Managing Labor with Pitocin: Medical Discourse and Decision-Making in Contemporary Clinical Settings

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Managing Labor with Pitocin:
Medical Discourse and Decision-Making in Contemporary Clinical Settings

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ABSTRACT

In this study, I explore how clinical practices and systems of decision-making influence the use of Pitocin during labor in the hospital setting. I study these processes by understanding women’s reflections on their experiences as well as comparing the diverse philosophies of medical practitioners, midwives, and doulas. In using ethnographic accounts of women’s experiences giving birth as a “slice through ‘multiple regimes of truth,’” we can recognize how Pitocin fits into a broader narrative of biomedicine (Delvecchio Good 2007; Foucault 1982). By understanding the broader biomedical context in which Pitocin exists, we can understand how dynamics of the medical system are created and sustained, the implications of birthing in the hospital environment, and the relationships between practitioner and patient. I argue that the factors that influence the current use of Pitocin during labor are a result of the ways in which women giving birth are made to be subjects in hospitals, fitting them into a prescribed medical discourse of illness, treatment, and standardization. In this discourse, the presence of Pitocin normalizes the management of an ideal labor curve, which has emerged through philosophies of actively managed birth. In this thesis, I discuss how protocols, ideals, and subjectivity are integrated into the medical discourse of Pitocin use; I talk about the concept of risk aversion, the implications of other types of medical interventions, the effects of hospital settings, and the process of decision-making as related to Pitocin use. These different aspects of clinical care inform perspectives on the need for Pitocin in individual ways, but they fit into a broader narrative of what constitutes medical discourse through a biotechnical lens.
**INTRODUCTION**

*I think that the first thing to do is to do nothing. That’s the hardest thing to do when you’re a birth attendant. But it’s usually the smartest thing to do, to sit on it and let it go. What’s the hurry? Usually, there’s nothing wrong. The only thing wrong is our expectations* (Certified Professional Midwife 2, 2011).

Physicians are expected to treat illnesses; that is the objective of their profession. They are the experts that manage our symptoms, surgically repair problems in our bodies, and give us medications to cure our diseases. Yet when it comes to childbirth, there is oftentimes nothing to “fix.” Childbirth is a natural process, not an illness that necessarily needs to be treated or stopped unless complications emerge. But if there is nothing to fix, then what is the role of the physician?

The growing influence of medical practitioners’ involvement in the birth process emerged alongside the invention and development of many recent medical interventions. Medications and procedures that are now routinely accepted and used during childbirth did not exist one hundred years ago; it was not until the second half of the twentieth century that they become commonplace in obstetric practice (Wertz 1989). Pitocin itself was not synthesized until the 1950s, and the infamous epidural was not introduced into widespread use until the 1980s. With surgical advancements and shifting ideologies about birth, cesarean section rates have steadily been climbing for the past few decades, now accounting for one third of all deliveries (Block 2007). With the presence of such technologies to help women give birth more efficiently, without the previously accepted degree of pain, and in a more controlled manner, our expectations of what we now anticipate during labor are continually being reinterpreted and reinvented. What we accept to be a “normal” childbirth in contemporary practice is therefore a construction—and a recent one that accounts for the prevalence of technologies and their influences on birthing rituals.

The medication used to induce and augment contractions, Pitocin, was discovered at the turn of the twentieth century and developed in its current state only in the 1950s, yet it plays a central role in the birth experiences of over half of the women who have given birth today (Block 2007). It is
perhaps most well known for its use when inductions are considered necessary and Pitocin is utilized as the means to establish the labor pattern, but many women are becoming increasingly familiar with its use in maintaining progress, intensifying contractions that are already underway, and making labor more efficient. This management of labor is now synonymous with Pitocin, and indications for its use appear pervasive as more and more women are administered the drug. Amidst the increased use of this medication, questions as to its future complications and risks, side effects, and medical necessity has garnered much criticism and controversy (Goer 1995).

In exploring the medical and social contexts of Pitocin use, I found that the dominant narratives of the medication exist in the debate between natural childbirth philosophy and the medicalized childbirth model. With ninety-nine percent of births occurring in the hospital, this debate is centered on the rationale behind medically managed births, and whether this management is effective or necessary in providing positive outcomes in a country that has one of the worst maternal mortality rates among developed countries (Block 2007). In exploring these philosophies and their social frameworks, I have gathered stories that illustrate how these different ideals of the birth experience come into conflict with each other and determine the way that decisions to use Pitocin are carried out.

In this study, I seek to understand how clinical practices and systems of decision-making influence the use of Pitocin during labor in the hospital setting; I explore these processes by understanding women’s reflections on their experiences as well as comparing the diverse philosophies of medical practitioners, midwives, and doulas. In using ethnographic accounts of women’s experiences giving birth as a “slice through ‘multiple regimes of truth,’” we can recognize how Pitocin fits into a broader narrative of biomedicine (Delvecchio Good 2007; Foucault 1982). By understanding the broader biomedical context in which Pitocin exists, we can understand how dynamics of the medical system are created and sustained, the implications of birthing in the hospital environment, and the relationships between practitioner and patient. I argue that the factors that
influence the current use of Pitocin during labor are a result of the ways in which women giving birth are made to be subjects in hospitals, fitting them into a prescribed medical discourse of illness, treatment, and standardization. In this discourse, the presence of Pitocin normalizes the management of an ideal labor curve, which has emerged through philosophies of actively managed birth. I discuss how protocols, ideals, and subjectivity are integrated into the medical discourse of Pitocin use; I then talk about the concept of risk aversion, the implications of other types of medical interventions, the effects of hospital settings, and the process of decision-making as related to Pitocin use. These different aspects of clinical care inform perspectives on the need for Pitocin in individual ways, but they fit into a broader narrative of what constitutes medical discourse through a biotechnical lens.
MEDICAL BACKGROUND AND CONTEXT

Although its particular purpose has been debated especially in recent years, the pharmaceutical drug Pitocin has been a central component of obstetric practice throughout the later twentieth and twenty-first centuries. A Pitocin drip, administered intravenously, regulates the presence, frequency, and intensity of contractions while a woman is in labor, essentially managing a woman’s progress and labor curve. The drug is a synthetic form of the hormone oxytocin, and today it is manufactured in a laboratory and distributed through multiple pharmaceutical companies (FDA 2011). Oxytocin is frequently referred to as the hormone of love for its role in facilitating processes such as bonding, intimacy, sexuality, nursing, and labor. While it has often been perceived as a dominantly female hormone stemming from its intimate relationship with mothering and nursing, it is produced by both sexes and appears, though in slightly different variations, in every species of mammal (Uvnas Moberg 2003).

Oxytocin is released by our bodies to maintain a sense of calmness and attachment. It acts to balance the mind and body by lowering blood pressure and pulse, and reducing stress hormones. Activities such as meditation, nursing, and intimacy tend to trigger this response; after oxytocin is secreted by the pituitary gland, it circulates through both the bloodstream and the nervous system (Insel 1992). The specific implications of the hormone have been more intently studied in recent years as researchers have sought to establish the exact nature of its relationship with the fight or flight response, the production of neurotransmitters such as serotonin, and feelings of love and peace (Uvnas Moberg 2003). But among all of the associations it sustains, oxytocin’s affiliation with childbirth is especially pivotal.

During pregnancy, and particularly towards the end of gestation, the numbers of oxytocin receptor cells in the uterus increase (Insel 1992). It is the secretion of oxytocin that stimulates uterine contractions in a woman’s body, initiating labor and cervical dilation as contractions intensify. The hormone thus regulates the labor pattern, but its other roles, like in facilitating
bonding and reducing stress, are more difficult to isolate during a woman’s labor. Pitocin is of particular interest because of oxytocin’s complexity, including the nature of its role in childbirth beyond the stimulation of contractions. These relationships continue to be researched (Uvnas Moberg 2003). Although Pitocin is often purposefully used to produce uterine muscle contractions, many people still question its consequences and necessity. It is important to note that while I refer to this medication as Pitocin so as to distinguish it from the naturally-occurring hormone, sources cited throughout this paper may refer to it as oxytocin or synthetic oxytocin. In the following sections, I explain the historical and contemporary perspectives of Pitocin as seen through the evolving childbirth practices and customs in the United States.

**Historical Background**

The most influential event in the history of childbirth in the United States was the shift from home births to hospital births in the early twentieth century. Prior to the mid-eighteenth century, women customarily dictated the rituals and practices associated with childbirth. But, with the expanse of medical education and information, particularly during the Enlightenment, male physicians began attending births. Formally trained in medicine, they brought with them a more medicalized perspective of the process of labor. The conventional dynamics of birthing were challenged as this medicalized perception of the event of birth favored the use of active intervention, through drugs and physical instruments, in order to aid labor progress. The increased awareness of medical advancement throughout the eighteenth and nineteenth centuries, coupled with the first presence of men as “experts” at births, initiated an optimistic new perspective about this profound ability of man: to intervene, correct, and control a woman’s labor.

Such ideologies allowed for an easy transition of births from the home to the hospital in the twentieth century. It was at the hospital that the profession of the physician surged in influence, and the use of interventions could be readily incorporated into a standard of care. Hospitals in the 1900s
became places where patients “received” care from physicians, who were well regarded and trusted, as physicians then became the central figures in determining birth procedures (Walzer Leavitt 1986). Such circumstances concurrently set the stage for women’s attempts to reassert their control in the birthing process. Ever since childbirth became hospitalized, there has been resistance to the influences of medical technology and physicians (Wertz 1989). Within the scope of increasing technological intervention, medicalization, and hospitalization during childbirth, we can understand the historical roots of Pitocin’s role in childbirth.

The oxytocin hormone was officially discovered in 1906, when Sir Henry Dale found that the extract of the postpituitary gland in humans was able to augment labor in a cat. It was subsequently named from the Greek roots “oxy” (quick) and “tocos” (birth). Oxytocin accordingly has a long history of association with fast labors (Uvmas Moberg 2003). This association drew wide attention from the greater community, and by 1909, oxytocin was being harvested from cattle in slaughterhouses specifically for the purpose of augmenting labor in women. The postpituitary extract obtained from cattle was put up for sale as Pituitrin, a medication marketed as an alternative to the use of forceps and derivatives of ergot (Block 2007). Forceps had gained popularity in previous centuries as one of the only physical means of intervention available to use during difficult labors. While useful in overcoming problems of presentation and position, forceps were often used too frequently, causing unnecessary harm and complications. Ergot, alternatively, had been used following the discovery that this toxic fungus produced contractions, albeit extremely unreliable and often dangerous ones. It was sometimes associated with fetal suffocation from continual contractions that would restrict oxygen, and it was often misused and given before the full dilation of the cervix. Because it produced such strong contractions, it would cause lacerations as the fetus was forced against the perineum (Walzer Leavitt 1986). These interventions, though they often initiated a host of other problems, were used alongside the prevailing ideologies that favored active involvement and intervention in the birth process so as to manipulate positive outcomes.
Pituitrin, while it too had unpredictable and harmful side effects, was recognized as more dependable than ergot and was embraced by the medical community. After its introduction into the medical market, the diagnosis of “uterine inertia,” or failure of the uterus to contract adequately, increased, which begs the question of whether the possibility of an expedited labor changed the reference for the length of a “normal” labor (Walzer Leavitt 1986). At this time, the drug was administered via injection, which made it difficult to regulate as there was no way to remedy harmful effects once administered. Furthermore, these negative side effects started to become more apparent both to the medical community and the public. Patients sometimes reacted poorly to the animal proteins of the medication. But the most threatening aspect of Pituitrin was that its instability produced contractions that were unable to be controlled. With no way to effectively regulate the medicine, its use led to situations of psychological stress, uterine rupture, hemorrhage, embolism, and even death for the mother and/or the fetus (Block 2007).

In 1928, the Parke Davis pharmaceutical company launched a new brand name, “Pitocin,” in an attempt to dissociate from the negative attitudes that had developed towards Pituitrin. Under this new name, the chemical formula was refined, although its outcomes still remained largely unpredictable. It was not until 1953 that oxytocin was synthetically manufactured in a laboratory under this same name, Pitocin, becoming the first polypeptide hormone ever to be synthesized. This means of manufacturing Pitocin allowed its full integration into the medical system, both because it was economically marketable and because the synthetic nature was perceived positively (Block 2007). This advancement marked a turning point in Pitocin’s history; for the first time, the drug was considered a safe and effective way to regulate labor. Although its use was not particularly well documented (its use was not officially tracked until 1989), studies published during this period indicated that Pitocin was frequently being used not only for augmentation but also to prevent postpartum hemorrhage (McBride 1954). It was at this time that the culture of birth became increasingly complex with the management and regulation of new medical interventions. There was a general
surge in the production of scientific knowledge in the 1950s, resulting in the development of the polio vaccine and numerous other medical advancements (Wertz 1989). The social atmosphere of the decade thus reflected a new confidence in technological innovation in all aspects of life. Eighty-eight percent of births in 1950 occurred in the hospital, and this percentage subsequently rose throughout the decade (Walzer Leavitt 1986).

However, with this drive towards medically managed birth, there was also an greater polarization of perspectives; along with the growing confidence in technology and medical knowledge, a portion of the population began resisting the medicalized process of birth and advocated the philosophy of natural childbirth. This philosophy was first brought into public awareness in the 1940s when Grantley Dick-Read coined the term in his publication *Childbirth Without Fear*. In his book, he argued for women’s innate ability to birth without significant medical intervention (Dick-Read 1959). Natural childbirth was popularized in the following decades through the creation of natural childbirth method classes.

The Bradley Method of natural childbirth was developed by Robert Bradley, a physician, in response to increased intervention in birth; his philosophy advocated natural management of pain through support systems, trust of the body, breathing techniques, and husband-coached labor. Bradley’s book was published in 1965. The Lamaze Technique, developed in the 1940s and popularized in the 1950s and 1960s, likewise sought to provide women with methods to cope with pain and facilitate labor. Women who engaged in these methods sought to dissociate themselves from the medicalized process and reaffirm an active role in their births (Walzer Leavitt 1986). However, even with increased recognition of these natural childbirth practices, the emergence of new medications, interventions, and research continued this trend of medicalization.

There were several defining articles published throughout the 1960s to 1970s that set the stage for more concrete conceptualizations of what “normal” labor was, as well as what role intervention should play. The Friedman curve, which documented the progress of active labor,
became popular among physicians in the 1960s. Emanuel Friedman was an obstetrician who, in the 1950s, began observing and documenting lengths of labor in patients during his rotations (Block 2007). In his publications, he argued that labor averages followed a labor curve of one centimeter per hour during active labor, and that this rate would most often result in vaginal birth as opposed to surgical birth (cesarean section) (Friedman 1969). Although his findings sought only to document averages, this research was largely misinterpreted as defining what one should expect a “normal” labor to look like, thereby categorizing everything else as “abnormal.” His research was viewed through the perspective that this curve should be actively maintained, since labors that did not progress at this rate were somehow unusual (Block 2007; Friedman 1969). Pitocin thus came into play as it was used to regulate the emerging notion of an ideal, standardized labor curve. Following this publication, the diagnosis of dystocia, defined as an abnormal or very difficult birth and includes—as one indication—incoordinate uterine activity, tripled in frequency (Block 2007).

The regulation of labor through the use of Pitocin simultaneously gained widespread attention from a philosophy of care termed “Active Management of Labor.” In 1969, physician Kieran O’Driscoll, along with several other medical doctors, published Prevention of Prolonged Labour in the British Medical Journal, which proved to be a pivotal argument for the use of Pitocin and other interventions during labor (O’Driscoll et al. 1969). This article centered on the idea that prolonged labors create physical and emotional complications for the mom and baby, and advocated the use of active monitoring and intervention to shorten the length of labor.

While the system of active management is complex, the rationale rests of the idea that practitioners take an active role in monitoring the patient, so as to act promptly whenever the need arises (Pates and Satin 2005). This philosophy includes the use of amniotomy, Pitocin, and other interventions to aid progress. Through these techniques, the authors essentially argued that “every woman [should be] delivered within 24 hours” in an actively managed labor (O’Driscoll et al. 1969). O’Driscoll et al did not, however, support the use of Pitocin in all scenarios; the authors outlined not
only in what cases Pitocin should be used, but also contraindications when it should be avoided. The authors also state how the drug should be ideally administered to mimic intensification of contractions and how women should have constant monitoring to prevent misuse. In these suggestions, this article included specific numeric values and how these values should be increased; these suggestions have been continually reinterpreted and applied in many protocols throughout the United States (Pates and Satin 2005; O’Driscoll et al. 1969).

The article *Prevention of Prolonged Labour*, along with other publications at the time, acted as bases for the roles Pitocin would fulfill in what is now considered an “actively managed birth.” More recently, some physicians and researchers have pointed out that current protocols that emphasize “active management” tend to misinterpret this definition, favoring very “aggressive induction protocols, early amniotomy, operative delivery, epidural analgesia, and even early admission to labor and delivery units (Pates and Satin 2005). Such aggressive tendencies are part of the reason that the technocratic model of childbirth has garnered criticism.

This current critique of modern obstetric practices was largely born out of the production of publications over the past thirty years. The late 1970s and 1980s saw the emergence of feminist theory in anthropology, which focused on women’s health and critiqued the hegemonic structure of maternity care and birth rituals established by a male-dominated discipline (Martin 1987). At this time, anthropologies of reproduction and gender emerged through an expanse in medical anthropology interest and research, cementing discussions of birth in the context of broader theoretical frameworks focusing on the central role of these processes in everyday life (Rapp 2001). In 1992, Robbie Davis-Floyd published *Birth as an American Rite of Passage*, which examined the culture of birth not from a feminist perspective, as much literature had, but from a symbolic anthropological perspective. In her book, Davis-Floyd criticized the technical nature the process of birth had taken on, including arguments about how practices like that of prescribing Pitocin had become overused. This publication also made famous the “technocratic” model, a term coined by
Davis-Floyd to illustrate the perspective of the human body as a mechanical operating system (Davis-Floyd 1992). By drawing in the symbolic associations of birth practices in the hospital, Davis-Floyd explored the role of birthing options and the way birth in the hospital continued to be normalized and sanctioned.

Works published by natural birth advocates such as Ina May Gaskin and Henci Goer during this period also tapped into critiques of relying on technologies to birth, and brought to the mainstream the idea that women can have better birth experiences by relying on non-medical methods, like by hiring a doula and avoiding medication (Gaskin 1990; Goer 1995). With a continually rising rate of cesarean section, in addition to other statistical indicators that reflected the use of medical technology, the attention on this issue only intensified. Much attention was drawn to the statistical outcomes of births in the US, which, compared to other countries with similar socio-economic statuses, were weak. The medicalized system of childbirth was attributed in part to this lack of better care (Block 2007). But at this time, the medical system of the United States as a whole came under greater scrutiny as medical ideologies were compared to those of other countries, and the more “active” or “aggressive” nature of these medical ideals were made transparent (Payer 1988). These recent critiques, both of maternity outcomes and the practices of obstetric care, set the stage for contemporary conflicts about the management of birth.

**Contemporary Context**

Today, births tend to be actively managed, in the sense that intervention is common and often favored throughout the labor process (Block 2007). Pitocin is currently the most commonly used medication in labor, and for this reason, its name is widely recognized even among women who have not yet given birth (Varney 2004). As Pitocin has long been associated with the medicalized model of childbirth, so too have procedures like cesarean sections, epidurals, amniotomies, vacuum and forceps, and cervical ripening agents. While the practice of episiotomies has declined in many areas
of the United States, the use of other technocratic interventions has remained constant and even risen in recent years. Cesarean sections are currently estimated to occur in about one third of all births with a rate of thirty-four percent. This trend has lead scientists, anthropologists, journalists, and women to question the underlying reasons for this increase. One hypothesis is that because up to fifty percent of labors that result in cesarean section can be attributed to dystocia, the rising prevalence of cesarean section is a product of ideals about the length of a normal labor (Block 2007). Some researchers have also speculated that evolutionary changes, such as growth in fetal head size, are responsible for the cesarean section trend (Goer 1995). Others, still, maintain that cesarean sections are used as a risk-aversion strategy and are performed when any complication emerges. Because surgical birth is doctor-friendly and economic, these researchers uphold the belief that the line is often blurred between immediate medical necessity and elective surgeries, driving the movement towards cesarean section (Ponte 2007).

The cesarean section rate is often cited as the most prominent example of technocratic birth. But technocratic birth is not limited to surgical birth. Epidural anesthesia has become so common that it is used in approximately eighty percent of births today. Epidurals have a complex relationship with Pitocin, one that is often seen as codependent (Buckley 2005; Block 2007). Cervical ripening agents, commonly Cervadil, Cytotec (Misoprostol) and the Foley catheter, are often employed to initiate inductions prior to the use of Pitocin even though their use for this purpose has been debated (Goer 2002). Cytotec (Misoprostol), for example, is not approved by the FDA for use in cervical ripening during inductions (Haire 2001). Still, both the numbers of inductions and the reasons for induction have risen in recent years, and these drugs are offered as the most effective means for inducing labor (Goer 2002). The standards for birth, as seen in hospital protocols, statistics, and birth stories, are now made to account for intervention as the norm rather than the exception.

Not all women, or practitioners, adhere to this model of intervention during labor. Women who want a natural childbirth might choose to give birth with a midwife rather than an obstetrician if
this option is available to them. Midwives generally ascribe to more of a holistic, natural method of care. Certified nurse-midwives are becoming more popular and more widely accepted in the hospital setting or in birth centers, while certified professional midwives often facilitate care for women who want to birth in their own homes (Block 2007). In the Midwifery Model of Care, birth is perceived as a natural process requiring less intervention, whereas in the medical model birth is often something to be “managed” (Gaskin 1990). Home births have slowly become more accepted as an alternative to hospital births, especially with the release of The Business of Being Born and other prominent documentaries and publications that illustrate the validity of birthing at home and challenge the idea that births have to happen at the hospital (Epstein 2008).

These sources emphasize how statistics have shown that for normal, low-risk pregnancies, midwifery care at home can prove to have as good or better outcomes than those taking place at the hospital. However, this option is not always accessible. Certified professional midwives are regulated by the state, and currently home birth midwifery is only allowed in twenty-seven states (Block 2007). Women’s choices for birth are then determined by their location. Where a woman lives establishes not only whether she can choose to have a home birth, but also what hospitals or birthing centers she can go to. In Boulder County, for example, there are no birth centers; women have the options to birth either at home with a midwife or at the hospital.

Insurance also comes into play to affect these decisions. Home birth midwives are not generally covered by insurance; the choice to have a home birth is therefore limited to those who can afford to pay at least part of the cost out-of-pocket. Women are further constrained by which hospitals and medical practices accept their insurance. These factors affect not only where women birth, but also what kind of birth they have. Although women are seen to have choices in determining their birth experiences, these choices are often dictated by external factors.

For women who want to avoid medical intervention but want (or need) to birth in the hospital, the option of having a doula has become more popular in recent years (Albers 1991; Goer
Doulas provide continuous non-medical emotional and physical support to women in labor, adhering to the philosophy that women benefit from the support of other women to help mitigate pain and navigate the psychological challenges of labor. Women might choose to hire a doula in a hospital birth setting to help them cope with pain management in order to avoid an epidural or other interventions. Doulas are frequently hired to act as a mediator between the hospital staff and the woman and her partner, to help them understand their decisions through the process and to serve as a patient advocate (Davis-Floyd 1992; Block 2007; Goer 1995). However, doulas are also an out-of-pocket expense that many women cannot afford.

The current statistics regarding Pitocin use are varied. Over half of the women who have given birth have had Pitocin during inductions or augmentations, but this does not include the use of Pitocin in third stage labor. These statistics are difficult to establish in part because its use is not necessarily recorded in a patient’s history. Furthermore, there are no consent forms that are required for a practitioner to have a patient sign, which can raise the issue of informed consent. Pitocin rates are reported by individual hospitals; we can therefore see trends in data to show how hospitals diverge in rates of use. According to studies conducted at different hospitals, eighty-one percent of women received Pitocin at some point in their labor, while another claimed that this rate is closer to forty percent (Davis-Floyd 1992; Block 2007). These numbers beg the question of what is accounting for such different rates of use. And while it is difficult to get accurate statistics about how often Pitocin is given to patients, it is even more challenging to identify statistics that reflect specific details like for what use it was given, when it was given, or how much was used.

**Medical Context of Pitocin**

Today, Pitocin is prepared synthetically. It is manufactured by JHP Pharmaceuticals, King Pharmaceuticals, Inc., Parkedale Pharmaceuticals, Inc., and Monarch Pharmaceuticals (Haire 2001). The FDA description of Pitocin made available to the public reads:
Pitocin (oxytocin injection, USP) is a sterile, clear, colorless aqueous solution of synthetic oxytocin, for intravenous infusion of intramuscular injection. Pitocin is a nonapeptide found in pituitary extracts from mammals. It is standardized to contain 10 units of oxytocic hormone/mL and contains 0.5% CHlorobutanol, a chloroform derivative as a preservative, with the pH adjusted with acetic acid. Pitocin may contain up to 16% of total impurities. The hormone is prepared synthetically to avoid possible contamination with vasopressin (ADH) and other small polypeptides with biologic activity. Pitocin has the empirical formula C_{43}H_{66}N_{12}O_{12}S_{2} (molecular weight 1007.19) (FDA 2009).

Pitocin is often diluted in a saline solution and administered intravenously as “mu/min,” or milli-units per minute; one of the reasons it is used so frequently now is due to its ability to be accurately titrated, administered, and monitored. It may be injected intramuscularly, but because it is less easily regulated through injection, it is only administered in this form in emergency situations when there is no IV port. This scenario usually only occurs during third stage labor (National Institute of Health 2007). Although it is indicated for use when induction or augmentation is medically necessary, Pitocin is not currently approved by the FDA for use in elective inductions or elective augmentations (FDA 2009, Haire 2001).

When Pitocin is administered, the uterus responds rapidly and contractions occur almost immediately. The drug enters the bloodstream and circulatory system of the fetus through the placenta when given to the mother. However, the half-life of the medication in the plasma is between one and six minutes and it is removed quickly from the plasma by the kidney and liver. Because it enters and exits the body quickly, it can be more precisely regulated. Currently, Pitocin use is broken down into three principle uses: induction, augmentation, and management of third stage labor (Tharpe 2009; Block 2007). These different uses and their implications are discussed below.

Induction

Induction of labor is the process through which labor is artificially initiated by the use of medical intervention(s) (US National Library of Medicine 2009). Labor may be induced for a number of reasons, both medical and nonmedical. Often it is the development or risk of complications, most notably preeclampsia, hypertension, gestational diabetes, presence of infection,
and postdate pregnancy that commonly bring about the need for an induction. With these kinds of complications, the risk to the mother or fetus is considered to be great enough that induction is favored over continuing the pregnancy normally (American Pregnancy Association 2007). Postdate, or post-term, pregnancies are classified as pregnancies extending beyond the forty weeks of gestation that mark the due date. Some evidence suggests that there is a correlation between prolonged gestation and an increase in maternal or fetal complications, which has led to the widespread accepted wisdom that all births at forty-two weeks must be induced or delivered via cesarean section; in some cases, practitioners might induce at forty or forty-one weeks (Roos et al. 2010). These policies are largely dependent on the particular hospital and practitioner.

However, researchers like Henci Goer have criticized this methodology by questioning the accuracy of the due date model, arguing that the results of cited evidence are not significant enough to warrant induction, and contending that the medical management of postdate pregnancies leads to further complications (Goer 1995). Women may also be induced without a medical reason, although different hospitals and different practitioners have divergent views on this practice. Women might elect to have an induction as a result of physical discomforts or a want to schedule the birth (US National Library of Medicine 2009). It is rare that elective inductions are allowed before thirty-nine weeks if there is no risk to the mother or fetus, although this practice is largely at the discretion of the practitioner (Physician 1, 2012).

Prior to an induction, doctors and midwives often use a Bishop’s score to determine if the cervix is favorable (Tharpe 2009). In an induction, the practitioner often admits the patient to the hospital and starts the process with a cervical ripening agent to achieve a higher bishop’s score. According to Helen Varney, the lead author of Varney's Midwifery, “Use of the standard oxytocin protocol with the parturient who has an unripe cervix is unsuccessful in leading to a vaginal delivery in approximately one-half of the women who are induced by this method” (Varney 2004: 726). Inductions thus have been shown to correlate with increased cesarean deliveries.
Cervical ripening agents are often the primary means of achieving a “favorable” cervix, which precedes the administration of Pitocin (Klein 2009). When patients start receiving doses of Pitocin, they will often be administered “an initial dose of 2mu/min, which is increased in increments of 1-2mu/min at 30-minute intervals” (Varney 2004). These numbers, however, only represent a hypothetical situation. Varney goes on to explain that while established procedures are often similar to this example, being that they start at a low dose and are increased at certain intervals, they may differ depending on the protocols and practices individual hospitals and practitioners adhere to (Varney 2004). Even as protocols about Pitocin administration are debated, particularly concerning their relevance to the specific clinical picture of each patient, hospitals tend to employ some sort of standardization of induction procedures. In inductions, women are generally on a Pitocin drip throughout the entire process, unless the mother or baby has a poor reaction to the medication or a woman’s body starts having noticeable contractions on its own (King 2011).

**Augmentation**

According to Tekoa King, “Medical augmentation of labor is a decision based on the clinical evaluation of the adequacy of uterine activity to promote cervical dilation and the pace of cervical dilation” (King 2011). In these instances, practitioners try to augment labor that has already begun naturally, for reasons relating to the efficiency of contractions or maintaining a certain progress with labor. Usually in these circumstances, the cervix has not dilated within a given amount of time, nor have contractions increased in frequency or intensity. According to *William’s Obstetrics*, the administration of Pitocin should occur when “hypertonic uterine dysfunction” is diagnosed; this essentially means that the practitioner observes that the uterus has become ineffective in achieving labor, with labor defined as contractions that produce cervical dilation (Cunningham et al. 1997). However, the frequency of Pitocin use raises the question of whether or not hypertonic uterine dysfunction is truly occurring in cases where Pitocin is administered. Today, “failure to progress,” or
dystocia, has become synonymous with Pitocin use, and instances in which this diagnosis is made are on the rise (Buckley 2002).

**Third Stage Labor**

Third stage labor, which lasts ten to fifteen minutes on average, is defined as the stage of childbirth that begins right after the baby is born up until the placenta is delivered. Contractions continue in this stage in order to expel the placenta and are instrumental in stopping bleeding. This period immediately following the birth of the baby can prove to be one of the most difficult parts of labor from a clinical perspective, as hemorrhaging can occur quickly. Pitocin in third stage labor is thus used to prevent postpartum hemorrhage by enabling the uterus to “clamp down” more efficiently (Prendiville et al. 2007). In this case, Pitocin is either allowed to flow through an IV, or, if the patient does not have an IV port, it can be given through an injection. Active management of third stage labor advocates that the practitioner administer Pitocin before delivery of the placenta. This philosophy is often contrasted with expectant management of third stage labor, which entails a more moderate involvement (Rogers et al. 1998). In expectant management, the placenta delivers spontaneously, but the delivery can be assisted through gravity, nipple stimulation, massage or Pitocin if deemed necessary (Prendiville et al. 2007). Current research often pushes active management as a standardized preventative measure to control bleeding and offset the risk of hemorrhage (Gulmezoglu et al. 2001; Rogers et al. 1998).

**Pitocin’s Controversy**

The arguments about Pitocin use are often situated in the perspective of the debate between the natural childbirth and medicalized childbirth models. In this context, Pitocin has become politicized and controversial in the sense that it is used to inform perspectives on how and why physicians intervene in childbirth. While many people perceive Pitocin as a useful tool that can prevent the development of complications and contribute to labor progress, it is frequently regarded
with caution, particularly among patients and those who advocate the philosophy of natural childbirth. These perspectives have developed simultaneously from its widespread and frequent use, as well as in response to its implications and side effects. Pitocin is known to intensify pain during contractions, which is one of the most immediate reasons why many women want to avoid it (Davis-Floyd 1992). But these concerns go beyond the physical. Increased pain means that a woman might need further intervention. Because there is often a link between the use of Pitocin and epidurals, women who want to have a natural childbirth and avoid an epidural may resist Pitocin (King 2011).

As with any drug, Pitocin has the potential to initiate a range of responses and effects in the body of both the mother and the fetus. Two of the most common complications from the use of Pitocin include uterine hyperstimulation and fetal distress (which is often precipitated by uterine hyperstimulation). This effect occurs most often in inductions. In these cases, higher doses of Pitocin are required to strengthen the pressure of contractions in order to manage the labor curve, because the initial doses instigate the presence of a labor pattern altogether (Goer 2002). Of ten studies, it was shown that “at the higher [Pitocin] dose, hyperstimulation rates ranged from 13% to 63%, and half reported that 25% or more of the women experienced hypertension” (Goer 2002). Because hyperstimulation can result in fetal distress, which is grounds for cesarean section, this relationship of Pitocin use and cesarean section has been debated. Some people, often practitioners, argue that labors necessitating Pitocin use are abnormal and high risk to begin with, and therefore contend that this correlation is a result of births that are already more challenging (Physician 1, 2012). Others maintain that Pitocin itself creates further complications that require medical intervention through surgery. One concern that is attributed to hyperstimulation of the uterus is that the increased pressure of contractions constricts oxygen. The blood and oxygen supply to the fetus is reduced during contractions; if contractions occur too quickly or intensely and do not allow for re-oxygenation, the fetal heart rate could drop or the fetus could develop complications (Davis-Floyd 1992).
Hyperstimulation and its associated effects are some of the more recognized side effects of Pitocin use. But according to the FDA, use of Pitocin can lead to the following adverse effects in the mother: water intoxication, anaphylactic reaction, postpartum hemorrhage, nausea and vomiting, hematoma, cardiac problems, hypertension, and uterine spasm or rupture, among others. These complications can cause other problems: for example, severe water intoxication may induce a coma state. For the fetus, the presence of Pitocin could lead to damage of the central nervous system or brain, seizures, jaundice, retinal hemorrhage, low Apgar scores, or death (Haire 2001; FDA 2009; National Institute of Health 2007). The drug information of Pitocin lists a number of contraindications and precautions about scenarios that increase the likelihood of complications.

Specific protocols have been developed in order to prevent the misuse; misuse of Pitocin has been an indicator in the development of some of these complications (Varney 2004). These protocols include procedures about starting the Pitocin drip at a low dose and increasing it only gradually over a set period of time, in addition to continually electronically monitoring the fetus (Goer 2002). This monitoring, in combination with the fact that being administered Pitocin means the mother is continuously hooked up to an IV, means that mobility is limited. Women on a Pitocin drip may not be able to walk around, labor in water, or interact with their bodies to facilitate labor in ways they otherwise might (Davis-Floyd 1992). Some hospitals, in response, have implemented telemetry technology that allows for women to be able to move around during labor while still being monitored (Block 2007). However, this practice is often only employed at more “progressive” hospitals that tend to encourage natural childbirth philosophies.

One of the most commonly cited arguments against the use of Pitocin during labor is that there have been few studies done to determine the long-term effects of the drug. Part of the reason for this lack of research is that specific effects are difficult to trace given the number of variables present during the birthing process and how relatively new the drug is. The drug information states that “there are no animal or human studies on the carcinogenicity and mutagenicity of this drug, nor
is there any information on its effect on fertility” (FDA 2009). This lack of identifiable research has drawn criticism from patients. As with any medication, there is also the risk of negative interactions when used in combination with other drugs. Cyclopropane anesthesia, for example, has been shown to produce cardiovascular changes resulting from its interaction with Pitocin.

More recent studies about potential long-term effects of Pitocin include research on autism. Several researchers have posited the idea that there might be a connection between Pitocin inductions and autism, an opinion that has gained much widespread attention given the surge in autism diagnoses in recent years (Hollander et al. 1998). But research differs on this issue. In 1998, Hollander et al. published a study that suggested there were “increased rates of Pitocin-induced deliveries in children later diagnosed with autism” (Gale et al. 2003: 206). This study attracted much media attention and concern from the community; nevertheless, others studies did not replicate this same finding. But these studies have still implied that perhaps, “Pitocin itself is not a risk factor for autism, but that its administration is correlated with some factor that puts the fetus at risk for later developmental problems, such as obstetric complications or genetic vulnerability” (Gale et al. 2003: 207). The idea that there might be some relationship between Pitocin use and autism is commonly debated not only in the scientific community, but also by expectant and current parents.

This relationship has garnered attention from the community predominately because of the nature of Pitocin as a synthetic form of oxytocin. As discussed, oxytocin is a hormone with a strong social component, since it is intricately involved in behaviors like nursing, attachment, intimacy, and bonding (Insel 1992; Uvnas Moberg 2003). Because autistic children have reduced levels of oxytocin in their plasma and higher levels of oxytocin precursor peptides, literature has proposed there to be a failure in normal oxytocin processing (Gale et al. 2003). Hollander argues in his study that Pitocin induction, which produces high levels of synthetic oxytocin, could cause this decreased regulation of oxytocin receptors in the fetal brain at birth, thereby making the child more susceptible to autism (Hollander et al. 1998). Other researchers have pointed out that Pitocin initiates a negative
feedback loop in the brain. Buckley argues that because of the presence of Pitocin in the body, oxytocin receptor cells signal the brain to stop the secretion of oxytocin (Buckley 2002). This system of negative feedback means that the mother and perhaps the fetus are not producing adequate levels of oxytocin, which could implicate complications with bonding or other psychological effects. However, little research has been done on this matter (Epstein 2008).

Many researchers have questioned the extent to which Pitocin use is immediately and medically necessary. The classification of complications such as hypertension and preeclampsia, which often necessitate induction and Pitocin, has been questioned as those who fall on the verge of what is considered preeclamptic might still be induced (Goer 1995). In these cases, the use of Pitocin during an induction might be considered a more preventative measure. It is in these ways that inductions are perceived as the cure for potential complications that occur towards the end of pregnancy. Similarly, the “active management” philosophy propelled by O’Driscoll is very much a prevention technique advocated to avoid the development of complications (O’Driscoll 1969). In augmentation, subjectivity of the practitioner as to when to offer Pitocin has raised concern about whether it is fundamentally needed or simply used to advance labor. The same holds true for Pitocin’s use in third stage labor; in active management care, it is given universally to prevent postpartum hemorrhage, regardless of whether there are any indicators that postpartum hemorrhage may occur (McBride 1954). In such scenarios, women and practitioners alike question whether Pitocin is a drug used out of necessity or convenience.

Although Pitocin is one of the most commonly used medications in labor, evidence about its potential complications and its relationship to oxytocin have led many people to be wary of its routine use in labor (Varney 2004; Goer 2002). While many patients are concerned about side effects and long-term consequences, many also question the medical necessity of the drug and why it has become so present at births over the past twenty years. Although Pitocin’s use can reduce complications from difficult labors, the very definition of dystocia, and what “normal” and
“abnormal” labors look like, continues to be debated. Through the growing instances of induction and “failure to progress” cases, patients have questioned whether Pitocin is merely a drug of convenience for the timetables of physicians or for women who wish to schedule their child’s birth. As Henci Goer writes, “If 40% of women need oxytocin to progress normally, then something is wrong with the definition of normal” (Goer 1995: 84). By looking at how we categorize complications and the use of Pitocin, and understanding the current controversies about the medication, we can start to understand these trends in greater depth.
DESCRIPTION OF STUDY

In this study, I seek to understand the complex systems of decision-making and the factors shaping the use of Pitocin during labor, as well as its implications on patients in the hospital setting. I draw upon an analysis of my own fieldwork conducted along the Front Range of Colorado while taking into account historical and theoretical perspectives about maternity care and the “technocratic” model of childbirth care that exists in the United States (Davis-Floyd 1993). The use of Pitocin in itself is one component of an increasingly complex system of medication and medical intervention that characterizes obstetric practice. It is by understanding this context in which Pitocin exists that we can begin to understand the dynamics of the medical system, birthing in the hospital environment, and the relationships between practitioner and patient that are shaping its use. In order to situate my study in this context, I have examined historical trends, social responses, and changing medical practices that reveal these evolutions in childbirth practices. I have integrated this study of Pitocin with examinations of other interventions, like epidurals and C-sections, not only to determine their relationship with Pitocin use but also to describe Pitocin within overarching trends in intervention use and their established necessity in obstetric practice. I take into consideration theoretical perspectives concerning medical anthropology in order to frame the results of my fieldwork in these evolving medical contexts. Drawing on the research and analyses of contemporary anthropologists, I have chosen to employ a primarily Foucauldian perspective in my analysis of Pitocin use.
RESEARCH METHODOLOGY

The fieldwork carried out for this study focuses on participant observation research methodology, done through my interactions with different individuals to gather a collective understanding of the dynamics of Pitocin use during childbirth. I conducted interviews with thirty-two individuals who have experienced the use of Pitocin as practitioners, receivers, and third party observers. I spoke with nineteen women who had given birth in the past twenty years, many of whom had been given Pitocin at some point during labor. I spoke with three physicians and three nurses, all of whom had specialties in labor and delivery, about the clinical use of Pitocin and the constructs of decision-making, patient interaction, and protocols. I spoke also with three midwives, two of whom were Certified Professional Midwives and one of whom was a Certified Nurse-Midwife, about these issues. I spoke with four doulas about their roles in childbirth, their approaches to care and intervention, and their observations as witnesses to these processes. Due to the nature of this subject matter, and the very personal stories that were related to me, the names of all individuals interviewed are anonymous in this thesis. For most quotations, I have numbered the interviews (i.e. Physician 1), but for a select few whose stories I talk about in greater depth, I have created pseudonyms.

I began interviews in November of 2011 with individuals whose names I had been collecting from people I knew in the Boulder community. These initial interviews served partially to help me set up further connections, and also allowed me to establish myself as a researcher. Each interview provided me more references I could contact; I would end each meeting by asking whom else I might benefit from speaking with. Through this pattern, I was able to establish credibility with many individuals I contacted. In my interviews with patients, I also wanted to stretch beyond the traditional scope of personal references so as to get as much diversity of experience as I could. In December, I was able to get in touch with women who had given birth with Pitocin by identifying local community groups for moms. I posted on “Boulder Rockin’ Moms,” an Internet support group
for moms in the greater Boulder community, as well as on a board at the Yomama Yoga Studio in South Boulder. In these postings I briefly explained my study and asked women interested in participating to contact me. Through this method, I was able to talk to women with a great diversity of experiences, stories, and perspectives. I carried out interviews until mid-January, 2012.

I conducted these conversations at coffee shops, in workplaces, and in conference rooms. In a few cases, when meeting in-person proved too difficult because of distance and schedules, I spoke with people over the phone or through video calls. However, I carried out most meetings in-person because I felt that these interactions provided a stronger opportunity to develop a personal relationship and an understanding of each individual. The individuals I spoke with live in the Boulder community, Denver metropolitan area and greater Front Range of Colorado, although some carried with them and shared experiences from other locations. These meetings, which lasted between thirty minutes and two hours, were recorded by digital recorder and later transcribed.

To establish individual and purposeful relationships with those I interviewed, I initiated meetings by explaining my purpose in my research, and by going through the informed consent form (Appendix A). Although I offered no incentives to participate in my study, most people were compelled to talk to me because of personal interests in the topic and a desire to express both positive and negative experiences. While each interview was carried out differently, depending on whom I was interviewing, I often structured the interviews in much the same way. I drew upon my research and experience to form questions independent to each individual, centering on how decisions about the use of Pitocin might be characterized and carried out, how relationships are developed in a clinical setting, and what roles protocols and individual circumstances play in its use.

I asked women to openly share the entirety of their birth story with me. In my questions, I tried to understand as fully as I could what was understated—not just what women experienced, but why they chose or did not choose to make certain decisions throughout the process, what compelled them to engage in certain actions or non-actions, who they trusted, and who they did not. I wanted to
know what knowledge women had about Pitocin before giving birth and after, and how they conceptualized its use in their labor. I often spoke with women about other births they had had, and births they plan to have, to get a sense for how their perspectives have changed or might be changing. When I spoke to medical professionals, I not only asked them about their common practices and protocols, but I also tried to understand how their personal philosophies influenced their clinical experiences and decisions. I asked for their interpretations of patients who accepted or resisted certain forms of care. In my interviews with doulas, I wanted to understand how Pitocin use has been witnessed. I wanted to get a sense of how they might support their clients, how they came to understand their clients’ desires, and where their roles in the medical setting were supported or constrained. I asked for their interpretations of experiences in different locales and with different medical professionals, since many of them had practiced in multiple settings according to where their clients chose to birth. Because this study seeks to understand both the individual and collective experiences of Pitocin use, each of these perspectives, from the patient, to the practitioner, to the doula, is central to my research.

While I have used the word “patient” here to refer to a woman who has given birth, I frequently use the words “women” or “woman” when discussing the individuals I interviewed. While the word patient is useful to delineate the affiliations women have in the hospital setting, to elucidate their relationship with the practitioner, and to convey the subject position of the woman giving birth, it also takes away from the humanism of this research. It puts women solely in the role of being passive “receivers” of care rather than as individuals actively taking part in their birth experience. It also limits them to the context of when they were in the hospital, isolating this experience rather than understanding the entirety of it. While “patient” may be an effective way to communicate these relationships and separate these women from the practitioners and doulas I interviewed, it is important for the purposes of this thesis to note the implications that this label carries with it. When I use this term, it is deliberately to highlight this subject position.
By using qualitative methodology to synthesize and evaluate individual experiences, I am able to theoretically interpret the implications for how and why these patterns occur in clinical scenarios. This discussion allows for the issue of Pitocin use to be explored in ways that would be lost in quantitative analyses. Throughout this process, I have done my best to understand the positions of each person I interviewed, to assess the ways in which different variables contribute to the use of Pitocin, and to discover how its use is incorporated into the patient experience of birth. By including individual and diverse narratives about this medication, I hope to cultivate an understanding of Pitocin use as it relates to historical, contemporary, and theoretical perspectives about medical interventions and power dynamics during childbirth in the hospital setting.
FINDINGS AND DISCUSSION

As ethnographic research has often demonstrated, the way that social meanings are constructed has everything to do with the way people interpret human experience. It is for this reason that I have chosen to situate my research in the experiences of women, doulas, and medical professionals to discuss the processes that contribute to Pitocin use in clinical settings. I have combined my findings with my discussion because I find that these two elements of analysis are intricately connected to one another. I begin this section by situating my findings in relation to the socio-cultural backdrop of Boulder and discussing in detail the experiences of four women. From here, I move into a discussion of the different aspects of clinical care that shape the use of Pitocin. This discussion draws on the use of Pitocin from historical and medical perspectives to discuss how the experiences of women, doulas, nurses, midwives, and physicians embody the following collective themes: the application of protocols, ideals, and subjectivity; the notion of risk aversion; the relationships between medical interventions; the dynamics of the hospital environment; and finally, the establishment of clinical relationships and its effect on decision-making.

As I embarked on more and more interviews, I found that many of the women with whom I was speaking had adopted more of a natural childbirth philosophy, and they had planned for a hospital birth with little or no intent on having intervention. Some of the women had hired doulas to be present at their birth, while others had participated in Bradley Method or Lamaze classes. Most had tried to educate themselves about their birthing options as best they could. But not every woman wanted a natural childbirth; some planned for epidurals and were open to the use of other interventions. Most were amenable to intervention only if it was considered absolutely necessary, because they wanted to do whatever was best for the health of the baby. Amidst this concern and the need for precaution, natural childbirth still seemed the ideal vision of labor. As I interviewed more practitioners, I found that this trend was not limited to the women I was speaking with. Many medical professionals and doulas referenced that their clients and patients in Boulder were interested
in natural childbirth philosophy, that they questioned the need for intervention, and that they purposefully incorporated natural childbirth practices into their birth plans.

Boulder and its surrounding area provide an setting that is unique in this sense—a setting which juxtaposes the desire for women to want more natural childbirths in an era when medical intervention is commonly accepted. As I differentiated the experiences people have had and uncovered the attitudes of medical professionals who work in different settings, I found that the institutions of hospitals seemed to reflect values similar to the populace they serve. Boulder Community Hospital at Foothills did not, for the most part, evoke the same degree of technocracy I found referenced in so many bodies of literature. Rather, this hospital seemed to be more committed to natural birthing methods by providing options like birthing tubs, telemetry, and childbirth classes that emphasized natural birthing. As I interviewed women who had given birth elsewhere, doulas who had had clients in different counties and hospitals, and practitioners who practiced in other settings, I noticed that these attitudes diverged more towards an active management philosophy of care, even in locations as nearby as Louisville, Lafayette, and Fort Collins.

It is in these contexts that I am grounding my discussion of the use of Pitocin during labor: to see its acceptance and refusal as a part of the larger narrative of medical norms, continually influenced by the subjectivity of practitioners, philosophies of care, and settings. While not every woman I interviewed initially wanted to avoid intervention, the trend towards natural childbirth philosophy among the patient population in Boulder is significant. The perspectives in this ethnography accordingly reflect the way that the contesting ideals between natural childbirth and medicalized childbirth, in principle and in practice, appear throughout the Front Range of Colorado.

I have chosen four birth narratives that together can represent the collection of birth experiences I encountered and can further provide compelling examples to start my analysis. Each story I have chosen reflects themes that resonate throughout all of my interviews. While it is impossible to convey the details and circumstances of each birth story I heard, portraying four
women’s experiences in more depth can offer a more comprehensive framework through which to explain the concepts highlighted in my discussion. Although I apply these case studies to illustrate the ways these processes unfold throughout an entire birth, I bring testimony from all of my interviews into this analysis. I have also interviewed medical professionals and doulas as a central part of my research, but I find that it is individual experiences that make clear how these generalized clinical practices are put into effect and what their social implications are. I use the experiences and philosophies of medical practitioners and doulas to then inform and interpret the birth events of individual women.

Four Birth Stories

Nicole

Nicole’s water broke twelve days before her due date. She had hired a doula, but because her water broke so early (and so unexpectedly), the woman she had hired was out of town and unable to be reached. She hadn’t yet gone into labor, so she called her obstetrical practice, Boulder Women’s Care, at Boulder Community Hospital at Foothills. The nurse she spoke with told her, “‘Ok, wait a few hours and if and when labor starts, come into the hospital. If it hasn’t started by 8:00pm tonight (and it was about 4:30pm at that point) come in and we’ll check you to see what’s really going on’” (Nicole, 2012). When Nicole’s husband got home from work, they tried taking walks to see if she could stimulate her body to produce contractions. But as time passed, nothing happened. They went to the hospital that evening, where it was confirmed that amniotic fluid was indeed present. But because contractions still had not begun, they sent her home with instructions to come back no later than 8:00am the next day if she continued to not experience any signs of labor.

When she got home, Nicole contacted a back-up doula who was affiliated with the doula she hired. The doula told her that if she went back into the hospital the next morning without any signs of labor, she would be induced. Nicole, who hoped to have a natural childbirth and wanted to avoid
any additional intervention during her labor, knew she didn’t want an induction. But by the next morning, nothing had changed, and she again called her back-up doula. The doula explained to Nicole that in the hospital setting, a woman usually has twenty-four hours from the time her water breaks to the time that she will be given a C-section if she has not been fully induced; this protocol sought to avoid the risk of infection. Still unsure how she felt about an induction, and with no signs of labor, Nicole decided to wait longer before going into the hospital. Instead, the doula came to her house at 10:00am and offered her natural remedies to initiate contractions. She said,

At about 11:00am, the hospital starts calling and says, “You have to come in.” And I said, “Well no, I’m with my doula and I think it’s fine, I’d really like to do most of the laboring at home and nothing’s started.” That’s when the hospital started saying “You’re putting you, yourself and the baby at risk—at serious risk—because of infection. You have to come in.” That’s a terrifying thing for medical professionals to tell you, and so we said okay, and we jumped in the car and drove to the hospital. Within fifteen minutes of parking in the hospital they had me hooked up to Pitocin (Nicole, 2012).

The nurse gave her a large dose to start with, but she couldn’t recall the amounts. The doula told her the nurses and doctor hoped to jumpstart her labor, given that it had been so long since her water had broken. Despite this increased dose, nothing happened for hours. Her body resisted labor.

It wasn’t until six hours after they started her on Pitocin that the nurse increased the dose to an amount that started producing contractions, which quickly turned uncomfortable. Because she wanted to avoid an epidural, Nicole continued to try natural methods with her doula to get her labor to progress. During this process, she was given an amniotomy. She told me that she was completely baffled by the need for an amniotomy; she said, “I thought that was ridiculous. The only reason why you’re doing this (inducing me) is because my water broke” (Nicole, 2012). The obstetrician told her that what had probably happened was that she had had a small tear in her bag of water, which had since resealed itself. So even though she was being induced because her water broke, the practitioner still had to break her water to get her contractions to progress.
Because the hospital staff was so concerned about infection, Nicole wore an external fetal monitor that prevented her from moving around the hospital. She had wanted to be able to labor outside and in the birthing tub:

There was one balcony we could get to that was outside, but as soon as we entered there the baby’s heart monitor stopped working so they wouldn’t let us stay for more than ten minutes out there. Unfortunately when I was outside, my labor progressed really well and as soon as I would come back inside it would slow back down. If they put me in the bath, my labor would progress really well. It would progress, progress, progress, and they would say, “Ok, we’re ready to start pushing,” and they’d pull me out, check, and I wouldn’t be dilated enough so we’d do the whole thing over again (Nicole, 2012).

By this point it had been about thirty-eight hours since her water had broken. She hit the transition point at this hour. She described the feeling of transition as though she was losing her grip on her sanity and losing all control. She told me that at this point, she gave in to the feeling that she could no longer control the process and started screaming that she wanted an epidural. Even though it was 4:00am, the staff called in an anesthesiologist who gave her the anesthetic. After the epidural, her nurse noticed that when she was lying on her side, the baby’s heart rate would go down; they found out later it was because the umbilical cord was wrapped around the baby’s neck and it would tighten at certain angles. But without this knowledge at the time, they monitored her closely to ensure that there were no complications and make certain the baby’s heart rate remained stable. Two hours after the epidural, she was fully dilated, and after two more hours of pushing, and the use of a vacuum, Nicole delivered the baby.

The baby was born with jaundice and a bruised head from the vacuum extraction; he had to stay in the hospital for a few extra days, but otherwise he was born healthy. The entire experience was forty-two hours; her water broke at 4:00pm, she had gone into the hospital at 11:00am the following day, and she delivered at 11:00am the day after that. She said that she had made it very clear that she wanted to avoid a cesarean section at all costs, and no one even mentioned it throughout her entire experience. She felt that she was able to be a part of every decision, with the
exception of the decision to use Pitocin. She said her doula helped her understand her decisions, allowing her to reject the use of an internal fetal monitor. Nevertheless, she could not refuse Pitocin because an induction was deemed absolutely necessary after her water broke.

Nicole is currently pregnant for the second time. She chose to see nurse-midwives instead of obstetricians for this pregnancy. She assured me that this time, “The one thing I know I don’t want is Pitocin” (Nicole, 2012). She believes that she had “the experience of someone who was induced two weeks early,” and that the tear in her bag of water was a fluke because her body wasn’t actually ready to give birth. She thinks that although “according to a formula” Pitocin might have been necessary, in her individual situation it wasn’t (Nicole, 2012). When I asked her whether she had a positive birth experience, she told me that it was the worst experience of her life, but that she would do it again in a heartbeat because the outcome was positive, and “All’s well that ends well” (Nicole, 2012).

*Casey*

Casey developed gestational diabetes during her pregnancy, but it was her only complication. Because of this diagnosis, she was originally scheduled to be induced one week prior to her due date. However, she asked her nurse-midwife to wait until her due date instead. Her midwife agreed that waiting an extra week for the induction wouldn’t pose much more of a risk and her induction date was moved. As it turned out, it was on the morning of her due date that she went into labor, meaning that she was able to avoid an induction. She said she was thrilled about this, because she wanted to have a natural birth without Pitocin or any subsequent interventions. Casey labored at home throughout the morning; her contractions were spaced out evenly and she was able to handle each one through techniques she learned in a Bradley method class. She went to her midwife for the appointment she had previously scheduled at 3:00 pm, and she confirmed that her water had broken and told her that she would be going to the hospital that afternoon to have her baby. Casey went home to collect her things and contacted her doula, who met her at the hospital.
She labored into the night and through the next morning. Casey said that, “Throughout the laboring the doula really helped and I had a midwife and any time I would say I can’t do it anymore, they would say ‘You’re doing it, so don’t say you can’t do it because you are doing it.’ That kept being my mantra” (Casey, 2012). But by the early morning of that next day, it had been twenty-four hours since she had gone into labor. Casey was starting to sleep in between her contractions and her contractions weren’t progressing in frequency. She said at that point,

My partner asked everyone to leave the room; my midwife had said, “This could turn into a c-section if we don’t use some Pitocin,” and I was adamantly against Pitocin because of primarily the Business of Being Born, but also every horror story you hear and other people’s experiences. I was just so scared it was going to be unbearable. So she asked everyone to leave the room and she sat down by the bedside while I was still laboring. She had tears in her eyes and she said, “This is what we need to do, we need to try the Pitocin and see how it goes so you can not have the c-section and have the natural birth that you want.” So she brought everyone back in and we started the Pitocin drip. My midwife told me that she had a natural birth on Pitocin, she said “You can do it, you’re strong enough because I did it and I know it can be done” (Casey, 2012).

Her midwife started her on a small first dose of Pitocin, which kicked her body back into action. She started laboring really well. She noticed a huge difference in the way the Pitocin felt. She said naturally, there’s a space in between the body’s contractions that gives a break from the pain, allowing the body to “revive you so that you can then go through the contraction. With Pitocin, I found that to be nonexistent” (Casey, 2012). But she still wanted a vaginal delivery so she kept managing her contractions with the support of her partner and doula.

Casey said that she was able to deliver her baby naturally, despite the Pitocin drip. Her midwife “said she’s never seen a more perfect script when it comes out from the monitor, and that she was not in any sort of distress” (Casey, 2012). She delivered at Lutheran Hospital in Denver with a nurse-midwife from Westside Women’s Care, but she told me that if she hadn’t had any constraint from her insurance plan, she would have liked to deliver at a birth center. In the end, she described her experience as positive, saying that she was a part of all the decisions made. She said,
I’m praying I’ll have a natural birth next time with no Pitocin. I work as a newborn baby hearing screener, so I see the disadvantages of starting labor with Pitocin. Both my sister and sister in law started labor on Pitocin and it was difficult for them. My opinion is that that’s not the greatest idea. But for a jumpstart of finishing the leg of a relay, I consider it caffeine for your uterus (Casey, 2012).

Lauren

Lauren was diagnosed at thirty-four or thirty-five weeks with preeclampsia. She had been going to Boulder Nurse-Midwives and had planned on doing everything naturally, without any intervention. Even though she had a mild case of preeclampsia (her blood pressure was borderline normal, but the protein levels in her urine were low), her practitioners became very concerned and wanted to induce her as quickly as possible. She said they wanted her induced at thirty-seven weeks, but she kept resisting. Over the next week her blood pressure remained stable but her protein levels dropped slightly, and her midwives told her that she was risking stroke, seizures, and even death if she did not induce. At thirty-eight weeks, Lauren and her husband reluctantly agreed to the induction. They had tried natural remedies like castor oil and acupuncture, but her cervix remained completely closed and firm, not showing any signs she would be going into labor on her own. She took her time getting to the hospital on the day of her induction, telling me that in her heart she knew she was not ready to be induced.

Her practitioner started her on a Foley catheter, a mechanical cervical ripening device, and left it in overnight to allow her cervix to become favorable for induction. By the next morning, she was only dilated a centimeter. Looking back, she said she often reflects on the fact that the Foley catheter hadn’t really worked, and thinks she should have decided to stop the induction and go home. But instead, the nurse started her on a Pitocin drip, which she had wanted to avoid. She started the dose low and upped it every half an hour, but with no response from her uterus, a midwife broke her water around noon. Although the amniotomy initiated contractions, they failed to progress, and so her nurse continued to increase the dosage at intervals of thirty minutes.
Lauren said that suddenly, after hours of the Pitocin drip that had had little effect, her contractions became extreme. She knew she was on a very high dose of Pitocin at that point, but didn’t know exactly how high the dose was; she recalled it to be somewhere in “the thirties” (Lauren, 2012). She said that on Pitocin, she knew contractions were coming and going but that, “for whatever, reason my body translated that and it felt like one long contraction for the entire labor until I got the epidural.” (Lauren, 2012). Although she had planned on a natural birth, after six hours of trying to manage the contractions at such an intensity, she decided she wanted an epidural. Once she was given the epidural, her practitioner told her to go to sleep and see if her body would progress any more. Lauren had checked into the hospital Sunday evening for the Foley catheter, and it was now in the early hours of Tuesday morning. She said that someone woke her up at 2:00am or 3:00am and she tried pushing, but the baby’s heart rate went down so her practitioner told her to stop and go back to sleep for a few hours.

Lauren woke up at 6:00am, and again tried pushing. It was then that the nurse realized the baby was face forward instead of face down and that he wasn’t moving down into the birth canal. She said that, “By 8:30 in the morning, they said, “We think you need a c-section.” I was so defeated by that time; he was stuck, and I had pushed, and he had not moved, and so I was like fine” (Lauren, 2012). She was wheeled into the operating room crying because she had not wanted or planned for a cesarean section. She told me, “They cut me open and they had a hard time getting him out because he was sort of wedged into my pelvis. When they took him out, he wasn’t breathing so he had an Apgar score of 1” (Lauren, 2012). The obstetrician revived him within a minute or so.

The baby was jaundiced and had a hematoma on his head from the experience. One of his testicles hadn’t descended yet. Lauren believes that he wasn’t ready to be born yet; she maintains that she ended up with a cesarean because she was induced so early. Her body had not shown any signs of being ready for labor and resisted the process. She explained, “I just felt like the whole thing was out of control” and that none of the decisions were presented as options (Lauren, 2012). She
says that she would tell people to avoid Pitocin like the plague, because it caused such an intense
labor, rushed the process, and forced things to happen before they were ready to happen. When I
asked her whether the experience was at all positive, she laughed and shook her head. “No!
Unfortunately. The outcome was good, the prize was good, but not the experience itself” (Lauren,
2012).

*Erica*

_Erica_ gave birth at Exempla Good Samaritan Hospital in Lafayette. She was late, at forty-
one weeks, and was scheduled to be induced, but she ended up delivering the baby twelve hours
before the planned induction. She started having contractions on Friday night every forty-five
minutes or so and stayed at home until 5:30am when they became five minutes apart steadily for
about an hour. Following the “5-1-1 rule” (contractions are five minutes apart, last one minute each,
and continue in this pattern for an hour) she then called the hospital so the nurses could set up a room
for her, and she headed to the hospital. Although she initially wanted to try a natural childbirth, she
was flexible about her birth plan and wanted to do whatever was necessary to have a healthy baby.

Every time Erica had a contraction, she threw up. She had had an extremely difficult
pregnancy in that she was prone to nausea constantly, and her labor only worsened this feeling. At
around 9:30am, after being in the hospital for a few hours, the anesthesiologist came in and asked her
whether she wanted an epidural. Erica told him she wanted to wait a little longer, but he told her that
he was going to scrub in on a cesarean and that it would be three to four hours before he would be
available again. So, she agreed to go ahead and get the epidural, unsure of how extreme the pain
would be in a few hours. At 11:30am, the nurse came in to inform her that the doctor was going to
come in to break her water shortly.

I was like, “Oh no, that’s not going to happen. You don’t just come in and announce
that, that’s not ok.” And she was like, “Oh, well why not? What do you have against
it?” And I said, “Well, first of all, you could explain to me why you want to do it
because I know it’s not typical and it’s not necessary in most cases,” and I said my
baby and I were not on any shift schedule, so don’t worry about that. I didn’t really
care for the nurse. And she said, “You know, we’re just trying to speed things along because you’ve been stuck at 3 minutes since you got here for the contractions.” I got there before 7:00am and this was about noon, and she said they’d slowed a little since I’d had the epidural at 10:00. So I said, “Let’s give it a little while longer” (Erica, 2011).

The doctor came in at about 1:30pm and explained that things were slowing down and that she’d stopped dilating at about 6 ½ centimeters. The obstetrician told her that they wanted to use Pitocin. Erica told me that even though she had planned for an induction and accepted the idea of using Pitocin in that scenario, she found herself reluctant to use it in this situation. She said that,

Once it had already got underway, I think it had a lot to do with the attitude of the doctor and the nurse that I didn’t care for either one of them, particularly the doctor who I didn’t hardly see at all; she barely even talked to me. And when she did, she was cold and would say “This is what we’re going to do,” and not “How are you feeling?” or “What do you want?” (Erica, 2011).

She said that because she had rejected the amniotomy, her doctor told her that Pitocin was the alternative. Although she resisted it at first, she finally gave in. Once they started the drip she said the contractions became a lot stronger. She watched them on the monitor and could feel the pressure despite the anesthesia. Because of both the epidural and Pitocin, she was hooked up to monitors continuously and couldn’t stand up or move around.

She had one strong contraction, during which her water broke on its own. At about 6:00pm, there was a shift change and the new doctor came in. He told her that she was 9 ½ centimeters dilated and fully effaced, and she could try pushing if she wanted to. The nurse helped with “practice pushes” a few times before realizing that the baby was ready to deliver. She screamed into the hall for the doctor, and on the next push, Erica delivered the baby.

When I asked her to describe her feelings about the birth experience, she said,

That’s something that I kind of struggled with, about going against the plan. I couldn’t actually hack giving birth so I felt like I copped out a little bit and that’s something I kind of struggled with for a long time, and about the Pitocin too because that’s a drug. But I decided that it’s over, it’s done with and it is what it is and any regrets that I have aren’t worth much (Erica, 2011).
She continued, “I feel like for the most part I had a reasonable amount of control; I wasn’t happy with the way some of my options were presented because they weren’t presented as options, but I made my wishes quite clear to them” (Erica, 2011).

Being pregnant again with her second child, she said that she wanted to try for a natural childbirth this time because she knew better what to expect. But she also mentioned that she had been diagnosed with placenta previa, so there was a strong likelihood that she would be having a scheduled cesarean.

Protocols, Ideals, and Subjectivity

*It just seems like I got put on a track that said, “This person has had x happen, and therefore y and z have to happen next,” whereas each birth and each person is different* (Nicole, 2011).

For Nicole, the need for induction was brought about by the fact that her water broke two weeks prematurely. When she failed to progress during the induction, her doctor physically intervened to re-break the amniotic sac, which had resealed. But, because her water had technically broken, protocols mandated that she be induced. This section explores these protocols and the ways that they influence care. Protocols provide, in essence, the standards of care that dictate how (and when) Pitocin should be used. But the process of standardization of care has continually been influenced by the creation of expectations and ideals about what is considered “normal” and “abnormal” when it comes to the process of labor. These ideals are historically and culturally situated; they are characterized both by the notion of a normal labor pattern and cultural interpretations of progress and time. In this discussion, I integrate these themes into the construction of a broader medical discourse that regulates how medical professionals approach care. To understand where medical guidelines and standardization merge with the subjectivity of the clinical experience, we must look at the conceptual lens through which physicians evaluate individual patients to determine the uses of Pitocin.
Protocols

In almost every interview I conducted, protocols were alluded to. To patients, protocols seemed to dictate the practitioner’s approaches towards the next steps to be taken. To practitioners, protocols seemed to reinforce standards that would inform clinical decisions. As both written and unwritten “guidelines” for treatment, medical protocols illustrate how Pitocin should be used and outline in what cases intervention is necessary. In this regard, protocols become a part of the medical discourse that constructs definitions for what is “normal.” Most hospitals employ some form of protocol for the use of Pitocin, agreeing with the idea that there should be some standardization.

Historically, the inability to effectively regulate dosages of ergot, Pituitrun, and Pitocin, and the unpredictability of the medications, led to poor outcomes and negative reactions. Today, Pitocin’s FDA drug information lists all the possible side effects, contraindications, and drug interactions, and a standardization of protocol has been established at every hospital as to how to initiate and increase doses. Given the extent of problems that can incur from situations when the fetus goes into distress or cannot handle the medication’s effects, these standards have largely been put in place to avoid misuse and malpractice.

Management philosophies published as early as the 1950s and 1960s continue to act as a basis for how to use this medication. And while the approaches to using Pitocin can be interpreted differently depending on hospital protocols or personal beliefs, the general construction of protocols is similar. A nurse I spoke to explained that with Pitocin, “They can bump it up every half hour; they get to a certain point and the doctor will say you can bump it up to this amount and then they just stop. It’s a gradual [process], [we] let the body get used to it during that half an hour. Get used to it, bump it up; get used to it, bump it up” (Nurse 2, 2011). One doctor explained, “You start super low, like two milliunits a minute, and then every twenty minutes, that’s the protocol at our hospital, it can go up by one or two milliunits, depending on the nurse’s judgment” (Physician 1, 2012). Both explanations of protocols are quick to point out that while final decisions about protocol management
are deferred to the physician, it is often left to the discretion of the nurse to manage the Pitocin drip. In these protocols, the increase of doses mimics the gradual intensification of contractions in an idealized labor curve.

Many medical professionals also spoke about the need for Pitocin in induction cases when the bag of water has ruptured and labor has failed to start. Such was the scenario in Nicole’s birth, when protocols began what she referred to as a “track” that mandated Pitocin. Women seemed, throughout my interviews, to be exceedingly aware of this protocol, and the more generalized practice that if a woman doesn’t give birth within a certain amount of time due to lack of sufficient progress, she will be faced with a cesarean section. For women whose water breaks, the period of time is twenty-four hours; for women whose water doesn’t break, the risk of infection is lessened and this time-frame becomes more subjective and dependent on the clinical picture as a whole.

Oftentimes (except for one or two exceptions), practitioners I spoke to seemed to employ a blanket protocol during third stage labor that mirrored active management, the philosophy of care that emphasizes proactive involvement to minimize complications. What complicates this practice is that these protocols are sometimes personal and sometimes part of a clinic-wide practice. I spoke to a certified nurse-midwife who explained that personally, she deferred to expectant management of third stage labor. However, the medical doctors I spoke with adhered to active management philosophies. One obstetrician stated that, “I standardly give Pitocin to everyone once the placenta is out unless they ask me not to” (Physician 3, 2012). In this universalized scenario, active management becomes the norm and patients must deliberately refuse it. Specific active management protocols, though, differ depending on the practitioner’s personal training and approach. One of the other physicians I spoke with explained her personal protocol for third stage labor by saying, “Typically, fifteen to twenty units are put in a one liter bag and it is given over thirty minutes to an hour” (Physician 1, 2012). The protocols for management of third stage labor are not as standardized
across boundaries; it seems, however, that to each practitioner a personal philosophy of care is generally put into effect.

These subjective interpretations of standards are highly political. One practitioner’s deviations from an assumed set of principles can even be claimed as malpractice; historically, misuse of medications or failing to intervene could prove to be very dangerous. The presence of protocols in hospitals can allow the practitioner to rely on standardized care when giving women Pitocin or deciding that Pitocin needs to be given. In the four cases I discussed, protocols about inductions particularly seemed to dictate the process of decision-making. But these scenarios also bring up the point that this notion of standardization has its limits. Standardizing care is intricately connected to the ways that we idealize and create expectations during birth, both of which undoubtedly influence care because they create models on which to base individual cases. As a result, I find that I cannot discuss protocols without talking about the way that ideals permeate medical practices.

The Medical Imaginary

As I embarked on more interviews, it became apparent that the most lasting implications of these protocols were the ideals of progress as defined by cervical centimeter dilation and frequency of contractions, with the use of Pitocin to maintain or achieve progress. In conversation, women shared that the administration of Pitocin was preceded by discussions of how their labors “stalled out,” (meaning that their contractions either kept the same regularity for a certain time, became more spaced out, or became irregular) or that they had been “stuck” at a certain centimeter of dilation. A practitioner I spoke with reiterated this point, saying, “We use Pitocin when labor has stalled out; so they’re either not having adequate or frequent contractions, or they’re not changing their cervix. It usually means unchanged for two hours once they’re in the active stage of labor, so once they’re past four centimeters” (Physician 1, 2012). To understand where these specific conceptualizations of how labors “look” come from, I turn to a discussion of the medical imaginary, the way that conceptions of labor are grounded in the visual, and the biotechnical embrace.
When Friedman made famous the ideal labor curve (even though his research sought to establish averages in labor patterns, not determine or classify what is normal or abnormal), the idea was quickly disseminated that there was a standardized, ideal labor curve that should be maintained through active management techniques to avoid complications. Although Friedman’s curve became popularized in the 1960s and 1970s, I habitually encountered rhetoric that embodied this ideology forty and fifty years later. Women would explain that the necessity of Pitocin was due to a “stalled out” labor, or because they “failed to progress.” In describing labor patterns, one of the obstetricians phrased the need for Pitocin as based on the physical manifestation of progress that, “Once you are in the active stage of labor, women should progress at about a centimeter an hour. If they really start to fall off the curve or you see they are contracting every five, six minutes, it’s not gonna happen” (Physician 2, 2012). This rhetoric is both technical and visual. In a sense, it creates a mechanistic view of the body’s processes in keeping with Davis-Floyd’s technocratic model, which allows for practitioners to “correct” the malfunction; simultaneously, it cements the notion of a labor in something that can be imagined. The “curve” becomes not only a visual manifestation of what is normal, but also something that can be worked towards.

Pitocin, which is the means to create this curve, fits into the narrative of the medical imaginary, which Delvecchio Good characterizes as the cultural and moral landscape of biotechnology and the realm of possibility (Delvecchio Good 2007). She writes about the medical imaginary in the context of the biotechnical embrace, saying, “An ethnographic slice through ‘multiple regimes of truth,’ narratives of patient experience and clinical science, and documents on medicine’s political economy suggests ways in which the affective and imaginative dimensions of biomedicine and biotechnology envelop physicians, patients, and the public in a ‘biotechnical embrace’” (Delvecchio Good 2007: 364). In this excerpt, Delvecchio Good argues that the imagined possibilities of medicine become difficult to resist in the narrative of hope. In the stories I have encountered, Pitocin, as a medication, comes to characterize what is possible in a labor. How we
visualize labor patterns and progress creates a mental picture of our expectations, and what is classified as “abnormal” can be visualized as having “fallen off the curve” of what is normal.

The ways these experiences are imagined to occur, both by medical professionals and patients, affects the way they are perceived. With Pitocin, women need to be monitored, so contractions become visible in yet another way. I spoke to a midwife, who said,

The hospital likes to keep it on and keep it going to see those contractions doing that, doing that, doing that. In a normal labor you never see that. Every contraction is different, talk to any laboring woman. Some are hard, some aren’t; the uterus has its way of working with the baby and the mom so when we try to make it be this strong, this rhythm this amount of time, it really feels different for the woman so she’s rarely able to do it naturally. So now we’re medicating the mom, disrupting the relationship with the mom and the baby and now it’s all about the machine (Midwife 2, 2011).

The visual construction of contractions with Pitocin is different; contractions are made visible and documented by technology. This idealized labor pattern emphasizes the efficiency of contractions, pointing out that progress in labor means the continued intensification of regular contractions. The midwife went on to say,

You know, babies have to turn and reposition and the uterus knows that, it’s communicating and so often when the uterus stops contracting its because the baby has to turn; that’s a cardinal movement of labor, we study it in all the textbooks, but we forget about it. We’re like, “No contractions? Let’s make one happen” (Midwife 2, 2011).

Contractions are seen to inform whether or not progress is occurring because they are, in a sense, the most tangible indicator of what is going on in the body. Giving Pitocin to a woman in labor can create a specific expectation in which progress can be “seen” and actively managed.

These differing ideologies about the ways labor can be assessed have profound implications on the way that labor unfolds, with or without intervention. In the biotechnical perspective, labor not made to fit the curve fails to progress, thereby necessitating Pitocin to regulate progress. Conversely, in the natural childbirth perspective, progress is more open to interpretation and can be stimulated in different ways. Focusing the attention on this capitalist notion of progress during labor can affect the way women might experience labor as something to be “achieved” rather than something that is
naturally occurring in their bodies. Because progress is grounded in the visual and enveloped by the biotechnical embrace, the passing of time and its implications becomes intimately associated with the experience of labor.

**Time as an Ideal**

In “Time, Work, and Industrial Capitalism,” E. P. Thompson writes about the time discipline, which explores how conventions and expectations are managed through the awareness of time, an awareness that has become apparent in industrial capitalism. In his argument, Thompson asserts that the “western” notion of time is interpreted economically and linearly, in keeping with the way assembly lines function to expound progress. As I began to explore this concept more, I found that protocols and expectations were saturated with references to time. Progress is measured, for example, by saying that the cervix of a woman in active labor “should” dilate one centimeter every hour, functioning mechanistically. This protocol is particularly reminiscent of “progress” as perceived through the framework of a disciplined linear time. Time further becomes an assessment strategy for determining whether a labor is progressing normally. Because Pitocin effectively manages these expectations of progress, and this notion of progress is rooted in a conceptual understanding of “western” time, the awareness of time measured against progress during labor can be seen to drive the use of Pitocin.

It is not long before these references begin to be manifested through the practices of practitioners and the perceptions of women in labor. Both practitioners and women commented on how the presence of time is perceived through labor. Lauren, who ended up with a cesarean section, remarked that, “They were concerned that I wasn’t progressing past the eight centimeters and that I should have gotten there by then” (Lauren, 2012). In her scenario, the passing of time became something that her practitioner associated with failure to progress, because the expectation of further cervical dilation was not met. As this linear construction of time is assimilated into the definition of progress, the lived experience of labor became a sort of waiting game for some women. Casey even
said, “I didn’t want to know what time it was. We took the clock off,” when she was thinking back to her labor (Casey, 2012). Another woman, who agreed to an amniotomy but resisted the use of Pitocin, explained that, “I felt like their impatience was making me nervous. I felt like they were being impatient. I remember them looking at their clocks and just their facial feedback that I was getting was not very positive” (Patient 5, 2012). Labor itself can embody the passing of time for women. In this experience, the perceptions of time both for the practitioner(s) and the woman in labor drives the use of Pitocin, creating visible spaces in which “progress” is absent.

Throughout interviews, I found that women seem to be aware of time predominately in the hospital where strict protocols incorporating time are put into place. For instance, women are very aware of the protocol that after twenty-four hours of having her water break, a woman will be faced with a potential cesarean section due to an increased risk of infection. Varney’s Midwifery, however, points out that it is not time itself that dictates whether or not an infection will occur, but that this cutoff acts as a management of risk; that after twenty-four hours, women are not suddenly more prone to infection, but that there must be some limit to mitigate this risk so as to avoid malpractice (Varney 2004). When a woman decides to stop laboring at home and go to the hospital, conceptions of time shift; one woman who had planned a home birth with a midwife but decided to go to the hospital for pain relief from back labor, said that she decided to tell them she went into labor later than she did so that they did not “shorten the window” she had to give birth (Patient 7, 2011). Still, she was given Pitocin. She indicated that she became much more aware of the passing of time once at the hospital.

Among practitioners I spoke with, the notion of having “efficient” contractions was pervasive. “Efficient” contractions are seen as contractions that every time produce cervical change and bring the body closer to giving birth. But the idea of having continually efficient contractions is a notion that only exists through the use of Pitocin. A labor and delivery nurse I spoke with explained,
The difference between Pitocin and a natural labor is that Pitocin makes them efficient, every single contraction. That is what is hard about it. In a natural labor pattern one contraction might be a little less intense than another, there might be more variety, whereas a contraction pattern based on Pitocin is very efficient; you’ll get a good one every time (Nurse 3, January 2012).

The notion of efficiency in a labor is closely tied to the cultural assumption that women need not delay what is inevitable. The philosophies about induction and augmentation rest on this idea that it is better to have the baby early so the process can be controlled and actively managed, rather than waiting to see what would happen should, for instance, a woman not be induced at forty weeks or not be given Pitocin for augmentation. I spoke to one practitioner whose philosophy towards birth rested on this ideology: that the woman was going to give birth eventually, and that Pitocin was a drug that could be used to achieve this outcome even more quickly (Physician 2, 2012). And while many patients might agree with this mind-set, many I spoke with were also concerned that it meant Pitocin was being used only for convenience.

An obstetrician I spoke with reflected on the question of why Pitocin was needed for augmentation by saying, “I just don’t see any benefit in sitting around watching people contract every six to eight minutes when they are supposed to be progressing” (Physician 2, 2012). This quote is indicative of the extent to which medical practices, like that of giving Pitocin, are situated in cultural and historical explanations and conceptions of time. The linear understanding of time has profound ramifications on the ways that progress is determined and characterized; Pitocin is a drug that is therefore used to achieve linear, visual, and systematic ideals of progress in labor.

**Clinical Setting**

One of the most important aspects of protocol management, apart from differences in individual perspective, is the difference in clinical setting. Because protocols are often left to the discretion of individual hospitals, the frequency with which Pitocin is used for different purposes varies. Standards at a particular hospital are often perpetuated not only through the individual protocol but also through the training of doctors during clinical rotations and residency, when
medical students witness the use of Pitocin in person as opposed to learning about it theoretically. In the greater Boulder area, hospitals have a tendency towards adopting a more natural or “hands off” approach, yet there are still significant differences among these hospitals in how Pitocin is used.

Different management strategies in labor can be seen in the frequency of different Pitocin uses. A certified nurse-midwife said that at her nurse-midwifery practice in Boulder, “Maybe a third [of women] if we include third stage hemorrhage will use Pitocin. Maybe a quarter get an induction or augmentation at some point in time” (Nurse-Midwife, 2011). In other words, a third of women will get some form of Pitocin at some point in labor, but one out of four will have Pitocin for contraction management. Conversely, an obstetrician who worked at St. Joseph’s Hospital in Denver (which is a Kaiser Permanente hospital) revealed, “Let’s say 10% of patients are induced and 100% of them get Pitocin and somewhere slightly less than 50% of laboring patients get Pitocin” (Physician 3, 2012). These statistics then imply that 60% of women will have Pitocin for contraction management. However, she also stated that she regularly gives Pitocin to patients for third stage labor to prevent hemorrhage unless her patient explicitly refuses the medication; 90% of her patients get Pitocin at this stage. The way that hospital protocols and ideals interpret normalcy in labor must therefore be individualized if 60% of patients need Pitocin at one hospital while 25% need Pitocin at another. By looking at the rates of epidural use, and other interventions in these hospitals, we can more fully understanding this trend; at the second obstetric practice, the doctor revealed that 80% of women received epidurals, while at the other practice epidurals were far less common.

A labor and delivery nurse I spoke with commented on the juxtaposition of Pitocin use across the boundaries of hospitals, saying “I didn’t even know what a natural labor pattern looked like until I moved here and started working at Boulder Community Hospital” (Nurse 3, 2012). Because Pitocin is used (in some hospitals across the country) in almost every instance, regardless of the clinical scenario, the drug has gained recognition as a drug of convenience. Boulder is unique in this way, in that hospitals seek to dissociate from this notion, while other hospitals studied seem to
advocate more of an active management. At Exempla Good Samaritan Hospital in Lafayette, a nurse said,

   The [hospital staff] will let them labor for a bit and then they’ll suggest if the patient wants to get it rolling, then we’ll start the Pit. If your water breaks and you’re not having contractions, they’ll start you on Pit. The longer your water is broken, the easier it is to get an infection. They want to get it rolling. They just want to get it started. (Nurse 2, 2011).

Even though Boulder Community Hospital and Exempla Good Samaritan Hospital are only twenty minutes away from each other, they seemed to have very different philosophies about how Pitocin can benefit patients. In the interviews I did with women who gave birth at these hospitals and with practitioners who worked there, Boulder Community seemed to have more of a hands-off approach with Pitocin, whereas Exempla Good Samaritan seemed to communicate a sense of urgency about the labor process.

   The divergence in approaches further reveals that although standards are put in place to prevent misuse, the extent to which protocols are followed is also dependent on the training of doctors and the ways that interpretation is passed on. Several physicians and nurses I spoke with commented that although Pitocin was referenced during medical school and nursing school, it was not until they began to practice that they saw how other practitioners were using Pitocin and formed their individual perspectives about Pitocin use in daily clinical practice.

   Hospitals act as independent institutions, in which dynamics about Pitocin use or when to use intervention become standardized not only through protocols and the philosophies they embody, but also through the influences practitioners have on each other. In discussing subjectivity, then, we must look at the constructions of what is “normal” that are shaped through the dynamics of the clinical setting. Where one labor might be seen to progress “normally” at one clinic, it might be interpreted as “abnormal” and necessitating Pitocin, at another. While protocols in some ways accentuate overarching ideals about what progress in a labor is and how it is characterized, the way
these conceptual frameworks are then employed at a very individual level is the result of these subjective interpretations.

**A Note on Medical Discourse**

Michel Foucault’s definition of medical discourse is multi-faceted. Medical discourse takes into account how the medical community establishes what is normal, the practices and approaches of practitioners, and the relationships between subjects and objects (Foucault 1982). In understanding the medical discourse of childbirth and particularly regarding the use of Pitocin, we must realize the norms that are imagined in labor are the result of these historical constructions and cultural ideals. This subjectivity creates specific clinical narratives through the dynamics of the practitioner and patient, which are highly indicative of the medical gaze. Medical discourse creates space for subjects, who become a part of the discursive formation and take on roles within the established framework (for instance, women become patients who must be treated). I will discuss these subject positions when I talk about how decision-making occurs in the clinical setting. By understanding the medical discourse and medical gaze, we see how these embedded ideologies influence how women receive care and how what is normal becomes a social construction. Through protocols, ideals, and subjectivity, medical discourse and the medical gaze establish norms not only of expectations, but also of practices to manage these expectations.

**Risk Aversion**

Our interpretations of events during labor, and our reactions to them, are intimately tied to the categories we ascribe them to. Through medical classifications we are made to understand diagnoses through a specific frame, in which illness becomes standardized and must then be treated through a certain set of principles. In this section, I write about the ways that diagnoses and their treatments reinforce the medical necessity of Pitocin and the ways that statistics are employed in decision-making.
Through the medical gaze, abnormalities are seen as a malfunction or something that can be isolated and then treated in the body; patients who experience labor that is “abnormal” can thus be categorized. We saw that following the inventions of Pituitrin and then Pitocin, the diagnosis of dystocia (an especially long or difficult labor) surged in frequency. By diagnosing these patients with dystocia, they could thus be treated through Pitocin, the “cure” to long or difficult labors (Block 2007). These categorizations in discourse essentially promoted the ability to diagnose labors as abnormal. By making space in the medical discourse for Pitocin, we can see how the body then needed to be managed to an extent that did not exist before (Philo 2000).

If the woman does not progress according to these notions of what is normal, something has to be done; the decision to intervene accounts for the possible risk if this already abnormal labor proceeds abnormally. In many of my interviews with patients, “moving things along” in a labor was seen as an effective way of managing possible problems. In one of my interviews, a woman who had been feeling sick and running a slight fever was given Pitocin to intensify contractions because her practitioner did not know whether this fact might affect the birth, and wanted to get the baby out more quickly (Patient 13, 2012). The medical discourse, particularly around childbirth, has been historically structured in such a way when confronted with the unknown, it is better to intervene to try to manage the process.

By categorizing these processes, we also bring into play protocols and assumptions about that diagnosis; for instance, diagnosing a woman as having preeclampsia necessitates the response of needing an induction. This response is based on an understanding of risk aversion, that if a woman decides to wait until she naturally goes into labor, the risk of seizures or other complications will increase. By falling into the category of “preeclamptic,” a woman then possesses a certain risk and decisions are made to avoid that specific risk. One practitioner I spoke to explained this concept, saying,
The diagnosis usually speeds up the labor. Sometimes we say someone has preeclampsia but they might have it just mild and it’s not too bad of a disease, but the teaching is that if someone really has preeclampsia the labor will progress really quickly because the body recognizes it is sick and that it needs to get the placenta out. What it really needs is the placenta to be out of your body. So this would be one of those times when you would need to medically induce someone so you would use Pitocin (Physician 1, 2012).

In her explanation, this physician conveys that the categories that define illness are broad and open to interpretation. However, even when a woman might have a mild case, the risk of not inducing is higher than the risk of inducing. Because inductions are seen as a standard of care, and they allow for the practitioner to intervene prior to complications, the intervention is warranted.

The notion of risk aversion applied in many of the cases I encountered; statistics, then, were frequently used to draw these conclusions and inform the decisions made by practitioners and women. Many women I spoke to referred to how statistics and risks became the final motivating factors in their consent to use Pitocin. One woman explained, “They put data in front of me that were legitimate risks and so we made the decisions together” (Patient 10, 2011). Another patient explained that the use of risk and statistics came into play in her relationship with her practitioner:

The way my physician explained it was that “Either you wait, and you put yourself at higher risks because I was a bit of an older mother, and you are asking your body to do the hardest part of pregnancy when your placenta is the oldest and so a lot of things can go wrong if you are 43 weeks or whatever into your pregnancy. I was very sure about my dates so I knew just how far along I was, so to be safe we felt like we needed to be induced” (Patient 12, 2012).

Especially because these decisions influence women as well as their babies, the mentality among almost all of the patients I spoke with was that it was better to be safe than sorry. Many women chose to give birth in the hospital for this reason alone, and accepted intervention because they were afraid of what would happen if they refused it. Statistics, whether they showed any chance or a strong chance of complications, played a role in decisions for inductions, augmentations, and use of Pitocin during third stage labor.
Interventions in Labor

Because Pitocin often exists in conjunction with the use of other interventions during childbirth, we cannot isolate it from other procedures. When complications emerge in labor, or events do not proceed “normally,” active management philosophies encourage multi-faceted approaches as management strategies. By understanding how Pitocin’s relationships with these other actors are formed and how they are continually interacting with each other, we can interpret how their presence shapes dialogues about Pitocin and the need for Pitocin. In this section, I therefore move from theoretical discussions of conceptualizations that determine Pitocin use to a discussion of amniotomies, epidurals, and cesarean sections as they inform the need for Pitocin.

Amniotomies

*It was only after I said no to the water breaking, which she wanted to do first, that she [offered the Pitocin]. She was like, ‘Well, I don’t understand your hesitation because I would want to use the instrument to break your water, because there’s no drugs involved and I know you wanted as few drugs as possible’* (Erica, 2011).

The use of amniotomies, or artificially rupturing a woman’s bag of water, to augment contractions seems to be discussed less often than the use of other interventions. Because it is a non-pharmaceutical option, practitioners may proceed with this intervention when a woman wants to have a natural childbirth. However, women may or may not accept this mind-set. To some, pharmaceuticals may seem to pose more of a threat. To others, the thought of using an instrument to manually “break” the bag of water seems more intrusive than using a pharmaceutical. Such was the case with Erica, who decided she did not want an amniotomy even though her doctor first recommended it to augment her contractions. She agreed to the Pitocin only secondarily.

This pattern, in which women wanted to deliberately avoid either Pitocin or an amniotomy, resonated throughout several of the interviews I conducted. Among the women I talked to, several specifically wanted to avoid an amniotomy, a deference that contributed to the use of Pitocin in their cases. One woman, already hooked up to an IV Pitocin drip, decided to resist an amniotomy, and as
a result her nurses continued to increase the Pitocin dose. When she did agree to have her bag of water ruptured by her doctor later, the nurses stopped increasing the dosage, maintaining the dose she was already on because the amniotomy intensified her contractions (Patient 10, 2012). In this case, the use of Pitocin was regulated according to whether or not she agreed to an amniotomy.

While which intervention is offered first is left to the discretion of the practitioner, I found that the practitioners I interviewed tend to offer the use of Pitocin first in induction cases to try and establish a labor pattern, and later employ amniotomies if adequate progress is not made. Conversely, I found that these practitioners tend to offer amniotomies first in cases of augmentation when a woman’s bag of water is still intact. In these scenarios, one physician I spoke with told me that amniotomies were used more generally to try to augment contractions, whereas Pitocin would be employed secondarily to regulate “adequate labor” (Physician 1, 2012).

These two interventions serve slightly different purposes, depending on how the practitioner wants to manage the labor. I spoke with another obstetrician who said that, “Pretty routinely, once people are really in active labor, I break the water because it can decrease the need for Pitocin, and I like to know whether or not there is meconium” (Physician 2, 2012). The use of an amniotomy can therefore be seen as an attempt to decrease the need for Pitocin; on the other hand, the resistance to an amniotomy can increase the likelihood for Pitocin. The relationship between amniotomies and Pitocin is not confined to their similar use to augment contractions, however. I interviewed one woman who was given an amniotomy partially to augment labor, but also so that her doctor could monitor the baby’s heart rate internally (Patient 5, 2012). Because Pitocin necessitates fetal monitoring, sometimes through more accurate internal monitors, rupturing the membranes could act as a component of the management of Pitocin.

In my fieldwork, I found these two interventions to be very intertwined in principle, and sometimes in practice. When patients resisted one of these interventions, their choice became about deciding between one or the other. The theoretical use of these interventions then becomes
something that is used to inform clinical decisions, both from the practitioner and patient perspectives. Still, these interventions are often used in conjunction with one another because when one fails to achieve adequate progress, the other is employed.

**Epidurals**

Because use of Pitocin has increased in the past twenty years, in parallel with an increase in epidural use, many people have postulated that there is some kind of relationship between these two interventions (King 2011). Whether that relationship is dependant on a significant difference in pain during a labor managed by Pitocin, the effects of the epidural, or a similar patient or practitioner philosophy is widely debated. Throughout my interviews, I found that the nature of this relationship cannot be reduced to one reason or one direction, but rather that it is multifaceted; Pitocin can increase the likelihood for epidurals, epidurals can increase the likelihood for Pitocin, Pitocin and epidurals can remain independent of each other in some scenarios, and Pitocin and epidurals can be used in accordance with an active management philosophy that does not see one as leading to the other even though both are present.

One of the most cited reasons for wanting to avoid Pitocin, purely from a physiological standpoint, is that Pitocin intensifies contractions and therefore the level of pain in the body. Many practitioners have argued that, “there’s probably something intrinsically different about a labor that doesn’t progress normally and needs Pitocin,” and that, “Those people who need Pitocin weren’t contracting adequately so you give them Pitocin and get good contractions it hurts,” implying that Pitocin does not make labor hurt any more than a “normal” labor would hurt (Physician 3, 2012; Physician 2, 2012). However, almost every woman I interviewed who had been given Pitocin without pain management could feel that something was inherently different and described this difference in much the same way. Lauren said that, “It felt like one long contraction for the entire labor until I got the epidural” (Lauren, 2012). Other women similarly remarked that, “Before, I would have a contraction and I would have a little down time, and the Pitocin just shortened that
down time until they were coming one right after the other, quickly,” and that “The Pitocin was fabricating contractions and they were back-to-back; I got to the point where I wasn’t recovering from the contractions, so I asked for the epidural.” (Patient 13, 2012; Patient 10, 2011). Many patients thus attributed this kind of pain to the reason they then requested an epidural. Nicole, whose story I told earlier, was pregnant when I interviewed her. When I asked her about her upcoming birth, she responded that

The only reason I can see [myself getting Pitocin] is if my water breaks and I have to be induced, or I’m late. Should either of those happen, I will—when they start the Pitocin—I will also order an epidural. I wouldn’t have it immediately because I do want to be able to walk around, but the moment it’s uncomfortable in my mind, I will [get it]. Pitocin and epidurals are very linked. If I have Pitocin I’ll have the epidural. Based on my last experience (Nicole, 2012).

Past experiences, which can include personal experiences or experiences of people a woman knows, might easily influence the decision to request an epidural if Pitocin is used.

In the two cases I encountered where women were given Pitocin but chose not to get an epidural afterwards, both women were given Pitocin at a later point in their labor as an augmentation technique (Casey, 2012; Patient 13, 2012). They were also given low doses. In both of these cases, interestingly enough, the women said that Pitocin had acted like “caffeine” for their uterus, stimulating their contractions enough that their labors were able to progress quickly. Each woman also mentioned that the support system she had in place (which in both scenarios involved a doula, a supportive partner, a trusted medical professional, and knowledge of natural pain management strategies), allowed her to maintain her plan to avoid an epidural. Several of the doulas and practitioners I spoke with supported the idea that by using natural remedies like massage, laboring in water, visualizations, breathing techniques, and assistance by an emotional support system, a woman giving birth with Pitocin might be able to avoid an epidural.

I also found that conversely, epidurals contribute to the use of Pitocin. A certified nurse-midwife I spoke with told me that, in fact, “I think in our practice I don’t necessarily see Pitocin as
leading to epidurals so much as epidurals leading to Pitocin” (Nurse-Midwife, 2011). In medical literature, epidurals have been documented to slow the progress of a labor because a woman is not able to move around and interact with her labor in the same way. The medication is associated with “spacing out of contractions, and so oftentimes if [a woman] wants an epidural and doesn’t keep a regular labor pattern, then we might need to use Pitocin on top of that” (Nurse-Midwife, 2011). Several women I spoke with, like Erica, articulated this tendency. In her case, her labor slowed after being given an epidural, and several hours later she was faced with needing intervention to resolve this tendency.

And while epidurals might physiologically necessitate the need for Pitocin, I also noticed that there appeared to be conceptual reasons driving this pattern. One woman explained that “Once I got the epidural, they were like ‘Ok, now that you’ve got the epidural we might as well start on Pitocin; your water has broken we might as well get this going, you can’t feel it anyways so we’ll just crank it up’” (Patient 8, 2011). In this logic, the nurses assumed that the only reason to avoid Pitocin was due to pain. Once the epidural was introduced, it eliminated this rationale. Other women asserted that once one of these interventions became involved in their birth, the birth was no longer “natural” and that the avoidance of other interventions was less important. Nicole furthered this reasoning by saying that, “You’re already not having a natural birth; cut yourself some slack at that point and accept that you’re going through a process that’s unnatural that may be greatly aided by drugs” (Nicole, 2012).

Through these analyses I found the relationship between epidurals and Pitocin to be dynamic and constantly in motion. While the use of Pitocin and the use of epidurals can each contribute to the other’s use in physiological ways, this relationship is also dependent on expectations, natural methods of pain management, and interpretations of the extent to which childbirth can still be considered “natural.” This relationship is therefore based on interactions, and the approach that
practitioners and patients take influences the extent to which these two interventions occur dependently.

_Cesarean section_

While there has been shown to be an association between the use of Pitocin and a subsequent cesarean section, there is much debate as to whether this relationship is correlative (Goer 1995). Many advocates of natural childbirth I spoke with referred to this as the cascade of interventions. This theory suggests that there is a link between women being given Pitocin that stresses out the baby, needing an epidural to cope with the new pain which slows the labor down, and ending up with a cesarean section for reasons related to fetal distress or dystocia. Medical professionals, in opposition, argue that there is something inherently different about a labor that needs Pitocin in order to be normal, and so the risk of cesarean stems from this abnormality rather than from the use of Pitocin itself. While these theories continue to be debated, if a woman has Pitocin, there is an correlated possibility of then having a cesarean section. But the relationship becomes more theoretical in the context of how clinical decisions about Pitocin are made. More than tangible links, it is the potential presence of the cesarean section that influences immediate decisions to use Pitocin.

In many of my interviews, I found that the possibility of a cesarean section alone often dictated when women would or would not accept the use of Pitocin. Among women who wanted a natural childbirth, and even among women who were open to intervention, the cesarean section seemed to be the intervention they most wanted to avoid. Because of the widely known protocol that a woman whose bag of water ruptures has twenty-four hours to give birth before being faced with a cesarean section, women emphasized that they made certain decisions about Pitocin deliberately so they could mitigate the risk of having a cesarean. I spoke with one woman who had initially planned on having a home birth with a midwife, but after eight hours of laboring at home with severe back labor (the baby was in an inverted position) went into the hospital for an epidural. She said that after she went in,
At some point they told me that they wanted to administer Pitocin to speed up the labor because it had stalled, and my concern was that if I didn’t give birth within their time frame they were going to do a c-section, and I wanted to avoid that at all costs. So, I decided ok, I guess we’ll do the Pitocin because I don’t want to have a major operation, and I wanted to have a vaginal delivery. It’s like the looming threat of the c-section was what motivated me to accept interventions when I previously decided I did not want to have any medical interventions (Patient 7, 2011).

In this case, Pitocin was perceived as the lesser of two evils. Because Pitocin speeds up and controls labor, in essence, it was seen to lessen the likelihood that a cesarean section would be needed. In Casey’s scenario, too, both her midwife and her partner were concerned that if her labor did not progress, she would be faced with having a cesarean section. Casey decided to try the Pitocin so that she could still try to have a vaginal birth instead of a surgical birth.

When I spoke to practitioners, this idea seemed to be present as well. When I asked one medical doctor about the timeframes of birth, she responded that, “The actual timeframe really depends on the clinical scenario, and when you are going to give them trial Pitocin before you would go to cesarean” (Physician 1, 2012). When a woman is not progressing adequately, Pitocin can be seen as one of the steps of intervention that, when all else fails, ultimately leads to cesarean section. By referring to it as “trial Pitocin,” this physician concedes that Pitocin is perceived to be a risk aversion drug for cesarean section.

This theme resonated throughout many of my interviews. The possibility of cesarean section seemed to be present, at least theoretically, when women made decisions to accept the use of Pitocin. Surgical intervention, the most invasive intervention a woman could have, minimized the risks of using Pitocin by comparison, making it more acceptable to women. Although Pitocin is a drug that is often considered as a standalone drug, the use of interventions cannot be separated from one another. They all work to physiologically and theoretically inform the decisions or need to use others. In understanding the nature of these relationships in greater depth, we can recognize how these processes come together to contribute to the established necessity for Pitocin.
The Hospital and Standard of Care

Throughout my research, both in developing my historical and contemporary understanding of Pitocin and in my fieldwork, the attitudes of the public towards Pitocin were overwhelmingly negative. Women urged other women not to use it, research questioned its potential consequences, and women wrote birth plans that deliberately sought to avoid it. The question then became, why has it prevailed so persistently despite these cautions and despite the risks associated with its use? In understanding why Pitocin has become the standard of care, I discuss why alternatives are often discarded at hospitals and how the hospital setting itself might lend itself to the need for Pitocin.

As I asked medical professionals why Pitocin, specifically, was used to stimulate labor, I often heard, “It works.” But the way it works is controllable. In speaking with obstetricians, I found that, “There is no question that it works to make the uterus contract; it’s great. You can titrate it so precisely, turn it on and off and control the amount that you are giving” (Physician 2, 2012). Pitocin fits into the scientific discourse of treatment. In other words, it is a drug that can be given in precise amounts, for desired outcomes that can be immediately seen. Because of the extent to which it can be regulated, measured, and manufactured to perform a specific task, it is the favored course of action. For this reason, “Pitocin is the first thing I offer if a woman is not progressing” (Physician 2, 2012).

Alternatives

Because Pitocin then takes the position as the “go-to” drug, alternative methods are rarely presented as options unless a woman has done further research or has hired a doula to assist in her labor. As Pitocin is a synthetic form of oxytocin, it follows that the natural production of oxytocin in a woman’s body would induce contractions. Activities like nipple stimulation, anything that naturally secretes oxytocin like kissing or intimacy, acupuncture, castor oil, walking, using a labor chair, evening primrose oil, and herbal remedies were all alternatives for inductions and augmentations that I encountered, some of which seemed to be more useful to women than others.
But as I explored these options, I found that the way they were referenced within the medical community was much more restricted. Walking seemed to be one of the only methods of augmentation that was suggested to women I talked to, and even then it was often an aside. One nurse (when I asked what alternative methods she would suggest) whispered to me that women could try nipple stimulation (Nurse 2, 2011). Another physician said, “There will be patients who want to try things like nipple stimulation, but that I usually don’t offer to patients, it’s something they already have in mind; either they want to do that or not” (Physician 3, 2012). While these options seek to increase the natural levels of oxytocin in the brain and body, they do not fit into the standard medical discourse of what constitutes treatment. Such natural methods are perceived by some healthcare providers as “alternative” and therefore unscientific; because they cannot be accurately monitored or regulated and the fact that their effects are not as visible, Pitocin is the favored course of action.

The doulas and midwives I interviewed, on the other hand, seemed to embrace these alternatives. They were particularly adamant that labor can be aroused in the body through the action of nipple stimulation. Women who had hired doulas more often mentioned that they tried more natural ways to stimulate labor; in some cases they were successful, and in other cases they failed to make adequate progress and Pitocin was used. The approach practitioners take towards alternatives has everything to do with their philosophies towards childbirth as a whole; in a medical setting, non-medical techniques are often overlooked in favor of the drug that can be seen to have immediate effects, while in a less technical setting, like a home birth, these alternatives are instead the norm.

*The Hospital Environment*

In exploring the connection between oxytocin and labor, I began to notice women talking about the physical implications—and constraints—of giving birth in the hospital. In the natural childbirth model, women interact with their birth, both psychologically and physically. However, with the use of IVs, the existence of monitoring, and the prevalence of hospital protocols, birth becomes a technical process that is externally, rather than internally, managed. One of the doulas I
spoke with argued that these processes change the way labor occurs, saying, “I actually believe that it’s other factors that are coming into the picture that impede the progress” (Doula 4, 2011). The hospital’s physical environment can thus contribute to Pitocin use by preventing the process from unfolding naturally.

Hospital policies often dictate that women must have an IV port, that women should have vaginal exams to keep track of her progress, and that women should be monitored, requiring physical constraint to the bed. These processes are seen to disrupt the natural rhythm of labor. One of the women I spoke to commented, “I had taken all these classes about how to progress your labor and how to walk and how to work through contractions and do all these things and I couldn’t do any of those things because I was stuck in a bed with a monitor” (Patient 12, 2012). Progress can be made when women are able to move through a labor; by restricting movement, a woman’s labor might progress more slowly because the baby has a difficult time readjusting and repositioning. A doula I spoke with had witnessed many births in which she believed hospital policies and restrictions created an environment where progress was impossible:

If the hospital policy is that we do a vaginal exam every hour, yeah, maybe we are going to see a slower rate of progress in the labor because she’s staring to get in her flow and then we ask her to lay on her back, get a really painful vaginal exam, get out of her flow, and then sit there for another thirty minutes while she’s being monitored and told not to move (Doula 4, December 29th 2011).

One of the midwives I spoke with furthered this argument, saying that as mammals, women who feel watched or threatening during their labor will even stop laboring (Midwife 1, 2011). A woman who does not feel safe in the hospital environment, or who feels uncomfortable interacting with her birth, might not progress as she might under different circumstances, in which case Pitocin would be introduced to manage her contractions.

These policies are not always limited to vaginal exams and restriction of movement. In Nicole’s story, “There was one balcony we could get to that was outside, but as soon as we entered there the baby’s heart monitor stopped working, so they wouldn’t let us stay for more than ten
minutes out there. Unfortunately when I was outside, my labor progressed really well and as soon as I would come back inside it would slow back down” (Nicole, 2012). The same can be said of birthing tubs; many women have found that laboring in water can ease labor pains and encourage relaxation, and yet there can be restrictions on how long women can labor in water without monitoring. Some hospitals even prohibit laboring in water.

The limitations and protocols that hospitals put in place can have profound implications on how a woman is able to labor. Pitocin can be seen as a means of counteracting these physical factors that impede progress, which themselves are created by the environment in which a woman is laboring. These factors do not encourage (and probably even discourage) the natural production of oxytocin in a woman’s body.

**Decision-Making and Informed Consent**

*What Defines Informed Consent*

*I don’t know if I was asked if I wanted Pitocin or if it was just given to me. I know I didn’t have to sign a consent form for the Pitocin like I did for the c-section (Patient 11, 2012).*

Women who are concerned about avoiding Pitocin and other interventions during their birth often create birth plans that list what they do or do not want to happen during labor. Among the patients I interviewed, I found that most of the women who had written birth plans wrote them so as to avoid medical interventions. I talked to a nurse who told me that when a woman comes in with a birth plan, every medical professional assumes that she wants a natural childbirth, or at least that she does not want certain interventions (Nurse 1, 2011). As I heard more birth stories, I discovered that even women who wrote birth plans often ended up with interventions that were deemed necessary throughout the course of labor. Birth plans do not act, then, as a binding contract, but rather as an expressed desire for what a woman wants. A woman may write that her practitioner should not give her Pitocin, but through the process Pitocin may still be used. Although birth plans act as one
indication of preferences, the process of decision-making that plays out in the clinical scenario is much more complex.

What makes the question of informed consent complicated is the fact that there is no consent form that needs to be signed in order for a patient to receive Pitocin. It is not like giving an epidural or a cesarean section, which a patient must agree to by signing a document ensuring that she is aware of the risks involved. With Pitocin, women must rely solely on a medical practitioner to inform her of all the risks and benefits in the instance; this means that informed consent can be understood much more broadly and is therefore more difficult to define.

This fact has led to several court cases about the informed consent of Pitocin use. In one of these cases, Neighbors vs. Wolfson, the question was raised whether a physician must restate the risks of Pitocin at the time of an induction, or whether its discussion prior (at an earlier office visit) was sufficient to be considered informed consent. In this case, the jury found in favor of the physician (Woolery 2000). In another court case, a woman claimed that there was no informed consent for the use of Pitocin, which she believe contributed to a cesarean section and her son’s subsequent cerebral palsy. In this case, the jury again found for the physician (the defendant) because “a reasonably prudent person would have given that consent” (Woolery 2000: 248). In my research, similar issues of informed consent were raised. While some women maintained that they understood the benefits and risks of Pitocin before they agreed to its use, others claimed that they were only told of its benefits and that they did not feel educated about the drug. One woman even stated, “Honestly, if I knew then what I knew now, I wouldn’t have had them give me Pitocin. It even said in my birth plan I didn’t want Pitocin unless it was absolutely necessary. And I reread that and I was like, ‘Oh my god, we were so not informed, we just didn’t know anything’” (Patient 11, 2012). But because there is no physical documentation of informed consent with Pitocin, the findings of the court have shown that if it is considered necessary by the medical practitioner, then a reasonable person would consent to its use.
For the use of Pitocin during third stage labor, I found that these questions of consent were more ambiguous than ever. Many of the obstetricians I spoke to asserted that they gave Pitocin almost universally to patients for the prevention of hemorrhage, and yet a significant number of women were unsure whether they were given Pitocin in this stage. Even more said they were not given Pitocin, or that if they were, they were not made aware of it. This discrepancy resonated throughout almost all of my interviews, bringing me to question whether women did not remember being given Pitocin at this stage or whether they were informed of its use at all. Most of the practitioners said that Pitocin use for third stage labor was often discussed at clinical visits prior to birth, allowing the woman to either deliberately refuse or implicitly accept its use. According to one doula, patients who requested to opt-out of Pitocin in third stage labor previously were still often given Pitocin:

I’ll be with a practitioner who says “Yes, that’s fine. Of course we’ll honor that.” And then when we get down to it, when we’re in there and having our baby, and we’re waiting for the placenta to come out, we’re watching the natural process unfold, the practitioner—I mean I can’t give a percentage, but I would say enough to make an impact, enough times—that the practitioner will say, “You know what, I’m just seeing a little too much blood here, I’d like to give you that Pitocin shot now” (Doula 4, 2011).

Decisions in the moment are defaulted to the medical care provider, who has ultimate control over what diagnoses and assessments are made. Regardless of prior agreed-upon decisions, the doctor still has the ability to evaluate the clinical scenario and recommend courses of action—courses that might adhere to already-established protocols. To explore how this power struggle unfolds, I will discuss how decisions are portrayed in the clinical setting, the consequences of refusing, and the development of the doctor-patient relationship.

Deciding and Refusing

Decisions revolve around the appearance of choice. But in medical scenarios, decisions often seem urgent and might not always be something chosen by patients. When doctors recommend that a course of action be taken, they appear to the patient as the expert whose advice should be followed.
How patient decisions are made, then, results from acceptance of, or resistance to, medical advice. The communication between doctors, nurses, and patients is complex, but how communication occurs, in addition to what is said, is critical to understanding clinical decision-making. In this section, I analyze and interpret the processes of decision-making about Pitocin as they occurred among the individuals with whom I spoke.

To some women, protocols and procedures dictated the course of action, creating the impression that decisions were not occurring, or at least that the decisions were not theirs to make. Lauren told me that her induction seemed to follow a specific set of procedures that were out of her control: “Once I checked into the hospital it didn’t feel like there were any decisions. It wasn’t presented as options, it was just like ‘This is how it’s going to proceed.’ When I checked in I said, ‘I don’t want to use Pitocin if I don’t have to,’ and they basically said, ‘Well, you’re here for us to induce you so if the Foley catheter doesn’t work that’s our next step’” (Lauren, 2012). Lauren expressed then that decisions about the birth process did not exist to her. She felt that when one technique for stimulating labor failed, her practitioner would move on to the next without much discussion.

About half of the women I spoke to felt this way during their birth experience. They felt that decisions were outside of their knowledge and/or control. Others maintained that they were involved in the decision-making, either fully or to a degree. In these instances, women told me that either their practitioners had shown them statistics that made clear potential complications, or that they wanted to avoid a cesarean section. Their decisions to use Pitocin then rested on the fact that they wanted to mitigate these risks. Pitocin seemed like one of the interventions that, while certainly not welcome, was not as drastic a measure as other possible interventions. Therefore, when it came to deciding between options, Pitocin would often be seen as less of an extreme measure.

In order to ground this discussion in an understanding of clinical relationships, I use a theoretical interpretation to understand how subjects are created and defined by medical discourse.
and the medical gaze. The very term “patient,” for instance, refers to someone who is receiving care from someone who is administering it. By labeling a woman giving birth as a patient, the woman is defined as the subject of medical discourse. Being a subject makes evident her subject position as she is situated as a recipient of the constructions of medical power and knowledge. In this position, she can be objectified and treated in accordance with established categories she comes to embody (Foucault 1982). These structures are reinforced by the objectification of the medical gaze, which lets the practitioner isolate and treat abnormalities in the body rather than perceiving the entirety of the person. The subject position then comes into play as the patient is categorized in relation to the practitioner; the patient may create conceptions about what the practitioner’s position is by understanding herself to be a subject.

By the same token, patients are aware of themselves as subjects by recognizing these power dynamics and perceiving themselves to be recipients of this knowledge and care. Patients are not only positioned by this medical discourse, but they also position themselves within this medical discourse. One woman remarked that in giving birth in the hospital, “You have no idea what you’re doing, and you’re relying on the medical professionals” (Patient 6, 2011). Knowledge in this setting is generally perceived as something to be “acquired,” through extensive specialized education and experience. Women might then discount their own knowledge of the situation. Although the woman who is giving birth is more familiar with what she is feeling and she knows her own body, I frequently heard women talk about the need to defer knowledge and decisions to their doctor.

The subject position in the clinical setting sets up the dynamics of power between practitioner and patient, which ultimately influence who the primary stakeholders are perceived to be in decision-making. Foucault writes in *Subject and Power* that power is not a thing to be possessed, but rather that “‘power’ designates relationships between partners” (Foucault 1982: 786). Through this definition, power is in the relationship between the patient and practitioner, and it becomes discernable through the action of decision-making (Foucault 1982). An obstetrician I talked to
commented on this relationship, saying, “I would say most patients are willing to do whatever is recommended for their labor, and I think most women don’t have any big feelings one way or another, but there’s a vocal minority that feel really strongly that that is something they want to avoid. [But] we have so much more experience with this” (Physician 1, 2012). This statement legitimates the standard of these power relations. From the practitioner’s point of view, experience and clinical education provide physicians not only knowledge but also credibility to advise the patient and make decisions for them.

The way that medical professionals communicate information can furthermore change the way women conceptualize decisions in the moment. One woman told me that after her doctor became concerned about possible complications, she suspended her previous ideal that she wanted to avoid Pitocin and agreed to any decisions made by the practitioner. She continued that, “It was pretty concerning as a first time parent and you’re second guessing yourself the entire time. Like when they say, “Hey, this is what you should do,” you say, “Ok, I guess I should do that” (Patient 6, 2011). Here, the issue of trust became central to whether or not the woman accepted her doctor’s recommendation. Clinical decisions about Pitocin use can be yielded (by patients) to the discretion of the healthcare provider when the woman trusts not only the doctor but also the medical profession, and through this action the power dynamic that favors the medical professional becomes transparent. Relational power can only exist in this process if the patient then recognizes her subject position in this medical discourse.

Resistance

Resistance to medical advice then becomes a critical focal point in this discussion. To challenge the medical professional is to question the medical profession and medicine. But the boundaries where decisions are truly in the domain of a medical professional to act versus where doctor recommendations are given are sometimes difficult to discern. In other words, there is a line at which doctors must intervene, but this line is often blurred. Refusing doctor’s recommendations
can seem dangerous, and even antagonistic, which can lead women to comply with processes they otherwise might resist. Even though she tried to make her wishes clear, Erica told me that with Pitocin, “I held off on that and then finally gave in” (Erica, 2011). I encountered this rhetoric often; women would explain that they initially sought to refuse intervention but came, in one way or another, to accept it. I found that these processes often involved the way women felt they could interact with doctors. To some, the doctor-patient relationship was missing because the physician they had seen throughout their nine months of pregnancy was not the same physician who delivered them. In such cases, women end up having someone they have no clinical history with be in charge of their medical care. I spoke with one woman who reflected, “I feel like because I didn’t want to piss people off or have people make accommodations for me, I didn’t speak out early enough; that’s a recurring theme” (Patient 5, 2012).

Resistance also embodies the consequences of saying no to medical professionals. This concept partially revolves around liabilities, and whether a medical professional communicates that if something goes wrong, he or she is no longer responsible when a patient refuses advice. One woman who refused the use of Pitocin throughout her labor reflected on the way that she was made to feel at her birth, revealing to me that, “Obviously [the baby’s] fine and she’s healthy, but if she wasn’t, she wouldn’t have been fine. That would have been something I would have had to accept. But for them to make you feel like it’s because of a decision you made, I think that’s really unfair” (Patient 6, 2012). In her eyes, she saw that the blame was placed on her. In the following months after her daughter was born, she struggled to come to terms with the guilt and judgment she felt during this experience. Although she did not use Pitocin, she agreed to amniotomy after her doctors kept questioning whether she wanted what was best for the baby, and telling her that something would go wrong if she did nothing.

Some of these instances were more extreme than others. The residual implications for women seemed to encompass to what extent they felt they were able to discuss decisions as they
were unfolding. To several women, doulas acted to help them understand and navigate decisions, protocols, and communication with medical professionals. The women I spoke to who felt they had hired an effective doula said their role as patient advocates in the hospital helped establish decision-making based not solely on doctor recommendations, but also on how the woman felt about the intervention. Doulas were able to do this by requesting that the woman have an hour to try alternative methods and to decide; another method was to request that the medical professionals leave, allowing the woman and her husband to discuss the intervention independently of outside pressure. One woman told me that her doula helped her navigate the decision to use Pitocin by giving her an extra hour to think about it, and that, “For a first time mom, I probably wouldn’t have been comfortable negotiating like that” (Patient 13, 2012). By creating physical and emotional space, the rationale is that the woman has time to reflect on her personal opinions and make informed decisions she is comfortable with (and that she does not feel pressured into). If the mother or baby is not in immediate danger, allowing for more time can lessen the sense of urgency that often accompanies medical situations and can cloud the mind-state of the mother.

In Casey’s experience, her partner asked everyone to leave the room so that they could discuss the decision to use Pitocin privately, which she emphasized in her birth story as a pivotal moment in the process for her. Medical decisions that appeared to be immediate when presented by doctors were often met with the same sense of urgency by patients. The production of decision-making in the experiences of those I interviewed is consequently a result of the medical discourse surrounding the doctor-patient relationship, medical knowledge and expertise, and the communication of information. The birth experiences of women revolve around not only the course of events, but also how these courses of action are presented to, understood by, and decided by the woman giving birth.
CONCLUSIONS AND IMPLICATIONS

I think my husband and I look back on it as a pretty bad day, two-and-a-half days. It’s hard to think of it as negative though because then you have your baby that comes out of it so it’s kind of clouded over the nastiness of it. And I felt really disappointed for a long time but then when you realize that your child is healthy you just think, “Whatever, I just got to forget about it” (Patient 8, 2011).

It’s not about the experience. It’s about ending up with a healthy mom and a healthy baby. How we achieve that goal isn’t really important (Physician 2, 2012).

As I asked women whether or not their birth experience was positive or negative, I began to hear the same answer repeated again and again. “The outcome was positive; the experience, no” (Nicole, 2012). “I feel like my birth experience was negative with a positive outcome” (Patient 12, 2012). It was in this rhetoric that women talked about their births. They struggled to express how they came to terms with the experience that was so negative but that still marked the birth of their child. Some women told me they tried to forget about it, others told me that they did not deal with these emotions until the birth of their second or third child. Birth can be a traumatic experience. And yet when the baby is born healthy, and alive, women have trouble coping with the negative, or feeling like they have a right to call the experience negative.

In the excerpts at the beginning of this section, we see the way that one woman has tried to reconcile the negative aspects of her birth experience, and the conflicting view of the practitioner that the birth experience does not matter, which likely guides her approach to medical care. On the one hand, women must cope with experiences that are traumatic, and yet these experiences are discarded as negligible. These ideologies could not be more discordant. I spoke with a doula who told me,

I see the cascade of interventions fall out all the time. Mom feeling like she has post-traumatic stress disorder from the use of Pitocin, yes. Moms who have been victims of sexual abuse and we just heavily, heavily intervene into her birth, and compound the issues. The psychological components, which weigh heavily on some women: “My body is dysfunctional, my body wasn’t made right because I can’t do this on my own.” Yeah, I see that all the time (Doula 4, 2011).

The idea of “managing” a woman’s labor becomes a concern that is not only physiological, but is also psychological. How interventions play out is central to this discussion, and yet there is still a
blatant dissonance between the way practitioners interpret the events of birth and how women interpret them.

One woman told me, “It was a clashing experience from what I thought on my end and what they thought on their end. There was no compromise. There was no compromise.” (Patient 5, 2012). Perhaps it is the competing notions of what the birth experience should be that are guiding these power struggles as decisions about Pitocin are made. Our differing expectations are shaping what we come to accept as standard of care, how we approach management of the process of labor, and the way these experiences are lived by women.

Oxytocin is never left out of the equation. Some people have argued that oxytocin creates the link between a woman’s wellbeing and the way that her labor unfolds, and that Pitocin interferes with this natural process. Others have posited that labors on Pitocin can still be considered natural (if other interventions are avoided). Women even spoke of having a natural childbirth despite the Pitocin drip. The way that we categorize such labors are not yet fully realized; women struggle to distinguish what it means to them to use a medication to manage labor. With Pitocin’s prevalence in contemporary clinical settings, subjectivity as to what can be considered natural (and normal) is continually being reinterpreted and redefined to accommodate its use.

Among women who need it during their labors, Pitocin is still seen as a necessary evil. Many still question its exact role, maintaining that they would want to avoid it in the future, that they did not like it, or that the decision to use it was not theirs to make. Nevertheless, Pitocin use in the hospital setting is largely emblematic of the ways that women experience medicalized childbirth. Pitocin, in its most fundamental function, allows medical professionals to control the process of laboring in a way that is only matched by the use of cesarean sections to control the process of delivery. It fits into the scientific discourse of progress and the deep-seated cultural importance of a linear time. It allows results to be seen, visualized, and regulated. It allows risks to be averted; it allows labor to be efficient. This medical perspective of Pitocin’s purpose conveys the extent to
which contesting ideals, between how birth is perceived by the medical community (in medical discourse) and by women, become realized in the birth experiences of individual women.

Almost as an afterthought, after I turned off the digital recorder, Nicole started to reflect on something that happened after the birth of her son. She questioned her career path, saying,

I went from being very convinced that I was going to be a professional academic, a PhD who would teach at a university and go through that very striated path; it’s what I had spent my whole life working towards, it’s what I respected more than anything: the people who had PhDs and MDs and had reached that level of training. Gone through that process and gotten that piece of paper (Nicole, 2011).

She said that all of a sudden, instead of being committed to this path, her professors would advise her and she would not listen. Rather than following their directions, she would question them. Even though she was close to finishing her program, she considered dropping out. In this crisis of identity, she went to a therapist who specialized in career changes. She reflected,

What [the therapist] helped me realize is that I was reacting to my birth experience. and it’s because I went into it thinking that these are professionals who have the highest level or mark of respect that anyone can have. They have all the answers and they’re oracles that you can go to and they will tell you and know exactly what’s going on. And what I learned is that they don’t. They’re human beings and they’re ruled by their training but also their egos and their emotions and their personal lives (Nicole, 2011).

She began to understand that she had always been building towards this greater version of herself, and that once she attained her doctoral status, she would have all the answers.

Nicole’s newfound awareness of her situation helped her realize that, “Wait, I don’t need that piece of paper. I have reached that and I know better what I need in certain circumstances than someone who just happens to have that piece of paper. That was really an eye opening and difficult process for me to go through. But it came out in my professional life” (Nicole, 2011). In this sense, the social implications of Pitocin use during labor are far-reaching. They inform not only the directional course of events during birth, but they also cut to the core of what it means to possess knowledge, how power struggles are played out through these conceptions of knowledge, and how we assess what is normal through notions of objectivity and standardization. In a system that
emphasizes scientific discourse, we struggle to understand the implications of the medication beyond its treatment value. To women, however, the processes that unfold during the birth experience are never isolated to the delivery room.


http://www.ncbi.nlm.nih.gov/books/NBK51222/


Personal Communication:

Nicole, patient, January 12th 2012

Casey, patient, January 13th 2012

Lauren, patient, January 11th 2012

Erica, patient, December 29th 2011

Patient 1, November 14th 2011

Patient 2, November 21st 2011
Patient 3, December 4th 2011
Patient 4, January 7th 2012
Patient 5, January 6th 2012
Patient 6, December 27th 2011
Patient 7, December 29th 2011
Patient 8, December 28th 2011
Patient 9, December 23rd 2011
Patient 10, December 27th 2011
Patient 11, January 4th 2012
Patient 12, January 9th 2012
Patient 13, January 2nd 2012
Patient 14, January 4th 2012
Patient 15, January 27th 2012
Doula 1, November 15th 2011
Doula 2, November 28th 2011
Doula 3, December 7th 2011
Doula 4, December 29th 2011
Certified Professional Midwife 1, November 18th 2011
Certified Professional Midwife 2, November 28th 2011
Certified Nurse Midwife, December 6th 2011
Registered Nurse 1, November 14th 2011
Registered Nurse 2, December 4th 2011
Registered Nurse 3, January 15th 2012
Physician 1, Obstetrician and Gynecologist, January 4th 2012
Physician 2, Obstetrician and Gynecologist, January 7th 2012
Physician 3, Obstetrician and Gynecologist, January 21st 2012
Managing Labor with Pitocin
Principal Investigator: Anna Hermann

PARTICIPANT INFORMED CONSENT FORM
Consent for Patients
October 19, 2011

Please read the following material that explains this research study. Signing this form will indicate that you have been informed about the study and that you want to participate. We want you to understand what you are being asked to do and what risks and benefits—if any—are associated with the study. This should help you decide whether or not you want to participate in the study.

CONTACT INFORMATION

You are being asked to take part in a research project conducted by Anna Hermann, an undergraduate student in the University of Colorado at Boulder’s Department of Anthropology. This project is being done under the direction of Professor Donna Goldstein, Department of Anthropology, Hale 455 UCB. Anna Hermann can be reached at 720-308-0968. Professor Goldstein can be reached at (303) 492-5484.

PROJECT DESCRIPTION

The purpose of this study is to examine the ways that the education and practices of doctors, doulas, and patients affect decision-making about Pitocin use during childbirth. By looking at the different camps of thought about the use of medication during childbirth, this project aims to determine the differences in Pitocin administration depending on setting, social perception, patient ideals and medical professionals. This research from this study will be central to a complex understanding of the politics of medication use during childbirth and the ways that individual experiences are shaped.

You are being asked to be in this study because you have had experience(s) giving birth in the past twenty years.

Twenty participants will be invited to participate in this portion of the research study.

PROCEDURES

Taking part in this study is completely voluntary. You do not have to participate if you don’t want to. You may also leave the study at any time. If you leave the study before it is finished, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled.

Description of Procedures
If you agree to take part in this study, you will be asked to:

84 initials ______
A. Take part in an interview which will last approximately one hour
   i. These interviews will be recorded

Description of Surveys/Questionnaires/Interview Questions
You will be asked questions about your experiences of giving birth. Initial questions will involve specifics about where the birth took place, who was present, and if you had a birth plan (and if so what it specified). The following questions will involve whether or not your birth plan was followed, what medical interventions were used and for what reason, if and when Pitocin was administered, the effects of Pitocin, your role in decision making during the birth, the role of medical professionals, and the outcome of your delivery.

Time Commitment to Complete Research Procedures
Participating should take approximately one hour of your time, but could take more or less time depending on how long it takes to get through the interview questions.

Research Location
Participation will take place at coffee shops, in classrooms, in cafeterias, and over the phone when necessary.

Audio and/or Video Recordings
Participation in this research may include digital recording. These tapes will be used for documenting trends and capturing transcripts if necessary and will be retained for one year.

Those individuals who will have access to these tapes will be the principal investigator and the faculty advisor.

Being taped is not a requirement for participation. You may still participate in the study should you choose not be taped.

RISKS AND DISCOMFORTS
There are some minimal risks if you take part in this study.
These may include:

Emotional discomfort while recalling past experiences giving birth.

There are some things that you might tell us that we CANNOT promise to keep confidential, as we are required to report information like:
- Child abuse or neglect.
- A crime you or others plan to commit.
- Harm that may come to you or others.

BENEFITS

85 initials ______
You may not receive any direct benefit from taking part in this study. However, your participation in this study may provide you an opportunity to reflect on your experiences giving birth and will help us learn about the politics of decision-making about medication use during childbirth.

**COST TO PARTICIPANT**

You or your insurance company will be responsible for costs you incur by participating in this study, such as driving to and from the interview site.

**SUBJECT PAYMENT**

You will not be paid for participation in this study.

**ENDING YOUR PARTICIPATION**

You have the right to withdraw your consent or stop participating at any time. You have the right to refuse to answer any question(s) or refuse to participate in any procedure for any reason. Refusing to participate in this study will not result in any penalty or loss of benefits to which you are otherwise entitled.

**CONFIDENTIALITY**

We will make every effort to maintain the privacy of your data. Your name will not be included anywhere in the thesis or on the interview file; you will be referred to by a letter (i.e. Patient A). Anna Hermann and Professor Donna Goldstein will be the only ones with access to interview tapes, which will be securely stored on the principal investigator’s password-protected computer. Video will be erased from the card as soon as it is downloaded onto the computer. These videos will be retained until the study is completed and will then be deleted. Identifiable information such as names, locations, and age will be removed from the results in order to protect confidentiality. However, specifics about a birth may be included in analyses; these data will be aggregated with the other interview subjects in order to assure confidentiality.

Other than the researchers, only regulatory agencies such as the Office of Human Research Protections and the University of Colorado at Boulder Institutional Review Board may see your individual data as part of routine audits.

**QUESTIONS?**

If you have any questions regarding your participation in this research, you should ask the investigator before signing this form. If you should have questions or concerns during or after your participation, please contact Anna Hermann at 720-308-0968.
If you have questions regarding your rights as a participant, any concerns regarding this project or any dissatisfaction with any aspect of this study, you may report them confidentially, if you wish to the Institutional Review Board, 3100 Marine Street, Rm A15, 563 UCB, (303) 735-3702.

**AUTHORIZATION**

I have read this paper about the study or it was read to me. I know the possible risks and benefits. I know that being in this study is voluntary. I choose to be in this study. I know that I can withdraw at any time. I have received, on the date signed, a copy of this document containing 4 pages.

Name of Participant (printed) __________________________________________

Signature of Participant ______________________ Date ________________
(Also initial all pages of the consent form.)

I am consenting to be recorded during the participation of this research.

_____ Yes, I would like to be taped during my participation in this research.

_____ No, I would not like to be taped during my participation in this research.
Appendix 1

Managing Labor with Pitocin
Principal Investigator: Anna Hermann

PARTICIPANT INFORMED CONSENT FORM
Consent for Medical Professionals
October 19, 2011

Please read the following material that explains this research study. Signing this form will indicate that you have been informed about the study and that you want to participate. We want you to understand what you are being asked to do and what risks and benefits—if any—are associated with the study. This should help you decide whether or not you want to participate in the study.

CONTACT INFORMATION

You are being asked to take part in a research project conducted by Anna Hermann, an undergraduate student in the University of Colorado at Boulder’s Department of Anthropology. This project is being done under the direction of Professor Donna Goldstein, Department of Anthropology, Hale 455 UCB. Anna Hermann can be reached at 720-308-0968. Professor Goldstein can be reached at (303) 492-5484.

PROJECT DESCRIPTION

The purpose of this study is to examine the ways that the education and practices of doctors, doulas, and patients affect decision-making about pitocin use during childbirth. By looking at the different camps of thought about the use of medication during childbirth, this project aims to determine the differences in pitocin administration depending on setting, social perception, patient ideals and medical professionals. This research from this study will be central to a complex understanding of the politics of medication use during childbirth and the ways that individual experiences are shaped.

You are being asked to be in this study because you are a medical professional who is knowledgeable in and has experience with childbirth.

Ten participants will be invited to participate in this portion of the research study.

PROCEDURES

Taking part in this study is completely voluntary. You do not have to participate if you don't want to. You may also leave the study at any time. If you leave the study before it is finished, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled.

Description of Procedures
If you agree to take part in this study, you will be asked to:

88 initials ______
Appendix 1

B. Take part in an interview which will last approximately one hour
   i. These interviews will be recorded by digital recorder

Description of Surveys/Questionnaires/Interview Questions
You will be asked questions about your experiences with birthing. Initial questions will involve how you became involved in this area of medicine, your training, what kinds of places you practice at, and your role at births. Following questions will involve questions about general Pitocin use, your opinions about when Pitocin should or should not be used, and how you work with other medical professionals and doulas.

Time Commitment to Complete Research Procedures
Participating should take approximately one hour of your time, but could take more or less time depending on how long it takes to get through the interview questions.

Research Location
Participation will take place at coffee shops, in classrooms, in cafeterias, and over the phone when necessary.

Audio and/or Video Recordings
Participation in this research may include audio recording. These tapes will be used for documenting trends and capturing transcripts if necessary and will be retained for one year.

Those individuals who will have access to these tapes will be the principal investigator and the faculty advisor.

Being taped is not a requirement for participation. You may still participate in the study should you choose not be taped.

RISKS AND DISCOMFORTS

There are some minimal risks if you take part in this study.

These may include:

Emotional discomfort while recalling past experiences and legal consequences if any information is provided that involves breach of patient confidentiality or malpractice.

You will not be asked about any illegal activities, but if you should discuss such activities, the information could be requested by authorities such as the police or court system.

There are some things that you might tell us that we CANNOT promise to keep confidential, as we are required to report information like:

- Child abuse or neglect.
- A crime you or others plan to commit.
- Harm that may come to you or others.
## BENEFITS

You may not receive any direct benefit from taking part in this study. However, your participation in this study may provide you an opportunity to reflect on your experiences with birth and will help us learn about the politics of decision-making about medication use during childbirth.

## COST TO PARTICIPANT

You or your insurance company will be responsible for costs you incur by participating in this study, such as driving to and from the interview site.

## SUBJECT PAYMENT

You will not be paid for participation in this study.

## ENDING YOUR PARTICIPATION

You have the right to withdraw your consent or stop participating at any time. You have the right to refuse to answer any question(s) or refuse to participate in any procedure for any reason. Refusing to participate in this study will not result in any penalty or loss of benefits to which you are otherwise entitled.

## CONFIDENTIALITY

We will make every effort to maintain the privacy of your data. Your name will not be included anywhere in the thesis or on the interview file; you will be referred to by a letter (i.e. Medical Professional A). Anna Hermann and Professor Donna Goldstein will be the only ones with access to interview tapes, which will be securely stored on the principal investigator’s password-protected computer. Video will be erased from the card as soon as it is downloaded onto the computer. These videos will be retained until the study is completed and will then be deleted. Identifiable information such as names, locations, work information, and age will be removed from the results in order to protect confidentiality. Any specific data, such as kinds of places you practice, will be aggregated with the other interview subjects in order to assure confidentiality.

Other than the researchers, only regulatory agencies such as the Office of Human Research Protections and the University of Colorado at Boulder Institutional Review Board may see your individual data as part of routine audits.

## QUESTIONS?

initials ______
Appendix 1

If you have any questions regarding your participation in this research, you should ask the investigator before signing this form. If you should have questions or concerns during or after your participation, please contact Anna Hermann at 720-308-0968.

If you have questions regarding your rights as a participant, any concerns regarding this project or any dissatisfaction with any aspect of this study, you may report them confidentially, if you wish to the Institutional Review Board, 3100 Marine Street, Rm A15, 563 UCB, (303) 735-3702.

| AUTHORIZATION |

I have read this paper about the study or it was read to me. I know the possible risks and benefits. I know that being in this study is voluntary. I choose to be in this study. I know that I can withdraw at any time. I have received, on the date signed, a copy of this document containing 4 pages.

Name of Participant (printed) ____________________________________________

Signature of Participant ___________________________ Date ______________.
(Also initial all pages of the consent form.)

I am consenting to be taped during the participation of this research.

_____ Yes, I would like to be taped during my participation in this research.

_____ No, I would not like to be taped during my participation in this research.
PARTICIPANT INFORMED CONSENT FORM
Consent for Doulas
October 19, 2011

Please read the following material that explains this research study. Signing this form will indicate that you have been informed about the study and that you want to participate. We want you to understand what you are being asked to do and what risks and benefits—if any—are associated with the study. This should help you decide whether or not you want to participate in the study.

CONTACT INFORMATION

You are being asked to take part in a research project conducted by Anna Hermann, an undergraduate student in the University of Colorado at Boulder's Department of Anthropology. This project is being done under the direction of Professor Donna Goldstein, Department of Anthropology, Hale 455 UCB. Anna Hermann can be reached at 720-308-0968. Professor Goldstein can be reached at (303) 492-5484.

PROJECT DESCRIPTION

The purpose of this study is to examine the ways that the education and practices of doctors, doulas, and patients affect decision-making about Pitocin use during childbirth. By looking at the different camps of thought about the use of medication during childbirth, this project aims to determine the differences in Pitocin administration depending on setting, social perception, patient ideals and medical professionals. This research from this study will be central to a complex understanding of the politics of medication use during childbirth and the ways that individual experiences are shaped.

You are being asked to be in this study because you are a doula who is knowledgeable in and has experience with childbirth.

Five participants will be invited to participate in this portion of the research study.

PROCEDURES

Taking part in this study is completely voluntary. You do not have to participate if you don't want to. You may also leave the study at any time. If you leave the study before it is finished, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled.

Description of Procedures
If you agree to take part in this study, you will be asked to:

92 initials ______
Appendix 1

C. Take part in an interview which will last approximately one hour
   i. These interviews will be recorded by video

Description of Surveys/Questionnaires/Interview Questions
You will be asked questions about your experiences with birthing. Initial questions will involve
how you became involved in this area of medicine, your training, what kinds of places you
practice at, and your role at births. Following questions will involve questions about general
Pitocin use, your opinions about when Pitocin should or should not be used, and how you work
with medical professionals and patients.

Time Commitment to Complete Research Procedures
Participating should take approximately one hour of your time, but could take more or less time
depending on how long it takes to get through the interview questions.

Research Location
Participation will take place at coffee shops, in classrooms, in cafeterias, and over the phone
when necessary.

Audio and/or Video Recordings
Participation in this research may include audio recording. These tapes will be used for
documenting trends and capturing transcripts if necessary and will be retained for one year.

Those individuals who will have access to these tapes will be the principal investigator and the
faculty advisor.

Being taped is not a requirement for participation. You may still participate in the study should
you choose not be taped.

RISKS AND DISCOMFORTS

There are some minimal risks if you take part in this study.

These may include:

Emotional discomfort while recalling past experiences.

You will not be asked about any illegal activities, but if you should discuss such activities, the
information could be requested by authorities such as the police or court system.

There are some things that you might tell us that we CANNOT promise to keep confidential, as
we are required to report information like:
   • Child abuse or neglect.
   • A crime you or others plan to commit.
   • Harm that may come to you or others.

BENEFITS

93 initials ______
Appendix 1

You may not receive any direct benefit from taking part in this study. However, your participation in this study may provide you an opportunity to reflect on your experiences with birth and will help us learn about the politics of decision-making about medication use during childbirth.

**COST TO PARTICIPANT**

You or your insurance company will be responsible for costs you incur by participating in this study, such as driving to and from the interview site.

**SUBJECT PAYMENT**

You will not be paid for participation in this study.

**ENDING YOUR PARTICIPATION**

You have the right to withdraw your consent or stop participating at any time. You have the right to refuse to answer any question(s) or refuse to participate in any procedure for any reason. Refusing to participate in this study will not result in any penalty or loss of benefits to which you are otherwise entitled.

**CONFIDENTIALITY**

We will make every effort to maintain the privacy of your data. Your name will not be included anywhere in the thesis or on the interview file; you will be referred to by a letter (i.e. Doula A). Anna Hermann and Professor Donna Goldstein will be the only ones with access to interview tapes, which will be securely stored on the principal investigator’s password-protected computer. Video will be erased from the card as soon as it is downloaded onto the computer. These videos will be retained until the study is completed and will then be deleted. Identifiable information such as names, locations, work information, and age will be removed from the results in order to protect confidentiality. Any specific data, such as kinds of places you practice, will be aggregated with the other interview subjects in order to assure confidentiality.

Other than the researchers, only regulatory agencies such as the Office of Human Research Protections and the University of Colorado at Boulder Institutional Review Board may see your individual data as part of routine audits.

**QUESTIONS?**

If you have any questions regarding your participation in this research, you should ask the investigator before signing this form. If you should have questions or concerns during or after your participation, please contact Anna Hermann at 720-308-0968.
If you have questions regarding your rights as a participant, any concerns regarding this project or any dissatisfaction with any aspect of this study, you may report them confidentially, if you wish to the Institutional Review Board, 3100 Marine Street, Rm A15, 563 UCB, (303) 735-3702.

**AUTHORIZATION**

I have read this paper about the study or it was read to me. I know the possible risks and benefits. I know that being in this study is voluntary. I choose to be in this study. I know that I can withdraw at any time. I have received, on the date signed, a copy of this document containing 4 pages.

Name of Participant (printed) ______________________________________

Signature of Participant ___________________________ Date ______________.
(Also initial all pages of the consent form.)

I am consenting to be taped during the participation of this research.
____ Yes, I would like to be taped during my participation in this research.
____ No, I would not like to be taped during my participation in this research.