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THE SOCIAL ORGANIZATION OF NATURAL CHILDBIRTH: THE CASE OF CENTER FOR MIDWIFERY CARE

Natural childbirth is a practice that aims to minimize the amount of medical interference during childbirth while maximising the active involvement of mothers in decisions related to this process. This practice has spread steadily in Russian obstetrics since the 1990's and has become a significant challenge to official medical techniques assisting delivery. Both proponents and critics of natural childbirth usually see this practice in an essentialist way, i.e. as an attempt to restore in modern society some "genuine" experience of delivery. In this article, the category of social control is employed in order to emphasize the social aspects of natural childbirth and to analyse the core principles of its social organization in midwifery care. The methodological approach of the work springs from the qualitative sociological tradition. The analysis presented within is based on in-depth interviews with both the staff and mothers from one of Russia's centres for midwifery care, and on data gathered through observation carried out at courses for prospective parents.

Keywords: natural childbirth, midwifery care, social control, sociology of childbirth, the social transformations of Russian obstetrics.

Both within everyday understandings and in academic literature, "natural" childbirth and hospital birth are treated as two diametrically opposed phenomena. Since the 1970s, when the study of the reproductive sphere became a

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legitimate focus of sociological analysis, comparisons of these two poles has formed the central axis of research into birth and the assistance provided for it (Graham, Oakley 1979; Oakley 1979, 1984; Jordan 1997; Davis-Floyd 2001; Jones 2012). This article aims to contribute to this discussion by examining "natural" childbirth at the level of everyday practices implemented in one of Russian centres of midwifery care and by identifying the core social characteristics of this type of birth.

The first part of the paper presents a definition of "natural" childbirth as a social phenomenon and singles out the key theoretical contradictions arising from the use of this concept in social studies. This is followed by a description of the research case (a midwifery care centre) and a presentation of the methods used to collect and analyse the data. The third part is devoted to a critique of the medicalized approach to birth and analysis of how "control" over childbirth is understood within this approach. The fourth part is focused on developing an analysis of the empirical data, examining the specifics of the conception and implementation of control in the "natural" childbirth.

"Natural" childbirth: a definition and critique of the concept

In both sociological literature and the midwifery practice, the category of "natural" childbirth is used to describe a particular system of ideological beliefs and practices related to preparing mothers for childbirth, assisting delivery and providing postnatal care. This system is considered to be an alternative to the dominant mainstream childbirth methods utilised in modern health care systems. The concept of "natural" childbirth was developed in the 1960s in the US and Western Europe, when members of the midwifery movement, the movement for the patients' rights and the second wave of feminism presented criticism of the mechanistic approach to the female body and reproductive experiences employed in the medical profession.

On the one hand, this criticism rallied against the idea of seeing the female body as a vulnerable and unpredictable thing that deviated from the "normal" and "healthy" male physical form (Bordo 1993). On the other hand, it was directed at the simplistic approach adopted in modern medicine, which depict and explain diverse female reproductive experiences through reducing them to mere physiological processes. This was also a rejection of the metaphorical perception of childbirth as a series of actions aimed at the creation of the child as a "product" (Oakley 1979). Both these criticized positions legitimized the intensive interference of doctors during pregnancy and childbirth. The goal of obstetricians in this case was to use standardised scientific methods to control the work of the female body, which was seen as an imperfect machine (Martin 1992).

The "natural" approach to childbirth opposed the official medical view of the female body, preferring instead to describe it as strong, healthy and perfectly adapted to the needs of childbirth. Women were also presented as actors

capable of making informed decisions about reproductive practices. This entailed the rejection of the technocratic model of childbirth, which focused predominantly on the anatomy of a woman in labour, leaving her feelings without attention and thus making her birth experience fragmented. In place of this technocratic model, the concept has been put forward of seeing childbirth as a holistic life experience, including emotional and spiritual components (Davis-Floyd 2001; Belooussova 2002).

However, the idea of presenting "natural" childbirth as the opposite of a "medicalized" childbirth is theoretically problematic. Having emerged as an ideological category, when this concept is applied to the study of everyday phenomena it often transmutes into an empirical category, which authors use to point out various birth practices that somehow depart from the medical model of childbirth that is accepted in their country or region. Thus, a birth can be called "natural" if it occurs through the vagina rather than by caesarean section; if it is supervised by a midwife, not a doctor; if it is done as a water birth and not in a hospital ward and so on. As a result, "natural" childbirth becomes a somewhat "slippery" concept (Macdonald 2006: 251), i.e. a concept that threatens to become a simple reference to empirical circumstances. As such, this concept should be used very carefully for analytical purposes.

It is worth mentioning a few of the pitfalls that befall researchers of "natural" births. The first of these is the trap of essentialising "natural" childbirth. As anthropologists have shown, childbirth, being one of the most important events in the life cycle, is socially constructed and regulated in all cultures (Jordan 1978). However, many supporters of the "natural" approach, and academics charmed by this discourse (Kitzinger 1988; Davis-Floyd, Davis 1996; Cheyney 2008), share the myth of the "free" birth that supposedly existed in the past and can still be found in pre-industrial societies. Such essentialising often goes hand in hand with the romanticization of "natural" childbirth. In condemning the technocratic model of birth dominant in developed countries, some authors contrast it to the pre-discursive, "genuine", natural experience of childbirth enjoyed by women from other cultures (Macdonald 2006: 239). The unreflective moralizing view on "natural" childbirth associates this phenomenon with biological predetermination and proper course of physiological processes (even if in modern culture an equally legitimate parallel could be drawn between "natural" and "dangerous" events).

The second trap lies in the problem of painting a sharp contrast between "natural" and "hospital" births (and, correspondingly, providing a definition of "natural" childbirth through this juxtaposition) (Beckett 2005; Walsh 2010). In part, this contradistinction is established with reference to the aforementioned controversial division between "natural" childbirth and socially controlled (especially medical) childbirth. On the other hand, the division between "natural" and "hospital" births can be maintained through other criteria: above all this is done by the contrasting of "warm" midwifery care, that is sympathetic to its patients to the "cold", impersonal and technical style of medical care provided by obstetricians

(Bondas 2002). Such an approach, however, does not take into account the point that even a "natural" birth involves a certain level of intervention into the process of delivery, including giving medical advice (Lowis, McCaffery 2004: 10–11) and that technological equipment is usually a prerequisite for realization of care for the patient (Mol 2008: 5). To give an example, even in the practice of "natural" childbirth at home midwives often use oxygen tanks for neonatal resuscitation.

In their analysis of what constitutes the ideology of the "natural" childbirth movement, sociologists and anthropologists have put forward the following criteria. Firstly, the new mother and her partner are seen as active participants during labour, taking part in the decision-making process on an equal footing with doctors and midwives. Secondly, the "natural" birth model demands both serious physical and psychological preparation on the part of parents. Thirdly, at the very heart of "natural" childbirth is the principle of minimal use (or even rejection of) medical intervention (Beloussova 2002; Mansfield 2008).

However, the above definition of "natural" childbirth is not sufficient. In this article we look at the everyday level of midwifery care and consider how "natural" childbirth manifests itself as a social practice. We will not only describe these practices but also provide a sociological interpretation of them, primarily by reference to the category of "control", which is fundamental to modern research on reproductive medicine (see the A. Temkina article in this issue).

In this article, we will focus on "natural" childbirth in hospitals. In this case, childbirth takes place in a hospital ward that is not only in possession of all the required equipment and the necessary medical professionals but also has procedures in place to ensure that childbirth complies with the quality standards and bureaucratic requirements of the Ministry of Health. In spite of all of these apparently artificial features, such deliveries are considered by the participants involved to be "natural". In examining this case we will try to identify the key social regulations permitting the "natural" birth to occur, even in hospital settings.

"Natural" births in hospital settings: a description of the research case

The practice of "natural" childbirth in hospitals emerged in many developed countries in the second half of the last century within the context of midwives' struggle for professionalization. In Russia, the first centres of midwifery care providing such services appeared only in the late 1990s. They were set up in large cities as structural subdivisions of maternity hospitals or as private clinics that actively cooperate with state medical institutions. A key aspect of the services this centres offered was the opportunity to carry out a "natural" birth under the close supervision of medical professionals.

Perhaps the ideal type of the "natural" birth are so-called "home" deliveries, where the child is born not in the hospital ward but in the private setting with the help of a midwife (or without if a "solo-birth" is being performed) (Beloussova

2002; Pivovarova 2013). However, many of those parents striving to reduce the level of medical intervention in childbirth are also aware of the health risks associated with this strategy. They understand that life-threatening situations can arise during labour, potentially leading to emergency medical intervention. Furthermore, in the Russian case, there is no official recognition or regulation of "home" deliveries (Order 2012). In other words, "natural" birth in a hospital setting is the only legal option for parents wishing to receive skilled assistance for this kind of birth.

This article considers the case of the Rainbow centre of midwifery care in St. Petersburg, which is one of the most successful Russian examples of "natural" childbirth being implemented within the settings of the a medical institution.[1] The centre was established in 1997 as an independent self-supporting department of maternity hospital № 15 (now renamed as hospital № 17)[2]. At the time of the study (February-September 2013), the centre was made up of six midwives delivering babies and running training courses for expectant parents. In addition, three midwives worked in the postnatal ward.

The work of the Rainbow Centre is organized around the guiding principle of continuity. This entails the creation of a continuous chain; starting with preparation for childbirth, moving through to the actual delivery of the child and concluding with postnatal care. The centre accepts women and couples who are expecting a child up to 25 weeks prior to the due date. Preparation for childbirth involves twelve four-hour lessons in the hospital. The course includes lectures, performing exercises, watching training films, lessons in a swimming pool and sessions in a sauna. All the classes are led by professional midwives. When necessary, the client (the family) can turn to the doctors of the hospital for help with consultation, taking advantage of their diagnostic capabilities.

The clinic functions under the assumption that women (or couples) will have their baby delivered by the very same midwife who had led their courses and overseen their training. Deliveries take place in a specially equipped room in the maternity ward, with the maximum use of water to aid birth, and the possibility is left open for the mother to choose a variety of bodily positions during labour. The Rainbow Centre also has postnatal wards where new mothers are supervised by the midwives of the centre after labour. After being discharged, the clients are subsequently visited at home by midwives to encourage breastfeeding and to answer any questions related to the care of the infant and the health of the mother.

In 2013 there were 394 births at the Rainbow Centre, 370 of which occurred as normal deliveries. 39 births took place on obstetric delivery beds, while 13 births occurred with the assistance of epidural anaesthesia. The average age of first-time mothers at the centre was 28.5 years of age, with the youngest women giving birth being 21 years old and the oldest 41.

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[1] The name of the centre is published with the consent of the centre

[2] By the time this article was published the centre had became a department of St.Peterburg Snegivera Maternity Home No. 6

The empirical basis of this article consists of semi-structured interviews with midwives delivering babies in the Rainbow Centre (N = 7), clients of the centre (N = 12), as well as data collected while observing 24 hours of the childbirth training provided at the centre. Texts of the interviews and observations were analysed and highlighted under the following thematic sections: (a) how "natural" childbirth is defined (b) how mothers are prepared (including self-preparation) for such births, (3) the interaction of mothers and midwives during childbirth and (4) comparisons of experiences of medicalized and "natural" births.[1]

In analysing the practice of "natural" childbirth, we will focus on the interaction between the two main actors at the heart of it: the mother and the midwife. Other participants in childbirth include the mother's partner and the minimally involved obstetrician. However, in my opinion, a detailed consideration of the position of the partner and doctors in "natural" childbirth should be the subject of an entirely separate study.

Control of childbirth in medicalized obstetrics

"Control" is a fundamental category used to describe the way modern obstetrics is organised as a social institution (Ginsburg, Rapp 1991; Zadoroznyj 1999; Carter 2010; Zdravomyslova, Temkina 2011). Mothers, their partners, midwives and doctors are seen both as subjects on whom responsibility over reproductive experience is structurally imposed, and as agents who seek to extend their control over the process of childbirth.

From the multitude of interpretations on birth control two aspects are important for us: control as an opportunity to take rational choices and make informed decisions on childbirth and control as the chance for the woman to play the role of "the one who gives birth", in other words, the freedom to experience and interpret her own bodily sensations (Namey, Lyerly 2010: 771–772).

According to another scholarly tradition, the study of care, these two forms of control can be linked to the logic of choice and the logic of care, respectively. In the first case, research focuses on patients and physicians as subjects of rational choice and its available options. In the second case, participants in childbirth are examined more as subjects of different types of activity, with the analysis focusing on how they act in a concrete situation, as they attempt to cope with the particular challenges facing them (Mol 2008: 8–10, 52).

"Natural" childbirths function as an alternative to the medicalized outlook of the reproduction process and as such are mediated by these views (Viisainen 2001: 1110). Therefore, we will begin by considering issues of control with relation to the dominant medical model.

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[1] The research was supported by Novartis AG in the frame of A. Temkina professorship on sociology of public health and gender.

Control as the ability to command one's own body. The ability to control your own body and emotions is one of the basic moral perquisites that society demands of an adult. The period of pregnancy is a rare occasion when a person, who is not otherwise considered to be ill, is allowed to lose control of her body. Pregnancy and especially childbirth are seen as a period in which a transforming body becomes unmanageable; given the presence of the foetus within, it ceases to be wholly owned by the woman herself (Carter 2010: 995; Lupton 2012: 4).

Within the framework of the dominant medical view of childbirth, the physical unity of the mother is broken up and fragmented. The active agents in labour are seen to be hormones, the uterus, the foetus, etc. The capacity of a woman to function as a social actor and consciously have an influence on all this is seen as very limited (Akrich, Pasveer 2004: 69). The body's rejection of its previous state of relative submission is perceived as a constant source of danger to the physical well-being of mothers and infants in pregnancy; water can break too early, labour can suddenly stop or "freeze", etc. This loss of control over the body also has social consequences and creates risks for the mother as a social actor. One example informants relate is the case of how the male partner of another couple, having attended the birth of his child, finds himself no longer attracted to the young mother. As such, the birth of a child is defined in the modern society through, on the one hand, the loss of control of a women over their own body, and, on the other hand, through the pressing need to restore this control.

Medicine presents itself the main force capable of providing rational control over the "uncontrollable" body of a pregnant woman. Such control is primarily achieved by the fact that doctors create their own discourse, allowing them to describe and classify changes in maternal body (as is evident above, the very lack of control over the female body is interpreted through a set of medical categories). It is hoped that through consultation with an obstetrician, reading materials for parents and visiting specialized courses, the expectant mother will learn this discourse and thus will obtain, if not control, then at least an understanding what is happening in her body (Browner, Press 1996: 144).

Doctors and midwives follow the standardized schemes of childbirth assistance and rectify abnormal bodily processes. As a result, births become more predictable and presumably safer. One of the midwives, who participated in the study, describes the obstetricians' role as a normalising response to the bodily "behaviour" of mother during childbirth:

> Our maternity clinic, and in general, many others [maternity wards – E.B.] are attempting to standardize obstetric care. I mean this kind of thing: if the water broke and the mother has high temperature then… [we take predefined acti-ons – E.B.]; and if a mother's temperature is normal and the water did not break then [we follow some other instructions – E.B.] (midwife, 52 years).

It is also important to note that the use of medical technology allows a woman to give birth with "dignity"; saving face even at such an extreme point in her life.

According to Canadian researchers, some middle-class women explain their preference of a caesarean section as a method of delivery by their desire to avoid the "chaos and filth" of a vaginal birth (Malacrida, Boulton 2012: 760–762).

Control as the right to exercise choice. The right to make choices about life events and thus to achieve some degree of control over them can be seen as one of the key values of the middle class. This rule also holds true with regard to the childbirth (Zadoroznyj 1999). It is no surprise that highly educated, well-to-do parents, who are used to making rational strategic decisions about their work and the organization of family life (or, at least, feel the need to make decisions of this sort) apply similar principles and standards to the case of the childbirth. They seek to find out about various methods of delivery, inquire into what hospital and doctors have a good reputation and strive to gain access to them (Zdravomyslova, Temkina 2009; Melnikova 2012). Mothers who do not adhere to this behavioural standard are socially labelled as "irresponsible", indifferent both to their own health and to that of their children (Odintsova 2009).

In fact, the ability of patients to choose their preferred method of childbirth aid extends only to the limits of the delivery room, after which it is restricted. Even middle-class women, at all other times able to act as reflective consumers of health services, delegate control over their body to medical professionals upon entering the hospital ward:

> The mother is the heart of the childbirth process, the midwife is the hand that delivers the child and the brain, well that's the doctor that manages the entire process. I mean, in my case, it wasn't the midwife or me who directed the birth but the doctor who monitored me from one stage to the next, correcting the process and giving instructions. You could say he pulled all the strings and ran the show (mother, 30 years, university educated).

It is accepted practice for the patient to agree in advance with medical staff with respect to the course taken in childbirth (in Russia this is typically the case in paid healthcare). The patient also has the right to refuse medical interference in the birth process. Nevertheless, obstetricians, given their monopoly over authoritative knowledge on childbirth (Jordan 1997), usually have priority in choosing the strategy of delivery. To take one example, if an expectant mother, wants to receive anaesthesia, she can have it only on the condition that the obstetrician determines that the patient has arrived at the hospital at an appropriate stage of labour. Obviously, doctors also hold dominant rights in childbearing due to the limited ability of women in the process of giving birth to offer serious resistance.[1]

Even the existence of a preliminary agreement does not ensure the delivery will take place in accordance with the patient's preferences. This is not merely a question of doctors changing plans in the face of unexpected complications. For

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[1] As Russian researchers have noted (Temkina, Angelova 2009: 488), the participation of the father in childbirth is one of the ways to overcome this problem. In this case, the role of the partner is to «control the situation» and remain informed of changes from staff.

example, one of the mothers interviewed in this research signed an agreement to receive paid childbirth care in a private hospital. One of the essential terms and conditions agreed upon in the first instance by the doctor was to deliver the child on a regular bed. Nonetheless, during the active pushing phase of labour the obstetrician put the woman on an obstetric delivery bed, even though the birth did not require significant medical intervention:

> Actually I had agreed beforehand with the doctor about that ghastly delivery be. I mean, I told them I didn't want to lie flat and asked if we could find something different, more comfortable for me. The doctor said "sure". Only later did I find out she had only been talking about the first period of labour, when you only get contractions. And they really did keep their word in the first stage. But when the pushing started they moved me onto the bed. Well they didn't actually move me. When I was lying on the couch, they told me "Alright, now we are really going to push". They reassembled the couch into a delivery bed, I couldn't believe it. But I was no longer in any condition to stop them (mother, 29 years, college educated).

To give birth by yourself: control and care in the "natural" childbirth

In contrast to the ideas behind medicalized births, "natural" childbirth is based on the notion that a woman can (and should) be the main character in the story of childbirth. The patient is expected to be able to control her body at the critical moment of bringing a new child into the world. This control, however, is not so much about making informed choices about how delivery is conducted. In fact, it is about the mother's ability to be "the one giving birth", to be in touch with her bodily sensations and adhere to them.

> It is necessary to give a woman the right to decide the manner of childbirth, she should be able to feel the process and we should remain on the sidelines supporting and looking out for her. That means if she is breathing, if she is singing then she is giving birth the right way. And if a woman does not do anything and doesn't change her position, then she is clamming up and withdrawing [into herself- EB], this is not a real birth (midwife, 50 years old).

The ability of the mother to control the processes of childbirth is not taken for granted and seen as an inherent gift that all women possess. The "natural" approach to childbirth, as well as the medicalized version, offers its own means of interpreting the reproductive experience. This approach must be actively learned by the mother prior to giving birth. The mere fact that a woman chooses to have a "natural" birth with a midwife does not infer that she may lay idle in labour or simply do as she pleases (Mansfield 2008: 1087).

In actual fact, "natural" birth requires even more comprehensive preparation on the part of mother than the medicalized alternative. Firstly, as is the case with medicalized childbirth, this is about acquiring new knowledge to improve under-

standing of the on-going changes in her body. The amount of knowledge involved in this, as a rule, is greater than that required for a "traditional" birth with a doctor. As the data in this study shows, the majority of women choosing "natural" childbirth were members of the educated middle class who tend to be sufficiently on the subject of childbirth and obstetric practices. As patients, these clients have a keen desire to deepen their understanding of both the challenge before them and the main features of the "natural" approach to childbirth. One of the informants described the preparation she underwent for childbirth in the following way:

> Yes, I read quite a lot, Sears, Michel Auden, and all these texts […] I found myself reading a lot of English sites, well, I mean, not English but just in English language. That's because for some reason there is much, much more information on this in English on the Internet. In addition, I did gymnastics at home and bought a CD with some exercises for pregnant women (mother, 35 years, college educated).

Secondly, significant attention is paid by the centre's staff to ensure patients master the physical skills needed during labour. This includes learning to regulate spontaneous physiological processes (such as breathing) and even develop bodily reactions that one can't control consciously (for example, "training" the blood vessels by visiting a sauna). To achieve this, the patient is required to regularly attend the sauna and the swimming pool in late pregnancy, as well as doing other special exercises. Such prenatal preparation demands a high level of self-discipline on the part of the pregnant women, including a willingness to significantly alter their daily routine in order to gain the desired result, i.e. a safe "natural" childbirth.

Another important feature of the "natural" approach is the allocation of control over birth. In medicalized childbirth the default position (or rather, the one settled by the rules of the healthcare system) is for the obstetrician to decide the course of action. In the case of "natural" childbirth, full control is not assumed by any of the parties involved. There are no overriding, predetermined rules such as "birth should be controlled in the main by the midwife" or "birth should be controlled by the mother". Each particular birth is seen as unique to its participants, causing those present to focus on each other (and the essentially unpredictable process of delivery) and find the most suitable balance of controls for them. This pragmatic control is embedded in the "here and now" situation and cannot be fully predefined prior to the onset of labour. In this sense, the process of giving birth is connected to a sort of fine-tuning of the interaction between the mother and the midwife leading the delivery.

The following story demonstrates how a midwife avoids any binding preliminary agreement with the client about the course to take in the birth process.

> She [the patient – E.B.] said at the beginning: " <…> I want to have a separate delivery room for me, so that nobody bothers me… I don't want them to cut the baby's umbilical cord [straight away – E.B.] or for them to do an artificial rupture of membranes". Then I told her straight out, "Hold on a moment there. Yes, I am ready to agree with that up to a point but there will be times when I

> won't be able to guarantee that everything will go as we hope, it might just be that your mem-branes will really need to be ruptured" <…> And it just so happened that it was necessary to perform an amniotomy. I even held a kind of bucket in front of her and lowered a little ball into it to demonstrate that she had a lot of water and how it would all come out. And then, when she was about to give birth for the second time, she told me, "Let's do it the way you see fit". But then I told her, "That way won't work either" (midwife, 50 years).

In order for this model of birth to function both sides must put in a great deal of preparatory work. The focus of this work lies in building personal relations of trust between the mother and the midwife. The midwife must have trust in the mother giving birth (and in her level of physical preparation). This means understanding that she will be able to "give birth herself" and to overcome all the challenges of the process without resorting to unnecessary medical interventions. The mother, in turn, must give her trust to the midwife and support the potential decision of the latter to intervene in the delivery if the need arises.

In a sense, the construction of friendly, emotionally involved relationships between the client and her midwife is driven by pragmatic necessity (along with the desire to provide greater comfort for the expectant mother). Empathy allows participants to interact more effectively and readily trust each other the emergency situation of childbirth. The lengthy preparation for childbirth that the centre's programme provides is the key to the formation of such personal contact:

> This approach is fundamentally based on the individual. This is an essential element. There are some women I have been seeing since 22 or even 18 weeks of their pregnancy, every Friday I spend four hours with them. We have a chat together, joke around a bit, we socialise beyond just the lectures. Then I might see them in the pool. Sometimes I might even be able to help them with family problems. You can ask the women themselves about this but I would say by the time of birth we have already built a pretty close relationship with them (midwife, 48 years).

Conclusion

Within the ideology of the "natural" childbirth movement there is a generally widespread understanding of deliveries being, first of all, "natural" or "authentic" and, secondly, a pleasant and joyful event. This practice, combined with the methods of midwifery care, is associated with caring for the mother giving birth, building an emotionally involved relationship with her, as well as giving woman the chance to avoid unnecessary medical interventions.

In this article, I intended to show that such a romantic view is, in the main, misleading. In modern society, "natural" childbirth is a particular kind of social practice, requiring considerable work from the women (and from the midwife) who choose to follow it. This work entails a long and careful preparation phase for the expectant mother, including not only the development of new knowledge

and the attainment of new physical skills, but also the building of a trusting relationship with the midwife. Although conventional medicine often defines "natural" childbirth as the preferred option for "irresponsible" parents (see, the article by A. Novkunskaya in this issue), it should be underlined that such deliveries actually demand more control and responsibility from women in the process of giving birth.

In making distinctions between natural and social phenomena, we can define the former as occurring without human interference or control and even resistant to human will. The latter can be seen as occurring only as a result of conscious and intentional activities of people (Goffman 1974). If one subscribes to this version, "natural" childbirth at the level of interaction between the patient and the midwife is, rather paradoxically, a phenomenon that has a more sophisticated social organization than medicalized childbirth. Whereas the medical profession holds that the body in labour can be controlled only through biochemical and surgical intervention, the "natural" approach focuses on social interaction and crafts a complex situational balance of control during delivery. While in the case of "traditional" hospital birth, mother's control is limited to the choosing of her doctor and the ward, "natural" childbirth demands her active involvement in the process of delivery. And if virtually any woman "off the street" can have a successful medicalized childbirth[1], then in stark contrast to this, giving birth "naturally" without a laborious and painstaking preparation, is basically impossible.

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[1] By 'successful' we mean here the criteria of success put forward in the medical profession for medicalized births.

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