PART THREE:
ANNOTATED BIBLIOGRAPHY
A multi-pronged approach was employed to gather relevant literature.

The research included a computer search of journal articles written in the last twenty years which focused on birthing and environmental design.

A review of standard references on the birthing process was conducted to identify the behaviors and activities that occur during birth that can be influenced by the physical environment.

The resulting set of approximately twenty citations represents a broad range of disciplines including architecture, obstetrics, health planning, nursing and social science. Roughly one-third of these citations are chapters or entire books, and the balance are research reports in journal articles.

In all cases, the goal was to identify items which provide the latest and most up-to-date information regarding the birthing process and/or provide guidance for environmental planning and design. Given the specialized focus of this project and the intention to cover only the most recent literature, this bibliography is not meant to be exhaustive.

The Index on the following page is keyed to topic headings within the text of the annotations. The intention is that the reader can quickly zero in on the items that match his/her immediate needs.
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**Description**

This article is an historical overview investigating the birth setting as it reflects the social values towards childbirth and the meaning of the physical setting. During pre-industrial societies women probably attended each other and the attending group was small because other adults could not be spared from their many tasks. Some cultures included the father in the birthing process.

**Environmental Context**

A special birth setting was evident in some primitive societies, such as a birthing chair, stool and special structure to house the event.

Through the 1800's, assistance to the laboring mother by women relatives, neighbors and midwives was the norm in America. Births took place in the home, sometimes in a special "borning room", or in the parent's bedroom. By the end of the 19th century the trend was to give birth in a hospital with a trained male physician. It was felt to be more comfortable (medications for pain), safer (with the rise of obstetrics as a medical specialty), and more sanitary.

By 1975, 99% of all births in America took place in the hospital. The author describes the atmosphere and social attitudes of the traditional modern hospital birth. In the 1970's a birth reform movement arose, with an increase in "out of hospital" births and the emergence of alternative birth centers. The freestanding birth center most closely meets the social and physical requirements of a family oriented philosophy towards childbirth.
This paper explores the phenomenon of patient control in a midwife-run free-standing birth center which emphasized natural, patient controlled childbirth. Specifically, it addresses the ability of patients to translate an inner desire for control into actual controlling behavior during the birth process.

The research site used to explore these issues was a free-standing birth center located on the campus of a community hospital. Prenatal, intrapartal and postnatal care were provided by nurse-midwives backed up by obstetricians at the adjacent hospital. The philosophy of patient care in the birth center stressed both natural childbirth and patient control.

From the perspective of the patient, going to a birth center reflects a challenge simply because it goes against conventional opinions of where birth should take place and also because it involves an active seeking out of an alternative to the dominant mode, rather than a passive choice of the local hospital or doctor that ones family or friends may have chosen in the past.

In choosing the birth center, most patients were reacting against hospital care. The most prevalent reaction was that hospitals have a sterile and impersonal atmosphere. Others reacted against specific hospital practices and some specifically reacted against a lack of personal control in the hospital.
Part Three: Annotated Bibliography

Annandale, continued,

**Research Methodology**

The methodology employed included 18 months of participant observation, periodic interviews with 46 patients over the course of their pregnancies, observations of most of their consultations with the midwives and quantitative analysis of about 1000 medical records covering the five-year operating history of the birthing center.

**Research Findings**

The data revealed that although many women chose the birthing center because they had a desire for control (specifically, control of the decision making) in the birthing process, accounts of their perceived controlling role when in the birth center were vague and unspecified. The author concludes that information exchanged from the midwives to the patients had a limiting effect on the actual control the patient was able to implement during the birth.
A critique of the new system of obstetric practice, i.e., natural childbirth examines the role of the woman, the obstetrician and the hospital environment.

Hospital staffs must be trained, educated, and subjected to systems of surveillance, just as women must be trained, educated, and subjected to systems of surveillance, in order to assume their proper places in the new system of obstetrical alternatives.

A description of the Childbearing Center, established in New York in 1975 by the Maternity Center Association and the goals of the Center are presented. The author offers a critique of the birthing center and its ability to meet its stated goals.
This article explains how economic trends in obstetrical care impacts on the design trends for obstetric departments in hospitals.

The national average length of stay (ALOS) for normal vaginal deliveries has fallen recently from three days to two days, with a growing trend toward one-day postpartum discharge.

Each day of decline in the three day ALOS represents a 33 percent decrease in total patient days for the obstetric department, creating a vital interest in the need to increase the volume, or in some hospitals, the critical need to alter the patient reimbursement mix, balancing toward a higher percentage of "paying" customers.

These changes have resulted in increased competition between hospitals and increased importance of marketing strategies. All these factors have influenced the rapid acceptance of innovative facility design for obstetrics.

The LDR unit, designed for both high risk and low risk vaginal deliveries, is equipped well enough to give physicians the confidence that everything they need will be available. It is large enough to give staff adequate circulation room, and its interior design creates a
Bajo, continued,

pleasant, home-like atmosphere. The design of the LDR unit reflects the fact that in most hospitals at least 80 percent of births are normal.

LDRP Unit

LDRP, (labor/delivery/recovery/postpartum), is also known as the single room maternity care (SRMC) concept. The key difference between the LDR and the LDRP units is that in the LDRP the mother stays in the same room from admittance until she leaves the hospital.

The LDRP concept has recently become practical for hospitals in terms of total square footage (300-350 sq.ft. per room), due to the decrease in ALOS.

Cost

It is estimated that between 10 and 28 percent in operating cost savings can be achieved with the LDRP system over the traditional four-room design, because of the additional increases in productivity of nursing staff. Also infant care is reduced because the system is designed for the baby to be in the LDRP unit most of the time, under the care of the mother.
Cohen, Richard L., M.D.,
*Psychiatric Consultation in Childbirth*

**Description**

The purpose of this book is:

1. To provide mental health practitioners with a current overview of our knowledge about normal parental development during pregnancy and its relation to fetal development, with particular emphasis on the impact of acute and chronic stress on these developmental processes.

2. To provide an understanding of the general state of the field of pregnancy and childbirth care both in conventional health systems and in alternative options.

3. To provide an understanding of models of consultation and liaison that are adapted to the special conditions of pregnancy and childbirth care, as contrasted to the more traditional modes that characterize these activities in medical and surgical hospitals.

**Women in Childbirth**

Emotional disorders and mental illness associated with pregnancy and the postpartum period are addressed.

**Environmental Context**

**Birthing Room vs. Out-of Hospital Birthing Center**

A description of family centered hospital care (birthing room) and the alternative "out of hospital" birthing center is presented. The birthing room is one space where labor, delivery and recovery occur so that the woman doesn't have to be moved during the entire process. The out of hospital birthing center is generally a clinic run by midwives for prenatal care as well as birthing, with great emphasis on a natural approach to childbirth.
Cohen, continued,

**Research Based Findings**  The purpose of the study was to learn something about the factors that are leading women and their mates to choose one method of childbirth over another. The information was derived from 125 postnatal interviews conducted in six programs (two university hospitals, two "out of hospital" birth centers, and two "in hospital" birthing rooms).
Part Three: Annotated Bibliography


**Description**

This case study is a description of the LDRP units at the Family Birthplace, at Pacific Presbyterian Medical Center, in San Francisco, designed by Stone, Marracini, and Paterson. The designers advocate the LDRP over the LDR system because using a single room for the entire stay is less disruptive to the mother and allows the family greater privacy.

**Therapeutic Goals**

The designer's goal is to create an intimate environment with high-tech capabilities.

**Design Guidelines**

The result should be one room in which the home-like labor room can be converted to a functional delivery room in less than one minute.

Walls and ceilings specifically designed for high acoustical privacy are meant to encourage family members to feel a part of the birthing process.

Designs should give the patient the best views to the outside.

Designs should emphasize adjacencies so that no patient ever has to be moved far from her birthing room base, whether to use a special cesarian operating room or to visit the nursery.
The objectives of this research is as follows:
1. Determine the extent to which a hospital's future marketing planning for obstetric services should focus directly on women in the child bearing age group as opposed to obstetricians themselves.
2. Identify the community's perception of obstetric services offered at competing hospitals in a given service area.

To provide greater insight into the market dynamics in a particular service area, three focus groups were conducted by the first author in the spring of 1984. In total, 31 women aged 18 to 35 who had given birth to at least one child in the last five years were surveyed. Sixteen mothers delivered at a proprietary hospital, six at a teaching hospital, and nine at a community hospital in the same service area. Each focus group session lasted approximately 90 minutes. Furthermore, to corroborate and summarize the major points that were discussed, each woman responded to a structured questionnaire at the conclusion of each session. The structured questionnaire which measured the importance and satisfaction of 20 criteria as they related to each woman's most recent birth, was based on a review of the literature.

One of the most significant findings of this research was the rank ordering of the evaluative criteria. The order of importance of the characteristics, starting with the most important, is as follows:
high quality medical care, pre-delivery nursing care, adequate modern equipment,
Part Three: Annotated Bibliography

Danko, continued, clean hospital, father allowed in delivery room, post-delivery nursing care, family visitation rights, good hospital reputation, efficient admission procedure, privacy, delivery procedure options, pleasant physical surroundings, food quality, convenient location, attractive post-delivery rooms, preferred by physician, adequate parking, religious affiliation, respectable people as patients.

This study supports the notion that a positive birthing experience is in the best interest of a hospital if it is to continue to attract a patient base.

Design Guidelines

Based on the findings listed above, the design of birthing environments should emphasize accommodations for the father to be present during the entire birthing process, privacy, and pleasant physical surroundings. Privacy can be achieved by arranging square footage allocations so that all rooms are private, rather than two patient rooms. Entry to each room could provide initial screening from the patient bed.
This is a longitudinal study of 120 couples during the period of family formation. The paper focuses on how preparation of the wife during pregnancy and the husband's participation in the birth of their child affect the wife's reaction to the birth event. It is shown that the quality of a woman's birth experience not only is important for her own well-being but is increasingly recognized to be of importance for the marital relationship and parenting as well.

A model was formulated to explain the quality of a woman's birth experience. In the model both the woman's preparation level and husband's participation are taken as exogenous variables. Direct paths link both woman's preparation level and husband's participation to the perceived degree of pain during childbirth. Earlier work, described in the paper, documents the possible correlation between women's preparation for childbirth and the pain she experiences. In addition, one would suspect that the husband, by encouraging and comforting his wife, would reduce her anxiety (closely related to pain), and at least the pain would be more bearable with the husband present to help the woman in controlling contractions.

Both pain and the two variables prior to it are expected to act directly upon level of awareness - with less pain and less medication is required.
Women's birth enjoyment, the ultimate endogenous variable, is assumed to be directly affected by all of the prior variables, the reasons for which are explained.

Data source: The study utilized interviews of 120 Maryland women delivering a first child. Interviews were conducted twice before and once shortly after the birth. Half of the women's husbands were interviewed before and after the birth.

Measurements: Each variable was analyzed and formulated into a numbered scale based on relative degree of women's preparation, husband's participation, perceived pain, level of awareness and quality of women's birth experience.

Editor's note: Although this study doesn't directly address the environmental context as a variable for the quality of the women's birth experience, it can be concluded that the physical environment should accommodate and encourage the variables that do have a positive affect of the birth experience, specifically the husband's participation and the level of the women's awareness.

Research Based Findings

1. Preparation acts to increase the likelihood of a higher level of awareness at the time of delivery.
2. Husband's participation contributes both directly and indirectly to the woman's birth enjoyment.
3. The effects of pain on birth enjoyment are negative. Also, more pain reduces the level of awareness (more medication is required).
4. The importance of the level of awareness in predicting the quality of the women's birth experience is clearly revealed in this analysis.
As the tools of birth change from familiar household objects, such as hammocks and beds, to high technology objects, such as delivery tables and fetal monitors, significant changes occur in the ability to give physical support to women during labor and in who owns the tools and the information they provide. Data derived from the laboring woman herself are less sought after and less valued.

Changes from low-tech to high-tech result in a change of who controls the flow of information relevant to the management of the birth.

A low-tech birth involves the shared distribution of knowledge among the collaborative team, leading to joint decisions when trouble arises.

A high-tech birth involves specialized instruments which provide knowledge that is privileged to the medical team. All participants, including the woman, look to the machine for the crucial information, not to the woman's experience or the state of her body.

| Description | In response to consumer complaints, some physicians and hospitals have established in-hospital centers for family oriented maternity care. These programs are specifically designed as an alternative to those who may have chosen to give birth at home. |
| Environment Context | Alternative birth centers offer a home-like setting for birth in the hospital. The labor and delivery take place in a room designed to appear like a bedroom at home. Hospitals vary greatly in terms of policies for the extent of medical intervention permitted and/or required, and the extensiveness of high-tech medical equipment available behind the closed cabinet doors of the "ABC". This paper examines the reasons for choosing the alternative birth center and the satisfaction with the outcome using this type of facility for giving birth. |
| Research Methodology | Open-ended, semi-structured interviews were conducted with 36 women who chose to have their babies in ABCs in two private and one county hospital on the West Coast in 1980-1982. It compares the opinions of these women to those of women who selected either birth at home with lay midwives or conventional hospital birth with obstetricians. |
| Research Findings | When asked why women chose to use the ABC for giving birth, the most common answers given were: 1. to avoid obstetrical interventions and 2. to experience the physical comfort of a home-like atmosphere. Other answers given less frequently were: to be attended by a midwife, to insure fewer medical risks, and to experience a more "natural" |
childbirth than believed possible in conventional labor and delivery.

Women in this study chose the ABCs so that they could experience greater comfort and avoid interventions performed in delivery room births, but also have obstetricians and technological interventions on hand "just in case something goes wrong". Women in this study who chose home births expressed more critical and skeptical views of biomedical approaches to childbirth. These women adopt a different ideology of childbirth and do not trust hospitals.

**Conclusions**

Hospitals have established ABCs to attract women who would otherwise be giving birth at home. However, the evidence shows that they are in fact attracting women who would otherwise have given birth in a conventional labor and delivery suites. These women have been somewhat influenced by the birth reform movement, preferring no medications and as little intervention as possible, but they generally trust the established authority of modern obstetrics and the expertise of physicians.

**Design Guideline**

Designers should recognize that one of the top reasons for women choosing the ABCs was a preference for a "home-like atmosphere". The interior design for birthing rooms and birth centers should emphasize colors and furnishings that avoid an institutional and hospital ambiance and do promote a likeness to home.

**Description**

This paper presents an analysis of the risk perceptions of a sample of pregnant women in a large metropolitan area on the West Coast regarding childbirth and its medical management, and how these perceptions correspond to their choice of childbirth service. The analysis first summarizes recent experimental work in cognitive and social psychology on information processing in decision making and examines its usefulness for the study of women's reproductive strategies in real life contexts. Following this, perceived risks of childbirth and its management are examined in light of the concept of "bolstering" advanced in Janis and Mann's conflict theory of decision making. The findings, that women discount the risks and magnify the benefits of the chosen birth service, and exaggerate the risks and minimize the advantages of the rejected services, support the concept of bolstering and provide empirical evidence of its explanatory power in interpreting a decision making domain - women's childbirth care decision making.

**Research Method**

Interview respondents were healthy women with uncomplicated pregnancies who were drawn in purposeful samples from a variety of prenatal care services. Data on perceived risk associated with childbirth and its care were obtained by means of semi-structured, focused interviews conducted with respondents during the second trimester of pregnancy. To see if risk perceptions differed by choice of birth service, respondents were divided into three contrasting groups.
according to their choice of birth service: 15 women had chosen home births with lay midwives, 15 women had selected an alternative birth center with nurse-midwife care, and 17 had favored conventional hospital labor and delivery with an obstetrician as attendant.

Decision makers who have made a social commitment to a given birth service bolster their choice by playing up the risks of rejected alternatives and by discounting the risks of the chosen method. The bolstering hypothesis provides a plausible explanation of how women as consumers of obstetric care construct idiosyncratic risk-benefit assessments of childbirth care alternatives which make their choices appear as the most attractive and the least risky of the available options.

Description

This paper examines how important social networks are to women's choices for childbirth care, and if they assume distinct functions for women choosing birth at home. Social network is defined as a "unit of social structure that includes all of an individual's social contacts". The paper presents data which shows significant differences in social network uses between women planning birth at home and those planning birth in the hospital.

Research Method

Open-ended, semi-structured interviews were conducted with 45 women choosing birth at home and 69 women choosing birth in the hospital. Respondents in the hospital birth option included 37 women choosing in-hospital alternative birth center care, and 32 women choosing conventional labor and delivery care. Respondents were located through their prenatal care providers, and contacted by phone in the first or early second trimester of pregnancy to explain the study and request their participation. Each participant was interviewed twice, once before and once after the birth.

Research Findings

Women choosing home birth were found to be significantly different from women choosing both hospital birth services along seven network dimensions.

1. Home birth women knew many more women who had also given birth at home than did both groups of hospital birth women.
2. and 3. The second and third network variable compared friend's attendance at respondents' births and, reciprocally, respondents' attendances at the births of
friends. Home birth women invited more friends to the birth, and in turn, attended more births of friends, in particular home births, than did both groups of hospital birth mothers.
4. Detailed knowledge of friends births was more common among home births than hospital births.
5. Influence of friends as a factor: A large majority of home birth women felt that their friend's experiences and plans regarding pregnancy and birth influenced their own choices, and that they, in turn, influenced their friends' choices. Women who delivered in hospitals, conventional care choosers more so than ABC choosers, not only know less about their friends pregnancies and births, but also reported less influence from friends on their own plans.
6. and 7. The extent to which birth care choices deviated from social norms, as represented most vividly by the values and preferences held by social network members. Home birth mothers encountered the most disapproval and approval from network members. Because the choice of birth at home is still socially regarded as deviant, home birth mothers encountered stronger opinions on both sides of the issue from friends than did women making the much more conventional choice of having a baby in the hospital.

This paper cites some of the documented achievements of nurse-midwifery and presents a fantasized look at the status of the profession in the year 2001.

**Environmental Context**

**Free Standing Birth Centers**

Free standing birth centers with midwife attended deliveries offer a viable alternative to healthy pregnant women in this country. Birth centers are also economical.

**In Hospital Birth Center**

The in-hospital childbearing center is a new approach to labor, delivery and recovery in the hospital under the primary care of either a midwife or obstetrician. Even with an apparently healthy, normal pregnancy, many medical and obstetrical emergencies occur that cannot be anticipated. The author believes that a childbearing center remote from a medical facility cannot adequately cope with many emergencies.

**Research Based Findings**

A 1982 study of 11 birth centers whose primary caretakers were certified nurse-midwives with physician backup was reported. The findings showed that only 15% of the birth center families needed transfer to the hospital after the onset of labor. Ninety nine percent of the women began labor spontaneously, but 38% had augmentation of labor by artificial rupture of the membranes. Almost 60% of the labors proceeded without any medications for pain. 89% were spontaneous deliveries, and 5% had cesarean sections at the backup hospitals. The free standing birthing
center is a combination clinic for prenatal care and childbirth education center, and a place for childbirth for mothers that have been carefully screened for any high risk factors. The midwife team provides the health care with physician backup if the need arises.

Therapeutic goals for the childbearing center are safe care, low cost, family participation, effective primary care and referral, responsive governing body, mutual respect between professionals and families, and an extensive childbirth education program.
Part Three: Annotated Bibliography


**Description**

Research concerning fathers' birth attendance, early contact, an extended contact with newborn infants is reviewed in this paper. Relationships between fathers' early history with infants and subsequent patterns of involvement are discussed. Methodological challenges of studying the effects of fathers' birth attendance and early contact with infants are considered. Implications for future research and policy-making are discussed.

**Conclusion**

An objective reading of the existing literature suggests that although some father-infant relationships may benefit from increased exposure, birth attendance, early contact, and extended contact are neither necessary nor sufficient for the establishment of positive father-infant relationships.

Evidence does suggest that father involvement in birth attendance, early contact and extended contact enhances the marital relationship (if the experience is viewed positively by the couple) and father's feelings of inclusion in the evolving family (Parke, 1978). Based on this review of the literature, it appears as though the indirect effects of marital enhancement and feelings of inclusion in the evolving family exert a more powerful impact on the father-infant relationship.
than the direct effects of early interaction with the infant.

**Design Guidelines**

[The editor recommends that since the literature points to the positive effects of father's birth attendance and since that is the current expectation of couples and the policy of most hospitals, that birthing rooms be designed to accommodate the needs of the fathers. This includes space allocations and appropriate furnishings for father's relaxation, refreshments and space at his wife's bedside.]
Part Three: Annotated Bibliography


Description

This chapter examines the design of the obstetrics and delivery environment in the hospital setting. A brief summary of the history of childbirth and the changes taking place in the obstetrics and delivery department and the underlying philosophies is presented. Design implications are suggested, based on the author's personal experience and observations.

Therapeutic Goals
Provide Flexibility and Options

In order to provide a responsive, sensitive, and meaningful environment for the potentially wide range of activities and needs experienced by today's expecting mother, the design must not preclude a correspondingly wide range of perceptual and behavioral options. These options include mobility during the early stages of labor, involvement of other family members, and various posture options during the actual birth. Because every mother is different and will experience childbirth differently, each mother will have different physical and psychosocial needs and should be able to find the appropriate amount and kind of support from her labor/delivery environment.

Design Guidelines
Admitting

A small admitting office provides privacy and lends a formal sense.
of importance to the admitting interview, thereby reinforcing the patient's individual identity.

Prepping

When the woman has to undergo some dehumanizing procedures or invasions of privacy to be "prepped" this should take place in the mother's bedroom. She should have her own home base while she is in the hospital.

Labor

During the beginning stages of labor many women may choose to be alone or she may prefer to walk and socialize. These options should be made available to her. As the labor progresses to the more intense and painful phase, the woman and her husband will be primarily in her bedroom and the focus of attention will shift from the social support of a lounge to the medical support of the staff work area or nurse station. The design recommendation is that the cluster or row of LDR units be centered between a wing that is a "social", public space and a wing that is a "medical" private zone.

Delivery

There is a clear demand for delivery facilities which are less technologically dominant, less complex, less frightening, and more comfortable or homelike. Yet, emergency backup services must be provided.

Most normal deliveries do not require the antiseptic environment of the typical delivery room and could therefore occur in the mother's bedroom, provided there is enough space for staff and equipment. Three hundred to three hundred fifty square feet is the recommended minimum.
Recovery, with time for mother, father and child to be alone, can take place in the same room as labor and delivery. The delivery environment should be adaptable to the quiet nature of this recovery period. If it is possible for the mother to remain in her homebase-bedroom for the remaining 2-3 days of her hospital stay, then it is suggested that the room accommodate the father to stay overnight with mother and baby.

**Description**

This study sought to determine the attitudes and values of prospective parents choosing three approaches to childbirth: maternity center, hospital, and home birth. The investigation examined (a) decision-making procedures and considerations for choice of birth environment, and (b) attitudes toward traditional parenting and values.

**Research Methodology**

Sixty four prospective mother-father pairs from the three birth environment groups participated in the questionnaire survey.

**Research-Based Findings**

The birth environment groups differ with respect to how and why they select a particular delivery mode for their first child. Maternity center couples emerge on the whole as less traditional and more representative of sex-equalitarian attitudes toward parenting.

Although the 128 participants in this study were from the same metropolitan area and had access to birth environment information, only maternity center and home birth couples indicated full awareness (95%-100%)of the three available birthing modes. This suggests differences in the initial approach to childbirth, with pairs in these two groups, as compared with those in the hospital group, more fully investigating options for childbirth environments.
Part Three: Annotated Bibliography


DESCRIPTION: From 1975 to 1978 there was a major increase in the number of "out of hospital" births in New Jersey. As birthing centers were opening, midwifery licenses increasing in number and OOH deliveries on the rise, it appeared that a trend toward an increase in birth alternatives was taking hold in New Jersey. A data base was being established by the New Jersey Department of Health, Maternal-Child Health to study all OOH births.

RESEARCH METHODOLOGY: This study was designed to collect residence location and personal data on all OOH births from New Jersey birth certificates, determine whether the birth was planned or unplanned to occur outside the hospital, plot locational data on New Jersey maps, tabulate the data and compare both locational and personal data on OOH births with statewide birth data. Interviews with midwives, physicians, Health Department personnel, medical educators, consumer advocates, mothers and birthing center personnel were conducted to elicit explanations for data results.

RESEARCH FINDINGS: Trends:

1. While a rise in the number of OOH births in 1977 provided the impetus to begin data collections, the absolute number of planned OOH births did not rise over the next three years, nor did the
percentage of planned OOH births relative to the total number of births in the state.

Caregivers:

2. The majority of planned OOH births were attended by midwives. The data showed that of 208 births that were attended by physicians at home, 172 were attended by the same physician. Of 214 home deliveries attended by midwives, 156 were attended by the same midwife. The entire birth alternative movement in New Jersey was dependent on the activity of less than a dozen individuals.

Infant Weight:

3. The data showed that the proportion of low birth weight infants born at planned OOH births is significantly lower than the proportion of low birth weight infants born to the total population.

First v.s. Second Births:

4. Significantly more second children were born in planned OOH births than would be expected from the number of second children born to the total population. Interviews revealed that women often chose the OOH birth after an unsatisfactory traditional first birthing experience.

Women:

5. Women who chose planned OOH births were more than likely than the total birthing population to be married, unlikely to be under 19 or over 35 years of age, having their second child, to have had 13 or more years of education and often had post-graduate training, as well.
Schneider, continued,

HEALTH PLANNING IMPLICATIONS:

There appears to be a small but consistent demand for birth alternatives in New Jersey. In some areas the medical establishment has answered this demand by in-hospital midwifery services and birthing rooms. This arrangement satisfies the medical community in regard to safety and that they are providing the alternative services necessary to meet the demands of women.

A small but widely diffuse birthing population continue to demand a planned OOH birth. For some the answer is the free standing birthing center. Here they will be treated as clients rather than patients. The normalcy of their pregnancy and birthing experience will be confirmed by the staff, and the woman will participate in her care and decisions about her body.

Home birth remains firmly entrenched in New Jersey as a birthing alternative.
This book describes the history and rationale behind the Manchester Memorial Hospital, in the small town of Manchester, Connecticut. In 1969 this hospital became the first hospital in the United States to establish a birthing room. The author, who was the driving force behind the formation of the birthing room concept at the hospital, reviews how he came to be convinced that a natural, rather than pathologic and technological, approach to childbirth is the better way.

Informal interviews with couples taking an active and meaningful part in childbirth and utilizing the birthing room at Manchester Memorial Hospital are presented in an anecdotal fashion. The women and their husbands offer their critique of important aspects of their care, their environment and how it affected their feelings about the birth experience.

The birthing room at Manchester Memorial Hospital and its primary furnishing, the labor-delivery bed, are described in great detail and shown to be far superior to the traditional hospital delivery room and delivery table. Different types of delivery beds are illustrated and described.
Part Three: Annotated Bibliography

Sumner, continued,

**Therapeutic Goals**

1. The physical and emotional preparation of the mother and father.
2. Availability of continuous, one-to-one support for mother and father throughout labor and delivery by a maternity nurse (monitrice) prepared in psychoprophylaxis.
3. Individualization of each birth experience with maximum emotional support for the new family.

**Design Guidelines**

A single, all-inclusive unit for both labor and birth, with all mothers eligible for this unit is recommended.
An informal study, based on interviews of nurses, was conducted to determine what changes nurses report in maternity care and how these changes affect them and their practice. Changes related to family centered maternity care, short postpartum hospitalization, and patient characteristics are reported.

Nurses report more job satisfaction overall, but that their workloads had increased as a result of these changes, with more "traffic managing" and patient teaching required. Conflicts arise from a lack of postpartum teaching time, lower patient census causing job insecurity, and from the need to care for all the members of the family instead of only mothers and babies.
Part Three: Annotated Bibliography

Thiede, Henry A., M.D.
"The Case For the Hospital Delivery," in
Maternity Care in Ferment: Conflicting
Issues, ed. Martin Kelly, New York: Maternity
Center Association, 1980.

Description
The author is an obstetrician who compares free standing birthing centers and hospital childbearing centers. Nurse-midwives provide the primary care in the free standing birthing center. They are skilled in normal obstetrical care, strongly pro-feminist, and seek independence of expression and less accountability to physicians. Midwives intend to isolate themselves physically from the medical community through the use of free standing birthing centers.

Environmental Context
Free Standing Birthing Center
The free standing birthing center is a combination clinic for pre-natal care and childbirth education center, and a place for childbirth for mothers that have been carefully screened for any high risk factors. The midwife team provides the health care with physician backup if the need arises.

In-Hospital Childbearing Center
The in-hospital childbearing center is a new approach to labor, delivery and recovery in the hospital under the primary care of either a midwife or an obstetrician. Even with an apparently healthy, normal pregnancy, many medical and obstetrical emergencies occur that
Theide, continued, cannot be anticipated. The author believes that a childbearing center remote from a medical facility cannot adequately cope with many emergencies.

Therapeutic Goals

Therapeutic goals for the childbearing center are safe care, low cost, family participation, effective primary care and referral, responsive governing body, mutual respect between professionals and families, and an extensive childbirth education program.

**Description**

This article describes the Family Maternity Center at Holy Family Hospital, which opened in 1983. The program demonstrates how hospitals can provide cost-effective maternity services without sacrificing quality of care or client and nurses' satisfaction.

**Women in Childbirth**

Social Control and Social Support

Throughout pregnancy and childbirth, expectant mothers are considered partners in their care which is delivered according to a plan that they design with their physician. Support persons, including children, can remain in the birthing room. The birth process is kept as normal as possible. Mothers actively participate in all decisions pertaining to labor and childbirth. After the birth, close relatives and support people are permitted into the birthing room with the baby present.

**Environmental Context**

LDRP Rooms

The Center was designed as a cluster system based on the concept of single room maternity care, for labor, delivery and postpartum care. Seven birthing rooms are clustered around a central service core. The birthing rooms are equipped to handle all obstetrical procedures except cesarean births. They are decorated in attractive, individual styles, and each has a shower and toilet, a childbirth
Waryas, continued,

bed/chair, a table and chairs, a dresser and nightstand.

Nursing Stations

The central core contains the nurses station, storage space for equipment, a traditional delivery room and a cesarean delivery room, and a waiting room. Next to the nursing station is a nursery area for infants with special needs.
Part Three: Annotated Bibliography

Wertz, Richard W. and Wertz, Dorothy C.
Lying-In, A History of Childbirth in America.

**Description**

This book integrates the cultural, social and technological events surrounding birth into a comprehensive approach to the history of birth. It explains how changes in gender roles and cultural values interacted with the medical profession as it emerged with its technologies to transform birth from a natural to a technological event.

**Social Trends in Childbirth**

The last two chapters of the book examine the decade of the 1980's and how contemporary women choose to have their babies. Most women today give birth awake and aware in the presence of husbands or another companion, receive fewer drugs, hold their babies right after birth and are likely to breastfeed with the hospital's encouragement. It appears that the consumers' demand for a more humane birthing process has been fulfilled.

Yet most pregnancies and births actually use more kinds of technology today than in the 1970's. This is because most of the participants, (parents, doctors and the general society), have shifted the emphasis from creating a humane birth to producing the "better child". The primary goal of families in birth is to produce the newborn that is unblemished, free of inherited disease and birth trauma.
Women

Women have been increasingly willing to surrender some control over their bodies and some of their aspirations to natural birth by choosing to collaborate with medicine's new birth technologies.

Political Influence on Birthing Environments

An historical review of the movement for free standing birth centers is presented. Birth centers fulfill the desires of middle class women who seek to avoid the hospital but still wish to have medically trained attendants. They also fulfill the need of some of America's 1500 certified nurse-midwives who use the centers as a means for an independent practice. Actually 28% of free standing birth centers are owned and run by physicians.