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Contractions or Constructions: A Content Analysis of Birthing Facilities in Miami, Florida

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CONTRACTIONS OR CONSTRUCTIONS: A CONTENT ANALYSIS OF BIRTHING

FACILITIES IN MIAMI, FLORIDA

by

SHAMEKA THOMAS

Under the Direction of Wendy S. Simonds, PhD

ABSTRACT

Numbers of caesarean sections, epidurals, and other forms of medical interventions for birthing are rising in the United States healthcare industry. One possible reason is the medicalization of birthing and labor techniques. Another potential reason is the increasing distinction between laboring in a hospital versus laboring in the home or an independent birthing center. The dominance of the medical model of birthing has led to social constructions of birthing that divide women by diagnosis, into either high-risk or low-risk prenatal categories, further perpetuating the medical model's power to marginalize the midwifery model.

Forty percent of U.S. births are financed by Medicaid insurance. Because Medicaid insurance is based on the technocratic medical model, birthing providers that accept Medicaid insurance may be pressured, directly and indirectly, to adopt the medical model as the most

appropriate birthing option, decentering the midwifery model. Inevitably, this potentially shifts birthing options and experiences for low-income women in the U.S. In order to understand how low-income women experience birthing in U.S birthing institutions, we first need to take a closer look at how birthing facilities socially construct birthing. Among many areas of influence for the social construction of birthing, website content has been neglected as a form of primary data. Using content analysis, this study investigates how web content aids in the social stock of knowledge on labor and delivery.

Analyzing the websites of three birthing centers and two public hospitals that accept Medicaid insurance in Miami, Florida, this study's findings indicate that the language used on birthing center websites aligns with the midwifery model, but reverts to the medical model used by hospitals, in language and policy, when discussing cases of emergency birthing. The public hospital websites, meanwhile, appropriate the language and procedures of the midwifery model without providing the practical benefits of natural birthing.

Findings in this study also capture a snapshot of birthing models used by providers in Miami, Florida ahead of its 2016 transition from the Florida Medicaid system to the Federally-Funded Marketplace, as per the Affordable Care Act of 2009. By assessing how birthing providers socially construct birthing, we could reduce the underrepresentation of natural birthing, exposing low-income women to more balanced depictions of both the medical and midwifery models of birthing, possibly reducing negative socio-emotional outcomes during birthing, postpartum depression and maternity-mortality rates among the poor.

INDEX WORDS:	Birthing Facilities, Health, Medicaid, Labor and Delivery, Reproduction,

Sociology, Women

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SHAMEKA THOMAS

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Georgia State University

August 2015

DEDICATION

Dedicated to my beautiful 3year old daughter, Zaiyah River Akinsete: your birth has

inspired me to keep pursuing my PhD and to keep studying birthing for many women in this life.

Also, dedicated to 7 year old Malachi…as of June 2015 you are free to play…

...Rest well in Peace.   Thank you for teaching us how to be wise.

ACKNOWLEDGEMENTS

To God, Thank you for everything and every soul who's helped me figure this out!

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1   INTRODUCTION / STATEMENT OF THE PROBLEM

Women and families with Medicaid insurance have limited access to health facilities in the United States healthcare system due to the increased privatization of healthcare (Olsen 2010). Birthing facilities serving low-income women are situated in a highly medical western society that privileges certain medical services and marginalizes non-medical services. Governmental institutions, such as Medicaid[1] are offered to help low-income women afford birthing services. Medicaid is based on a technocratic medical model of birthing (Bridges 2007). If the birthing models of Medicaid providers are based on the medical model of birthing, then low-income women are increasingly presented with medical birthing options over midwifery birthing options. My study analyzes how the website content from Medicaid providers contributes to the social stock of knowledge on labor and delivery. In order to understand larger maternal health issues such as socio-emotional outcomes, postpartum depression and maternal-mortality rates, we need to gain further insight as to how Medicaid providers represent birthing models on their websites.

I define birthing facilities as social institutions, offering services and reproducing knowledge about birthing to the general population. Birthing institutions include hospital-maternity departments, independent birthing centers, and home birthing practices (offering mobile services in the home or predetermined place of choice). Such institutions of labor and delivery also are sites and spaces, contributing to how women perceive and experience birthing. In this study, I argue that we cannot understand how women experience birthing in such institutions, if we do not first investigate how providers represent birthing services to their clientele. Though there are many areas of influence that providers use to represent birthing, website content is neglected as a source

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[1] The federal definition of Medicaid states "Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources." http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html

of primary data. Website content is online non-verbal and verbal messages that also contribute to the social stock of knowledge on birthing. My study explores the website content of five Medicaid-accepting birthing facilities in Miami, Florida. I am curious to know how the social construction of birthing vary across birthing facility websites and how this contributes to the social stock of knowledge on birthing. Is Medicaid insurance discussed on these websites, and if so, what details does it provide about its services?

My study has two primary objectives. First, my research addresses how the websites of birthing facilities socially construct the birthing. Do they depict birthing as a natural event (requiring no medical intervention), a medical event (requiring formal medical assistance), or both? (Katz Rothman 1982).[2] Do the websites employ language, images, or policies that would be considered women-centered, infant-centered, or family-centered? What kind of birthing environment does the website portray of the birthing facility? How are staff and services discussed on the website? What specific language do they use to address pregnant women and the labor and delivery process?

Second, my study examines how Medicaid insurance is discussed (or not discussed) on the websites of birthing facilities. As Medicaid's website explains,

> "Pregnant women receive care related to the pregnancy, labor, and delivery and any complications that may occur during pregnancy, as well as perinatal care for 60 days postpartum. States have the option to provide pregnant women with full Medicaid coverage, or they may elect to limit coverage to certain pregnancy-related services."

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[2] For instance, epidurals (anesthesia) and cesarean section (surgical removal of the fetus) are types of medical interventions performed during birth. Although (some of) these medical interventions may be provided by midwives, they are typically performed by physicians (OBGYNs).

(http://www.medicaid.gov/medicaid-chip-program-information/by-population/pregnant-women/pregnant-women.html)

According to the federal Medicaid website, "Medicaid plays a key role in child and maternal health, financing 40% of all births in the United States." (http://www.medicaid.gov/medicaid-chip-program-information/by-population/pregnant-women/pregnant-women.html). Thus, I argue there is a need for social scientists to investigate the role how Medicaid-providers represent birthing in its websites and its possible contribution in shaping the birthing experience for low-income women and their families.

1.1.1   Literature Review

1.1.1.1   Website Content as Data for Social Constructions of Birthing

Magazines, newspapers, television shows, films, and commercials are a few of the media industry products researchers have used to collect data about the social world. However, in the new millennium, the World Wide Web has helped shift social constructions from print to digital, changing how people perceive their world and their lives. From social media websites, such as Facebook, Twitter, Instagram, etc. to banking, education, and shopping people are increasingly using the internet for many day-to-day activities (Duggan et al. 2015). Thus, I argue website content makes a unique source as primary data regarding present-day social constructions.

Sociologists have long used public content like magazines and newspapers to investigate the social construction of beauty, health, race, age, death, and so forth. They have recently begun to use website content for the same purposes (Baumgarten and Grauel 2009: 94). For example, Maxwell and Wexler provide research on how photography of pregnancies and births posted on

the internet reveals social constructions of human reproduction (Matthews and Wexler 2000). Other scholars have studied how online health advertisements via direct-consumer-marketing socially construct maternal health to sell pharmaceutical drugs (Dumit 2012). However, there has been little to no research regarding how website content can be used to construct labor and delivery by birthing providers themselves.

Internet content, such as web text, web imagery, hyper web text, and links provide information about the political positioning of institutions (Baumgarten and Grauel 2009). Baumgarten and Grauel also argue "what is published on organizational websites is often controlled internally, and the interests of (possible) alliances have to be taken into consideration" (2009: 99). Dumit argues that direct-consumer- marketing via the internet appears to be neutral, but often serves as a manipulated vantage point. Website creators know that consumers often take online content for face-value and "like most media, the internet can be bought" (Dumit 2012: 41).

Researchers argued that socio-economic status affects internet access (Zillien and Hargittal 2009). However, these researchers fail to take into account how low-income groups still interact and negotiate with the digital world regardless of socio-economic status. For example, cellular phone companies now provide affordable services for smartphones and Wi-Fi—and apps are often free. Public access to the internet is increasingly available at public libraries and Wi-Fi hotspots. Libraries across large cities like Miami provide public access to computers, loaner laptops, and even classes on how-to "surf the web." Moreover, local welfare offices are seeking ways to make internet accessibility obtainable for many low-income households (Department of Children and Families 2015). Comcast also offers a subsidized internet program for low-income families with school-aged children (Comcast 2015). Thus, I argue that socio-economic status does not determine internet-access anymore.

Moreover, website data collection is limited without older versions of the website. Baumgarten and Grauel discuss how websites rarely include an archival database that is open to the public and "older versions of websites are often no longer available" (2009: 100). Also, most outsourced website creators typically do not update the website to reflect an organization's current status. For instance, if a staff member leaves the organization, that hiring change will: 1) most likely not be reflected on the website right away; and 2) not tell us what happened to that staff member (i.e. left voluntarily, or fired). These are questions that website content cannot answer for us. However, using website content as primary data does capture social constructions and provide a snapshot of how the organization or institution represents itself.

Berger and Luckman provide an example of how the telephone aided in the stock of knowledge in the emerging decades of the 1960s and 1970s. Even today, the telephone exchanges information and distributes knowledge through interactive verbal communication, allowing individuals to send and receive constructions about everyday life. The authors argue how "telephone lore is [a] recipe knowledge since it does not concern anything except what I have to know for my present and possible future pragmatic purposes" (Berger and Luckman 1966: 42). However, Berger and Luckman could not have forecasted how the internet and websites would eventually compete with the telephone. In this vein, websites are also sources of information that distribute knowledge to the general public. People interact with websites in similar ways to that of the telephone. Recent trends have merged the telephone and websites into a hand-held device known as the cellular phone or smartphone. Smartphones allow people to interact with the internet on their cellular phones for immediate interaction with the internet.

Because website content is readily available on computers and phones, it is critical to take into account how social constructions and social knowledge is distributed. Berger and Luckman

explain how the social construction of reality is a collection of several knowledge systems interacting and overlapping to create meaning over time and space. In this case, the websites of birthing facilities contain knowledge constructions about labor and delivery, contributing to how women make sense of birthing. Interaction with websites is a part of everyday life which allow active "participation in the social stock of knowledge [and] thus permits the 'location' of individuals in society and the 'handling' of them in the appropriate manner" (Berger and Luckman 1966: 42). Based on the authors' claim, everyday life is impacted through what is presented and represented as the social stock of knowledge. Without understanding how providers represent birthing on its websites, we fail to understand how women receive meanings, constructions, and knowledge about the reality and experience of giving birth.

1.1.1.2 Feminist Perspectives on Procreative Issues

In the U.S. healthcare system, women's bodies are conventionally situated as inferior by the medical profession, compared to men's body as the supreme standard (Martin 1987). Gender inequality perpetuates gender stratification as "the unequal distribution of wealth, power, and privilege between men and women" (Macionis 2007: 272). Low-income women on Medicaid become duly oppressed by both gender stratification and socio-economic status, rendering them powerless in the overall U.S healthcare system. Healthcare institutions that serve low-income women maintain medical dominance by "help[ing] to legitimize and reproduce social class structure and the economic system" (Lupton 2006: 118). Low-income women are subjects of medical dominance rooted in preconceived notions about their bodies, gender, sex, race, abilities, and socio-economic class positioning.

Characteristics of women as the other, weaker gender guide medical ideological paradigms and continue to still do (Martin 1987). Women's reproductive capabilities were and still are viewed

as sites of controversial gender differences and social constructions in medicine. Lupton argues that "the woman / nature metaphor was characterized by ambivalence: women were represented as softer, more sensitive, and more vulnerable than men, but also tougher and more tenacious about life" (2006: 73). First, gender inequality is a core part of feminist theory. Social institutions, such as birthing facilities operate in the larger society that continue to situate men and women in a hierarchy to with another (Macionis 2007).

The medical profession situates women in hierarchy to men as the "sick or incomplete version" (Lupton 2006: 143). Human reproduction is also framed as a woman's problem that needs to be fixed by doctors through medical intervention. The relationships between doctors and women translates into a relationship of power and control. The doctor, typically a male is conventionally characterized as knowing more than the patient or women—perpetuating medicalization. Feminist scholars argue that medical discourse often perceived women's bodies with fear and condemnation, translating birthing processes into medical problems (Lupton 2006: 147). Simonds et al. argue that doctors, such as obstetricians "define pregnancy itself simply as pathological, a condition of illness, quite frankly a disease. That was how doctors gained control over the management of pregnancy" (Simonds et al. 2007: 31).

Feminist scholars note that medical intervention during birthing is both oppressive and liberating. That on one hand, medical intervention liberates women because it has saved the lives of women and infants, providing more options for in-vitro fertilization and genetic disorders (Inhorn and Balen 2002). However, advanced medical interventions during birthing can and often continues to oppress women who may or may not view them as revolutionary acts of liberation.

Feminist scientists on procreative issues have tried to depict birthing as liberation, but "they have feared essentializing woman's biological role and equating it with her social prospects"

(Matthews and Wexler 2000: 3). Constructions of birthing conventionally use biological reproduction interchangeably with social constructions of motherhood which is also both liberating and oppressing. Birthing as biological and social captures the full maternal spectrum of the motherhood and can be liberating for women who embody both roles. However, Neyer and Bernardi suggest that lumping the biological and the social elements of motherhood could worsen gender inequality in the U.S healthcare system (Neyer and Bernardi 2011). Lumping the biological with the social aspects of maternity also fails to incorporate other forms of birthing such as, surrogate motherhood.

1.1.1.3 The Midwifery Model of Birthing Care

Midwives function with the general principal of being "with-woman." The woman in labor is the center of the birthing process. The birthing woman receives holistic-styled support from the midwife and labor-doulas or birth coaches. Teman argues that "midwives, actively help other women give birth to themselves as mothers" (Teman 2010:134). Midwives help the woman in labor feel a sense of empowerment during labor, assisting with the activation of her own inner power, spirit, wisdom, and intuition during her birthing process (Gaskin 2002). Midwives view the woman in labor as a human who births another human, rather than as a machine who births a product (Martin 1987). Gaskin further discusses how traditional midwives strive to incorporate humanity in birth processes, such as touch, movement, emotions, and even love (Gaskin 2002).

According to the Midwives Alliance of North America (MANA), the midwives model of birthing care is fundamentally a women-centered approach to birthing. The midwifery model is also conceptualized as a process that minimizes technological intervention while providing hands-on psychological, emotional, spiritual, and cultural support to birthing women during labor and delivery (http://mana.org/about-midwives/midwifery-model). MANA defines midwifery as an

"empowering model of maternity care that is utilized in all of the countries of the world with the best maternal and infant outcomes" (MANA 2015). MANA estimates that 15,000 midwives practicing throughout the United States. However, there are approximately 33,624 obstetricians and gynecologists (ob-gyns) practicing throughout the U.S, which significantly outnumbers midwives altogether (Raybum et al. 2012). MANA believes the low number of midwives practicing around the country "continues to rank [the U.S] behind most of the developed world in terms of infant and maternal mortality" (MANA 2015).

Barbara Katz Rothman is cited by MANA as one of the first sociologists "to define the difference between the medical model and midwifery model of care" (MANA 2015). Katz Rothman writes that the distinct differences between the midwifery model and medical model are based on their ideological, political, and often personal approaches to birthing (Simonds et al. 2007). The midwifery model aligns with the ideology that pregnancy and birthing are natural processes that "emphasize the normal nature of pregnancy [and birthing] in order to justify nonmedical control in a society on which medicine has a monopoly on illness management" (Simonds et al. 2007: 52).

The U.S healthcare system has systemically controlled the practices of midwives by appropriating licensure and certifications to validate midwifery techniques. According to MANA, there are four types of midwives that are recognized as licensed professional practitioners: CMs, CNMs, CPMs, and DEMs.[3] However, every state in the U.S healthcare system has its own rules

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[3] CMs are Certified Midwives trained according to the American College of Nurse-Midwives. CNMs are Certified Nurse-Midwives who are trained in both nursing and midwifery according to the American College of Nurse-Midwives. CPMs are Certified Professional Midwifes who are licensed to practice independent midwifery according to the North American Registry of Midwives. DEMs are Direct Entry Midwives who are trained through self-study or apprenticeship and can practice out of hospitals as Licensed Midwives (LMs) or Registered Midwives (RMs). [MANA 2015].

regarding which type of professional midwife is allowed to practice in that state. For instance, Florida allows DEMs to practice midwifery, while Georgia does not provide licensure for DEMs. Also, across the country: 27 states allow DEMs to practice midwifery, while 24 states do not regulate the practice of DEMs and provide no licensure for DEM practices (http://mana.org/about-midwives/state-by-state). Licensure plays a role in how birthing care conducted by midwives is conducted, funded, and constructed. Licensure also complicates the traditional midwifery model because midwives are increasingly expected to be trained under the medical model (Simonds et al. 2007).

1.1.1.4 *Medicaid's Technocratic Medical Model for Birthing Care*

Medicaid's incorporation of pregnancy as a legitimate health event is fairly recent. Conversations and legislation for adding pregnancy under the Medicaid umbrella began in the 1980s. The Prenatal Care Assistance Program (PCAP) [4] was charted in 1986. PCAP was followed by the Omnibus Reconciliation Act of 1987, "requir[ing] states to offer Medicaid coverage of pregnancy-related services" (Bridges 2011: 44). Hospitals that accept Medicaid insurance receive money back from the state for prenatal care. However, for a birthing facility to receive its funds back from the state, "the hospital itself must be qualified as a Prenatal Care Assistance Program provider" (Bridges 2011: 42). To be a PCAP provider means you have to follow specific Medicaid guidelines. Private insurance companies do not have to follow Medicaid policies.

Most studies assume that Medicaid-accepting institutions are a part of PCAP (Olsen 2010). Few studies go into detail about the exact requirements of being a PCAP affiliate (Bridges 2007).

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[4] PCAP functions as a network of Medicaid providers. For example, "Medicaid-PCAP insured women can avail themselves of dental, optometric, dermatological, and general medical services (among others) should the need of or even desire arise… men and non-pregnant women are excluded…[PCAP] insurance coverage given to pregnant women terminates just eight weeks after she gives birth (Bridges 2011: 12)

Each state mandates PCAP requirements for respective participating birthing institutions. PCAP requirements can include, but are not limited to having a HIV counselor, social worker, and routine prenatal tests that may or may not be deemed necessary by the physician. If a pregnant women with Medicaid insurance is in "good" health (i.e. with low-risk prenatal diagnosis), she is still required for routine prenatal screenings, testing, and ultrasounds. PCAP affiliates must complete all routine prenatal tests to be reimbursed by the Medicaid industry. Bridges explains, "in the event that a patient ultimately receives Medicaid coverage, the hospital can be reimbursed for its services as it has satisfied all of the PCAP requirements for Medicaid reimbursement for that patient" (Bridges 2011: 43).

Having Medicaid insurance is paradoxical. Everyone deserves health coverage, but low-income women are limited to government insurance that "renders [their] pregnancy an opportunity for state supervision, management, and regulation" (Bridges 2011: 43). Medicaid insurance also situates low-income pregnant women in a health system that both hyper-screens them and stigmatizes them. The paradox situates low-income women in a catch-22 position. The catch-22 positioning of having Medicaid means that "in exchange for the state's payment of medical bills, [women] are obliged to open their lives to the possibility of state intervention" (Bridges 2011: 49).

The Medicaid for Pregnancy program is framed on a medical ideology called the technocratic model of pregnancy, a term coined by medical anthropologist Robbie Davis-Floyd. The technocratic model of pregnancy frames pregnancy and birthing through a lens of deficiency and incapability (Bridges 2007). The social construction of PCAP requirements can *and does* raise critical issues as to how Medicaid-PCAP affiliates advertise and promote their birthing services to prospective clients. Also, the social construction of birthing from Medicaid-PCAP providers raises concerns about the stereotypes birthing facilities receive because they serve low-income women.

Medicalization theory supports the notion that as the medical industry expands, basic human processes like pregnancy and birthing become medicalized processes. Conrad defines, "a problem is defined in medical terms, described using medical language, [and] understood through the adoption of a medical framework or treated with medical intervention" (Conrad 2007: 5). Medical licensure is an example of how the process of medicalization and social constructionism interact with each other. In the U.S healthcare system, the notion that midwives have to be certified under the medical model before being licensed to practice midwifery perpetuates medicalization (Simonds et al. 2007).

Monitoring and ultrasounds are examples of the medicalization process during birthing. Monitoring the fetus is conducted through a series of prenatal ultrasounds via medical technologies and machinery. In the 1970s, ultrasounds started to increase and presently have become the norm for monitoring pregnancy (Lupton 2006: 162). Though it is liberating to monitor the fetus prior to birthing, over-monitoring contributes to the diagnoses of high and low risk pregnancies. Welch et al. also argues how "monitoring does lead to far more emergency [cesarean] sections" (Welch et al. 2011:105). Increased monitoring of the fetus not only leads to more medical intervention, but also decentralizes women-centered approaches during birthing. Over-monitoring the fetus then situates birthing as an infant-centered process. The fetus becomes a thing to be monitored as a separate entity from the women carrying the embryo (Simonds 2007). Because Medicaid insurance is based on the medical model, then low-income women with Medicaid are required to be monitored during birthing, reinforcing how birthing institutions represent medical models over midwifery models to the poor.

Risk language plays a critical role in the process of medicalizing birthing. The problem is that, "more and more pregnancies are subsumed under the heading of 'high-risk,' until by now

more pregnancies are high-risk than are low-risk" (Simonds et al., 2007: 31). When a pregnant woman is diagnosed "high-risk," her birthing options are typically restricted to medical intervention performed by obstetricians, who are surgical specialists (Simonds et al. 2007). Conrad and Schneider argue that the definition and diagnosis of high risk itself is ambiguous. (Conrad and Schneider 1979). With an emphasis and expansion of risk terminology, birthing continues to be constructed as diseased and "if one sees birth 'as disease,' one cannot see birth as a 'natural' life process" (Simonds et al. 2007: 166).

Risk language also perpetuates medical diagnosis. Diagnosing pregnant bodies further categorizes and controls pregnant women, either by expanding or restricting women's birthing options. Brown argues that the diagnosis model does not just play a key role in the naming and framing of an illness, but in the representation and projection of power (Brown 1995: 38). Pregnant woman diagnosed as "high-risk" have a higher chance of going into pre-term labor or experiencing other complications (Simonds et al. 2007: 31). A pregnant women diagnosed as "low-risk" is constructed as having the standard, normal, able body for pregnancy and birthing—and thus has more options to explore the realms of natural birth.

The medicalization of birthing is political for all women, but I argue that it is especially political for low-income women of color. Pejorative stereotypes of 'unfit motherhood' are ascribed on the pregnancies and births of low-income women of color by medical institutions, who are often give quality healthcare to those who are affluent and white. The politics of motherhood is damaging for low-income women because they face stereotypes of unfit-motherhood if they are not compliant with medical authorities (Roberts 1997). Medicaid plays a role in socially-condemning defiant pregnant women and "if these women cannot manage to be seen by a provider

four times before delivering their babies, those babies will be held at the hospital until 'the air is clear' at their homes" (Bridges 2011: 49).

Moral sanctions ascribed onto low-income women from medical authorities, possibly lead to negative images of motherhood and postpartum depression. Moral sanctioning also continues to stratify reproduction in the U.S. Reproductive stratification is an ideology that encourages privileged and affluent groups to reproduce humans and discourages underprivileged and poorer social groups are birthing and reproducing (Inhorn et al. 2002). Reproductive stratification is based on the on the fear that low-income women and families on welfare will produce children who are deemed as an addition burden to the society (Hayes 2003).

Because Medicaid for Pregnancy programs are framed on the technocratic medical model of pregnancy, the social construction of birthing is depicted as a life process that needs medical intervention via state supervision from specialized medical authorities. Since Medicaid is public insurance that serves the poor, the politics of reproduction reinforce myths of who can mother and who cannot mother. By failing to pay closer to attention to how Medicaid providers present (and represent) birthing models to women, we run the risk of missing puzzle pieces as to how the social stock of knowledge about birthing is constructed and distributed. If we continue to miss how providers construct birthing, we also fail to notice how reproductive stratification is continuously perpetuated in the U.S healthcare industry.

2   METHODS

Content analysis provides an adequate approach to answering my research questions. Qualitative researchers define content analysis as "a set of methods for analyzing the symbolic content of any communication [and] may involve the systematic description of either verbal or nonverbal materials" (Singleton and Straits 2010: 420). Content analysis it gets at the language,

contexts, and images birthing providers use to represent labor and delivery on websites. My data collection largely focuses on web content, web language, and web imagery used by the birthing providers themselves. However, my analysis specifically draws on web texts, using descriptive web imagery as a supplement.

Five websites of birthing institutions are analyzed in this study (see Table 1). The Miami Maternity Center, an independent birthing center (affiliated with other local hospitals, but physically separate from them); *The Gathering Place*, a birthing center located in the heart of Miami, that offers prenatal care work outside of the hospital, while the actual labor and delivery is done in partnership with a local hospital or birthing center; *Spirit of Life Midwifery*, an independent traditional midwifery practice that solely offers home birthing services and serves the Miami area via mobile birthing services that goes to pregnant women's predetermined birthing sites; The *North Shore Medical Center*, one of the largest public hospitals in the central Miami area. North Shore also has one of the largest maternity centers and neonatal intensive care units; and the *Miami Jackson Memorial Hospital*, a flagship hospital in the Miami Jackson Health system[5] (and one out of the five hospitals in the Jackson health system).

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[5] Miami Jackson Memorial Hospital is only one of two hospitals in the Jackson health system that has a Certified Nurse-Midwifery program. Miami Jackson South is the second hospital within the Jackson health system chain that partners with Miami Jackson Memorial's Certified Nurse Midwifery program.

Table 1 Names and Acronyms of Each Birthing Facility in this Study and URL

The Five Birthing Facilities in this Study	URLs to Homepages
The Miami Maternity Center	http://www.miamimaternitycenter.net/index.html
The Gathering Place *(Pregnancy, Childbirth, and Parenting Resource Center)*	http://theplacewegather.com/
Spirit of Life Midwifery *(An Independent, Traditional Midwifery Home Birthing Practice)*	http://spiritoflifemidwifery.redberrydesigns.com/index.html
North Shore Medical Center *(Mother & Baby Unit)*	https://www.northshoremedical.com/our-services/mother-baby
Miami Jackson Memorial Hospital *(Obstetrics & Maternity Center)*	http://www.jacksonhealth.org/maternity.asp#memorial

2.1 Data Collection

Each birthing facility was found using two types of sampling measures: 1) referral sampling or word-of-mouth; and 2) purposive sampling or researcher-selection sampling. Referral sampling is a type of "sampling technique devised to handle [subgroup] problems utilize[ing] some form of referral, wherein respondents who are initially contacted are asked to supply names and addresses" (Singleton & Straits, 2010: 177). Referral sampling techniques are instrumental for locating respondents of small subgroups or for finding sites that are harder to locate in the mainstream. Purposive sampling is when the researcher selects specific cases matching the pre-

determined selection criteria (Singleton and Straits 2010). My selection criteria was restricted to birthing institutions that accepts Medicaid insurance and are located within the city-limits of Miami, Florida.

My referral sampling techniques included asking a variety of women within my personal and professional network for their recommendation. I specifically asked women who have given birth to at least one child because they have first-hand knowledge of birthing services about healthcare providers. Also, I asked professional contacts within my network, such as midwives, obstetrician doctors, doulas / birth coaches, and practitioners who work in the Miami area. Once I received their recommendations, I began a google search of the birthing facilities to compare my referral information to what is available online. I purposively selected each website after reviewing recommendations online.

Purposive sampling allows this study to incorporate selective judgment that random sampling measures would neglect. Because Miami has so few birthing institutions that actually accept Medicaid insurance, random sampling would not capture the details adequately. It is critical to understand city dynamics before actually selecting rare facilities, such as birthing centers and public hospitals. For instance, Miami, Florida does not have a plethora of birthing centers to choose from in selection. The Miami Maternity Center is the only birthing center in the city-limits that actually has labor and delivery services on site. Though the *Gathering Place* provides pre-labor services, it partners with local hospitals at the start of the official laboring process. However, the *Gathering Place* is aiming to raise funds to eventually provide labor and delivery services on-site. *Spirit of Life Midwifery* is a traditional midwifery practice, providing home-birthing services, *Spirit of Life* also does not technically call itself a birthing center, but rather a birthing practice. However, I will intentionally call Spirit of Life Midwifery a birthing center for the purposes of

consistency in this study. *Miami Jackson Memorial Hospital* is only one of five hospitals in the Jackson Health system that has a Certified-Nurse Midwifery program. Though Miami Jackson South Hospital provides a Certified-Nurse Midwifery program, it is located outside of the Miami city-limits. *North Shore Medical Center* is located in the heart of North Miami and accepts Medicaid, but does not endorse or represent midwifery practices. Purposive sampling captures such nuances about the maternal health dynamics of Miami, Florida which are severely understudied.

My target area is restricted to Miami, Florida. According to the U.S. Census Bureau, the state of Florida is located in the South Eastern region of the North America continent and comprises some of the poorest states. Based on U.S census data from 2013, Florida has a 16.3% level of persons below poverty level compared to the national statistic of 15.4% of persons below poverty level (U.S Census Bureau 2015). In 2013, Miami was 19% Black, 65.6% Hispanic, and 56.6% White (U.S Census Bureau 2015). Because Miami, Florida has a high concentration of Black, Hispanic, Caribbean, and immigrant populations within the low-income percentile, it is imperative to study Miami as a city that is distinctively different from the rest of Florida.

Another justification for studying Florida is because Florida legislatures decided not to renew its Medicaid contract for 2015. The Affordable Care Act of 2009 impacted Florida's healthcare legislation tremendously. According to the Florida Medicaid.Gov website, "The Federally-facilitated Marketplace (FFM) is offering health coverage in Florida in 2015. The FFM will make assessments of Medicaid/CHIP[6] eligibility and then transfer the applicant's account to

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[6] CHIP is defined as Children's Health Insurance Program. Infants born to women with Medicaid insurance are automatically enrolled into the Medicaid-CHIP program. In 2013, there were 8.1 million children in the United States on Medicaid-CHIP insurance. And still so many infants and children who do not have health insurance, at all. (Medicaid.gov, 2014).

the state agency for a final eligibility determination. Florida has not expanded Medicaid coverage to low-income adults" (Florida Medicaid 2014). Each state has an option to renew its contract with Medicaid or to switch over to another version of affordable healthcare plans. My study is unique because it captures healthcare data before the transition between Medicaid and FFM.

Low-income populations in Florida are in a critical time with health insurance as "few states—such as Florida—began endeavoring to privatize the entire Medicaid program, but with disastrous results for the poor" (Olson 2010: 3). This is a critical circumstance for individuals who have received Medicaid insurance in 2014, but will now be in transition or without insurance coverage at all during the Medicaid transfer for 2015. For pregnant women and birthing facilities that accept Medicaid, this could mean tremendous changes—for better or for worse, in sickness and in health.

2.2 Five Content Categorical Themes

I started with the homepage of each birthing institution's website. Because public hospitals are multi-layered with multiple web pages, I started with the hospital's maternity center homepage. I restricted my analysis to the websites and webpages of the public hospital's maternity center because it is important to concentrate on the web content of its maternity center, rather than deviating to the web content of the entire hospital. Thus, I am intentionally interested in what the hospital represents on their maternity center's webpages. In contrast, the birthing centers have their own respective URL domains that are specific to the birthing services that they provide. Overall, I analyzed all of the webpages on each respective website for an in-depth content analysis.

There are five categorical, semi-structured content themes (see Table 2.0). According to qualitative researchers, "selecting and defining the categories for content analysis is analogous to deciding on a set of close-ended questions in survey research. Instead of giving questions to

respondents who provide the answers, the content analysts applies them to a document" (Singleton & Straits 2010: 421). In order to make sure my content analysis categories are exhaustive, I relied on researchers from my literature review who have produced research on both the midwifery and medical model of birthing. I developed content categories that can help us understand how website content builds the social stock of knowledge on labor and delivery. I based my findings on literature on feminist theory, medicalization theory, and social constructionism.

Table 2 Five Categorical Content Themes

Five Categorical Content Themes	*Key words (for coding purposes)*
1) Midwifery Model of Birthing Care	Birth as a natural process /the body is capable with guidance and without medical interference (Simonds et al. 2007; MANA, 2015)
2) Medical Model of Birthing Care	Birth as a medical process / needs medical interventions / high-risk births / risk language (Brown 1995; Conrad and Baker 2010; Lupton 2006)
3) Women-Centered Approaches / Infant-Centered Approaches	The woman in labor is the focus and has autonomy The infant or fetus inside of the woman is the focus (Martin 1987; Simonds et al. 2007;)
4) Representations of Healthcare worker relationships to Women	Midwife and staff's relationship to woman in labor Obstetrician and staff's relationship to woman in labor (Lupton 2006; Simonds et al. 2007; Bridges 2011)
5) Representations of Medicaid Contexts	Insurance plans Types of birthing services covered by Medicaid Or no discussion of Medicaid on website (Olsen 2010)

Theme 1: The midwifery model is coded as any web content or web text that aligns itself with the natural process of birthing. I coded the midwifery model as a birthing process that is without medicine / medical intervention during birthing and labor / delivery. I coded any contexts that defines, explains, names, or frames any and all representations of the midwifery birthing techniques (Simonds et al. 2007; MANA, 2015).

Theme 2: The medical model is coded as any web content or web text that aligns itself with using medical intervention or medical technology during the process of birthing. I coded the medical model as any web text that discusses ob-gyns or certified-nurse midwives who are trained to conduct surgery during labor and delivery. I coded for contexts that defines, explains, names, or frames the birthing process as illness, disease, high-risk, and or needing medicine during labor (Brown 1995; Conrad and Baker 2010; Lupton 2006).

Theme 3: Woman-centered and or infant-centered approaches are codes that help to determine who the birthing facility frames its model on—either women, infants, or both. This is an important code because it provides further insight as to how providers construct their services to birthing women and infants (Martin 1987; Simonds et al. 2007).

Theme 4: Because healthcare workers have to interact with women in the process of the labor and delivery. I coded web texts and web imagery that depicts how the website constructs the staff's relationship or role in the birthing process. I coded how the staff discuss themselves and or how the web text discusses staff interactions with birthing women. Also, I coded any web testimonials from former birthing women or families who have interacted with the staff at each respective birthing facility (Lupton 2006; Simonds et al. 2007; Bridges 2011).

Theme 5: Although all of five websites in this study accept various types of insurances, they also accept women with Medicaid insurance via subsidized insurance for low income pregnant women. In this section, I coded for constructions about Medicaid or other insurance types. I coded whether or not Medicaid was discussed on the website. I also coded for links or resources that would redirect individuals with Medicaid to different websites or webpages. Moreover, I coded any and all discussions about the financing for labor and delivery on the website.

Particularly, I coded any web texts regarding which birthing services are covered or not-covered by Medicaid insurance (Olsen 2010).

2.3   Limitations

My data collection began in the spring of 2015. A majority of systematic healthcare changes regarding Medicaid coverage will not go into effect until either the fall of 2015 or early 2016. Thus, my data collection will serve as a snapshot of Miami's status as of spring 2015. The birthing facilities in this study are at the end of a major health coverage transition from the Medicaid system to the Federally-Facilitated Marketplace system, based on the Affordable Care of Act 2009. Data collection during this unique transition does not compare web content prior or post the Affordable Care Act.

My sampling measures are also limited. Referral sampling restricts my study to individuals in my personal and professional network. Purposive sampling contains my own research biases within the sampling selection. Both of sampling techniques hold research bias and prevents generalizability. Futures studies could include randomizing referral recommendations, broadening selection criteria to other cities across South Florida, and interviewing Medicaid affiliates about sample selection.

Content analysis also cannot accurately inform us about women's perceptions of the birthing facilities' websites itself. Although these data can offer an understanding of Florida's Medicaid situation, this cannot help us comprehend how low-income women experience the website content. Furthermore, my study is not generalizable because it does not compare Medicaid content across various states and regions in the U.S healthcare industry. Though I cannot generalize my conclusions from the websites of five birthing facility institutions, these data may be well indicative of national trends. If we understand a small part of Miami, Florida's healthcare

situation, we can further understand how the social stock of knowledge on labor and delivery is constructed by Medicaid providers.

3   RESULTS

3.1   Discussion of Five Categorical Content Themes

3.1.1   *The Midwifery Model of Birthing Care*

The websites of the Miami Maternity Center, the Gathering Place, and Spirit of Life Midwifery socially construct birthing as a natural process, aligning with the midwifery model as defined by the Midwives Alliance of North America (MANA 2015). Each respective birthing center website socially constructs birthing as a "normal" process of "tradition" that should "take its course" without necessary interference of medicine. The opening representations on the homepages of the birthing centers debunk the technocratic medical model of labor and delivery, centering the midwifery model as normal, traditional, and beneficial for pregnant women.

Miami Maternity Center's website includes animated texts scrolling across the top of the webpage, stating "Traditional Non-Invasive Births" and "Water Births, Home Births." Miami Maternity Center's website defines a birthing center as, *"A birth center is a return to the traditional, safer, non-invasive way of giving birth."* [1] The Gather Place's website was set up like a blog, with an advertisement on the homepage for "Peapod Essentials All Natural Everything," a company that sells natural cloth diapers, organic baby foods, and toys. The words "all natural everything" as a homepage advertisement contributes to social construction of the midwifery model, trumping the medical model. Spirit of Life Midwifery's website constructs a narrative describing midwives'

role "since the beginning of time" relating to how MANA describes the role of midwives. Spirit of Life Midwifery's website states:

> *Midwives have been attending women during pregnancy and birth since the beginning of time. Care with a modern midwife is truly an art form - combining the guiding, healing hands of one's most trusted advisor and nurturer with today's knowledge, science and medicine. This fusion is what sets midwives apart from most doctors. ~Spirit of Life Midwifery* [2]

> *Giving birth to a child in the comfort of your own home is a wonderful experience. Surrounded by the people and environment a woman enjoys most in her life helps maintain a positive outcome and keeps anxiety and fears to a minimum. During this time a woman can enjoy the comforts that she surrounds herself with on a daily basis. ~Spirit of Life Midwifery* [3]

The websites of the public hospitals attempted to make the hospital setting similar to a home-like birthing experience. For example, North Shore Medical Center offers a "home-like" atmosphere in their Mom & Baby Unit. Miami Jackson Hospital offers has a "spa-like" setting, where certified nurse-midwives and deep-soaking tubs are available as "alternatives" for labor and delivery. Miami Jackson Memorial Hospital's website offers a certified nurse-midwifery program as an "alternative." Yet, the very notion of "alternative" is problematic because it places the medical model in hierarchy to the midwifery model.

The websites of the public hospitals fail to mention the benefits of a having nurse-midwifery program and the advantages of having a "home-like" or "spa-like" during birthing. Rather, the public hospitals use "home-like" and "spa-like" on its websites vaguely as if the benefits of such "alternative" settings are known prior to the birthing process. The websites of the public hospitals offering settings, such as "home-like" and "spa-like," portraying birthing as normal and natural, but remaining allegiance to the medical model, rather than the midwifery model. Rothman argues how hospitals attempt to include the midwifery model in its settings, but

"laboring women are [still] routinely confined to bed in hospitals, a situation that is as disturbing psychologically as it is physically" (Rothman 1992: 167).

Miami Jackson Memorial Hospital's website actually boasts a "second-to-none" certified-nurse midwife program. Miami Jackson Memorial Hospital is one of two public hospitals in with a certified nurse-midwifery program in the Jackson Health system, which includes five other hospitals. Miami Jackson Memorial Hospital partners with the Jackson South Community Hospital's certified nurse-midwifery program (in the Jackson Health system located outside of the Miami area). Miami Jackson Memorial Hospital's website went as far as reporting its lowest cesarean-section rates in Miami-Dade County and offering Jackson South's statistics of cesarean rates as its own.

Jackson South's OB team is proud of our low cesarean birth rate, which has been the lowest in Miami-Dade County for the past 10 years. In 2009, the cesarean rate was 33% for the Women's Center and 18% for our nurse-midwife practice. Jackson South Community Hospital is committed to offering alternatives to cesarean sections to our families and delivering newborns naturally. ~Miami Jackson Memorial Hospital [4]

Though Miami Jackson Memorial Hospital's website offers statistics on Jackson South's cesarean section rates, it fails to compare cesarean section rates between its obstetrics services and its nurse-midwifery program between both hospitals. Miami Jackson Memorial Hospital's website also claims a 33% cesarean section rate as low or acceptable, in comparison to the 18% of cesarean-section rates of its nurse-midwifery program. Miami Jackson Memorial Hospital's website brags about having the lowest cesarean section rate in Miami-Dade County for the past 10 years, but does not provide statistics as to how these data compares to the cesarean section rates city-wide. Miami Jackson Memorial Hospital's website only provides its cesarean section statistics from

2009, suggesting that the statistical information on its website has not been updated in over five years. Furthermore, Miami Jackson Memorial Hospital's website fails to offer the statistical amount of natural, non-medicalized births actually performed by its nurse-midwives, indicating that its nurse-midwifery program is not as integral as mentioned on its website. Failing to provide statistics on the successes and benefits of its certified nurse-midwifery program, undermines midwifery techniques and upholds the dominance of the medical model of birthing.

3.1.2   *The Medical Model of Birthing Care*

The websites of the public hospitals, North Shore Medical Center and Miami Jackson Memorial Hospital do not construct birthing as natural processes. Nor do the public hospital's websites directly construct birthing as medical processes. Rather its websites use medical specialization language, indirectly representing the technocratic medical model. While I noticed the websites of the birthing centers directly define birthing with the midwifery model, the public hospitals indirectly defined birthing by boasting about its medical specializations and its stellar health ratings in high risk birthing. The websites of the public hospitals hint at using the medical model of birthing, but they never represent the medical model directly. Rather, the public hospitals have a more subtle approach in socially constructing birthing as medical. For example, the public hospitals use language such as "just in case" and "peace of mind" to describe medical interventions. Berger and Luckman argue "language is capable not only of constructing symbols that are highly abstracted from everyday experience, but also of 'bringing back' these symbols and appresenting them as objectively real elements in everyday life" (1966: 40). Thus, the notion of "just in case" and "peace of mind" are abstracts from daily life, added to the social stock of knowledge on birthing to validate trust in the medical model over the midwifery model. The

websites of North Shore Medical Center and Miami Jackson Memorial Hospital use language to legitimize the use of the medical model of birthing in cases of emergency and beyond. The websites of the public hospitals prioritized its specialized services in obstetrics, high-risk labors, and neonatal intensive care units through every day language to establish its medical power:

> *North Shore Medical Center specializes in obstetric care for routine and high-risk pregnancies. Our goal is to give our patients the best pregnancy experience possible, and to provide them with peace of mind with our Level III Neonatal Intensive Care Unit. ~North Shore Medical Center [5]*

> *The center specializes in high-risk maternity care, is designated as a Regional Perinatal Intensive Care Center and has specialists available 24/7. Our anti-partum unit also cares for pregnant women who are in need of close monitoring and special care before their baby is born. ~Miami Jackson Memorial Hospital [6]*

Though the websites of the birthing centers did not mention any specialized medical services, the Miami Maternity Center's website mentions having an obstetrician who partners with the midwives "in case" of an emergency. The web content of the birthing centers relinquished its midwifery model to the medical model in cases of emergency birthing, indicating the superiority of the medical model over the midwifery model. The websites of the Miami Maternity Center and Spirit of Life Midwifery state:

> *We allow nature to take its course and allow the pregnancy and labor to develop without intervention. If an indication arises that calls for intervention, only then do we intervene. ~Miami Maternity Center [7]*

> *Hospitals exist to provide emergency care and other services. They are staffed with trained professionals who can provide immediate care for almost any procedure and are open 24 hours a day, every day. The problem that a lot of women have is the hospital setting is not the most relaxed, helpful setting for labor and birth (hospitals can slow down and even complicate a labor). Also, hospital-based methodologies differ from Spirit of Life Traditional Midwifery's in the respect that we believe pregnancy, labor and birth are joyous occasions that do not fit one particular method and should be catered to the needs of the individual. We only go to the hospital if we need to. ~Spirit of Life Midwifery [8]*

The power shift from the midwifery model to the medical model in cases of "high-risk" diagnosis is problematic. The problem is that the exact definition of high-risk is loosely constructed and harder to capture (Lupton 2006; Simonds et al. 2007). Brown argues how the power of defining a disease or illness as a medical problem is beyond its concrete definition, rather the power is in the definition's fluidity (Brown 1995). Definitions that are ever-changing and expanding are just as powerful as concrete definitions because the definition can be altered at any point. This gives the definition more power to evolve and collect more meaning over time. High-risk pregnancies that often lead to emergency birthing continue to expand the process of monitoring the fetus, running tests, inducing the labor, and or increasing medical intervention birthing. Because more pregnant women are diagnosed as high-risk or in need of emergency care once in labor, birthing centers lose clients, control, and validity as experts in birthing care—and public hospitals earn supremacy.

Diagnosing pregnant women into high and low risk categories restricts women's birthing options. Because of prenatal risk diagnoses, not every pregnant women is "eligible" for giving birth outside of the hospital or through home-birthing services. Spirit of Life Midwifery's website restricts its home-birthing eligibility requirements to "healthy, low-risk women with no pre-existing medical conditions such as hypertension, diabetes, epilepsy, or certain blood-clotting disorders." [9] Yet, as more prenatal monitoring increases, more pregnant women are being diagnosed as high-risk, without exact meanings of high and low risk definitions. In this vein, the medical model of birthing happens before the birthing process itself, generating an emotion of 'risk' prior to labor and delivery. Simonds et al. argue "medicine had to emphasize the disease-like nature of pregnancy, its 'riskiness,' in order to justify medical management" (Simonds et al.

2007: 52). Prenatal diagnoses not only restricts the midwifery model to the medical model, but also contributes to the medical meaning of pregnancy and birthing in everyday life, constructing a medicalized social stock of knowledge (Berger and Luckman 1966).

Website content adds to the social stock of knowledge on birthing, with the website as its source of knowledge distribution. Through website distribution, the social stock of knowledge on labor and delivery is constructed to the everyday world. Berger and Luckman argue how "interaction with others in everyday life is, therefore, constantly affected by our common participation in the available social stock of knowledge" (1966: 41). In this case, instead of daily interaction with others, my findings provide conclusions as to how interactions with websites contributes to our understanding of the midwifery and medical models of birth. Below, Table 3 illustrates a comparison between the available social definitions used by the Miami Maternity Center's midwifery definitions [10] versus the Miami Jackson Memorial Hospital's medical definitions. [11] The problem with the midwifery definitions versus the medical definitions in Table 3 is that "the obstetrical [medical] perspective on pregnancy and birth is held to be not just one way of looking at it, but to be the truth, the facts [of] science" (Rothman 1992: 33).

Table 3 Midwifery Model Techniques vs. Medical Model Techniques

Midwifery Model for Birthing *(Source: Miami Maternity Center's website)*	*Medical Model for Birthing* *(Source: Miami Jackson Memorial Hospital's website)*
Massage: Using pressure and counter pressure at the appropriate times to relieve labor-induced pains.	**Routine Obstetrical Ultrasound:** This type of ultrasound includes these types of first trimester screenings: evaluation of pregnancy, determining fetal life, number, presentation, gestational age, placental position and evaluation of the anatomy of the fetus, following the guidelines of The American Institute of Ultrasound in Medicine.
Hydrotherapy: Relaxing in a warm tub during labor, giving the baby buoyancy in utero and reducing the weight of the baby on your back.	**Detailed (Level II) Ultrasound:** This type of ultrasound is targeted towards mothers who are at risk for fetal abnormalities or a second opinion ultrasound of a high-risk pregnancy with a known fetal abnormality.
Respiratory Relaxation: Practiced breathing techniques designed to ease labor pains while simultaneously increasing oxygen flow to your baby.	**Nuchal Translucency:** This is a non-invasive prenatal screening test conducted during 11-14 weeks of pregnancy. A nuchal scan helps identify higher risks of Down Syndrome in fetuses, particularly for older mothers who have higher risks of such pregnancies. The scan assesses the amount of fluid behind the neck of the fetus; babies with Down Syndrome risks tend to have a higher amount of fluid around the neck. The test may also help confirm both the accuracy of the pregnancy dates and fetal well-being, as well as detect other less-common chromosomal abnormalities.
Freestyle Positioning: Allowing the mother to assume and deliver in any position that feels comfortable to her reduces labor pains and reduces fetal distress.	
Ambulating: Allowing the mother free mobility during labor, without being strapped to monitors, shortens labor and reduces pain.	**Fetal Well-Being Evaluation** (Biophysical Profile and Fetal Non-Stress Testing): This evaluation tests for movement, tone, fetal breathing, the amount of amniotic fluid surrounding the fetus and accelerations in heart rate with fetal movement.
Video Distraction: Taking the mother's mind off her labor by substituting video stimuli, including individually-selected movies.	**Doppler Studies** of the fetus including UA (umbilical artery), MCA (middle cerebral artery) and Ductus Venosus to evaluate the blood flow in the fetal umbilical cord and brain.

Professional Coaching: We provide a specially trained labor attendant who works with you through labor and delivery to relax and comfort you and keep you focused on your goal: delivering a healthy baby.	**Genetic Consultation** can help find suspected chromosomal abnormalities and fetal malformations. **Invasive Procedures** are performed when indicated, for women who have a significant risk for known genetic or hereditary disorders, abnormal ultrasounds or a family history of genetic diseases.

3.1.3   Woman-Centered Approaches and Infant-Centered Approaches

The Gathering Place's website demonstrates a woman-centered photo.[12] The photo shows several woman sitting cross-legged or Indian-style in a circle on the floor and couch. Some women are pregnant, while others are breast feeding, laughing, and appearing to enjoy themselves. No men were present in the photo. Spirit of Life Midwifery's website show many pictures of the midwife holding "freshly born" infants, giving the website a more women-centered and infant-centered approach. Spirit of Life Midwifery features a web image of a school-aged child wearing a tee-shirt saying, "SUPPORT MIDWIVES." The child wearing this tee-shirt demonstrate an activist stance from the child and women to center midwives as birthing attendants. Rothman argues that the woman-centered approach involves "a woman's perspective on birth, in which women are subjects, the doers, the givers of birth" (Rothman 1992: 34). The websites of the birthing centers show woman-centered approaches, with hints of infant-centeredness, indicating that its birthing representations are primarily about the woman and then about the child. Miami Maternity Center, the Gathering Place and Spirit of Life Midwifery show woman-centeredness and infant-centeredness illustrate,

Women and their families have the right to determine the standard of care
they desire during pregnancy and childbirth. ~The Gathering Place [13]

Women in labor are free to eat, drink, walk around and assume whatever position helps them. There are Jacuzzis, showers, massages, music, movies, and hands on coaching. ~Miami Maternity Center [14]

Midwives are women who respect women, women's bodies, and the process of having babies. ~Spirit of Life Midwifery [15]

North Shore Medical Center's website claims cater to the woman in labor as a part of the "mother & baby" unit, yet there are no web images of pregnant women or women in labor on its website. Though there is a web video virtual tour, featuring women (including their faces), holding their children, web imagery and web videos are two different knowledge distributions of woman-centeredness. Failing to provide web imagery alongside the web video virtual tour does not capture woman-centeredness representations. Moreover, North Shore Medical Center's website provides an infant-centered photo to the right of the web video virtual tour. The photo was of a woman's pregnant belly, with her face cropped out. The web image's focus is on the pregnant belly, with a laptop next to it and an image of a baby's face on the screen. The web image was part of an advertisement for baby photography, a service offered by the hospital in post-delivery. However, we must make note that the North Shore Medical Hospital did not choose this web photo per se, but perhaps gives rights to the infant photography company to represent this photo on its website. I questioned how could North Shore Medical Center's website claim to be woman-centered, but none of their web imagery had women's faces in them except in the web video virtual tour?

Miami Jackson Memorial Hospital did not necessarily frame itself as women-centered or infant-centered. However, I noticed that they placed security devices on infants' ankles to protect infants post-delivery. Miami Jackson Memorial Hospital states:

After a baby is born, a locator device is placed on each baby's ankle. If a baby wearing this security device is taken outside the unit without security and the nurses' knowledge, a series of alarms will sound and all doors allowing entrance on to the unit are closed and locked. ~Miami Jackson Memorial Hospital [16]

Miami Jackson Memorial Hospital's website constructs technological infant-centered security approach as a part of its infant-centered medical model. On the other hand, Miami Maternity Center's website discusses infant-centered through a woman-centered approach, claiming a philosophy that the "baby never leaves your side." Miami Maternity Center's website constructs infant-centered security through a midwifery lens that is without the use of medical technology and surveillance. Miami Maternity Center's website states,

> *You and Your Baby are NOT Separated. The safest place for your baby to be is in your arms. That is why we keep mommy, daddy, and baby together. While hospitals install multi-million dollar security systems to insure that your baby is not switched or stolen, we have a different approach: your baby never leaves your side. You don't have to worry about who has your newborn and what is being done to him or her. Remember, no one cares more about your baby than you do! ~Miami Maternity Center [17]*

Woman-centered and infant-centered approaches are represented as polar opposites between the midwifery and medical models of birthing. The websites of the birthing centers include web imagery of women in almost stage of pregnancy and birthing. However, the websites of the public hospitals only show web video virtual tours of a few women holding infants and the facilities amenities, with little to no web imagery of the stages of birth. The websites of the public hospitals also represent infant-centeredness through medical surveillance, while the birthing centers keep the infant and mom in close proximity without such security measures.

3.1.4 *Representation of Healthcare Worker Relationships to Birthing Women / Infants*

The websites of the Miami Maternity Center, The Gathering Place, and Spirit of Life Midwifery socially construct itself as providing a "with-woman" and "hands-on" approach in its

relationship with the women. The website of the Gathering Place refers to women as "clients," while the websites of the Miami Maternity Center and Spirit of Life Midwifery refers to women as "women" and or "moms." Referring to pregnant women as "clients" gives an impression of a corporate business nature. However, the Gathering Place was the only birthing institution offering doulas (or birthing coaches) as a part of its birthing services to pregnant women. The websites of the Miami Maternity Center and Spirit of Life Midwifery mentions doula services, but doula services are not a part of the birthing package, rather doulas are a separate service. The websites of the public hospitals, North Shore Medical Center and Miami Jackson Memorial Hospital do not mention doula services at all on its websites. Representations of healthcare worker relationships on the websites of the Miami Maternity Center, the Gathering Place, and Spirit of Life Midwifery illustrate:

> *I became a midwife to give women the option to choose the type of birth they want and the setting for their birth. I love caring for women and being a part of the "the miracle of birth". ~Miami Maternity Center [18]*

> *The basis of doula care is guidance, which includes offering information, tangible physical assistance, and emotional support. Doula care represents a return to the tradition of woman-to-woman support during pregnancy, labor, birth, and the immediate postpartum period. ~The Gathering Place [19]*

> *When you birth at home, your midwives are there to support you throughout your labor and birth, not just for a few minutes at a time every few hours, as in a hospital setting. Midwives have lots of ways to get labor moving along if it needs help, but most of the time support and encouragement are enough to birth the baby safely and efficiently. ~Spirit of Life Midwifery [20]*

The websites of North Shore Medical Center and Miami Jackson Memorial Hospital mentions having "skilled staff" who provide "compassion" and "comfort" to woman during their stay" in the hospital. The websites the public hospitals describe the skill-set of its specialists as professionals who are "striving" to give women in labor "peace of mind." I noticed the public

hospitals websites use specialization language to represent how it assists women during labor, while the birthing centers use emotional-support language. Representations of the hospital staff's relationship to the women are a part of the medical model framework. Rothman argues "the context in which medical knowledge develops and is used shapes that knowledge. Doctors see pregnancy, childbirth, and the entire reproductive cycle from their perspective" (Rothman 1992: 33). Thus, the websites of North Shore Medical Center and Miami Jackson Memorial Hospital represent itself and its staff as experts of specialization and high-risk emergency birthing, aligning with Medicaid's technocratic model of birthing.

However, I also noticed that the websites of North Shore Medical Center and Miami Jackson Memorial Hospital rarely use the words "medical," rather the websites displayed words like "specialization" and "skills" to legitimize its medical model of birthing as the supreme stock of knowledge. Berger and Luckman argue how individuals "require not only the advice of experts, but prior advice of experts on experts. The social distribution of knowledge thus begins with the simple fact that I do not know everything known" (1966: 46). Because the medical model decenters the woman from her birthing process, public hospital staff are socialized to approach pregnant women as though they could not know anything about birthing. The medical model empowers the specialist and disempowered the woman giving birth. Specializing staff in the medical model further separates women from the process of birthing.

North Shore Medical center's website provides one testimony from a former labor patient, who complimented the staff's services: *'I cannot say enough wonderful things about the hospital staff for everything they did for me   and my family,' says Sherry. "They made sure my babies were healthy enough to prosper outside of the hospital."²¹* Though website testimonials provide direct insight from the consumer, such testimonials are not always full reflections of the institution.

Baumgarten and Grauel argue that websites often post information and content that best supports their own political interests (2009: 99). Because website testimonials are typically positive reflections of the institution, it is important to analyze what is (and is not) displayed on the website. In future studies, it would be informative to compare the website testimonials of the birthing institution to its outside reviews to get a more accurate depiction.

3.1.5 Representation of Medicaid Insurance Coverage

Miami Maternity Center's website mentions "accepting Medicaid" insurance on its website, stating "*We work with most insurance companies and HMOs. We also accept Medicaid. In addition, we are able to work out affordable payment plans for those families that wish to pay cash.*" [22] Spirit of Life Midwifery's website also states,

> *Midwifery is Affordable and Cost-Effective Midwifery fees are typically one-third less than fees for comparable services provided by physicians; midwifery care saves money without sacrificing quality or safety. Medicaid accepted, as well as most major insurance plans. Cash payment plans can also be arranged.* [23]

The Gathering Place accepts Medicaid, but provides no representation of Medicaid insurance on its websites. Rather, the Gathering discusses its self-pay rates for doula or birth coaching services, stating "*once you hire one of our doulas, you will typically be required to pay a 50% non-refundable deposit, to hold the time surrounding your estimated due date. Payment is full is required by the 34th week of pregnancy.*" [24] North Shore Medical Center and Miami Jackson Memorial Hospital also accept Medicaid, but the actual web content of Medicaid is not on its Maternity Center's webpages. Rather, Medicaid information is on it's a webpage separate from its maternity center web pages. Redirecting web viewers to the overall hospital's insurance webpage does not qualify as an attempt to cater to viewers who are specifically looking for answers on its maternity center web pages.

My findings show that Medicaid is represented on the websites of Miami Maternity Center, and Spirit of Life Midwifery. North Shore Medical Center and Miami Jackson Memorial Hospital do not directly represented Medicaid on its maternity center webs pages, but redirects you to its insurance policies web link. The Gathering Place's website does not represent Medicaid on its website, but represents self-pay options for doula services.

Though it is clear that low-income women with Medicaid insurance have birthing options across all five birthing institutions, there is a contradiction in the results. What is the point of birthing institutions accepting low-income women with Medicaid insurance, if such women are heavily presented with representations of the medical model over the midwifery model? If women are diagnosed into high and low risk categories, then the entire stock of knowledge distribution is centered on riskiness. Thus, Medicaid's technocratic medical model of birthing trumps the midwifery model in the everyday social construction of birthing.

In this vein, it does not necessarily matter that these birthing institutions accept Medicaid. Rather, it matters that the common stock of knowledge and its distribution thereof is entirely based on the medical model of birthing, with hints of appropriating midwifery techniques. Rothman argues "the medical model shows us pregnancy and birth through the perspective of [a] technological society, and from men's eyes" (1966: 34). The medical and midwifery model of birthing represent a deeper ideology, situating the midwifery model as the woman's perspective and the medical model as the man's perspective (Rothman 1991: 34).Because Medicaid is founded upon the technocratic medical model, then the birthing institutions that qualify as Medicaid-providers represent the medical model of birthing and inherently view low-income women through a patriarchal lens. Though low-income women with Medicaid insurance are seemingly presented

with options across both midwifery and medical models, the interaction of such birthing facilities reverts back to the dominance of medical intervention.

4   CONCLUSIONS

My work challenges us to pay attention to how websites distribute language, images, and social constructions that continue to build upon the social stock of knowledge on labor and delivery. My findings alert us to recognize how Medicaid-providers socially construct and socially define the labor and delivery process on their websites. My conclusions also reveal the ways in which the midwifery and medical models are placed in hierarchical positions on the websites of healthcare providers in the Miami area. The websites of Miami Maternity Center, the Gathering Place, and Spirit of Life Midwifery align with the midwifery model of birthing care as defined by MANA. However, its web content reverts to the medical model used by North Shore Medical Center and Miami Jackson Memorial Hospital in cases of emergency birthing. The websites of the public hospitals appropriate midwifery model language, such as "home-like" and "spa-like" to fit into its medical model. The websites of the public hospitals also appear to be inclusive of woman-centered approaches as "alternatives," but the majority of their language focuses heavily on specialization, technology, medical intervention, and the security monitoring of infants.

The websites of the birthing centers provide holistic support—emotional, physical, spiritual, and inclusive of family—for the woman in labor. However, women whose pregnancies are diagnosed as high-risk are restricted to public hospitals like North Shore Medical Center and Jackson Memorial Hospital. If birthing institutions, particularly public hospitals, want to improve negative socio-emotional outcomes, reevaluating the ways its birthing services are presented on its websites would be an adequate place to start its social reconstruction.

The state of Florida has made its own distinct legislative decision to transfer from Medicaid to the Federally-Facilitated Marketplace in 2015. Future studies could include conducting this study when the Affordable Care Act of 2009 is more established, and Florida has completed its transfer to the Federally-Facilitated Marketplace. It would also be informative to conduct this study in other U.S. locations to compare and contrast how the Medicaid for Pregnancy programs ranges in variations.

Social definitions regarding birthing care are urgent because it contributes to the common stock of knowledge on labor and delivery in the U.S Human life depends on how knowledge is distributed because it impacts how individuals perceive, decide, and make meaning of every day processes, such as birthing. In an era of major shifts in health care, we need to know how medicalization impacts our birthing facilities and, especially, what it means for low-income pregnant women and infants who are subject to the regulations of the Medicaid insurance system. Perhaps this is beyond the Medicaid infrastructure, but my results reveal that the social definitions distributed by the websites of Medicaid-providers needs to be analyzed.

By assessing how birthing providers socially construct birthing, we could reduce the underrepresentation of natural birthing, exposing low-income women to more balanced depictions of both the medical and midwifery models of birthing. If low-income women are presented with adequate representations of both the midwifery and medical models of birthing, then this could possibly reduce negative socio-emotional outcomes during birthing, postpartum depression and maternity-mortality rates among the poor

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