Institutional and Cultural Perspectives on Home Birth in Israel

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ABSTRACT

This study exposes doctors' and midwives' perceptions and misperceptions regarding home birth by examining their views on childbirth in general and on risk associated with home births in particular. It relies on an approach of risk communication and an anthropological framework. In a qualitative-constructive study, 19 in-depth interviews were conducted with hospital doctors, hospital midwives, home-birth midwives, and a home-birth obstetrician. Our findings reveal that hospital midwives and doctors suffer from lack of exposure to home births, leading to disagreement regarding norms and risk; it also revealed sexist or patriarchal worldviews. Recommendations include improving communication between home-birth midwives and hospital counterparts; increased exposure of hospital doctors to home birth, creating new protocols in collaboration with home-birth midwives; and establishing a national database of home births.

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Over the course of human history, medical, social, economic, and political factors have led to shifts in practices associated with childbirth, including where and under whose supervision it takes place. The most dramatic change in developed countries, occurring over a relatively short period of time, has been the move of childbirth from the home of the birthing woman to the hospital. This transition, noticeable from the beginning of the 20th century, occurred simultaneously with the introduction of male doctors into a domain previously dominated by women (Gaskin, 2011; Rich, 1995) and the use of medical technologies (Gaskin, 2011; Shahar, 1990) and pain relief (Beckett, 2005; Rich, 1995) into the childbirth experience. The transition to hospital birth altered the way births were conducted, and during the 1960s, feminist activists claimed that birth had been taken out of the women's sphere and transformed into a male- and technology-controlled medical process (Balaskas, 1992; Beckett, 2005; Kitzinger, 2011; Rich, 1995). Women were called on to reclaim their rights over their bodies, and new schools of birth, emphasizing "natural" birth, were introduced (Balaskas, 1992; Beckett, 2005; Gaskin, 2011).

Women's organizations were not the only ones to express apprehension about the extensive use of technology in childbirth. Despite the risks inherent in this approach, *Care in Normal Birth: A Practical Guide*

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contends that "there is a temptation to treat all births routinely with the same high level of intervention required by those who experience complications . . ." (World Health Organization [WHO], 1996, p. 2). In addition, researchers from various disciplines have examined benefits versus detriments when using various technologies (Alfirevic, Devane, & Gyte, 2008; Chen, Chauhan, Ananth, Vintzileos, & Abuhamad, 2011; Grivell, Reilly, Oakey, Chan, & Dodd, 2012; Klein, 2006; Kornelsen, 2005; McGrady & Litchfield, 2004).

Gender, professional, and cultural differences may affect perceptions regarding childbirth and the use of technology. For example, the infiltration of male doctors into a previously female-dominated domain, which largely depended on traditional women's roles and experience, led to changes such as the invention of instruments and drugs including forceps, monitors, and chloroform, which were designed to improve and replace the skillful hands of midwives (Gaskin, 2011; Rich, 1995; Shahar, 1990). Today, there still are noticeable differences between doctors' and midwives' approaches to perinatal care. For example, doctors' textbooks deal mostly with female anatomy and the pathology of pregnancy and birth (Cunningham et al., 2010), whereas midwives' textbooks stress broader issues pertaining to birth such as the family, emotions of the birthing woman, and more (Fraser & Cooper, 2003). Moreover, studies show that doctors are more concerned than midwives about the detrimental effects of vaginal birth (Klein et al., 2009) and believe that the use of multiple technologies during birth enhances safety (Davis-Floyd, 2001; Klein et al., 2009; Monari, Di Mario, Facchinetti, & Basevi, 2008; Reime et al., 2004). Another finding shows that midwives hold positive attitudes toward home birth, whereas most doctors are in opposition (Ann & Freeze, 2010; Cheyney & Everson, 2009; Klein et al., 2009; Vedam, Stoll, White, Aaker, & Schummers, 2009).

For more information on The Israeli Home Birth Midwives Organization, see http://www.imahi.co.il/

In addition to the gender and professional differences, cultural differences also affect attitudes toward childbirth. For example, in the Netherlands, where childbirth is considered a natural process that requires monitoring and supervision (Davis-Floyd, Barclay, Daviss, & Tritten, 2009), the rate of cesarean surgeries is 15%, among the lowest in Western countries (WHO, 2011); only 10% of women are administered an epidural anesthesia during childbirth (Davis-Floyd et al., 2009); and about one third of all births occurs at home (Davis-Floyd et al., 2009). In contrast, 66% of births in the United States involve epidural anesthesia (McGrady & Litchfield, 2004), and only 0.72% of births occur at home (MacDorman, Mathews, & Declercq, 2012). Regarding Israel, where there were 166,000 births in 2011 (Central Bureau of Statistics, n.d.), only 716 (about 0.43%) were home births (Shiftan, n.d.).[1] There are researchers who argue that in Israel, a Jewish state surrounded by Arab countries, childbirth is seen as a "national duty" to impact the demographic balance (Ivry, 2009). Various incentives encourage procreation, including a birth grant (depending on location of birth), and fertility treatments funded by the state. For years, the Israeli Ministry of Health (MOH) has harbored reservations regarding home birth. Nevertheless, Israeli law did not forbid midwives or doctors from treating out-of-hospital births, and in 2008, the Ministry published a home-birth protocol that was expanded and amended in 2012. Throughout the protocol, the MOH (2012) stresses that the safest location for childbirth is a hospital and recommends that all women should give birth in hospitals. Currently in Israel, there are 18 active home-birth midwives, all associated with the Israeli Home Birth Midwives Organization (IMAHI), and three physicians who perform home births.

The issue of home birth is also controversial in places outside of Israel (Ann & Freeze, 2010). Its opponents argue that the safety of home births has not been proven because a randomized control trial cannot be conducted because of ethical reasons and because of risk of biased selection in choosing samples for research (American College of Obstetricians and Gynecologists [ACOG], 2011; Wax et al., 2010). Some studies show that home birth involves less intervention, greater maternal satisfaction, and fewer complications such as instrument use and tearing, among others (de Jonge et al., 2009; Fullerton, Navarro, & Young, 2007; Janssen et al., 2009; Johnson & Daviss, 2005; Wax et al., 2010). Other studies have found that the rate of neonatal death is higher in home births than in hospital (Bastian, Keirse, & Lancaster, 1998; Wax et al., 2010). A 2012 review by the Cochrane collaboration shows that hospital birth is not safer than a planned home birth attended by

a certified midwife (Olsen & Clausen, 2012). In the same year, the National Health Service (NHS) declared home birth to be the recommended alternative for low-risk women giving birth for at least the second time (Hope, 2012).

Discussions about safety do not sufficiently explain the controversy, and it seems that home birth is an emotionally charged issue, influenced by personal opinion and risk perception. In the area of risk communication that deals with public attitudes toward health hazards, the emphasis is on the different ways the public and specialists perceive risk. Sandman (1999), who proposes a model for risk communication, points out that risk perception is composed of hazard, which is the scientific side, focusing on unwanted effects, and of outrage, which is the emotional component, focusing on worries and fears of the public.

Despite misgivings regarding the safety of home birth, most women's organizations respect the right of a woman to choose the birth location that suits her best, although stressing limitations (American College of Nurse-Midwives, 2005; ACOG, 2011; Royal College of Obstetricians and Gynaecologists and Royal College of Midwives, 2007). For example, the WHO stated that a woman should give birth where she feels safe and where there is access to appropriate treatment, whether at home, in a birthing center, or in a hospital (WHO, 1996).

Most studies on home birth can be classified as one of three types. The first type is prospective cohort studies that examine the results of home births, or meta-analyses based on such studies; the second is survey studies that examine medical teams' stances on home birth; and the third is qualitative studies comprising in-depth interviews with women who elected home birth. This study is qualitative, and it is unique because it is based on in-depth interviews with medical and birth teams, allowing a deep understanding of their perception about births in general and home births in particular. Understanding various perceptions regarding home births can assist in the construction of an effective communication model between hospital teams, the home-birth midwife, and the mother to improve childbirth safety and increase satisfaction of home-birthing mothers.

RESEARCH METHODS

Study Structure and Participants

The study structure is qualitative using constructivist grounded theory, which assumes that neither data nor theories are discovered but are constructed by the researcher following interactions with the field and participants (Strauss & Corbin, 1990). It was carried out through personal interviews, which took place during January to August 2012. The interviewees who participated in the study were three male doctors and three female doctors, senior specialists in obstetrics with at least 10 years of experience, all but one holding directorial positions; five midwives working in hospitals for at least 17 years, all clinical instructors; six home-birth midwives, with 16–30 years of experience (with at least 4–20 of them at a hospital); the chairwoman of IMAHI, who works as a home-birth midwife; and one home-birth doctor.

Data Gathering

Following approval No. 083/12 of the ethics committee of Haifa University, one of the researchers contacted the department heads and/or head midwives of five randomly selected large hospitals in central and northern Israel.[2] The manager/midwife was asked to facilitate contact between the researcher and an interviewee with experience in birth who would agree to be interviewed. In addition, the researcher published a "public appeal" by means of a personal letter to all home-birth midwives in Israel. Interviews were conducted with the six home-birth midwives who were first to respond. In addition, the researcher phoned the chairwoman of IMAHI and a physician who performs home births, one of three in Israel. In-depth interviews of 1–2 hr were performed according to one of three protocols designed especially for this study; a separate protocol was designed for each group. The protocols included generic questions regarding birth perceptions, risk perceptions, norms, and communication channels. Midwives and doctors who work in hospitals were also asked specific questions with respect to their positions on home births, as well as questions designed to identify barriers, difficulties, and inhibitions that constitute their opposition to home birth. All interviews were recorded, transcribed, and read by two researchers for reliability.

Theoretical Framework

Our analysis considers the three different approaches to childbirth described by Davis-Floyd (2001)—the technocratic, the humanistic, and the holistic. According to Davis-Floyd, the technocratic model is the most widespread in birth rooms, and the

holistic model is most widespread among midwives. The technocratic model differentiates between body and mind, and childbirth from overall lifecycle. The technocratic caregiver prefers technology to contact, and the woman's body is considered "defective" as compared with the male body; therefore, various manipulations are required to "fix" it (Davis-Floyd, 2001). In contrast, the holistic model does not allow for the separation of body, emotion, mind, and environment. The holistic caregiver believes that the patient is an inseparable part of the treatment and that childbirth cannot be standardized. In addition, this type of caregiver makes minimal and cautious use of technology (Davis-Floyd, 2001).

Our analysis also considers Sandman's (1999) hazard plus outrage approach. According to Sandman, risk perception is composed of feelings of outrage toward the risk in addition to the scientific aspect. Within this framework, people associate high risk with issues toward which they have negative attitudes regardless of the proved risk. The audience's view of risk (as opposed to that of the experts assessing the risk) reflects not just the danger of the action (hazard) but also how they feel about the action and what emotions they feel about the action (outrage). Lack of agreement between experts' and the public's perception of hazard and outrage can lead to controversy. According to Sandman, one of the most important ways of dealing with negative feelings of a population toward a certain issue is continuous communication with that population.

Analysis

A multistaged thematic analysis was applied to the study's findings (Shkedi, 2003). In the first stage, each interview was analyzed separately and its themes were characterized. In the second stage, common themes from each group were determined. For example, themes that reappeared in all interviews with hospital doctors were located and analyzed. In the third stage, themes that all three groups shared were singled out and their similarities and differences were classified. The themes were analyzed with reference to the technocratic and holistic models of birth (Davis-Floyd, 2001) and the risk perception model (Sandman, 1999; Table 1).

FINDINGS

Ideal Birth

In the interviews, it was found that although all the interviewees believe that childbirth is the most significant event in a woman's life, there are significant differences among the three groups regarding what comprises an "ideal birth." According to the hospital doctors in the study, an ideal birth is one that results in a healthy mother and a healthy newborn, is quick, and involves minimum pain. The hospital midwives also referred to the issue of safety, but in addition, they stressed the mother's satisfaction with the process: "An ideal birth is one that ensures the mother's safety . . . and fulfills her wishes." For home-birth midwives, an ideal birth is one in which the mother is at the center, there are minimum interventions, and the mother feels empowered.

Midwives and Doctors—Between Physiology and Pathology

All interviewees agreed that whereas midwives deal with low-risk births, the role of a doctor is detection and handling of high-risk births. Both home and hospital midwives added that there are differences not only in roles of midwives and doctors but also in their approach to birth. According to the perception of all of the midwives as well as the home-birth doctor, hospital doctors regard birth as a medical event, risky and potentially pathological. This group argued that, although according to hospital doctors each birthing woman is a "ticking time bomb," the midwives regard birth as a natural process and their attitude is more holistic, taking into account psychological and familial aspects of the mother as well.

Perceptions of Home Births

All but one of the hospital doctors expressed opposition to home births. Among hospital midwives, three opposed it and two expressed reservations. It should be noted that the "opponents" stated that they had never attended a home birth. The hospital doctors' opposition was expressed by statements such as, "I think it is the highest possible level of stupidity. A person is willingly exposing [herself] to danger. That's it . . . I don't accept it."

In addition to their opposition to home births, the hospital doctors and midwives contended that natural (unmedicated) birth can be performed in a hospital, which according to their view, is a safer environment: "They can have natural birth . . . in a normal environment . . . with the hospital responsibility and being monitored by the staff." Some of the hospital doctors said that they did not understand the difference between home and hospital birth because "the infant comes out the same way in any case. What

TABLE 1
Analysis of Themes According to the Technocratic-Holistic Birth Model and the Risk Model

Model Name	Model Principles	Themes	Target Audience	Analysis of the Study According to the Model
The technocratic model (Davis-Floyd, 2001)	1. Mind–body separation	A. Perceptions of an ideal birth B. Midwives and doctors between physiology and pathology	Hospital doctors	Doctors refer only to the physical aspect with respect to ideal birth. In addition, the doctor is responsible for pathological births; therefore, the focus of his work is physical assistance.
	2. The patient as an object	Midwives and doctors between physiology and pathology	Hospital doctors	The doctors refer to the physical aspect of the mother only.
	3. Diagnosis and treatment from the outside in	A. Any birth has potential of complications B. Need of technologies at birth	Hospital doctors and hospital midwives	Because of the inherent risk of every birth, there is a need of external means to monitor and control the birth and treat as if it is complicated.
	4. Hierarchical organization and standardization of care	Birth and gender	Hospital doctors	The mother is treated in accordance with procedures and routine of the department.
	5. Authority and responsibility inherent in practitioner, not patient	A. Natural birth in hospital B. Birth and gender	Hospital doctors	Option to have "natural birth" in a hospital: like at home but with medical supervision. The doctor decides what will be the treatment, not the mother.
	6. Supervaluation of science and technology	A. Perception of risk at birth B. Objection and reservation regarding home birth C. Need of technologies and more staff at birth	Hospital doctors and hospital midwives	Emphasis on equipment and technology as a method to enhance birth safety. Home birth is perceived as riskier because it takes place in an environment with few technologies.
	7. Techno-medical hegemony	A. Objection and reservation regarding home birth B. Subjective norms of birth	Hospital doctors and hospital midwives	The techno-medical ideology is the standard; any other treatment option (midwives) is an "alternative."
The holistic birth model (Davis-Floyd, 2001)	1. Oneness of body, mind, and spirit	A. Perceptions of an ideal birth B. Midwives and doctors between physiology and pathology C. Perception of the uniqueness of home birth	Home midwives and hospital midwives	Midwives refer to aspects of emotions and feelings of the mother and her family and social relations. The differences in the location of birth embody deep differences in perceptions of birth.
	2. The body as an energy system	Perceptions of an ideal birth	Home midwives and home doctor	Work with birth energy—the mother is at the center. Prevention of disorders and holistic treatment of birth
	3. Healing the whole person in whole life context	Midwives and doctors between physiology and pathology	Home midwives and hospital midwives	The midwife refers to wide aspects of the mother's life, such as family, social, and emotional aspects.
	4. Diagnosis and treatment from the inside out	A. Birth is a natural process B. Female body is "built for birth" C. Perceptions of an ideal birth	Home midwives and home doctor	Home midwives believe that the know-how of birth is embedded in the woman's body, and ideal birth is one that allows the mother to be at the center and rely on her abilities.

(Continued)

TABLE 1
Analysis of Themes According to the Technocratic-Holistic Birth Model and the Risk Model *(Continued)*

Model Name	Model Principles	Themes	Target Audience	Analysis of the Study According to the Model
	5. Individualization of care	A. Perception of the home birth uniqueness B. Perceptions of an ideal birth	Home midwives and home doctor	Ideal birth is where the mother is at the center. Treatment of the mother according to her specific needs
	6. Authority and responsibility inherent in the individual	A. Perceptions of an ideal birth	Home midwives and home doctor	The mother is at the center. She makes the decisions. The midwife only accompanies her.
		B. The right of a woman to determine birth location	Home midwives and hospital midwives	
	7. Science and technology placed at the service of the individual	Careful use of technologies at birth	Home midwives and home doctor	Careful and controlled use of technologies, usually not invasive, that work with the physiology of the body (oxygen, jacuzzi, birth balls, and more)
The hazard plus outrage model (Sandman, 1999)	1. Risk is composed of hazard, which is the technical aspect focused on the unwanted results, and outrage, which is the nontechnical aspect focused on negative emotions associated with the situation.	A. Objection and reservation regarding home birth B. Unique perception of home birth C. Home birth as "primitive" or as a journey back in time	Hospital doctors and hospital midwives	Doctors and hospital midwives who express outrage toward home births perceive the issue of home birth as risky even if the risk factor is low. The outrage feelings are expressed in this study by objection and comparison of home births to primitive births in the distant past Third World countries.
	2. Even significant risk is tolerable if the outrage is low, on the other hand, when the outrage is high, even a low risk is rejected.	Lack of common policy	Home midwives and home doctor	Outrage of home midwives toward procedures of the MOH might prevent listening to home-birth risk warnings and prevent communication and dialog with the medical establishment.
	3. There are five ways of outrage management: (a) to speak about the center, not the extremes; (b) to admit past mistakes; (c) to admit current problems; (d) to modestly discuss successes; and (e) to share control and be responsible.	Lack of common policy	Home midwives and home doctor	To reduce objection of home midwives to home birth procedure, Sandman's principles of outrage management should be adopted: to deal with licensed home midwives who comply with the procedures, not midwives who work illegally. To admit past mistakes and current problems and cooperate with home midwives in compilation of procedures which refer to their work.

Note. MOH = Israeli Ministry of Health.

is the difference? That it is in her bed?" In contrast, home-birth midwives stressed that there is no such a thing as a "home-like birth": "It is just the hospital's way of attracting clients . . . Home birth is at home."

According to the perceptions of all the hospital doctors and midwives, home births are associated with premodern conventions or births in developing countries, births with high morbidity and mortality rates. "It is true that our great-grandmothers even gave birth in the fields, but that is why the mortality rate was so high." Some of the home-birth midwives argued that the hospital doctors' objections make transfer of birthing women to hospitals more difficult when it is necessary. Notwithstanding ob-

jections of the hospital doctors and midwives, all interviewees agreed that home births should not be prohibited, to guarantee personal freedom.

Birth Risk Perceptions

For most hospital doctors and midwives in this study, a birth is a risky event that can turn into an emergency at a moment's notice: "Every pregnancy is a risk, even a low-risk pregnancy." According to them, to minimize risk, a great deal of technological equipment and additional staff is required, including "sterile equipment . . . scissors, clamp, monitor . . . uterotonics . . . a newborn resuscitation station." All home-birth midwives stressed the fact that even though they carry a lot of equipment to each birth, they use it only when needed and that "using such equipment in a no-risk birth introduces risk." All the doctors and some of the hospital midwives expressed concern regarding home births and the belief that home birth involves a pointless risk. For example, one of the doctors argued, "I see no reason for an infant to enter intensive care because his mother thought that she had to give birth with dolphins." To illustrate this standpoint, the doctors and hospital midwives provided examples of home births gone wrong; for example, "A woman who arrived with . . . a ruptured uterus . . . a woman whose placenta didn't separate and she arrived almost in a state of a shock." On the other hand, the home-birth midwives argued that home birth is at least as safe as hospital birth and that the doctors' fears stem from lack of knowledge: "None of them ever attended a home birth . . . they don't know what it is."

Birth and Gender

Some of the hospital doctors who were interviewed used sexist imagery when referring to birth. For example, one doctor compared a gynecologist to a soldier in combat; another compared the work of a midwife to cake baking; and yet another female gynecologist claimed that home birth "is like, pardon me, prostitution—when it's illegal, it's a mess." Most of the midwives, as well as the home-birth doctor, expressed the position that in birth rooms, there tends to be a paternalistic attitude of the staff toward the mothers: "embodiment of paternalism . . . even chauvinist, paternalistic dictatorship."

Subjective Norms of Birth

Among the interviewees, there was a pronounced difference in perceptions of home birth as a norm. Whereas among hospital doctors and hospital midwives, none of them or their families had given birth at home, among home-birth midwives, some had given birth at home or assisted relatives in home births. Home-birth midwives believe that doctors should be exposed to home births as part of their medical education. In addition, these midwives argued that the public fear of home births is a cultural fear that is not based on science. "The anti-home birth approach is not an issue of health but an issue of culture, and if we wish to influence attitudes towards home birth, we must effect cultural change."

Lack of Common Policy

The interviewees agreed that most hospital doctors and most of the medical establishment are opposed to home birth. Some of the interviewees argued that midwives' views on the subject tend to be more open-minded. The study also shows that the doctors and home-birth midwives are not satisfied with the MOH protocols regarding home birth. The home-birth midwives said that they were not consulted when the protocols were written, whereas the hospital doctors and midwives spoke about the importance of regulation, which is not adequately enforced when births occur at home.

DISCUSSION

This study reveals major differences in perceptions of childbirth and in the approaches of hospital doctors, hospital midwives, and home-birth midwives (and the home-birth doctor) toward the birthing mother and childbirth in general and toward home birth in particular. The differences in attitude partially explain the discord and lack of communication between the home-birth midwives and hospital staff, differences that were revealed in various studies on the subject (Ann & Freeze, 2010; Cheyney & Everson, 2009; Davis-Floyd, 2001; Klein et al., 2009; Monari et al., 2008; Vedam et al., 2009). This study exposes hospital doctors' and midwives' perceptions and misperceptions regarding home birth by examining their views on childbirth in general and on risk associated with home births in particular.

This study also exposes the differences in perception regarding the risk level associated with birth. Although all the interviewees said that childbirth is a natural event, most of the hospital doctors and midwives argued that any birth, even one that is defined as "low-risk," can cause complications. This fear of complications is what has led medical staff to believe that technologies such as fetal monitors, drugs,

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resuscitation equipment, and a large staff are required to make childbirth safer, an approach in line with the technocratic birth model (Davis-Floyd, 2001). We can assume that hospital doctors' and midwives' reservations regarding home birth stem from both fear of birth complications as well as the belief in the necessity of many types of technological intervention. Indeed, all but one of the hospital doctors opposed home birth, and they all believed it riskier than hospital birth, a finding in keeping with studies on the subject (Cheyney & Everson, 2009; Klein et al., 2009; Klein et al., 2011). Hospital midwives demonstrated a wider variance. A correlation was found between the exposure of a midwife to home birth and the midwife's degree of opposition to the subject—midwives who had attended home births did not oppose them, and midwives who had never attended such a birth opposed them. Similar findings were found in a study by Vedam et al. (2009).

To demonstrate the risk inherent in home births (in their view), some of the hospital doctors and midwives in the study chose to give accounts of home births that ended badly and to compare home births to childbirth in developing countries or in the distant past—births which entailed great danger. Such a comparison is not supported by literature on the subject, which shows that results of home births are positive by most standards (de Jonge et al., 2009; Fullerton et al., 2007; Johnson & Daviss, 2005) and much better than outcomes in developing countries (WHO, 2011); thus, it reflects a minority and not majority of home births. We can therefore conclude that because most of the doctors and midwives in Israel work in hospitals and most of them have never attended home births, they are exposed only to home births that entailed complications and ended up with the birthing mother being evacuated to the hospital. This fact, as well as the fact that in Israel there is no database of home-birth outcomes, including rate of complications and evacuation to hospitals, can distort hospital medical staff perceptions, resulting in beliefs that home births with complications represent all home births, or as stated by Wagner (2001), "For obstetricians who have never attended a home birth, home births which entailed evacuation to hospitals are their only experience with out-of-hospital births . . . This is like the auto mechanic who sees several Mercedes with mechanical problems and concludes that all Mercedes are no good." A single home birth that entailed complications and evacuation to a hospital can turn into a doctor's anecdote to describe all home births. Ann & Freeze (2010) claim that doctors are inclined to recount home-birth stories by word of mouth, stories that become increasingly exaggerated with each telling. A similar feeling is expressed in a study based in Oregon, in which the midwives argued that doctors base their positions regarding home birth on anecdotal stories and not on studies (Cheyney & Everson, 2009).

The fact that some of the hospital doctors and midwives base their stances on home birth on such anecdotes and elect to use extreme cases to describe prevailing norms implies that their objection cannot be understood in medical and research terms only, and it seems that there is an emotional element involved in their negative attitude. Sandman's (1999) hazard plus outrage theory, which tries to explain health phenomena, can help explain medical teams' perceptions of home births. According to Sandman, risk perception is composed, in addition to the scientific aspect, also of feelings of outrage toward the risk. He says that people associate high risk with issues toward which they have negative attitudes regardless of the proved risk on the subject (Sandman, 1999). When this theory is projected onto home-birth risk perceptions, we can argue that most hospital doctors and midwives nurture negative feelings toward home birth and thus perceive them as risky. According to Sandman, one of the most important ways to deal with negative feelings of a population toward a certain issue is continuous communication with that population (Sandman, 1999). It is crucial to understand the fear (outrage) of medical teams regarding the subject of home birth to create a dialog between the medical professionals working within hospitals and professionals working outside the establishment, that is, home-birth midwives. The holistic approach stresses a balance between mind and body, which gives more weight to the emotions of the patient (Davis-Floyd, 2001). By connecting it to the Sandman model, we can apply this concern with emotions to the hospital staff as well, thereby broadening its application to take into account the concerns of patient as well as those of the midwife and doctor.

In this study, the negative feelings of the hospital doctors and some of the hospital midwives toward home birth contrasted with the home-birth

midwives, who expressed their belief that the woman's body is "built for birthing" and that a healthy pregnant woman whose pregnancy is holistically monitored is at low risk for birth complications. Home-birth midwives in the study observe that home birth is currently safer because of technological improvements that allow pregnancy monitoring, identifying "high-risk" pregnancies and effective and fast treatment of complications, should they occur, a treatment that may be possible and effective also in a home birth. Home-birth midwives also stressed the considerable amount of equipment they carry to every birth, and the fact that excessive use of technology in hospitals increases the risk at birth, an argument supported by various birth researchers (Beckett, 2005; Davis-Floyd et al., 2009; Gaskin, 2011; Kitzinger, 2011; Kornelsen, 2005).

Both hospital doctors and midwives believe that in light of recent changes in hospitals, childbirth in hospitals can feel almost "like at home." This is facilitated by increased openness toward birthing women's requests and by some cosmetic changes in birth rooms. Nevertheless, for the home-birth midwives interviewed in the study, as well as for pregnancy and birth researchers from various fields (Balaskas, 1992; Gaskin, 2011; Kitzinger, 2011), the difference between hospital and home births reflects profound differences in perceptions regarding childbirth and the birthing process.

In addition to differences in risk perceptions and positions with respect to home birth, the study found differences among all the midwives and the doctors regarding the degree of holistic attitude toward the mother and the birth. In addition to the importance of birth safety, all the midwives referred to emotional aspects and the importance of feelings of satisfaction and fulfillment of the mother's aspirations, a finding that is supported also by Ann & Freeze's (2010) study. In contrast, the hospital doctors in the study elected to refer to the safety aspect only. There can be several explanations for the doctors' exclusive focus on the physical health of the mother and newborn. First, by dint of their role, doctors set the health of their patient as their highest priority. This approach reveals a certain paradox in the role of an obstetrician because in obstetrics, the doctor is not asked to treat a sick person but rather, in most cases, a healthy woman. Second, because doctors regard every birth as potentially risky, the ideal birth involves a smooth birthing with a healthy mother and newborn. In line with professional literature (Davis-Floyd, 2001; Gaskin, 2011), this study found that doctors tend to work according to the technocratic model that separates body and mind, whereas the home-birth midwives believe in body–mind unity, an approach fitting the holistic model. It was found that among the hospital midwives, there is a certain amount of inner conflict. Although as midwives they tend toward the holistic approach, their very work in a hospital where work is conducted along the technocratic model, does not always allow them to express this view.

Another issue raised by this study is the lack of consensus regarding the MOH protocols for home birth. Although both hospital doctors and midwives in this study attributed significance to the protocols for the sake of control and minimization of risks taken by the home-birth midwives, most of the home-birth midwives expressed anger and argued that it was written by people with no experience or knowledge of the subject, without consulting with them, and that the purpose of the guidelines is the elimination of home births in Israel. The home-birth midwives were concerned that the protocols were not written according to updated research literature. This might lead home-birth midwives to dismiss the guidelines, instead abiding by updated literature they have read. In addition, it was found that countries that prohibit home births undermine public trust in the medical establishment and cause women with high-risk pregnancies to choose home birth (Kitzinger, 2011). These facts emphasize the need for collaboration with home-birth midwives in the compilation of professional guidelines regarding their work, and simultaneously, enforcement of compliance with the procedures by the state authorities.

This study also exposes an interesting finding which has not been studied adequately in the literature regarding childbirth: the use of sexist language by birthing professionals when describing childbirth. Some of the doctors chose to use sexist, stereotyped imagery to describe childbirth. According to Cixous (1976), the use of sexist imagery in society reflects patriarchal norms in which both men and women employ sexist imagery and internalize a patriarchal perspective. According to most of the midwives in our study, including the male home-birth doctor, the use of sexist language is associated, they believe, with the prevailing paternalistic thinking in birth rooms in Israel. This study shows that some of the midwives' choice to leave work in hospitals for work in people's homes is grounded in feminist ideals. Those midwives argued that home birth allows women empowerment and that the paternalistic atmosphere in hospitals transfers the power into the hands of male doctors

and, in doing so, takes power away from the birthing mothers.

Finally, all home-birth midwives and some of the hospital midwives in the study raised the subject of the lack of communication between hospitals and home-birth midwives. This is illustrated by problems that occur when admitting a home-birthing woman into a hospital. The problems that arise when transferring home-birth mothers to hospitals are well known in other places in the world as well (Ann & Freeze, 2010; Cheyney & Everson, 2009; Kitzinger, 2011). Moreover, various hospitals and organizations in the United States have forbidden their staff to support home births, either directly, by admitting home births, or indirectly, by providing consultations and support to home-birth midwives (Ann & Freeze, 2010; Chervenak, McCullough, Brent, Levene, & Arabin, 2013). The home-birth midwives and some of the hospital midwives emphasized the urgency of improved communication between home-birth midwives and hospital midwives for the sake of mothers' safety and improved service.

RECOMMENDATIONS

The first recommendation arising from this study is the importance of improved collaboration between midwives who work in people's homes and those who work in hospitals for the benefit of all concerned. Such collaboration can be carried out through joint seminars, compilation of guidelines that concern all midwives, finding the safest and most efficient way of transferring home-birthing women to hospitals if necessary, and productive communication between the home-birth midwife and the hospital midwife when transferring the mother or newborn for treatment.

Our findings demonstrated that hospital doctors and midwives tend to view home births from a generalized, distanced perspective. They tend not to distinguish between home births that occur in different settings and that may be affected by a range of variables including place, the birthing couple, the needs of the birthing mother, and so on. In workshops on home birth, it is crucial to include women who have undergone different home-birth experiences who can share their unique, subjective experience with home birth, including a discussion of the setting, their expectations, and the birth process as it actually transpired. Through such encounters, both hospital doctors/midwives and home-birth doctors/midwives can learn from individual, personal experiences of home birth, thereby enriching their understanding of home birth from multiple, authentic perspectives.

In addition, it seems that the lack of exposure of hospital doctors to home births causes gaps in perceptions of risk between hospital doctors and home-birth midwives. Therefore, exposure of medical students to home births in their clinical rounds is recommended. In addition, the risk of home births should be communicated to hospital doctors on a continual basis by an entity they trust. To allow doctors and the public to base their opinions on home births on reliable data and not on anecdotal stories or emotions, a national database of home births in Israel should be established as well as statistics on medical interventions (such as cesarean surgeries) in all birth rooms in the country. To mitigate hospital midwives' opposition to home births, Sandman's (1999) principles of outrage management should be adopted: by conducting a dialog with licensed home-birth midwives who comply with the procedures, and for both hospital and home birthing staff to admit past mistakes and current problems and cooperate with home-birth midwives in compilation of procedures which refer to their work.

Finally, follow-up studies should be conducted to verify whether the findings of this study are supported by other studies as well. In addition, there should be an examination of how the home-birth issue is presented in Israeli media and how it influences the public, including hospital doctors' perception of childbirth. Our findings indicated that the gendered language used by some of our interviewees had sexist overtones. We can assume that such language use is a result of lack of education of the medical staff regarding women's roles in their birth experiences. Organizations concerned with childbirth education should conduct seminars, workshops, and simulations for obstetricians and medical staff who provide care during childbirth, focusing on emotional needs of birthing women and ways to empower them.

Another topic that should be examined at length is how women giving birth in hospitals in Israel view the issue of paternalism in birth rooms. Despite an increased emphasis on patient rights in Israel and a tendency toward increased transparency in the health system in recent years, most women do not receive information on home birth because those involved in obstetrics are not knowledgeable about it. Therefore, those involved in birth education should address this lack of transparency and should promulgate information to pregnant women and their spouses about the range of home-birth options.

Exposure of the general public in general and doctors and midwives in particular to home births, as well as mutual enrichment and improved communication between all those who facilitate births, can benefit not only the home-birthing woman but also those who give birth in hospitals and wish to be active participants in their experience of childbirth. The use of risk is now integral to maternity care, despite the fact that the risk is not actual but potential. Yet in medical care, it is treated as fact and not as a possibility. This could be the basis for future study.

CONCLUSION

This study addressed the critical issue of how professional experts perceive the particular reality of childbirth. It also identifies how the health-care system influences that perception for different providers and may also show why they chose to work with birth in a particular environment. These cultural and environmental factors affect and influence risk perception. This emphasizes the need for childbirth education on the part of the public and the need for professionals to learn and address the fears and concerns of the public. This can facilitate communication between representatives of the health-care system and home-birth midwives.

NOTES

1. Shiftan is a home-birth physician who collects data of home births in Israel. Because there is no official database in the country, his database is the only source for home-birth statistics.

2. The doctors and the midwives worked at the time of the study in five large hospitals in Israel: West Galilee Hospital in Nahariya, Poriah Hospital, Rambam Hospital in Haifa, Ichilov Hospital in Tel-Aviv, and Shaare Zedek Medical Center in Jerusalem.

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