Partner

___ Mother
___ Husband/Partner's Mother
___ Father
___ Husband/Partner's Father
___ Sister(s)
___ Brother(s)
___ Friends
___ Other family member (Please specify) _____
___ Other non-family member (Please specify) _____

Which of the following were used or performed at the birth of your third child? (Select all that apply)
___ Artificial rupture of membranes (Breaking the bag of waters)
___ Birthing tub
___ Caesarean
___ Epidural
___ Other pain relief medication
___ Episiotomy
___ Fetal monitor
___ Forceps / Vacuum delivery
___ Labour induction or augmentation (Pitocin or other labour enhancing drug)
___ Other birthing practice (Please specify as many as applicable in the space below. Feel free to use as much space as necessary.)

Overall, how satisfied were you with the birth experience of your third child?
___ Extremely satisfied
___ Very satisfied
___ Somewhat satisfied
___ Somewhat dissatisfied
___ Very dissatisfied
___ Extremely dissatisfied

Why would you say that you are satisfied or dissatisfied with this birth experience? (Please feel free to use as much space as necessary.)

10. Should you ever become pregnant again, what aspects of previous births would you like to stay the same and which would you like to change? For example, birth at a different location, with a different birth attendant or with other people present, or with different medical or non-medical practices. (Please answer this question even if you do not plan on any future pregnancies and feel free to use as much space as necessary.)

11. Considering the birth that you wrote about at _____ concerning your child _____, which of the following people or sources of information did you rely on the most for information about pregnancy and birth? (Please select as many as applicable by placing a plus sign (+) next to the appropriate category or categories.

___ Physician
___ Nurse
___ Midwife
___ Doula
___ Mother
___ Husband or partner
___ Husband or partner's mother
___ Sister(s)
___ Other female relative
___ Male relative
___ Friend(s)
___ Pregnancy reference book
___ Pregnancy brochures
___ Internet
___ Magazines
___ Television programming
___ Childbirth association
___ Childbirth classes
___ Other

(Please specify as many as applicable in the space below.)

12. Considering the birth that you wrote about at _____ concerning your child _____, which of the following people did you rely on the most for support during pregnancy and birth? (Please select as many as applicable by placing a plus sign (+) next to the appropriate category or categories.)

___ Husband/Partner
___ Mother
___ Husband/Partner's Mother
___ Father
___ Husband/Partner's Father
___ Sister(s)
___ Brother(s)
___ Friends
___ Members of an Internet support or chat group
___ Other family member

(Please specify relationship to other family member.)

_____
_____

___ Other non-family member

(Please specify relationship to other non-family member.)

_____
_____

13. Please indicate the highest level of education you had completed at the time of this birth. (Please indicate your response by placing a plus sign (+) next to the appropriate category.)

___Some high school
___High school completion

___Some college / trade school
___College / Trade school completion
___Some University
___Completed University
___Master's or PhD
___Other
(Please specify other education level _____)

14. If applicable, please indicate the highest level of education completed by your spouse or partner at the time of this birth. (Please indicate your response by placing a plus sign (+) next to the appropriate category.)
___Some high school
___High school completion
___Some college / Trade school
___College / Trade school completion
___Some University
___Completed University
___Master's or PhD
___Other
(Please specify other education level _____)

15. What was your primary occupation at the time of this birth?
_____

16. If applicable, what was the primary occupation of your spouse or partner at the time of this birth?
_____

17. At the time of this birth, what was your marital status? (Please indicate your response by placing a plus sign (+) next to the appropriate category.)
___Single, never married
___Common-law
___Married
___Divorced
___Widowed
___Other
(Please specify other marital status _____)

18. At the time of this birth, what was your total annual household income, after taxes? (Please indicate your response by placing a plus sign (+) next to the appropriate category.)
___Under $20,000
___$20,000 - 40,000
___$40,000 - 60,000
___$60,000 - 80,000
___$80,000 - 100,000
___More than $100,000

19. In the space below, please feel free to make any additional comments. This may include parts of your story you would like to change or add. (Please feel free to use as much space as necessary.)

20. In the space below, please feel free to make any additional comments about this research or your thoughts on Internet birth stories in general. (Please feel free to use as much space as necessary.)

21. A copy of the key research findings will be made available to all participants. Do you wish to receive a copy of these findings? (Please indicate your response by placing a plus sign (+) next to the appropriate category.)
___Yes
___No

22. If you answered "Yes" to question 21 and you wish to have these findings forwarded to a different e-mail address from this one or to a postal address, please provide this information in the space below.

That's all of the questions I have. Thank you again for your time and contribution. Your help with my research has been greatly appreciated.

Appendix C: Additional Birth Stories

J's Story

E's Birth

Once again, childbirth has taught me more about my body and myself, than I ever thought I had left to learn. And once again, I'm grateful for the lessons learned and experiences gained.

This last journey began when I saw that second line appear in the window of a pregnancy test. I had suspected I might have been pregnant but I was still a bit surprised by what I was seeing. My first reaction was, "Wait a minute... I just DID this", but as I sat down and began to realize that at that very moment there was a little life growing inside of me, a smile spread across my face. And for those few minutes, my unborn baby and me shared an incredible secret together.

I chose a different route in prenatal care this time. I decided to use the services of traditional birth attendants instead of a registered midwife. It was a very personal decision and one I am very happy with. As I look back now, I feel I was really led to these women and am grateful for their help throughout this pregnancy and birth.

The pregnancy went very well and I particularly enjoyed the home prenatal visits. The problem of elevated blood pressure that I had experienced in my previous three pregnancies seemed to have resolved itself and I was able to go through this pregnancy feeling empowered and healthy.

We had fun trying to determine a 'due date' of sorts. Having only had one period between my last baby and this pregnancy, we didn't have a lot of history to go on. If we only used the typical calculations, April 29th would have been the date. But I knew that my cycles from years ago were significantly longer than average so we added some time onto that date. I picked May 7th for no particular reason, and figured that early May sometime would be likely.

More quickly than I had anticipated, April flew by and May settled in. Part of me was feeling ready to welcome this birth and baby, but another part of me wanted to keep this baby inside forever, as I had been preparing for this to be my last pregnancy. Then we received news that my husband was to take a job in Victoria, B.C. and it would be starting June 1st. Life went into fast forward at this point with fixing up our home to be sold, getting it ready for showings, etc. I started to grow weary of lugging around this large belly with so much else to do. And as the first two weeks of May passed with no significant signs of labour starting, I began to grow a bit impatient. That impatience was magnified with news that my mother was terminally ill and awaiting our arrival to Vancouver Island.

Despite all the goings on though, I tried to remember to enjoy those last days of pregnancy, and was successful some days, not so on others. I knew this would be the last time I'd feel a little person kicking me from the inside. I knew I would miss my round swollen belly, despite my uncomfort, soon after the birth was over. And each morning when I woke up still pregnant, I knew this would be one of the last magical days I'd have to wonder if this would be the day our baby would arrive. Conversely, other days I just had to lie down and cry because I couldn't field another phone call from someone asking if I'd had the baby yet, but on the most part, I tried to stay positive.

Finally on May 21st, and only when my body was ready, I awoke to mild contractions around 4:30 in the morning. They were not particularly painful, and they were too close together to make me think that this was the real thing, but they were consistent enough to catch my attention. I got out of bed around 5:00am and figured a warm bath would either stop or magnify these labour sensations. After soaking for a while, I got out and decided that I needed to stop wondering if this was the start of labour or not, and maybe get some more sleep. I lied down in the bedroom downstairs, so as not to awaken my husband or 22-month-old son. But sleep was futile. I was too excited that this may be it, as well as nervous that this may be it. I got up and did some computer work while the house was still quiet. As I sat at the desk, I began to notice that my attention would wander from the screen when a contraction came. I found myself doubting less and less that these labour sensations would dissipate. After coming to this conclusion, I decided to call my traditional birth attendants to give them a heads up that today may in fact be the day my baby was to arrive. I woke S

(Traditional Birth Attendant – TBA) up around 6:30am to let her know and told her I'd call her when I needed her to come over. After that, I began wandering around the house and feeling the sensations becoming slightly more intense. At some point, I got back into the tub to enjoy the water a bit more. The contractions became a bit stronger after that, but I was still feeling good and in control.

Soon, the household began to wake up. My oldest, R (son), was more than surprised to see me awake before him, and also to be in the tub. I let him know that it looked like the baby would arrive today and he replied with an, "Oh, okay". Not long after that, I decided that I could use R's (partner) help and support. He came to the bathroom door soon after I paged him, and let him know that it was looking more and more like today would be the day. He asked if he should have the N and S (TBA) come to the house yet, but I told him not yet, as I was still feeling like labour was only just beginning. But soon, I recognized the signs of increasing intensity and knew, from past experience, that if we didn't call now, there would be a mad dash later.

S and N arrived around 8:00am and came into the bathroom to talk with me and see how I was doing and what I was wanting at the time from them. I let them know that I was doing fine and that they could go about setting up their stuff. Part of me hoped that we hadn't called them too early, but I also knew that they wouldn't mind even if we had. But soon enough the sensations got more and more intense and I found myself having to really concentrate and focus on relaxing through them.

S and N had finished setting up their things and had settled into the bathroom with me. They knew from previous visits that I wanted to have a very hands-off, independent birth experience, so they watched quietly and asked before they did anything. I really appreciated their respect and care.

Pretty soon I was getting vocal through the transition contractions. And before I knew it, I was taken by surprise by that very unmistakable sensation of wanting to push. Unfortunately, I would willingly take a few more hours of cervical dilation contractions over the pushing contractions, as I find those ones to be very overpowering for me at times. I got very vocal at this point so R (partner) took the last of our three sons over to a neighbours house.

At this point, I felt like a ship being tossed at sea, and wasn't sure what I wanted or where I wanted to birth. The bathtub was nice, but I had a hard time getting into a comfortable position. I briefly thought about moving to the bedroom, but could imagine getting there. I also was really hoping for a water birth, so I found a position I could be comfortable in.

As I kneeled down and leaned over the side of the tub, I would grab R's (partner) hand and either S or N's, and squeeze their hands into my face. I don't know why that relieved some tension, but it did. And pretty soon, I felt that incredible feeling of having the baby slip through and past my cervix and down my birth canal. I announced to everyone that the baby was coming and began the task of trying to breath out the baby's head. S asked me if I still was going to catch my own baby, but I could only feel the intensity of birth at this point and didn't feel I was emotionally able to do so. Though I regret I chose not to catch my own baby, I also recognize that I had to respect my feelings at the time. And at the time, I was so very much into my own sensations that I couldn't reach beyond that. I will honor that decision.

After that exquisite pain of feeling the head pass through my vagina, followed by the shoulders, my baby was born into the water at 9:19am. S and N were there to help the baby out of the water and hand her to me. N was concerned that the membrane, which ruptured at the very end of the birth, was still covering her face, so tried to wipe away any membrane that may have been left. S noticed that copious amounts of brown meconium filled the bathtub after the sac broke and knew that she would be watching the baby closely for signs of problems. They gently did a bit of suction to help clear any meconium that may have been present.

R (partner) and I looked over this beautiful little baby as I cuddled her in the tub. She was definitely not overdue judging from the amount of vernix covering her. When we remembered, we took a moment to see if we had been blessed with a beautiful fourth baby boy or with our first daughter. To our complete surprise, we saw she was just that, a little girl. We actually had a baby girl! Finally, those girl hand-me-downs from friends and relatives would have someone to wear them!

We got out of the tub a little while later and went to lie down in our bed. There, we cuddled our newest little member and enjoyed counting fingers and toes. S and N noticed that I was bleeding a bit more than they were comfortable with, so we decided we needed to get my placenta out. I was also very uncomfortable from the contractions that were trying to push my placenta out. We think the placenta was caught up a bit in my cervix and was causing me the pain. With some active pushing, it finally came out. That was about an hour after she was born. And with the birth of the placenta, my bleeding slowed down and no longer was a concern.

By that time, E was sucking on her fingers, so we knew she was ready to begin breastfeeding. She took to that like a veteran and we haven't had any breastfeeding problems, thankfully. R (partner) went and got the boys from next door and invited them to come meet their new little sister. M and M (sons) were anxious to see her, but R (son) decided to wait a while. When he was ready, he, too, came back home and all three boys loved up their sister and took turns holding her and introducing themselves. When the novelty wore off a bit, they went with other friends for a day at the lake on a powerboat. They were loving life!

Thankfully, E had no problems from the meconium that had been present in her little sac that had actually been stained brown. We watched some possible chest retractions closely but they ended up being nothing and we're so grateful she is a healthy, thriving baby. We weighed her a little while later and her chubby little body came in at 9lbs. 10 oz. I was particularly pleased with myself at that point! And not a tear or road rash to speak of.

When all the checks, cleanup and rechecks were complete, my traditional birth attendants posted a wonderful notice of birth on the front door, let me know they could be reached for anything, and left us to enjoy our new baby. We snuggled under the covers and enjoyed new baby smells that are indescribable.

I'm so grateful for this last birth experience. It was quick and intense but it was empowering and beautiful. I had quiet moments that were reflective and relaxing, and times when I roared out from deep within my soul and felt great power run through my body. I'm so glad N and S were there with us to share the experience. Their quiet, unobtrusive presence was

comforting and supportive. And when things varied from normal slightly, there wasn't the medical drama that sometimes follows, but instead, careful and quiet readiness with professional attention.

E joined our family on May 21st and has enriched our family immensely.

B's Story

Nurse From Hell, Horrible Labor, Awesome Delivery

I am a 24-year-old from Alberta, Canada and my husband and I managed to conceive the first month that we started trying. My doctor told me that I was due in early April 1999. We were so excited!

I had a normal pregnancy, very little morning sickness, a few aches and pains every now and then, but nothing major. My last couple of months were the most uncomfortable because I am only 4-feet 10-inches tall with a pre-pregnancy weight of 99 pounds and a 20-pound weight gain is a lot for someone of my height. The doctor was concerned about my size and whether I would have a problem delivering naturally, so I was sent for an ultrasound two weeks before my due date to get a weight and head circumference. A few days later the doctor phoned to tell me that I should be induced. This was when I started to get annoyed with all the practitioners I had been dealing with because none of them would communicate with each other or me, so I never did find out what they discovered in the ultrasound that made them think I needed to be induced! So I was scheduled for an induction on Monday, March 29. I tried to get information about induction from any doctor or nurse that might be able to help me out, but nobody would tell me anything! I was getting more frustrated by the second!

I was given the prostaglandin gel in my cervix at 9:30 a.m. and immediately started to have contractions. The OB/GYN told me that they wouldn't decide whether I needed a Cesarean or not until the baby started to come so they could see whether his head was going to fit or not. I sat in a warm bathtub all morning, which made the labor manageable. At 12:30 p.m. I went back to my room to be checked by the OB/GYN and see how I was progressing. I was

2 centimeters dilated, so she told me that they were going to break my water to move things along a little faster. If I had only known how horrible it would feel!!!

The nurse that had been assigned to me was nasty and unsupportive, and she kept yelling at me to "RELAX!" while the doctor was shoving a 3-foot long crochet hook up inside me. Sorry, pretty impossible if you ask me! Having my water broken hurt like the dickens and my contractions immediately got 20 times worse than they had been. I tried to be brave for as long as I could, but finally had to ask the nurse for an epidural at about 2 p.m. She got this really snotty tone and told me that it was "too early" for that. (My dilation hadn't been checked since my water was broken at 12:30 p.m.) I tried to bear with it, but at 2:30 p.m. had to ask if there was ANYTHING I could have. The nurse acted really annoyed like I was inconveniencing her, and said no. I said, "But it REALLY hurts!" and she rolled her eyes and said, "That's what labor IS honey, get USED to it!" I begged and begged, all the while hyperventilating because the contractions never had a break in between. She finally said, "Well, I SUPPOSE you could have a shot of Morphine in your ass." I almost kissed the snotty witch!

She disappeared to find the hypodermic needle and finally came back with it at about 2:50 p.m. I'm sure she did the injection as slowly as she possibly could, but when she was finally done I went to stand in the shower and wait for it to work. (She had said that it would take about a half-hour.) Another nurse was sent in to keep an eye on me, and soon I started to push. She said, "No, no don't push yet, D (nurse) said you're not ready yet!" (My dilation still hadn't been checked since my water was broken.) I told her where D, the snotty nurse from hell, could go, I was ready to push, so I was damn well going to push. She said, "OK, I'll call the doc and we'll get you to the delivery room." Everything was a blur after that because it was such a relief to be pushing!

All the pain seemed to disappear while I was pushing and therefore I felt MUCH better. Lucky for me, there was a shift change just as I went into the delivery room and I ended up with fabulous nurses! Every time I felt the urge to push and they said that it was OK, I said, "Thank you, thank you, thank you!" I pushed for about 17 minutes and our son was born at 3:17 p.m. weighing 7 pounds 5 ounces. Unfortunately, no one had told us that when the

mother's labor is induced it usually results in a blue baby who needs oxygen. My husband thought that he was dead when he first came out because he was so purple and wouldn't cry or breathe. But he was fine after being given oxygen.

My delivery was such a relief after that terrible labor that it seemed like it had only taken five minutes from the time I was brought in to the time the placenta was delivered and the doctor left.

If there is one bit of advice I would share, it would be to make absolutely sure that you are going to be checked regularly for progress, and that pain relief is going to be available when YOU ask for it. I got really dizzy and shaky after our son was born because the Morphine had finally taken effect! What a joke!

I swore I would never have another baby, but three months later I got pregnant by accident because my doctor wouldn't give me birth control while I was nursing. Now I am due in mid to late April 2000 and I am scared to death!!!

I switched doctors when I got pregnant again and he has been very good so far, the real test will be at the hospital! Wish me luck.

R's Story

Thirty-five-weeker: Ready or Not, Here I Come!

Note: The story of D's birth was written mainly in my first week postpartum in October 2002 in Toronto, Canada.

I just walked in the house to find my computer still on and displaying my last minute Google search on "false labor." HA! D's still at the hospital and will be for quite some time. Five weeks premature.

My mother is downstairs making me a loaf of toast with grape jelly. I couldn't even look at my breakfast this morning, though our good friend B brought us the leftovers of a Canadian Thanksgiving feast in Tupperware containers last night that we ate with our fingers in the hospital room. Meanwhile, the nurses think I'm a riot and a pain in the behind!

Here's my labor story:
Saturday morning, I woke up with a few cramps – just like mild menstrual cramps. I had felt that before, so I just ignored it. We went to our prenatal class at 9. During the course of the day, the cramps got a bit stronger, but they were nothing big, and the relaxation and pain relief exercises we were practicing really helped. I mentioned this to D (partner). "Well, I'm glad we're doing this class today cause I'm feeling kind of crampy!"

We got a cab home from the hospital at 4, ordered Amato's pizza and I got in the tub to soothe the cramps. They seemed to abate after about an hour and so I got out and passed out in bed for another hour. Pizza came. I was ravenous. I think I ate most of the pie. Cramps came back, so I told D I wouldn't be joining him to play online video games for a bit and back in the tub I got with a "D*mmit, I want to go kill undead!"

Then they got rhythmic. Uhoh. I made D bring me the phone in the tub, and who did this 30-year-old woman call? Her mommy in North Carolina of course, who calmly advised that we should time the contractions and call the hospital. We timed the contractions, and they were four minutes apart. "Are we off to see the wizard?" asked D. The hospital said to come in. "Yep," I replied.

We arrived on the ward, and I told them everything. Our nurse, G, promptly turned to another nurse, stifling a laugh and said, "This is Mrs. R. She's at 35 weeks, and this is her first baby. She's been having lower abdominal cramps all day which became rhythmic around 6 p.m. The contractions are four minutes apart, and she thinks she's not in labor." The other laughed. "Put her in 74."

Uhhhhhh. They stripped me down and put me in a hospital gown. Two randoms came and asked me if I wanted an epidural. I said no. I still expected they would look at my cervix, laugh, and send me home to finish the false labor and go on with my life. I was rather confused that they appeared to think otherwise.

Finally, a resident came in and felt my cervix. Five centimeters dilated. "This baby is coming tonight," she said simply. D and I exchanged rather disturbed glances. He immediately got on the phone with our friend B who started calling friends and family.

Oh man, I was supposed to have another three weeks to prepare! The cramps got harder. I stood leaning on the bed with my arms for about an hour with D putting pressure on my lower back with each contraction. It had seemed to me that D had just put down the phone when B suddenly appeared in the room. This was good. She manned the phone while D and I got down to the serious business of pain management.

"When can I get in the tub?" I asked the nurse. It was becoming clearer to them that I wasn't the kind of girl to be laying on my back biting a rag. They got me a birthing ball, and I got naked and squatted on it with D behind me and B in front putting hot shower water on my lower back and massaging the ouchies.

My mom called. B answered it, and I immediately went into transition (where the cervix is open, and he descends – the most painful part). My poor mother got to hear me groan and scream at the top of my lungs. I think this is when she decided to get on a plane. Then a nurse came into the bathroom and said, "OK, out of the tub. That was a transition groan." Something told me she had seen this kind of thing before.

Begrudgingly, I got out of the tub and got up on the bed on my hands and knees. I was paralyzed there for a while, having the most pain I'd ever experienced ever. They wanted me to flip over so they could break my water (it hadn't gone yet). I refused. Even though it meant dragging out the pain, I was not going to be held responsible in any way for the premature birth of my son, since I knew I couldn't handle the guilt if I agreed to any intervention and something went wrong.

My water broke rather explosively about 10 minutes later, and I screamed like a banshee. When the nurse tried to shush me, I shot her the look of death as if to say, "Look lady, do you see a tube of piped-in pain reliever sticking out of my back? I didn't think so. Now sod off." I think she got the message actually. She was much more helpful after that.

I soon managed to flip over into a sitting position, and all of a sudden, there were 10 people in the room, like they all descended from the ceiling or something. Two spotlights were aimed at my wazoo, and everyone football-huddled around me. I felt like I was going to the Grammy's. "Push!" they all coached. I bore down.

After two pushes, the contractions became more like pressure than pain. I was very relieved to say the least. Then he crowned. Heh. I began to wish for those good old days of transition, but sending mental encouragement to my perineum, I pushed again. B held a warm compress to the area while D wiped my forehead with ice water, a marvelous combination that helped tons.

Many "Owwws," a few epithets and one or two useless pleas for Demerol later, D (baby) was out to see the world. Total active labor time: four hours. Total intervention: one IV with penicillin to protect the baby. Total stitches: three. "Wow," said one of the residents, taking off her mask, "we don't get a lot of natural childbirths around here." It only dawned on me then that that was exactly what I had done. I have never felt so in touch with my big bad female self. Ever.

As soon as my wee one was out, he cried the air into his lungs as the pediatrician on call took him to the warming table, cleaned him up and checked him out. Ten fingers, 10 toes, open eyes, beating heart, but my little man wasn't breathing properly. His breaths were shallow and panicked, as his lungs hadn't had time to fully develop.

Nevertheless, nice pediatrician man swaddled our son and presented him to us in this papoose-like wrapping. All we saw was his wee head. I think my first words to him were, "Welcome, and thank you for having such a wee head." Said head was thick with coarse blonde hair. He looked up at me with my father's ice blue eyes. Distracted by the magic of this for a moment, I only looked at the rest of his face when I heard B's incredulous voice in my ear saying, "Oh. My. God. *Look* at that pout." I scanned down the rest of his face and stopped. There, clear as day, were D's (partner) signature pouty lips and chin in perfect miniature, blowing spit bubbles. Euphoria! I nearly shrieked with glee.

I wanted to hold him all night and tell him all about us, but the pediatrics people were looking nervous, so I handed him back, and they rushed him to the neonatal intensive care unit. I lay there for a few minutes shaking, my teeth chattering, though I wasn't at all cold. Then D (partner), who started spinning around in a big wheelie chair with a giant grin on his face, roused me out of my postpartum stupor.

B was sitting in the corner in shock, having never seen such a thing from an onlooker's perspective before. "Oh. I have to call some people," said D. He picked up the phone. "Hi, this is D. I was on call this weekend, but I'm here with my wife and newborn son in the hospital, and I'm just calling to say that I'm no longer on call this weekend or Monday or Tuesday or the rest of this week or for a long time. Buh bye!" I laughed. "You sounded a bit too happy about that, dear." He just kept grinning.

Soon they took us to our postpartum room. We settled in and immediately went into the NICU to see our son. They had placed him in an incubator with an IV and an oxygen mask. He appeared to be panting. The pediatrician explained that he just wasn't able to oxygenate himself. He would have to stay in the NICU so they could observe him. We stayed with him until 4 a.m., then passed out. I promptly woke up two hours later, still on a high of endorphins, and went back to sit with him. The nurses all thought I was insane. I proudly explained that I was completely drug free and coherent. In fact, I still felt euphoric – the best high I've ever had. I felt fantastic, though very worried.

Update at two and a half months postpartum:
D's condition stabilized due to the respirator, IV and monitoring devices they eventually hooked him to, but he didn't improve rapidly. The doctors said he was absolutely exactly what they would expect for 35 weeks gestation and that it was simply a matter of how long he wants to take to finish building his lungs and exercising his diaphragm.

On his second day in the NICU, we had a brief scare that he had pneumonia, but all his blood tests came back negative for infection. He just had a bit of fluid left in one of his lungs that alarmed the doctors for a bit. I just wanted to take him home and snuggle! I hated seeing him bound up in all those needles and wires and monitor leads. I had to leave the room whenever they gave him a needle because I couldn't hear him crying without losing my mind. Heh. Welcome to motherhood.

I must say, the NICU was like a private support club for preemie parents. All of us mothers had to express our milk several times a day and then haul it to the hospital in time for the scheduled feedings! We really clung to each other like a community, and the hospital facilitated that by providing a breast-pumping lounge. It had magazines and chairs with

pumps pulled up to each one where the mothers would sit and gossip about the family dramas they had witnessed that day. Some of those mothers had been coming to the hospital three or four times a day for months! Wow.

Everyone cheered whenever we came in and saw one of the babies in a car seat being tested for proper oxygenation. That meant that a lucky someone was going home! I still think of some of the parents and babies we met there and hope that everyone is home and thriving. We were lucky that we only had to bear two weeks in the NICU before it was our turn to have his breathing tested in the car seat and go! We gave D one last chance to run for it before we put him in a cab and brought him home to spend the rest of his childhood with us.

Not even three months later, he's doubled his birth weight (5 pounds, 13 ounces), and you'd never know by looking at him that he was preemie! Go babyzilla go!

T's Story

Great Pregnancy, Long Labor and Boy, What Could Happen After Delivery!

My husband and I were trying to conceive our second child and we were so fortunate that it happened right away. Throughout the pregnancy, everything was great. Three sonograms and all normal. I went from 125 pounds to 173 pounds with not a bit of swelling anywhere, so we were sort of expecting a big baby.

Right on time, the day I was due, I woke up not feeling so great. I was considering going to the hospital, but I wasn't having any contractions other than the normal Braxton Hicks that I had been having for months. At lunchtime, I lay down on the couch for a nap and at 2 p.m. I woke with a very sharp pain. I went to the washroom and noticed that I was bleeding. So I called my husband at work and headed straight for the hospital.

I was admitted and hooked up to the monitor. The contractions were four minutes apart now, but unfortunately, I was not dilating at all. Eight hours later, I was still only 1 centimeter. I was feeling uncomfortable, so they gave me a shot of pain reliever. At midnight, my water broke and then from 4 a.m. to 9 a.m., I was pretty incoherent. Still only 3 centimeters dilated, they decided to give me an epidural. Thank heavens! I finally felt like I

was back in the land of the living. From 9 a.m., believe it or not, I went until 3:12 p.m. before finally delivering – 25 hours later. Our son D was born with the aid of a vacuum extractor (which did not concern me due to my first child being delivered the same way). D weighed a whopping 10 pounds, 9 ounces and was 22.5 inches long. Hence the long and hard labor. Everything seemed great.

The baby and I went home two days later. Six days later I woke up with one of my eyes feeling very hazy. Thinking it was probably my contact lense irritating me, I didn't think much of it. Then at lunchtime my drink was tasting very strange, but I still didn't think anything. During the afternoon, my cheek felt funny and at suppertime I looked in the mirror and I could not smile on one side. I thought first that I was having a stroke. We rushed to the hospital and the doctor diagnosed me with postpartum bells palsy, where one side of your face is paralyzed and drooped. My eye would not even close. It affected my speech, sight and taste. The doctor told me there was no medication and nothing he could do and that it would go away on its own, but it might take up to six months. I was devastated.

Two days later (eight days after birth) at home while resting, something started gushing. It felt like my water breaking 10 times in a row. I couldn't believe what I was feeling. Then I realized that I was hemorrhaging. Rushing to Emergency again, I was admitted. Just escaping a blood transfusion, I was treated for a urinary tract infection and an infection of the uterus, but I was also told that the hemorrhaging could have been caused by delivering such a big baby vaginally. While in the hospital for five days, I was pretty depressed. I had a new baby at home and I wasn't there, and aside from that, I didn't want anyone in my room to see my face all drooped from the paralysis.

Four days after returning home, I was in such discomfort trying to sit that I decided to see my family doctor. Now, I find out that on top of everything else, my tailbone was broken from the delivery. Needless to say, it was quite the ordeal. But in spite of it all, now four months later, I would do it all again to have this precious little boy that I have here today.

Even though I'm still on the mend, all my problems are so insignificant when I look at his little face each and every morning!
NF. Canada

N's Story

Sooner Than We Thought

I wasn't prepared to become pregnant. I had been told at the age of 18 that my chances of having a child were not that great because I had endometriosis. After laser surgery in 1994, my chances were only 70 percent, but in May of 1995, I found out that I was pregnant. My due date was February 3, 1997 so all was going well.

My husband and I decided that we would go to Elliot Lake between Christmas and New Years. I had gone to the doctor's the day before we left to make sure that it was okay. We did have a six-hour drive so the green light was given and we left the next day. Saturday morning I woke after a long night of sleeplessness and felt off, but dinner was to be a big affair so I managed to wake up and do what had to be done.

By around 8 p.m. that night, on December 28, I had what I thought was false labor, because I could walk it off. For the next few hours, I made frequent trips to the bathroom and had more slight pains in my back (that did go away when I walked around). My husband noticed that something was not right so we went to the hospital, thinking a checkup would prove to him that we were okay to go home in the morning. I went in and was examined and at that point the doctor told me that I was in labor and sitting at about 4-5 centimeters dilated, so there was no way they were letting me go home. You must remember at this point I was 600 kilometers from home and still had six weeks to go. The real punch was they were going to transfer me because I was in preterm labor, so I thought for sure they would send me closer to home, but no they sent me another two hours out to Sault Ste Marie. Now I was eight hours from home and had no family there to see. I was scared, but that would only be the start.

It was 12:30 a.m. I was in the ambulance and my husband was behind in the truck and all was well. There had been a really bad snowfall and the roads had not been plowed as of yet. Twenty minutes into the drive and the isolet in the ambulance blew a fuse. We pulled over. My contractions were still around five minutes apart and some were strong. The decision was made to keep going and the worst case was that I would have the baby on my chest if that was to happen.

Well, another hour passed and the roads were even worse as we got further out. We ended up hitting a deer 40 minutes out of Sault Ste Marie. Damage was assessed and we finally reached the hospital at 4:30 a.m. They broke my water at around 6 a.m. and things started to move quickly. Contractions were hard and fast and I managed without pain medication. Finally, after one and a half hours of pushing, our beautiful little girl was born weighing 4 pounds, 15 ounces and was 17 1/2 inches long. She remained in the hospital for 10 days and was then air-transported to Toronto for another two days.

She is now almost 5 and has two younger brothers. And they told me that it would never happen. I have had all three naturally and I don't think I would have done it any differently.

D's Story

D's Birth of A

On the afternoon of October 21st, 2000, we went to vote at a local municipal election. An election officer asked me when I was due, as I was feeling some pressure and rubbing my swollen belly, drawing attention to myself while I waited for J (partner) to finish his registration. I told her I was due November 29th, but if I had the baby tomorrow I would not be upset in the least. Well. It seems that A (baby) was listening, and decided to grant me my unintentional wish!

I began having what I thought were Braxton-Hicks contractions around 9 p.m. Saturday night while we ate pizza and watched the election results on TV. The back pain that accompanied the "false" labour was worse than the contractions, and I was getting more and more uncomfortable. I just chalked it up to pelvic pain, as my Dr. told me that it was a

normal thing this stage of the game, and I had been having menstrual like cramps for most of the day before.

I would look at the clock every now and again, timing the twinges, all the while telling myself it was nothing because there was no pattern to the twinges I was feeling. I basically tried to ignore the contractions, and concentrated on staying comfortable with the back pain. Certain positions were better than others were. While watching a TV movie (She's Having a Baby) I had J put his hands on my rump and rub my back and bottom to ease the pain. It helped, but he was unable to keep it up as much as I desired him to, so I decided to retreat to the bathtub. This was around 2 am, when the movie was over. The water was as hot as I could take it, and made me feel so much better that I did not want to get out. I lazed in the tub for a while, and then got out feeling better and retreated to bed with J. We laid and talked for a while, and the back pain came back lying in bed. We thought that making love would slow the slight twinges of contractions I was feeling in my belly, as having an orgasm for me had worked to stop false labour before. As it turns out I was actually in real labour and we were making love while my contractions were about 5 minutes apart!!! I had a contraction at the same time as I climaxed, and it was a very uncomfortable, intense and pleasurable feeling all at the same time.

The pain I was feeling was getting irritating now; I just wanted to go to sleep, because we were supposed to be painting the baby's room the next day. I could not relax in bed, and I was tossing and turning so I decided to get out of bed and do something to occupy myself. I tried to do the dishes, and chat online but I could not concentrate on the tasks when a contraction came. Each contraction I felt made the back pain really intense. By this time I am starting to feel a bit uncomfortable emotionally with how intense the pain was getting, and begin to worry that maybe I should be going to the hospital to get checked, but I knew if I did that I would regret it. I went and got back in the tub again, as it was the ONLY thing that made me feel good at all. I did not even think of setting up the pool because I still did not think I was really in labour. I lay in the tub on my side to get my belly under the water, and hung my arm and leg over the side of the tub. I actually dozed off a bit between contractions, waking up when one would come along. I am not sure how long I did that for. Once in a while I would get up and sit on the toilet and try to have a bowel movement, because it felt like I had to really bad. The baby had not lightened or engaged at all yet and I

had no bloody show at all that I had noticed. The last few days before hand I was losing a LOT more clear thick mucous. While I was sitting on the toilet it felt like I was losing more, and I would check and nothing came out that appeared to be my plug yet. I was sure I was not really in labour since all the signals that tell a woman she is in labour were not present. I moved back to the tub and got comfortable enough to rest more. I don't know how long after that I woke up from dozing with a rather strong contraction, and it quickly prompted me to throw up. I knew that some women threw up when in transition, so I figured that I MUST be in labour. It made no sense to me, the baby had not dropped or anything yet!!! Then, with that thought, the baby dropped and engaged in my pelvis, as I was standing in the tub, trying to get back in to ease the pain. I actually felt her drop, it happened rather fast, just one minute she was up, and the next she wasn't and I my belly felt softer at the bottom where her head used to be. I was also feeling a weird sensation in my vagina, and I kept checking to see if I was losing my plug. Looking back, I realize now that what I was feeling was actually the cervix opening very fast.

I was getting a bit concerned because if this is real labour, it is the weirdest labour I have ever heard of, The contractions were not set apart at definite times, and the baby just dropped, and I still had my plug. I called J a few times, but he was fast asleep and did not hear me. I finally went and woke him and told him that I thought I was in transition because I threw up and the baby dropped. He was irritated with me because I was being really whiny for false labour, and I am usually not, not to mention the fact that I just woke him up from a deep sleep. He got up and checked my cervix for dilation. J said there was nothing there, having checked and felt something that seemed firm like a closed cervix. I got back in the tub yet again, and while he sat there on the toilet watching me, I was in the middle of transition and feeling a lot of discomfort. I could not stay in one place so I got out of the tub walked around the house naked and wet trying to work through the contractions and back pain. J got me to lie down and checked my cervix again in case what he was feeling the first time had changed or he was not feeling what he thought he was feeling. He estimated that I was about 5 centimeters dilated, and what he really felt the first time was the baby's head. He was not sure enough to want to share this info with me because I was getting worried. I was still in denial that I was really in labour. At this point it was the most intense pain felt at all. I started to think stuff like, if this is fake labour and it hurts THIS much, what in the heck am

I going to do when the real labour comes along. It was negative thoughts, but the pain was getting the better of me for the moment. I got back in the tub, and I kept telling J that I could not handle this pain anymore. Once again back out of the tub, I grabbed the pillows off the bed and laid on the floor or our bedroom hugging the pillows on all fours and rocked back and forth, and begged J to rub my lower back and bum. He tried to talk to me to keep me relaxed and calm, and started to time the contractions, they were all over the place, at 6:46 am he timed the first one, it went until 6:47:10, and the next one came at 6:47:29 and lasted until 6:49:10. They were all over the place and really short. It just did not make sense to us, nothing was there to indicate that is was REAL labour. Until my water broke at about 7:20 am. I was going through a contraction in the living room, and I squatted down and supported myself with the couch and felt the most amazing pleasurable strong desire to push. I heard a pop noise and about a cup of my water spilled out of me. I told J that my water broke, and he asked me if I was sure that it was not just pee, since I, like most women at this late in the pregnancy have trouble with bladder control. I said, "No, it broke!"
He checked the puddle on the floor and determined that it was my water, clear and clean. J looked at me and asked me what I wanted to do and left the decision up to me. I then took 20 seconds to decide what to do. I was 5 weeks early, and this was going to happen whether I wanted it to or not. I said, "Get the pool ready, we are gonna do this here, and we'll decide later if we will take the baby to the hospital." I knew that if we decided not to have the water birth because the baby was early, that I would regret it later and that if I even called an ambulance the baby would probably have been here before they even arrived. (Our car had died about 4 weeks before, so we had no other options to get to the hospital.) My intuition told me that everything was going to be fine.

The contractions kept coming fast so J told me to get back in the tub, while he began to run around the house in a mad rush to get everything ready. I climbed back into the tub and tried not to push through my contractions even though the desire to was very overwhelming. J was coaching me to breathe through each and not push too much. Between contractions he ran around the house getting the already inflated pool that was sitting up against our dining room wall, and bringing it into the unpainted, unfurnished baby room, and cranking

the heat up; Running back to me to coach me through another contraction; running around again to get towels and fill the pool with the water bed kit.

I could not wait for him to get that pool set up; I just wanted to get in the pool. The tub was getting cool and there was not enough water to cover my belly. Finally, in record time (only about 5 minutes), there was enough water for me to climb into the inflatable kiddie pool and J helped me to the bedroom and I climbed in and kind of sat back with my arms up on the sides to support my back to ease the pain. The water was nice and warm and took away my pain. All I felt now was the desire to push. NO PAIN! I had another contraction and I pushed a little but breathed through the last of it. J warned me to take it slow to reduce the stress on my perineum, and I wanted to be sure I did not tear, as this baby was coming really fast. At some point around now I put my hand down and felt the baby's head about an inch from my vagina opening. It was all very overwhelming and amazing at the same time. J said the baby's head retreated a little back inward between the next contractions. With the next one I pushed again a little, and breathed through the rest of it. I told J that I could not hold back any longer. I had to push with the next one that was coming right on top of the last contraction. He massaged and supported my perineum to ease the chance of a tear, and asked me if I felt any stinging sensation that woman feel when the baby crowns. I did not feel anything like that at all, and certainly not anything that was bad or gut wrenchingly intense, like I was told to expect from family and friends.

With the next contraction I pushed and the baby's head was out of my body! To me, at this point, it felt like everything happened at once. I do not remember it taking another 30 seconds for the baby's body to be birthed, J was in the pool with me, and caught our baby at 7:37am.

She gave two little breaststrokes in the water and then he lifted her out, only 17 minutes after my water had broke! He lifted our beautiful child up and turned her over to reveal that she was a girl! J held her head-down for a moment or two to make sure all the fluid drained out, and checked her for mucous. She gave two little cries to let us know that she was fine, and was very calm and relaxed. I was over come by happiness and joy, and a little shock, because I had myself convinced I was having a boy, and it happened so fast. J said the expression on my face was priceless when he told me she was a girl. The first thing I said to our little daughter was, "Breathe little girl" calmly and gently, absolutely forgetting that we had her

name already picked out. She was the most beautiful thing I had ever seen in my life. We held her head-down again to be sure to clear her mucous, and I cradled her in my arms and kept her under the water to her chest to keep her warm. She was so curious and looked around the room in wonder. I tried for a bit to get her to suckle, but she was more interested in looking around the room. She was wide eyed and fascinated with everything that was going on.

I stayed in the pool with A while J brought a phone to the pool so I could call my mother. Still sitting in the pool with the cord still attached, I called her to tell her she was a grandmother and that she had missed out on her first grand daughter's birth. She was shocked, since she was two provinces away, at my cousin's wedding. She was amazed to hear A cooing so soon after birth and a little worried because she was not crying.

"Babies are supposed to cry when they are born!" She said. She was going to attend her birth to take pictures. The funny part of it was, that I joked with friends that it would be really funny if I went into labour and mom missed the birth while she was away. I never thought it would really happen. I'll never again scoff at the superstition of a wish coming true if you make it while rubbing a pregnant woman's belly!

We cut the cord long after it stopped pulsing (about 30-45 min. later) and wrapped the up in a pillow case of all things because that was all had that was soft for her skin, and then wrapped her in a towel for extra warmth. I tried to get her to suckle to help release the oxytocin I would need to deliver the placenta, but she couldn't get the tongue thing down right. I tried nipple stimulation, but I did not have any contractions starting.

About a half and hour to forty minutes later I had two contractions, and with the second, I birthed the placenta into my stainless-steel bread baking bowl. My grandfather had showed up by then to give us a ride to have the baby checked out and the expression on his face as I walked by with my placenta in a bowl was something I wish I had a picture of. It seemed to be intact, and I was not bleeding at all. We then got the baby bundled well and headed to the hospital to have her and the placenta checked over to ensure everything was fine.

A became a little jaundiced, nothing to be really concerned about, but they were being extra cautious because she was a month early, and we had had her at home. They told us the reason she was jaundice was because we waited "too long" to cut her cord. We did not have a chance to refuse the vitamin K shot, because the nurse was giving it to her before she even

explained it to J. I was irritated with that, because babies who have their cord cut later and get the extra blood from the placenta do not need the vitamin K shot, and it has been shown in studies to increase the incidence of jaundice. Waiting to cut the cord is beneficial to the baby, and they were acting like we took such a big risk with waiting. We refused the eye drops, with a lot of fuss from the doctor. But finally got our wishes followed. A and I spent 5 days as patients at the hospital, while she was put under phototherapy lights to lower her bilirubin. J was able to room in with me the whole time as well, so we were not apart too much from her. They were good to let me in as a patient as I really did not need to be there. But because I was breastfeeding they allowed me to stay.

Some things went on while we were in the hospital that still makes my blood boil even now when I think about it. They poked and prodded A being overly cautious because we birthed her at home on purpose. They tried over nine times to get a blood sample that was already done an hour earlier, but they were taking more blood "just in case" they wanted to reconfirm her results. She was so upset and cried so hard that she threw up all the precious colostrum that I had just fed her, and pooped all at the same time. The nurse then told the doctor that she was not accepting food and needed to be put on an IV I was livid!!! I sat and cried while my baby lay in an incubator because the hospital caused the need for her to be there.

Because I was crying they had nurses ask me is I was depressed and did I need a counselor? I wasn't depressed; I was pissed! I believe that she caused A to have two apnea episodes right after that trauma, and it was very scary. Especially to be told like it was as unimportant as if she had just had a poop and her diaper was changed.

J told the nurse off and demanded that she not touch our child again The Doctor apologized profusely and from then on took her blood himself to test her bilirubin. When her IV failed and they said they would have to put it in her head next I said "no way!" And refused and just showed them that she was able to feed well. They assigned a social worker to us while we were there, and she stuck her nose in our business when the doctor would be updating us on A's tests etc. She tried to get the doctor to say that we caused her to be sick, and that we took a really big change with "such a precious commodity" (her words) by the last day I was so ready to kill her that I had to have J head her off at the door so I would not see her, I was

ready to tear a strip off her. She was implying that we did not understand how precious our baby was, because we decided to keep her away from vultures like the NICU nurse.

Our birth was not the "perfect " birth that goes without it's twists and turns, but it was what we were meant to experience. I am so glad we had our little butterfly at home. It was perfect for us, and a very positive experience. I wish we had been able to skip the hospital routine crap, I feel it did more emotional harm than physical good, as she was very healthy from the start.

Looking back now, she was perfectly healthy and if I had not have been in such a state of amazement, I would have been better equipped to assess that and would have not allowed my mother's insane rantings on the phone over 1200 kilometres away, to make an assessment she was not qualified to make, and have me thinking I needed to go to the hospital.

The doctors and nurses kept calling her a preemie, with a tone in their voice like it was a bad thing. I think I am just one of those women who has a shorter gestation time. Who said nine months is an absolute anyway? Nine months is the "NORM" but I think I have proven that I am not the "NORM" in anything I do. I felt that she was just ready to come. She was the biggest "preemie" in the NICU. She weighed 5 pounds and 9.4 ounces. She is very strong and continues to amaze people with her determination for life. Even at 10 days old everyone commented on how full of love and life she was. Given that we HAD to be in the hospital, and was not comfortable with that, I felt that the paediatrician was a very good doctor, and looked out for A's best interest. And he respected our decision to have home birth even though he was not of the same opinion and as soon as she was able to room in with me, he let her out on a "pass". We got to take her home and just had we come back in for routine blood tests for three days to see that she was doing fine. He knew we wanted to get home to bond more with her. She was never alone long in the NICU, but it still killed me to leave here there, even thought I tried to reason with myself that it was a short time. I was there every three hours to nurse her and J and I stayed with her for about an hour each time. I still feel that she would not have been jaundiced and needed to stay so long, if she had not had the vit K shot.

I had only a small skin split in the perineum with her, which healed nicely without medical attention (that was offered profusely, but refused adamantly) in less than 38 hours. I had

some back pain that lingered and came up now and again for a few days, and my muscles were really sore from labouring, but I must say for me, that birth was a wonderful experience that I will always remember with happiness. I accepted the after pains with joy, knowing I birthed my daughter well.

We were in the local newspaper on the following Monday for having an at-home unassisted birth. It was a nice article, even though they made a few mistakes with the information. For me childbirth was the positive empowering experience I was looking for. For J, I think it was empowering as well, for it is not many a Daddy in our society who can claim that they caught and helped Mommy birth their firstborn child. It has definitely brought us closer together, being through such a joyous celebration of life. A few days after A was born I bought him a Thank You card to tell him how much he means to me, because it seemed I could not find the words to express my gratitude for this beautiful gift I call my daughter.

V's Story

My daughter's birth

T C M
May 14th 1997
23 1/4 inches long
10 pounds 3 ounces!

My name is A and I live in Langley, B.C. Canada. My husband J and I were expecting our first child in May of 1997. We wanted a baby very badly and were blessed when on our second month of trying we were successful. Our daughter was due May 4th 1997. My pregnancy was a dream. I had only about three months of nausea - off and on but luckily no vomiting. No real funny cravings only an addiction to grapes and a huge aversion to broccoli which luckily I am over. Our ultrasound was performed at 18 weeks and it was amazing to see our baby! As I have an extremely small bladder the whole procedure was quite painful and uncomfortable but my husband, as he used to be an X-ray technician, was 1000% into the whole experience. The ultrasound placed her due date as April 27th 2001 due to her size though I know, without a doubt, the night I conceived her so we proceeded with her due date being the 4th of May. I was HUGE as a house - all out front. We took pictures of my growing belly after each Doctor's appointment and I am still surprised today that I could still

stand upright with such a belly! I worked full time until the 5th of May. I had been suffering from false labour for two weeks at this point but I was sure that this was "it". After two weeks of timing contractions and getting down to 2 minutes apart for hours then them simply stopping, I was quite frustrated but now sure that my little bundle of joy would be in my arms. This was not to be. The labour stopped once again. We tried everything in the book to get this baby to vacate it's comfy home. My baby was a strong kicker and each weekly Doctor's visit found her moving from side to side - a clear indication she had a lot of room left to grow! After trying numerous attempts to get her into this world, everything from jumping off of stairs, driving real fast over speed bumps, you name it, she still held tight. I was brought into the Hospital at 6:00 a.m. Monday the 12th of May to have my labour induced but by this time I was once again in full fledged labour so no inducements were made. By lunchtime I still hadn't progressed as far as dilation was concerned but still having contractions. My Doctor decided at this time to break my waters in an attempt to get my labour progressing. As soon as he broke my waters my baby was in distress (I was hooked up to fetal monitors during this time). They quickly hooked me up to some oxygen and with the oxygen fed into me the baby was then again fine. The Doctor discovered though that my waters had meconium (fecal matter from the baby into the water) and as such, I would requite a Pediatrician on hand to properly clear the baby's lungs. I went through excruciating labour at one point spending five hours in the shower trying to deal with the contractions. My husband and my wonderful friend were at my side every step of the way and all of us were more than upset when I found out that I hadn't dilated past 2 cm., even after those contractions. The Doctor was called in once again and finally I was given an IV and a drip of Pitocin was put in to try and speed things up. After many more hours I finally begged for an epidural. The epidural was in for four hours which finally let my husband get some sleep - by this time it was the early hours of the 14th of May! As the epidural had worn off and I was once again feeling all the contractions in full force I was given a "top up". Unfortunately this too did not take and I was only relieved from pain for a short 4 hours! I was finally at 6 cms. at about 3:00 a.m. and the drip was continued. My Doctor was in at 5:00 a.m. and said that since things weren't progressing and I was extremely fatigued (this was Wednesday morning and my last meal was Sunday night) that I needed some relief so if I was not dilated by 7:00 a.m. we would have to perform a C-section. I was

upset by this thought as my epidural was worn off and I would have to be asleep during the procedure and then my husband would not be there to witness the birth. Luckily, by 6:30 a.m. my contractions were unbelievable and I just had to push. As I was only 8 cm. at this time it still wasn't time but the wonderful Nurse, feeling for my exhaustion and the long intensive labour, held my cervix open and thus manually dilated me so that I could push. I pushed for three long hours and my baby still didn't want to come out! She had not been in distress once since the Monday at lunch and was quite content to stay put. Finally, the doctor had to use the vacuum to extract her. Not fun I must say. With me pushing and the aid of the vacuum my child's head emerged, was quickly suctioned by the Doctor and with the umbilical cord being cut immediately was whisked off to the Specialist to deal with her lungs. It was 9:45 a.m. May 14th 1997 and my darling daughter was born. I had been so convinced that I was having a son that after 60 hours of hard intensive labour my first words were "are you sure it's not a boy". The Specialist had to lift my baby up to show me that indeed she was a girl. A very big girl at that. My daughter was 23 1/4 inches long and a whopping 10 pounds 3 ounces!!!!! I had two Specialists come in and see me during my delivery and I was told to expect a baby in the high 8 pound range. No one would have guessed the size of the baby. I have been told I have a very deep pelvis and if I was to deliver again I am facing an 80 to 90% chance of having twins (runs on both sides of mother and father's families) and could EASILY carry 7 to 8 pound babies - each!!!! We ran into some complications delivering the afterbirth as I started to hemorrhage. I, at this time, was running a fever and was dehydrated and exhausted and hence don't remember much but it was a sight my husband won't forget what with all the blood loss. Luckily they managed to stop the blood, sewed me up - stitches included my cervix which ripped due to being manually opened and luckily both Mom and baby were both healthy and extremely happy. Daddy got to hold baby first as I had her in my womb for 9 1/2 months and to this day she is still Daddy's girl! She is 4. She is wonderful. She is our life. Her name is T C M. She is my everything. Thank you for letting me share my story with you.

M's Story

J M P
October 22
M P

Hi folks,

Well, it took four weeks to write, but here it is, in all its infinite detail. I love reading all your birth stories, so I promised myself I'd post ours.

Background: My pregnancy had been totally uncomplicated, except for breech and then transverse positioning until week 37. This little one had me worried that he/she wouldn't turn and screw up my chances for a non-intervened-upon birth, but luckily he/she got around to it, so my plan for a natural labour and birth in the local hospital seemed to be a go.

At a quarter to four on the morning of Wednesday the 22nd, I awoke to an extremely wet sensation between my legs -- my first instinct was to try and hold it back, but no way. I woke B (DH) who managed to get me out of bed and dried off and dressed, and we woke J and V, my brother and sister-in-law who live with us, as they had promised to be my birth attendants as well. In short order it was clear that my water had broken, since I was on my second maxipad and flowing fast, but no contractions yet. We all had breakfast and finished packing for the hospital, and I called Dad, who had been making very strong hint noises about being the one to take us to hospital (we don't have a car).

We arrived at 5:30, and I was admitted, put on the fetal monitor for a while, and had the fluid checked to make sure it was the real thing. I had a whole load of questions asked me, and given a bed in a semi-private room -- I had asked for private, but they were all taken. I managed to sleep for a bit, and J and V went home to take the dogs out and get some sleep themselves, with the promise to come back in when they were needed.

My doctor came in at 9:00 AM, and told me that "now we wait" and if nothing had happened by the following morning, I would be induced via pill (instead of prostaglandin gel), followed by Pitocin if necessary. B and I went for a walk, as she also recommended, a very messy operation when one is leaking, or should I say, gushing, amniotic fluid! At 10:30,

still without contractions, I was put on the monitor again. Lo and behold, the tocometer (pressure sensor) after a while started showing regular waves abut 3-6 minutes apart. The nurse agreed that they might well be contractions, and left the monitor on. This was fascinating, that the machine could tell I was contracting when I couldn't! After some time watching the monitor strip, I identified a peculiar feeling in my abdomen, as if the baby were rolling very slowly from my left side to centre, with each wave from the tocometer. I played at anticipating them and got better at it as time went on -- they still were hardly noticeable at this point. I finally got bored enough to ask them to take the monitor off at 12:30, at which time J and V came back with fruit and champagne (for later), and kept us company for an hour or so.

Around 2:00 PM, the book I was reading no longer managed to keep my attention through contractions, and over the next hour they started getting painful, with the pain moving from the small of my back around my sides to the front. I tried various positions, and what turned out to be best was sitting up on the bed with my feet on the seat of a chair and my hands braced on the back, while B leaned on my pelvis from behind for the duration of the contraction. This seemed to be what I'd heard described as back labour, and I was rather grumpy at the thought that if my waters hadn't broken, I'd have gotten a full night's sleep and might still be home, since my contractions were still four minutes apart. I was still in the cramped semi-private room. By three o'clock I was really crabby and uncomfortable, and wanted my progress checked so I could go upstairs to one of the lovely birthing rooms. Turned out my doctor couldn't come until after her clinic closed at 5, a nurse wasn't allowed to check me since my waters had broken, and it being Wednesday all the residents were making rounds and couldn't be spared to come and do it! So we waited, and laboured, and by 5:00 they were down to two minutes apart and I was in Pain. My doctor finally came in and checked me, and told me I was 70% effaced and 1 cm dilated. Now this was a big disappointment at first, but she reassured me that this was progress and she'd see what she could do about getting me upstairs.

A room finally opened up at 8:00, and we went up with me in a wheelchair to get there quicker, except I had to stop and get out at every contraction so B could push on my back. We called J and V, who arrived within minutes; I was checked again and told I was at 2 cm,

80% effaced, and at +1 station. The doctor had promised me she'd be back at 10:00, so I settled in to a sitting position similar to what I had used in the room, and J took over the back pressure from B, whose forearms were giving out. J later described the force necessary as "pushing a car up an icy hill", and said that the fact that that was a RELIEF to me gave him some idea of the hard work I was doing! V and B held my hands and kept me focused, gave me water, and mopped up after me when I threw up my lunch -- I lost control for a few minutes then and started to cry, but they kept me on track and concentrating on breathing through the contractions. The nurses spent a bit of time trying to put a fetal monitor on me, but I absolutely refused to lie still on my back to keep it in a good position, so they finally strapped it on me as I was. All it ever picked up was my own pulse, though, and the tocometer part was missing, so no contractions were recorded. They didn't get any good data except during my internal exams -- fortunately J (baby) was fine and it wasn't necessary.

Between contractions (not very much time at all) I kept an eye on the clock, promising myself that when the doctor came back I'd think about asking for something for the pain, so I was counting down to 10:00. During contractions I had my head down on my arms on an adjustable bed-table, and the only thought that survived the fog in my brain was this: that I had to groan and keeping my voice low-pitched, since screaming was bad and tightened up the face and neck muscles. Mind you, not much was relaxed by this time, but the thought "groan, don't scream" stuck with me and that's what I did. Apparently I was sounding pretty loudly by this time, but I was in PAIN and not in any position to care.

Ten o'clock came and went with no doctor, and I said, "Get me checked, because if I'm only at three cm I'll never make it like this." At quarter after, somebody fetched a resident to check me to see if I could have drugs. Turning over on my back for the exam was hell, and I almost lost it again until the resident said the magic words: "Seven centimetres." I opened my eyes and said "SEVEN? All right! I can do this!" Getting five cm along in two hours was an enormous encouragement. The nurses and my attendants got me sitting up again and resumed their positions, and on we went again.

A few minutes later the doctor showed up and offered me Entonox, nitrous oxide and oxygen administered by a mask that I held -- I had heard of it before but couldn't remember, so she gave me the quickest rundown on it that ever was, in between contractions! I accepted, and concentrated then on keeping the mask tight over my mouth and nose and making it whirr, which meant I was breathing through it properly. It didn't do much for the pain (or if it did, I don't want to know about it), but was something to concentrate on and kept me breathing.

Someone relieved me of my glasses at this time (without which I can't see six inches) because I still had my head down on my arms and the glasses were in the way of the mask. This resulted in my having almost no visual memory of delivery -- I didn't see my baby being born, nor knew who was speaking to me or where anyone was, and didn't see my baby at all until afterward when I had my glasses back.

After the exam I felt more and more pressure between my legs, and soon I felt that if I breathed in, there was nowhere for the air I breathed out to go but down through my body. I interpreted this as The Urge To Push, and somehow communicated this to those around me. Over I went onto my back again, and it was indeed time to push! They asked me what position I wanted to be in, and I said "Squatting, if I can get into it." The nurses and my attendants got me up, took the mask away from me, and broke down the bed and put the squat bar up. I pushed and refrained from pushing when told -- the "urge" still didn't feel like an urge, but as if my body was doing it itself and all I could do was hold my breath to help. In a few minutes (so I'm told -- my sense of time was nil at this point), I heard V say something about a lot of dark hair, and someone told me to reach down to touch my baby's head. I did, and it was true -- I was actually birthing a real baby!

A few pushes later, the rest was born, and someone said, "It's a girl!" Without my glasses, I couldn't see anything more than a white shape on the end of the bed. I lay back on the propped-up bed and heard her cry as her cord was cut and she was taken to the crib to be toweled off and her ID bands put on. I was amazed to hear she was born at 11:01 PM; I was sure that the time elapsed between the declaration of 7 cm and birth had to be more than 45 minutes. I had asked earlier that she be given to me right after birth, and B says she was for a

few minutes while the cord was cut, but I don't remember it, probably because I couldn't see her! She was given back after a little attention in the crib, and only then did I have the thought to ask for my glasses, and had a good look at my baby girl. I started to nurse her, but felt faint and had to lie down flat; J (baby) stayed latched on, though, yanking her head up every so often to breathe, since her nose was pushed into my breast.

In one sense I was glad not to have my glasses so I couldn't see the blood -- apparently I had a second-degree tear and bled a lot. I did see the placenta after it was delivered, but it didn't make much of an impression at the time. It seemed like ages while I was being stitched up, during which time I received a shot of pitocin for the bleeding, and we took some pictures, told J (baby) her name, and got acquainted. B got a chance to hold her in the rocking chair while I was being washed off, and soon after that she was taken out to be weighed and measured; she turned out to be 9 pounds 9 ounces, 21 inches long, and 14 inches around the head. She was brought back for her shots and glucose test (done on all babies over 9 pounds), after which we held her for another little while, and she nursed for a bit. I was still flat on my back all this time, and when I tried to sit up to get off the bed I fainted for real, so I ended up going back to my room on a stretcher. It was now two AM, and I was never more grateful to be left alone to sleep.

To make a long story not much longer, the rest of my five-day stay in hospital was a big help although not very comfortable. The day after birth, I couldn't stand up without fainting, and had to be catheterized due to an inability to pee, probably because I was so swollen and sore. The day after that was better, though, and I was able to take a shower; I was also transferred to a private room, which was a great improvement. B stayed with me the whole time, except for going home to sleep (he found it impossible to sleep in the hospital chairs) and together we worked out breastfeeding and changing diapers and bathing, and everything else we had to know before going home. My milk came in three days after birth, so the nurses helped me with that and made sure I could manage breastfeeding and that J was nursing OK. I was very happy to come home, to my own bed, soft chairs, bright colours, and the people and animals that live there.

C's Story
(Portions have been edited to preserve confidentiality.)

IT'S A GIRL!
C and A B are proud to announce the arrival of
B E B
Born: April 9 at 1:04 am
8 lb 6 oz & 21" long
After a long labour, B was born at home, in our kitchen. Daddy held Mommy in a supported squat as C H (midwife) caught her. T, C's (mom) sister, took still pictures while B's (baby) oldest brother E captured the moments on video. C (mom) is still in amazement having accomplished her VBA3C! C (mom) and A (partner) are thrilled to finally meet their first daughter after 3 sons and loving every moment of being a family.

More pictures of B and our family

Birth Story

I had on/off labour the entire day before, but not strong or demanding so I worked on CDA (Canadian Doula Association) projects, read Special Delivery and the CAPPA Quarterly, and rested. B (son) had been up until 1 am the night before so I was a bit tired. A (partner) and I went to bed with the boys at 9:30 that night.

I awoke at 3 am to strong surges and decided a bit later to go into the tub to relax. That worked great and I stayed there until the water was cool. B (son) woke when I was planning on getting out and he didn't want A so I curled him up around my big belly in our easy chair and rocked him to sleep... the last time he would be my official 'baby' in my lap. I tucked him in and headed to bed myself to doze until morning as my surges had lessened with the adrenaline of B's waking.

All of my labours involved intense back labour from the onset, so I was prepared for this, but the intensity of this labour was different. I knew my placenta was attached in the upper left quadrant where baby's butt should be optimally, but what a difference when baby is moving into my pelvis from the right side.

My labour progressed slowly, becoming stronger and more demanding as the day wore on. I changed positions regularly, we found every 1/2 hour was a good time to change. I moved from side lying on our bed to the tub, to the chair, to the toilet, and different variations of

that all day. Between contractions I read the teaching notes from my Body Awareness workshop and reviewed the emails I had printed from Wintergreen. Wintergreen is the founder of Common Knowledge Trust, who produce The Pink Kit. Without the knowledge I gained from this kit I know I trusted my body much more and knew which positions worked best for me and my baby. It helped labour progress efficiently and allowed baby to move through my pelvis.

Baby was always in ROA (her back to my right front). By dinner time I was quite tired and C, our midwife (who had arrived earlier but had a nap), and I agreed on a cervical check. I knew I was dilating as I had checked twice during the day for baby station and found my cervix opening beautifully. I just couldn't check actual dilation because my belly made it so I couldn't reach the center of my cervix. I was 5 cm and -1, great info given a thick, posterior cervix and that she was floating prior to labour. Yet it was tough information to take given my fatigue and the intensity of the contractions at that moment. I remember B's (son) labour being this intense when I was 8 cms! I seriously thought about my options at this point and was truly ready to transfer for that blissful epidural I knew awaited my arrival... what a carrot to dangle in front of any labouring mother. Yet I also know transferring from a homebirth as a thrice sectioned mother without a caregiver with admitting privileges could easily spell disaster, so we continued working and changing positions.

We decided to call our doula, E W, to come to help spell A (partner) so he could focus on the boys and later called T (sister) to be with the boys so A (partner) could be with me. My water broke sometime in there while I was on the bed and it was everywhere! I have always had lots of amniotic fluid, but it still amazes me each time my water breaks as to how much there is, and continues to be, as surges keep expelling more. I braced myself for the inevitable increase in intensity of pain, but surprisingly there wasn't a huge difference. All the while I worked through the contractions, staying relaxed as possible, using open positions, and working with my sacrum to help B (baby) move down. I cannot tell you the difference in knowing my internal pelvis and how to move my sacrum did with this labour!

E, our doula, doing the pelvic lift as A provides sacral counterpressure.
(picture caption)

I held my mother's curler in my left hand, which I squeezed during contractions to give the benefit of accupressure for pain. My youngest sister T (who took these pictures) used this same curler during her homebirth of her daughter T 2 years earlier.

Deep relaxation between contractions. (picture caption)

Now I am going to step back for a moment. Ever since my first baby was born I have had intuitions or preminitions, whichever you want to call them, about my children. They are like waking dreams, a strong feeling comes over me while I am awake and I see things happen, just as if I was in a dream. I knew of my eldest sons food breaking as well as when his front teeth were knocked out days prior to them happening. I belive this clairvoyancy is a gift from God and feel blessed by them.

Now I tell you of a very strong intuition I had when I was pregnant with B (our third son). It was that I was of me pushing out my baby in my kitchen. Though I had sought a waterbirth with B, my premonition was of me in a supported squat, just as Michel Odent used so much at Pithiviers, with A (partner) *supporting me as I stared out into the darkness through the windows into the darkened back yard. With B's labour we never went into the kitchen as the pool was set up in the living room (I had wanted it in the kitchen) and we just moved from there to the bathroom to our bedroom and back. I never told anyone this...*

I was in the tub, left there to refocus (which I desperately needed) and my sister T came in. She sat by the tub and talked me through each contraction, talking me through the intense sacral pressure and pain. The water cooled and I needed a change of atmosphere. Both A and C (midwife) knew I was close so she explained to A how do do a supported squat (just as my intuition had been, even facing the back window) and we moved to that position from the bathtub. It HURT because gravity was playing a huge part now and the sacral pain was still incredible, I had so thought it would let up when she moved down. That was really discouraging. I had been anticipating the blissful pushing urges I had felt with B, but they didn't come. Instead it was intense, intense sacral pain ending with slight urges to push at the end of each surge. I would walk around our island between each contraction and would slide into the squat with each surge.

I tired quickly and though B (baby) was moving down, it was taking a long time and progression was slow. We decided to try a reclining position on the bed with A behind me. It was blissful between contractions to relax into A, but the sacral pressure made me arch off

the bed and not focus on pushing. We tried side lying which was worse, my legs were cramping with each surge. Yet I was finally starting to get a strong pushing urge during the surges.

As I was side lying on the bed, I could feel 'something' move down into my pelvis. Not big enough to be a head... but something. I told everyone of this and that it would disappear after the surge was over. Because of my legs cramping we moved again to the kitchen to assume the squat. As soon as I walked into the kitchen, I was immediately hit with a huge surge and I felt 'it' move down... and out. I had yelled at someone to catch me as I couldn't stand through the contraction, thankfully A was right behind me. It turned out to be a big balloon of water. I grabbed it with my hand thinking it was baby's head, yet wondering why it didn't hurt as it had moved down. It was smooth and grippy, but I couldn't see it. C (midwife) explained it was a balloon of water and not baby's head. She broke it and I was disappointed that baby's head wasn't right behind. She was still up a ways. So we moved over and I again squatted in A's arms, this time pushing well with each surge. I had no choice, my body demanded it of me.

During my premonition, I gazing out of our big back window into the darkness over our back yard as I pushed in this position. In it A would be sitting on a counter with his feet on two kitchen chairs with me between his legs with my arms over his thighs. That was physically impossible in the home we had been in, because there was no counter or anything solid by the window in which A could sit. We had no idea that we would be moving only a year after B's birth into a new home in another city.

I gazed out the window into the darkness through the big windows I was facing... that overlooked our back yard. I suddenly was feeling deja vu, then slowly realizing that it was from my premonition that I felt this familiar feeling. I couldn't articulate what I felt, but a warmth spread through my body and a smile crossed across my face as the surge ended.

I felt her head as she slowly opened me up, what an incredible feeling to touch her head as she moved down. I felt her move down quickly now and she was crowning... I felt my labia go (tear) as I tried to breath her out and couldn't help but push. I cried out to God as the pain was incredible. Then blissful relief as her head out. I braced myself for her body to pass through with the next contraction and pushed hard. Out she came in a rain of amniotic fluid into the waiting

hands of C (midwife). I sat down immediately on one of the chairs A had his foot on and she handed her to me.

Proud Daddy as he looks down from the countertop
(picture caption)

My precious little baby, I couldn't believe I had done it. I am almost in shock, still reeling from the pain and intensity of my labour and her birth. I had did it! I was holding my baby, still warm from my body. She looked quietly up at me, checking everything out in that wise way baby's have. The quiet, patient soul who had been a part of me for nine months was now in my arms. I just gazed at her... then it slowly dawned on me to look and see if we had a boy or girl... to my amazement - a girl! I was so shocked I had to check twice. I had thought she was a boy even though I had not had the "boy" dreams I had with E, R and B. Then I felt my cord lengthen... not even 2 minutes after she was out, that surprised me given the precautionary concerns of several of my friends given my three prior cesareans of retained placenta and hemorrhage.

E beams as sleepy R comes to meet his new sister
(picture caption)

E had run to get our second born, R, who came in drowsy from sleep and he was the first to hug his new sister, just as he had asked. He went right back to bed and when he woke the next morning he thought it had been a dream until he watched the video. B, our third son, slept through it all and though A expressed his wishing he could meet his new sister right away, we both knew it was best if he got his sleep. He would be up early enough the next morning.

K showing E how to cut the cord
(picture caption)

Time once again returned and I realized it was after 1 am. She had been born at 1:04 on April 9th, 2003. About 15 minutes after she was born her cord was completely limp so C tied it with strong string and E cut the cord. He was so proud! I gave her to her proud Daddy and I moved to our bed where I pushed out her beautiful, healthy placenta onto a pad. We showed it to E and explained what a placenta was (an organ like his heart that provided all baby's nutrients and oxygen while growing in Mom). He had helped me make

many cloth placenta's for Mother Care and now was able to see a real one. He was a sponge through it all, absorbing everything in the most calm way, like this was his hundredth birth he had been at.

A, E and B went to the living room while C (midwife) carefully inspected my bottom, finding what I knew - labial tearing, several 'skid marks' or stretching breaks of the skin, and a second degree perineal tear. I chose to have her stitch me up rather than leaving it to mend together on it's own simply because I knew I would not be able to rest as it would need to mend properly while chasing after three busy boys. C carefully sutured the tear and A (partner) came in shortly afterwards with a hungry little B (baby). I laid her across my chest and she couldn't quite lift her head high enough to self attach (given my being flat on my back), so I helped her up and she latched on like a pro and nursed well.

Enjoying our first bath together, better than LeBoyer!
(picture caption)

After C was done, B and I had a wonderful bath while she swam and looked around at everything, the most content baby on the earth. What a peaceful way to conclude our night. We crawled into bed and both slept until morning.

B is so excited about his baby sister
(picture caption)

B woke around 8 am the next morning and walked sleepily into our room as he always did. This time he was in for a surprise and didn't believe us when we first told him. He had to walk through the house to inspect everything (which was back to normal as everything had been cleaned up as I slept) and then came back and crawled into bed with us and his new sister. She is now officially "my badie" according to B and he is very protective of his little sister to this day.

B and mommy the morning after her birth
(picture caption)

My precious little daughter amazes us every moment we are with her. We are all so in love with this little bundle who has blessed our lives. It took a while for me to come to terms

with the intensity of her birth, but I truly would not change one thing... unless Wal-Mart had their pools in stock in time <grin>.

This strange house in this strange city that we had only lived in for a little over a year was now our home. My dreams in the past were completed in the present through the incredible birth of our first daughter... in the kitchen in a supported squat just as I had known would happen years prior.

Welcome to our family B E, our amazing and wise daughter. Let your birth be a new beginning for us and a gift to the many women who long for a vaginal birth and need to learn of others, like us, who have accomplished a dream.

I want to thank God for His blessing of this amazing birth experience. I knew He wanted me to have this wonderful birth experience through answers to prayers. Specifically they were in planning a homebirth, in choosing a midwife, and my uterus not rupturing during pregnancy or labour. They were all answered prenatally as A was very supportive of a homebirth, and in C H, our amazing Christian midwife, blessing us with her support. E W, our incredible Christian doula, was an integral part of our team too as she supported me and helped C as her second (assistant) while I pushed B out. We even learned about unassisted birth in preparation for Bs birth because of C's being over 2 hours from our home. I also prayed specifically about everyone's fear of uterine rupture (not mine surprisingly, I was more concerned about relaxation and fatigue which had been huge factors in my previous labours) and that prayer was answered prenatally, so we had prepared with confidence in God's design for our birth. God is good indeed!

Homeopathics for Labour and Birth

I wanted to touch on homeopathics as I have found them incredibly helpful during labour and in general for our family's health. I have studied them informally thus far and plan to do further, formal study in the future because of the benefits we have experienced in using them. For my last labour I relied on my midwives to know what remedies and potency to give. This time I studied several books, articles, and talked to several homeopaths and birth professionals about remedies, indications, dosages, etc. I compiled a cheat sheet that I referred to as did my support team during B's labour. I cannot tell you how beneficial they were! During the last half of my labour I used several remedies, starting with Kali Carb and Belladonna. Incredible help with back labour, though it doesn't take the pain away, it makes it more manageable. Close to the end I moved to Chamomilla and Arnica because of the intensity and the bruised abdomen feeling I was experiencing, especially my round ligaments. I continued with Arnica through postpartum

because of the involution and perineal pain and healing. I also took Hypericum for the suturing as it is specific to puncture or needle wounds.

P's Story

J L's birth story!
Born the 9th of March, 2003, 7:50pm.

Please note: this is a detailed account of J's birth, please do not read if the details of birth bother you.

Well, I suppose I could say that labour began the morning of Friday, the 7th of March. I woke up to quite a bit of bloody show and many contractions (though the contractions were not very strong or uncomfortable.)

By Saturday the 8th of March the frequency of the contractions had picked up and I went to the mall with my mother and other two kids to do some walking and try to get things going. Later in the afternoon I busied myself with making a baby quilt.

I laboured lightly all Saturday night, making hourly trips to the bathroom and getting some sleep between trips. The stairs were becoming more of a challenge and brought on very powerful contractions.

Sunday morning, the 9th of March, I had a nice relaxing hot shower and then we took my 41 week belly photos. I had once again gone a week overdue! I later had a soak in the tub to relax my back and sent my thoughts to the baby, telling him/her that we were ready for him/her to come out. I also tried to send myself some courage... I had been labouring lightly for quite some time but seemed stalled- so I kept telling myself that I could do this and telling my cervix to open with each contraction.

Throughout Sunday I had lots of strong, but manageable, contractions though they never became regular in frequency. At 6pm we had supper with the family, the contractions became more frequent, and I told R (partner) that I'd like to go to the hospital after supper to

get checked- just so I know if I'm making any progress. I wanted to have an idea if we may be running up there in the middle of the night or if I'd be able to sleep and go up the next day. I was half expecting the nurse to tell me that I was only dilated 3cm and that we should go home. At approximately 6:30pm we left home; the ride in was torture... being early spring the roads were full of potholes and I was literally sitting on the baby's head! Our friend (and acting doula) B met us at the hospital shortly before 7pm.

I was checked and told that I was dilated 6cm. I went to the bathroom, was very uncomfortable, told them they'd better call the doctor... I was checked again and told I was 8cm. (Within minutes of arriving.) The nurses called the doctor and quickly set up the room. I laboured standing on the floor while leaning on the bed, or kneeling on the bed while leaning over the back of the bed. My lower back and behind were very sore so these were the best positions for me.

The doctor arrived and said I just had a rim of cervix left and that I could try pushing through it any time I felt ready. I had a lot of back pain and after a few minutes he said the cervix was getting swollen, so they suspected the baby was posterior.

Several fetal heart checks were done while I laboured- one was quite low (around 70... it was normally 140)- a change of position corrected that. However, a few times they tried to get the heartbeat and they couldn't detect anything- fear clenched my breast. I begged them to tell me that the machine wasn't working. It turned out to be technical difficulties, thankfully. It is so reassuring to hear that heartbeat- in those few seconds when we were without a heartbeat, I had had visions of being rushed away for an emergency section...

I was getting quite uncomfortable, with a lot of pressure with each contraction, so we set up the squat bar and I climbed onto the bed. I leaned on the squat bar, had several intense contractions and fell down onto my knees and gave a few small pushes. They told me that I could push anytime I was ready, but that I should try to stay on my feet as it rotates the pelvis better. I told the doc that I didn't want to push- he asked me if I ever wanted to push- I said NO! I hate this part!

So I felt another contraction coming and got up onto my feet for a proper squat. I squeezed and twisted the foam cover on the squat bar so hard, moaned and yelled a bit and pushed with all my might. I did self-directed pushing this time, with no one but the baby and my body telling me when to push. Instead of a super-long "purple push" as I had been told to do in previous births, I gave a little push, took a breathe and pushed a bit more. I believe I gave a series of little pushes through one contraction and had the head and shoulders out. The doctor helped rotate the baby's shoulders, and with one more small push the baby slipped out onto the bed. I heard R say in amazement, "It's a BOY!!!"

As I had been squatting instead of lying on the bed, R and B couldn't see right away what was going on down below. When the doctor had said that the baby's head was "right there" they thought it meant that the head was low in the pelvis, not out! I of course, could feel that it was out! So they were amazed and surprised at how quickly the baby came out!

I had hoped to catch the baby myself, but the body had slipped out so quickly I didn't get a chance to. The baby landed on the bed, I leaned back and lifted the baby to my belly.
As the placenta was still inside, there wasn't enough cord length to lift him far, so the cord was clamped and cut.

What a surprise this little boy was! Towards the end of the pregnancy we had started thinking that the baby was a girl as we could not decide on a boy's name. We were wrong... so now we had to come up with a name!

I offered the baby the breast immediately after birth, but he wasn't interested right away. He just wanted to be held and look around. He was perfect and sweet, with a little fuzz of light brown hair and the same dimple in his chin that we all have. His dark blue eyes were alert and staring intently at me.

Within minutes of delivering the baby, I delivered the placenta and then had a couple of stitches for a small tear along old scar tissue. I believe if it hadn't been for the scar tissue I

wouldn't have torn this time.

I snuggled with my new baby boy for quite some time, took lots of photos, then let the nurse weigh and check him. His apgars
were great: 8, 8 and 9, and he weighed 8 pounds 6 ounces, or 3805 grams. He was 49cm long, with a 35cm head, and had
been born at 7:50pm. We had been at the hospital for approximately one hour when I was holding my baby.

R and I debated names for quite some time. We came up with M L and agreed to sleep on it and name him in the morning. Well, after giving birth I can never sleep, so I sat up all night staring at my new son, asking him who he was. I realized that he wasn't a M- for some reason it didn't suit him. Suddenly J came to mind and I wanted to call him that. When R returned in the morning, he said that he also felt that M did not suit him, and when I told him about J, he said it was perfect! So we decided on J L.

We were originally going to be discharged immediately, but they wanted to observe us for several hours, and I didn't want to be moving at midnight, so we spent the night and will go home in the morning.

So now I sit here at 2am, wide awake from adrenalin and after-pains, with a perfect little boy curled up in my bed where he had fallen asleep at my breast. He looks so sweet and beautiful; he is truly a miracle. I can't believe that this little person was inside of me for the last 41 weeks.

This was most likely my last experience of pregnancy and childbirth and overall I'd have to say it was perfect. It was a bit frustrating to labour for so long at home, with everyone calling to see if the baby had arrived yet, but it paid off in the end as I laboured for less than an hour at the hospital. My pushing stage, while extremely intense, was thankfully very brief. I believe it lasted for maybe 2 or 3 contractions.

Thank you God for blessing our family with one more healthy baby. Now the fun begins for our family of five...

C, R and J- moments after birth. (Picture)

F's Story

25 Hours

My labor lasted for a total of 25 hours. I had been having cramps for 5 days, with nothing happening and they had already sent me home once. I went in on Tueday January 8th, 2002, but not before I took the  for a nice brisk walk around a couple of blocks. I was going to make this trip worth while

I went in at 11am and was having contractions, but they didn't get any worse and my water hadn't broke yet. So they were going to give me demerol, let me sleep and then send me home, again! But the demerol made me sick, instead of sleepy and then my water broke and I felt better instantly, that was at 1:20pm. Then of course, the contractions quite. So they waited until 5pm and then started the oxytocin IV, which started the contractions again, but I couldn't feel a thing. I went for walks to try to get things moving along, I slept, I went to the bathroom a gazillion times. My dh couldn't believe that I couldn't feel anything, he said the contractions were off the charts. Oh well, back to sleep I went. Poor guy, he didn't even get any sleep.

At 5am on Wednesday, I got up to go to the bathroom, still not feeling anything, and as soon as I stood up from the can, it was definetly time for the epidural (thank God for the drugs!!!) The Dr. came in at 6am, gave me my drugs and it was another 8 hrs. before I felt anything again. You should have seen my legs, they were completely useless! I couldn't even move them.

At 2pm I knew it was time to start pushing. They wanted me to wait for the Dr. Yeah right! 20 minutes and 12 good pushes, completely painless, and we had ourselves a beautiful baby girl.

Her name is S R M, she weighed 6lbs. 10oz and was almost 20 inches long. She was born on

Wednesday January 9, 2002 at 2:20pm. She was 13 days early, lucky for me!
Well that's my story. I hope the next one is just as easy.

G's Story

J ARRIVES 2 DAYS EARLY!
NOVEMBER 28, 1999

Monday November 22, I was sitting watching the Young & the Restless, relaxing, and I heard this horrible sounding pop come from inside of me. I freaked out! What just happened to my baby? I had never experienced anything like this before. I tried to stay calm, and after a few tears of worry was able to stay relaxed. Later that evening after a bath, and upon going to the bathroom for yet another tinkle, I happened to look down into the toilet bowl and saw a tablespoon-sized glob of grey matter-turned out to be my mucous plug! Yay! Labour should start soon. At my regular doctor appointment the next day he agreed I could go any time, and that I had indeed lost my mucous plug. I wasn't sure, as there was no sign of blood or show. I started to feel cramps, very slight, by Thursday November 25, and by Friday November 26 felt even more. But we managed to go shopping for Christmas items we hadn't yet bought. On the Thursday as well I cleaned out the entire fridge top to bottom. A severe case of nesting. I had a great burst of energy that Friday, and as we went to bed that evening at 10pm, as I tried to lay down to sleep, I was hit with a strong contraction. For about two hours I tried to sleep, ignoring the ever-growing pain, but by midnight I had to wake M (partner) up to help me deal with what was happening. Labour. We kept track of the minutes between contractions for about three hours, and by 330am we had to get up. I was in pain. I was able to manage the pain very well though, and M was a fabulous coach. I laboured at home with M at my side until 8pm Saturday November 27, where we finally got the once very sporadic contractions down to every 5 minutes lasting about 2 minutes long. We were excited!

My mom met us at the hospital, and I was assessed quickly. I was already 7cm dilated, all on my own! The nurses were shocked! I had done most of the worst and hardest work on my own med-free! Just like I planned! But, we had no idea what lay ahead in terms of planned. I got into a nice labour & delivery room, with whirlpool tub and all! I decided to try the tub,

but soon found the jets of water too painful to withstand, so out I got. I managed another 5 hours med-free, at this point we were at the 29 hours mark of a very long and tiring labour, and two days of no sleep-so far! By 1am they found me to not be progressing at all, as we were stuck at 7cm dilation still. The nurses were concerned about me, especially that I hadn't any sleep in a couple of days, so I opted, actually I asked for the epidural. I only took it to fall asleep, as the pain wasn't the problem. The fact that I hadn't gotten any sleep was hindering my relaxation therefore not allowing me to further dilate. I was given the epidural- a very uncomfortable procedure, and not for the needles, as those don't bother me, just the horrible sitting up positioning and staying still for two whole minutes through very strong contractions and urges to push which I had to fight. Finally I got some rest once the epidural took effect. M slept on a couch chair our nurse had brought him, and we both slept from about 2am until 530am, when they came to check me. I had easily dilated to a full 10cm and was ready to push. But, I asked to sleep a bit longer, and was very happy to be able to. At around 6am I awoke and we started the pushing process. We were told this should last about 2 hours. Well, after 4 hours of no progress, the doctors came.

I was checked many times, and the baby was wedged up under my pubic bone with its hand stuck to its face. This was the reason for no progression. I begged for a C-Section, as the pain was horrible. Plus, I was still so exhausted I wanted to die. They said we were going to have to have a Vacuum Extraction delivery to help me get the baby out, as it was too late for a C-Section because the baby was too far into the birth cannel to do one. They hooked up the Vacuum and I was told I NEEDED to push with every ounce of energy I had left and that the baby had to be out NOW! So I somehow did this, pushed like there was no tomorrow, and out squirted our baby- A GIRL!!!!!!! We were so shocked!!! We had thought we were having a boy!! M cried out "It's J" and that, happily, was the birth of our daughter, J!!She weighed 6 lbs and 15 oz and was 19.5 inches long. She had a full head of black hair, and was the cutest thing!!

I required an episiotomy and then tore more, so I needed a lot of stitching done after the birth. But, that gave M time to bond with his baby girl! I was totally exhausted, and my

labour totaled 36 hours!! But, the end result was Jules!! I stayed in the hospital until Tuesday November 30, when our new little family went home!