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HOMEBIRTH POLITICS: FEMINISTS, CONSERVATIVES, AND THE STRUGGLE OVER EXPERT KNOWLEDGE

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HOMEBIRTH POLITICS: FEMINISTS, CONSERVATIVES, AND THE STRUGGLE OVER EXPERT KNOWLEDGE

Liora O'Donnell Goldensher

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Abstract

In recent years, some critics have proposed that we live in a "post-truth" world, or that expertise is dead. This dissertation argues that though the status of expertise and the professions is changing, it is not simply because professions are powerless, experts are no longer believed, or truth is no longer a relevant category. Instead, I focus on the rise of alternate forms of expertise. I examine what I term the *counterprofession* of homebirth midwifery in the United States. Contemporary homebirth midwifery arose from the convergence of late twentieth century challenges to medical authority by conservative off-the-grid and Christian communities, the feminist health movement, and back-to-the-land groups. A small but growing share of parents, many of whom wish to avoid the US's distinctively dangerous medical perinatal care system, now seek perinatal care from providers who train and practice outside of medical settings. I argue that rather than avoiding experts in pregnancy and birth, these parents choose counterprofessionals as their care providers.

Counterprofessions, I contend, emerge when critics of an existing profession's way of approaching a problem or task create an alternative body of expert knowledge and skill that they claim is better equipped to both understand and address that concern. They are fruitful sites from which to observe what I call a profession's normative epistemology, or its organizing principles for how knowledge ought to be produced and deployed. My analysis shows how critical and social movement writings find purchase in homebirth midwifery's normative epistemology, tracing the centrality of epistemic multiplicity and local expertise to the practice of *informed choice*. Practice guided by

this kind of normative epistemology leads a counterprofession such as home birth midwifery to a distinctive relationship with law. Counterprofessionals, I contend, must become active managers of law's contradictions with their epistemic and normative commitments, facing its paradoxical abilities to both limit and protect choice. Demonstrating how politically disparate midwives often bracket disagreements in service of collaboration, I highlight the fragility of right-left convergences around challenges to expertise. Through close examination of contemporary professional midwifery, I aim to contribute to broad debates about the contemporary politics of expertise.

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Introduction: Is Expertise Dead?

"As a catch-all phrase, 'post-truth' seemed to capture the times," wrote Lee McIntyre of the Oxford Dictionary's choice of the term as word of the year for 2016 (McIntyre 2018:1). It was 2017, and Donald Trump was baselessly insisting, as he continues to do two and a half years later, that there had been no Russian interference in the 2016 election in which he had claimed the presidency. These false claims, as McIntyre noted, followed close on the heels of and presaged others: that he had actually won the popular vote in the presidential election, once purported illegally cast votes were discounted; that this victory was the most decisive since Reagan's; that he had drawn the largest crowd to a presidential inauguration in United States History (McIntyre 2018:2). Responding to questions on Meet the Press about why White House Press Secretary Sean Spicer had "utter[ed] a provable falsehood" on this last matter, Kellyanne Conway famously defined Spicer's comments not as lies, but as "alternative facts[1]." On CNN, as McIntyre related, Newt Gingrich similarly dodged reporter Alison Camerota's insistence that he respond to her citation of FBI reports that, contrary to his reiteration of Trump's claims that the United States murder rate was at a historic high, crime rates had fallen. "Liberals have a whole set of statistics that theoretically may be right," Gingrich replied, "but that's not where the human beings are…what I said is equally true" (McIntyre 2018:4). McIntyre, like a host[2] of other commentators and the readers whose purchases drove 1984 to the New York Times Bestseller List, called the exchange Orwellian. What

[1] see Blake 2017
[2] see Calfas 2017, de Freytas-Tamura 2017

he called "a challenge not just to the idea of knowing reality, but to the existence of reality itself" (McIntyre 2018:10) had, by 2017, become widely accepted as a key problematic of the political moment.

For McIntyre, this was not simply a problem of truth, but a problem of the cultural status of epistemology. "This is not the abandonment of facts," he wrote, "but a corruption of the process by which facts are credibly gathered and reliably used to shape our beliefs about reality. Indeed, the rejection of this undermines the idea that some things are true irrespective of how we feel about them, and that it is in our best interests (and those of our policy makers) to attempt to find them." McIntyre diagnosed not simply a deficit of facts, but a deficit of what he called "respecting truth, by embracing those methods of inquiry—like science—that have customarily led to true beliefs" (McIntyre 2018: 11). His take was a popular one. Among liberals, a poster appeared on Facebook feeds and co-op bulletin boards and in apartment windows and front yards, announcing, "In this house, we believe: Black lives matter/women's rights are human rights/no human is illegal/science is real/love is love/kindness is everything." Epistemic propositions— that "science is real"—had attained a status similar to other recognizable liberal stances on race, immigration, gender, and sexual politics. There was, for McIntyre and many others, a very particular casualty in this new culture war. It was not just *any* truthful knowledge whose credibility had been politicized: instead, they saw the dismissal of *expert* knowledge as fueling the authoritarian conservatism they decried. "Post-truth," McIntyre wrote, "was foreshadowed by what has happened to science over the last several decades. Once respected for the authority of its method, scientific results are now openly questioned by legions of non experts who happen to disagree with them"

(McIntyre 2018: 18). "I fear we are witnessing *the death of the ideal of expertise itself,*" opined Tom Nichols, "a Google-fueled, Wikipedia-based, blog-sodden collapse of any division between professionals and laypeople, students and teachers, knowers and wonderers" (Nichols 3).

Laments like these over the advent of a "post-truth" era or an anti-expert cultural moment typically identify a turn away from scientific and technocratic expertise, alongside the rise of populist discourse. My research suggests that though the cultural status of expertise and epistemology is indeed shifting, the picture is more complicated. If the "post-truth" era is a moment of epistemic crisis for individuals, I contend, it is not simply because experts are no longer believed or because truth is no longer a relevant category. Instead, I examine a site in which a different ethic—one that increasingly values local expertise and epistemic pluralism—is ascendant. This popular and populist approach to knowledge and expertise that characterizes the current political and cultural moment is the focus of my research.

I take as my site the contemporary homebirth movement in the United States, focusing on Certified Professional Midwifery (CPM) practitioners providing demedicalized midwifery care in home and out-of-hospital settings. Homebirth midwifery—whose twentieth century resurgence is often traced to the feminist health movement and back-to-the-land groups of the 1980s, and to conservative off-the-grid and Christian communities—has experienced rapid growth and internally controversial professionalization over the past two decades (see Morgen 2002, Kline 2010, Murphy 2012, Craven 2010, Davis-Floyd ed. 2006, Simonds, Rothman and Norman, eds. 2007). A central concern of homebirth midwives that emerged in my fieldwork is that

of *informed choice*. Rather than seeking informed consent for a medical procedure that a doctor or other provider recommends, the midwives in my study seek to partner with parents[3] to gently assist the latter in making choices about their own care (MacDonald 2018). I find that in credentialing the ethic of informed choice, homebirth midwives are deeply engaged with critical and constructivist approaches to science and medicine, are firm believers in respecting multiple legitimate forms of knowledge, and see their role as one of encouraging this knowledge and of enabling lay participation in care.

Homebirth midwifery has experienced rapid change over the past decade and a half: families from both conservative and liberal or left backgrounds are opting for home births at ever-increasing rates, and the legal context around surrounding homebirth midwifery practice is shifting. Amidst these changes, the question of what to do with midwives' expertise in managing epistemic pluralism is at the heart of community members' pitched conflicts over how and whether to professionalize, seek state licensure, craft legal codes such as scope of practice regulations or training requirements, and establish relationships with other healthcare institutions and providers. These conflicts unfold in active conversation with diverse, sometimes opposing sets of normative and epistemic commitments: those of both a populist politics of knowledge and associated

[3] I use gender-neutral terms such as "parents," "birthing parents," and "clients" in this dissertation, except where referring to a specific person who uses gendered terms such as "mother" or "woman". The use of gender-neutral terms including these and others (childbearing parent, gestational parent) is now standard in many major homebirth midwifery organizations (see Midwives' Alliance of North America, "Position Statement on Gender-Inclusive Language" [https://mana.org/healthcare-policy/position-statement-on-gender-inclusive-language], National Association of Certified Professional Midwives, "Chapter Equity Resource Guide" [https://www.nacpm.org/wp-content/uploads/2019/01/Equity-Resource-Guide-1_8_19.pdf]). Organizations and practitioners have adopted this language in an effort to ensure that midwifery clients including trans men, genderqueer and gender nonconforming people are addressed and described respectfully. Gendered terms do appear in this dissertation to refer to groups of parents when I quote research participants or texts.

libertarian critique of the state and a feminist critique of expert knowledge and the politics of bodily autonomy and reproduction.

Why this site? Pregnancy and birth are both extraordinary events and among the most prevalent experiences: the Pew Research Center reports that by the time United States women reach the end of their childbearing years, 86% have become mothers[4]. As home birth and homebirth midwifery grow in prevalence, they become increasingly common reference points for families. Widespread, everyday experiences like these, I contend, are important sites for the production and sustenance of common-sense understandings of abstract ideas at the meeting point of ethics, epistemology, and governance: ideas of facticity, authority, freedom, and choice. The sociological miniaturism (Stolte, Fine, and Cook 2001) of the core proposition of this dissertation is a microsociological truism. Changes in popular understandings of expertise and epistemology are certainly in large part attributable to cynical collaborations by conservative media organizations, politicians, and industry figures who have aimed to trade on popular suspicions to foster doubt of both information and experts in order to undermine projects such as climate reform, industry regulation (see Oreskes and Conway 2011, Norton 2018). Yet other challenges to expert and professional knowledge and authority are simultaneously fostered in daily life. I look to one such location where a different, yet sometimes inconveniently compatible set of critiques of expert authority and investments in epistemic multiplicity constitute communal common-sense (Fine and Harrington 2004:343, cit Collins 1981). Twenty-first century homebirth and homebirth midwifery is the site of a thorny and disquieting convergence between a twentieth century

[4] 86% of US women between 40 and 44 are mothers (see Livingston 2018)

feminist critique of expert knowledge in medicine and a long legacy of United States conservative populism and anti-statism that has, since the Jacksonian era (see Starr 1982:57-8), frequently showed its face in mistrust of doctors and health science. To understand—and evaluate—the emergence of "post truth" or "death of expertise" arguments on the macropolitical stage, I contend that we must also attend to sometimes small, sometimes marginal communities such as this one. In turning to the tradition of practical knowledge in everyday life (Berger and Luckmann 1966, Schutz and Luckmann 1973, Kalekin-Fishman 2013), I take the quotidian scenes of reproduction as sites in which to investigate the politics of expertise precisely for their association with the taken-for-granted (Felski 1999: 17). "Post-truth," writes Lee McIntyre, "exists in us as well as our leaders" (McIntyre 2018: 15). In this dissertation, I turn to "us"—the many parents who seek an experience of pregnancy and birth in which they are prioritized as knowers and deciders—to argue for a more complicated understanding of the contemporary status of truth and expertise.

The project draws on 15 months of ethnographic fieldwork I conducted in the practices of four CPMs, who are the only providers who train and practice exclusively in out-of-hospital settings (Davis-Floyd 1998). CPMs today practice in the context of both crisis and rapid change in United States perinatal healthcare. Popular attention to the appallingly high rates of perinatal morbidity and mortality in the U.S.—unmatched among countries with comparably elaborated medical systems—has skyrocketed. A small but rapidly growing share of parents, meanwhile, have chosen out-of-hospital birth and care from providers trained outside of medical settings. After reporting steadily accelerating rates of homebirth between 2004 and 2012, the CDC announced that the

38,542 births occurring at home in 2015 was the highest such number recorded since place-of-delivery data collection began at the agency. By 2017, more than 1.5% of all United States births—those of more than 62,000 babies—happened in homes, freestanding birth centers, and other out-of-hospital settings. Over 25,000 of those infants were born in the care of providers other than physicians or nurse-midwives (MacDorman et al 2014, Martin et al 2017). In each of four primary field sites spanning seven states, I worked in the practice of a CPM and moved in the institutional and organizational spaces CPMs frequented, attending prenatal and postpartum appointments, births, regional meetings of midwives' organizations, regulatory board meetings, courses, study groups, and workshops. Aiming for a comprehensive view of the field, I also conducted ethnographic interviews (n=90) with additional midwives, homebirth clients, midwifery students and educators, childbirth educators, doulas, regulators, billers, collaborating physicians and nurse-midwives. Field sites were selected to capture elements of variation whose importance emerged during preliminary research: variation in state regulatory arrangements, relationships with other area healthcare providers, geographic location (United States region and urban/suburban/rural), and cultural/ideological context for homebirth practice (primarily conservative/primarily feminist, left, or liberal; religious/nonreligious). I coded interviews, field notes, and ephemera inductively by hand.

The dissertation follows the notion of informed choice. Chapter 1 introduces the backdrop against which the twenty-first century resurgence in homebirth and midwifery unfolds. I explain how a second-wave feminist and back-to-the-land midwifery movement in the 1970s, 80s, and 90s created a new midwifery credential on the basis of

both social scientific research and the knowledge of Black, immigrant, and indigenous community midwives practicing in areas underserved by mainstream healthcare. I describe the United States perinatal health system's current crisis (Morris 2016, Gallardo 2017) and introduce the turn to out-of-hospital birth and professional midwifery by parents seeking alternatives. In chapter 2, I describe the concept and practice of informed choice, explaining how the shifting public conversation about experiences of routine violation and coercion in hospital-based perinatal care set the stage for professionalization around this notion (Declercq et al 2013, Diaz-Tello 2016). I examine this key guiding commitment by which contemporary non-nurse midwifery distinguishes itself from its others both as an ethical ideal of care provision and as an active process in clinical scenes, describing its promise, its difficulties and its contradictions. Chapter 3 will argue that the work of facilitating informed choice—and the programmatic management of theories of knowledge required to do so—is the set of tasks over which contemporary homebirth midwives seek to establish jurisdiction (Abbott 1988), and the ethic of informed choice as the right way to provide care constitutes the core of contemporary professional midwifery's occupational mandate (Hughes 1993 [1971], Faulkner 1978). Practicing informed choice, as I will show, constitutes a distinctive way of living with knowledge, one that rests on normative approaches to choice, autonomy, and freedom as requiring the management and synthesis of multiple knowledges: expert and situated, social- and natural-scientific. I will demonstrate how this approach has drawn on upon social scientific critiques of expert knowledge production, objectivity, quantification, and expertise (Haraway 1988, Martin 2001, Smith 1974, Alonso and Starr 1987, Daston and Galison 2007, Espeland and Stevens 2008, Gigerenzer et al 1990,

Hacking 1990, Harding 1992, Hartsock 1983). Professionalizing around a commitment to epistemic pluralism, however, has demanded a distinctive relationship to law. In chapter 4, I describe disparities in how legal institutions have treated midwifery, particularly homebirth midwifery (Pope and Fisch 2013, De Vries 1996). Faced with this regulatory heterogeneity and a legal system at odds with epistemic multiplicity, I argue, law's hegemony is shaken and practical definitions of law (Sarat 1990, Ewick and Silbey 1998) expand to incorporate its paradoxical abilities to both protect or facilitate choice and to limit choice. Unable to assume that good practice will always mean following the law, midwives become active managers of law, making, breaking, and dodging laws to uphold their own ethical commitments to informed choice. Chapter 5 turns to conflicts within the field of homebirth midwifery, examining the dynamics surrounding the "strange coalitions" between conservative maternalists and feminist advocates that people the field of homebirth and out-of-hospital midwifery (Katz Rothman 1982, Declercq 2012). Does homebirth midwifery have a politics? Does informed choice? I describe the affinities between informed choice and homebirth midwifery's epistemic and legal positions and the political commitments of libertarians; intersectional, decarceral and rights-oriented feminists; Evangelical conservatives, and others. I demonstrate that these politically disparate actors frequently bracket their political disagreements in service of collaboration, and that when those brackets are removed, major disagreements emerge over the ethics of informed choice, epistemic justice, resource distribution in healthcare, and more. The dissertation concludes with a consideration of the tensions inherent in the project of professionalizing in an age of epistemic multiplicity and local expertise. Throughout the chapters, I provide illustrations of the day-to-day work midwives

undertake to approach this tension: the work of managing populist and popular orientations to knowledge and expertise.

I will take homebirth midwifery as a point of departure from which to examine the epistemic demands and the political and cultural contests involved in the process of professionalization. It thus will identify an earlier stage of professionalization than those considered by many previous analysts (Starr 1982, Abbott 2014 1988, Freidson 1974, Larson 1979, Whooley 2013). Before a professional field or expert domain can lay claim to cultural authority or control any set of knowledge or tasks, I will argue, the field must settle on a normative epistemology: a set of organizing principles for how knowledge ought to be produced and deployed. I will argue that the work of establishing a professional field always depends on establishing some ethical, moral, or normative consensus: there is, in other words, always a "should" to a jurisdictional claim. I will argue that homebirth midwifery and others I call counterprofessions are a particular kind of profession that emerges on the basis of a critique of an existing profession. Counterprofessions, in my formulation, emerge when critics of an existing profession's way of approaching a problem or task create an alternative body of expert knowledge and skill that they claim better understands that problem and is better equipped to address it. As is the case in home birth midwifery, they are frequently places where critical and social movement writings find purchase. As such, the debates that animate twenty first century homebirth midwifery are good places to examine the afterlives of twentieth century feminisms and critical intellectual projects. I will argue that though all professions have normative epistemologies, the fundamentally normative nature of jurisdictional claims is easier to see in the case of counterprofessions. Furthermore, I will

contend that precisely because establishing a normative epistemology involves the fundamentally political work of answering the questions of how knowledge should be made and used and who should be recognized as knowing enough to make decisions, this stage of professionalization is the site of potent political and cultural contests. Contests over professionalization and expertise such as this one, in other words, tell us much about how we live today and where the fault lines lie in debates over what should be understood to be true and what constitutes a good decision or a free choice.

Methodological Note

I conducted the fieldwork for this dissertation in four major sites. In each site, I worked in the practice of a CPM. I was a participant observer in two field sites, providing childcare in one and acting as a (highly amateur and likely unsatisfactory) birth photographer in another. Because those practices often covered areas including multiple states, the fieldwork was conducted in a total of seven states. In northern New England, I spent seven months working with a CPM whose practice included southern Vermont and New Hampshire, as well as the northern parts of western Massachusetts. In southwestern Louisiana, I worked with a midwife whose practice included east Texas. In north central Pennsylvania and the Bay Area of California, the practices I shadowed did not cross state borders. The research in each of these comparative field sites lasted somewhere between several weeks and a month. I also conducted 90 ethnographic interviews with additional homebirth midwives, including CPMs, non-credentialed homebirth midwives, and CNMs in homebirth practice; homebirth clients; midwifery students and educators; childbirth educators; doulas; regulators including board and council members, a legislator, and a Board of Medicine staffer; billers; and collaborating physicians and nurse-midwives at hospitals that frequently received homebirth transports. In order to familiarize myself in the online conversations that many participants described to me as key, I also followed several relevant Facebook groups suggested to me by participants, including a midwifery study group, an Indiebirth discussion group, the Birth Without Fear discussion group, and an unassisted birth discussion group.

I selected field sites with an aim to capture elements of variation whose

importance emerged during preliminary research: field sites represented states where CPMs held licenses and practiced under the supervision of regulatory boards of multiple different characters, as well as states in which licensure for CPMs was unavailable. I did not conduct participant observation in states where non-nurse midwifery is criminalized, but I did conduct interviews with midwives practicing in those states. Field sites also represented areas where relationships with other area healthcare providers were collaborative and areas in which they were extremely challenging for midwives; rural, urban, and suburban areas; the Northeast, South, and West Coast; and variation in state regulatory arrangements, relationships with other area healthcare providers, geographic location (United States region and urban/suburban/rural), and cultural/ideological context for homebirth practice (primarily conservative/primarily feminist, left, or liberal; religious/nonreligious). I coded interviews, field notes, and ephemera inductively by hand. In both field site selection and interview participant recruitment, I used a form of "inconvenience sampling" (Duneier 2011): I frequently asked participants about people I should talk to whose experience or perspective was divergent, or who disagreed with the person I was speaking to. I also asked midwives I knew better to suggest places with different contexts for home birth practice, and selected comparative field sites from those suggestions.

In each practice, I attended most prenatal and postpartum appointments during the period of fieldwork. I also attended births. This meant I was on-call, keeping my cellphone ringer—and, in New England, my landline ringer--on through the night, staying sober in order to be able to drive at any time, and sticking close to the birth locations. When a parent's labor was expected to be particularly quick, I sometimes

stayed with friends or acquaintances near a family's home. Midwives often told me they felt I understood the ways being on call—often as a solo practitioner, often at virtually all times—structured their lives. I, however, felt acutely aware that my experience of being on call was different from theirs: when I woke up in the middle of the night to drive to a birth, I was there to quietly make field notes, maybe take birth photographs, prepare food, or care for a child, and, in one circumstance in which the second midwife did not arrive in time for a very fast birth, watch a clock, call out times, and pass supplies to a midwife. Being on call for these tasks was, I knew, entirely different from being on call to potentially stop a hemorrhage or resolve a shoulder dystocia. And because my work, when I did have assigned tasks, was relatively replaceable, I was able to take days off to attend my own family's life-cycle events.

In addition to clinical settings, I also aimed to move in as many of the organizational and institutional spaces that area CPMs frequented as possible, and to attend meetings and events where decisions about home birth or midwifery might be made. I was a regular attendee at regional and statewide meetings of midwives' professional organizations in Vermont, New Hampshire, and Massachusetts during the period of fieldwork. I also attended California Association of Licensed Midwives' events in California. I attended regulatory board meetings in New Hampshire, as well as the Midwifery Advisory Council's meeting in Sacramento during my fieldwork in California. I also attended a midwifery study group; meetings of a course for midwifery attendants; meetings of parent- and birthworker-focused birth story sharing circles; and an elective course at a midwifery school taught by a midwife whose practice I shadowed. In 2018, I attended the national meetings of the Midwives Alliance of North America.

My access did have some key limits. In regulatory meetings, I attended public sessions and left during non-public sessions—in practice, this means I did not observe regulatory boards' proceedings surrounding reports or investigations. During intrapartum transports or consultations with physicians, I did not enter clinical spaces with parents or midwives, as I did not have access agreements with hospitals. This means I missed births at times, even if I was present for large portions of labor. I also missed one birth when my car wouldn't start! Even when I was present at births, I was frequently in another room for large stretches of time. This arrangement, while it might seem to impoverish the data, was an expression of actors' understandings of right care in birth—and indeed mimicked the behavior of midwives in many cases. If, as many say, each additional person in the room during labor and birth is an intervention, the right place for the midwife is often "tucked away" in a spare bedroom. My aim to be present only at those times when parents enthusiastically consented to my presence meant that I also left the room during elements of prenatal visits such as vaginal exams and skipped postpartum visits with parents experiencing severe postpartum mental health challenges. One key implication of these access limitations is that I did not directly observe any obstetric or nurse midwifery practice, even as it occurs in collaboration or coordination with homebirth midwives. This is not in any way a study of hospital-based perinatal care. Homebirth midwives' and parents' descriptions of their experiences of hospital-based perinatal care, however, do appear in the dissertation.

Writing about homebirth certainly requires writing about birth. Yet the reader may note that I do not write a great deal of birth stories, nor do I tell those stories in specific bodily detail. I have made this choice for several reasons. First, I found that the

knowledge work of homebirth midwifery care is at its most verbal—and therefore is easiest to write—before and after births. Homebirths are relatively quiet scenes, and the midwives I worked with were economical with their words during labor and birth. They were, I knew, aiming to disturb birthing parents' focus as little as possible. Yet they were also conserving their own energy in order to remain alert, prepared to make complex risk assessments, and physically ready to provide demanding life-saving care at any moment of the day or night over a period of time that could easily last days. I certainly talked with midwives during births, but I also erred on the side of allowing them to rest and focus, noting questions and observations we would discuss later. Births also feature relatively less prominently in this dissertation because the scenes of labor and birth themselves are relatively stable. At most births, I did not witness rupture or change in the ethnographic scene that was necessary to narrate in order to make the arguments of this dissertation. I came to see those regularities as just as important as moments when things proceeded atypically. In writing, I also frequently sought to describe regularities in the aggregate. I was welcomed in to hours and days of enormously hard work, invited to be with families as they fell in love with their children, and present for times of grief and fear. I will never forget the intimacy or intensity of the moments I was invited to witness. But the very intimacy of those hours has made me hesitant to describe them gratuitously. Where specific birth stories do not illustrate a particular analytical point, I have left them to families, as I believe those stories are theirs to tell.

While I mostly interacted with parents at appointments, births, meetings, and interviews, I spent a great deal of "backstage" time with midwives. We spent long hours in the car traveling to births and appointment locations, strolling clients' neighborhoods

during early labors, and napping in guest rooms and on living room sofas while parents rested. I conducted interviews while weeding gardens together, unloading boxes of birth center supplies together, hastily eating squashed sandwiches and doughnuts and tacos and chicken fingers together in the gaps between appointments on twelve-hour days. I got to know their kids, siblings, partners, parents, friends, and dogs. My presence was so closely linked to the midwife's for some parents that one former client only realized I didn't actually live with the midwife when I gathered my things to leave a birthday party—without her. Like others who have studied the field of homebirth midwifery, I experienced my interlocutors as "active cultural producers" (MacDonald 2008: 17). The homebirth midwives I worked with had sharp, creative and self-conscious sociological imaginations. They were, as I discuss in the chapters, often well-read in the social scientific literatures about birth and reproduction. Stimulating intellectual discussions were commonly a part of of day-to-day work . The midwives I worked with also disagreed with one another, sometimes passionately. It is my aim in this dissertation to do justice the multitude of their overlapping and contradictory perspectives and experiences.

The consent process I used for research participation was designed to avoid, as much as possible, any sense of pressure for parents to consent to participation in my research as a condition for receiving care. In addition to the process stipulated in my IRB, I reserved time at each first meeting with a parent to make myself available for questions about my research, training, dissertation aims, and more. In practices in which I played a role in care that enabled the midwife's work—particularly the practice in which I cared for the midwife's child during appointments and births—parents initially

consented to the participation of a researcher in their care at their first visit at which I might be present, but only were asked to consent to the use of data in research products at their six-week postpartum visit. Parents thus received all of their midwifery care and all of my work as a caregiver enabling the practice before being asked whether or not they were comfortable with my including their stories in my writing. Credit for this model of research consent after care belongs to Alex Holding.

Anonymity has been a key concern in the writing of this dissertation. I have used pseudonyms for all midwives except Alex Holding, the midwife in whose practice I worked in New England, who asked to be identified by name. I have also used the names of some midwives in their capacities as public organizational leaders. Following conversations about accountability in social media settings, I have also noted the names of participants in particularly heated online conversations. At times, I have anonymized some midwives with public profiles, such as those in organizational leadership, who were agnostic on the question of revealing their identities. I have done so in order to avoid making others identifiable by process of elimination. In accordance with what I offered to participants, and with the intent of rendering participants not only procedurally anonymous but as "un-Googlable" (Shklovski and Vertesi 2013), I have at times separated particular accounts or quotations from mentions of other identifying information or potentially identifying information, including pseudonyms. Any errors in the anonymization of participants are, as with all errors in this dissertation, my responsibility alone.

Finally, while this dissertation will be defended during the 2020 COVID-19 pandemic, all research was conducted before the outbreak began. Perinatal care, like all

other aspects of healthcare, has been radically reshaped by the pandemic. Since the first weeks after cases were reported in the United States, journalists have reported that parents are seeking out homebirth midwives in rapidly increasing numbers. Some, these stories report, are concerned that hospital birth might expose them to the virus (de Freytas-Tamura 2020). Others sought out homebirths when New York City hospitals began to ban painters from attending births (Blau 2020), a decision that was later reversed (Bobrow 2020). Reporters described homebirth midwives coming out of retirement to meet the increased demand (Emanuel 2020), hiring additional staff (Henderson 2020), and inundated with requests from parents. "We're used to getting a request a week—and we're getting three a day," one midwife reported (Emanuel 2020). Other reports described changes to homebirth midwifery. Usually relatively high-touch care providers described implementing social distancing during labor, avoiding all hands-on labor assistance (Epp and Kolb Noyes 2020). This dissertation describes a world before COVID-19. The pandemic has raised key questions for the field: Will homebirth midwives care for a larger share of pregnant parents in the world after COVID-19? Will licensure, payment, clinical practices and care partnerships shift permanently for the field? And how? The dissertation cannot answer these questions, but it can describe the backdrop against which the pandemic has unfolded in homebirth midwifery.

Chapter One

Orientation to the Field

Introduction

In this orientating chapter, I introduce the backdrop against which the argument of the dissertation unfolds. The chapter opens with a historical overview of midwifery and homebirth in the United States. I then explain how a second-wave feminist and back-to-the-land midwifery movement in the 1970s, 80s, and 90s fueled a resurgence of home birth and created a new midwifery credential and a new set of midwifery institutions, drawing on do-it-yourself counterculture, social scientific research, and the knowledge of Black, immigrant, and indigenous community midwives practicing in areas underserved by mainstream healthcare. I describe the United States perinatal health system's current crisis and introduce the twenty first century turn to out-of-hospital birth and professional midwifery by parents seeking alternatives. After providing an introduction to some of the community's core commitments, I describe major trends in the social scientific treatment of homebirth and midwifery. The chapter concludes with a description of the day-to-day realities of homebirth midwifery practice.

Midwifery and Homebirth in the United States: Historical Overview

Home to Hospital and Back Again

Historians of childbirth and medicine generally agree that most birth in what is now the United States occurred at home with midwives attending before the twentieth century. Birth in colonial and later white communities in North America before the

advent of physician-attended birth has often been termed "social childbirth" for the frequent involvement of women family and neighbors in addition to midwives in the care of laboring women and their families (Wertz and Wertz 1977:3, Starr 1982:49, Leavitt 1986, Varney and Thompson 2016: 9). Those midwives, many historians have noted, left relatively few traces, with the notable exceptions of Martha Ballard, whose diary formed the basis of Laurel Thatcher Ulrich's germinal *A Midwife's Tale* (Ulrich), and Anne Hutchinson, remembered more as a religious heretic and key figure in the development of 17th century colonial geography of New England than as a practicing midwife (Varney and Thompson 2016: 6-8). As was true of Hutchinson, colonial midwives were, as feminist historians have repeatedly emphasized, informally educated figures whose power and reach in their communities far exceeded the work of attending births. Many provided care during illnesses of various kinds and participated in the preparation of the dead for burial, and their central role in communal life is often highlighted by historians by the fact that their compensation frequently included housing (Rooks 1999: 11, 17, Varney and Thompson 2016, Wertz and Wertz 1977: 8-9).

Many emphasize that the frequency with which midwives were targeted in colonial New England witch hunts indicates that this power threatened patriarchal interests, and some contemporary midwives identify powerfully with this sense of a legacy of midwifery as a site of subversion of exploitative, repressive, and violent power arrangements. Others, meanwhile, identify with the work of the plethora of midwives who attended births in the United States throughout the eighteenth, nineteenth, and early twentieth centuries. Enslaved midwives, many of whom either had been midwives before their capture and enslavement or were descendants of those midwives, are often

identified as keepers of both a "relational vision of health" (Luke 2018:17) and technical birth and herbalism knowledge, as well as facilitators of communication between family and community members separated by slaveowners (Luke 2018:17, Logan 1989, Varney and Thompson 2016:10, Rooks 1999:18), holding "a power that the white medical establishment could not undermine" as physicians colluded with slaveowners in the violent management of enslaved Black peoples' reproduction (Luke 2018:17, 20). Community midwives continued to serve many—in some areas, most—families in Black southern communities until the 1970s. Historians also note that indigenous midwives, Latinx midwives in the Southeast, Cajun midwives in Louisiana, and white "granny women" in the mountain Southeast actively served families in their communities, frequently providing care to families who otherwise would not have been able to access any medical care at all. Japanese Sanba midwives, formally trained and licensed under physician supervision in Japan, who immigrated to the West Coast and Hawaii during the late ninteenth and early twentieth centuries and provided Japanese American communities with wide-ranging healthcare services, eventually including care addressing critical problems with the formal military medical system for Japanese-Americans interned after 1942 (Smith 2005). German, Hungarian, Polish, Italian, and Russian midwives, who arrived in the mid-to-late nineteenth century with the surge in migration from Europe to the Northeast and often bringing with them formal training from European midwifery schools, also provided care to migrant families living in desperate poverty. Their expectation that midwifery was work requiring formal training and schooling also spurred the foundation of one significant, if short-lived, set of US non-nurse midwifery schools (Rooks 1999:20, Varney and Thompson 2016:11-14).

Despite the ways they were seen—and treated—as untrustworthy or threatening by increasingly powerful interests such as physicians and the state entities those physicians' organizations managed to court, historians repeatedly note that midwives were deeply trusted and respected by their own communities (Varney and Thompson 2016:15), not only attending births widely but also serving as crucial cultural workers and central figures in public health work (Smith 1995:118-148, Smith 2005: 12). However, they also frequently note that this trust in midwives was profoundly local. Despite the fact that midwives actively served Black, Latinx, Indigenous, Asian immigrant, and European immigrant communities, these midwives mostly served their own communities, with the notable exception of Black Grand midwives who also attended the births of white women (Fraser 1998:91-2). By and large, community midwives did not collaborate with one another or form nationwide professional organizations[5] (Varney and Thompson 2016:14).

All these midwives—formally and apprentice-trained, worked in the context of an unprecedented set of changes to the circumstances under which babies would be born: the shift toward physician-attended, hospital-based birth accompanied by the use of new pharmaceutical and instrument technologies. Many historians trace these changes to the emergence of "man-midwives" in Europe in the 17th century, whose rise accompanied the development of obstetric forceps, the detailing of pelvic anatomy, and the description of mechanisms of labor (Rooks 1999:15, Wertz and Wertz 1989:31-3, Varney and Thompson 2016:22, Starr 1982:49). "Man-midwives" benefited both materially and symbolically from tight control of this knowledge and these instruments, leaving

[5] some did form local professional associations—see Varney and Thompson 13-15

European midwives, who, it is often noted, could not have attended the universities where new concepts and skills were taught due to blanket exclusions of women from higher education, "vulnerable to charges of ignorance" (Varney and Thompson 2016:22). When North American colonial physicians began to train in "man-midwifery" in the late eighteenth[6] and early ninteenth centuries, many noted the potential of birth services as powerful drivers of attraction and retention of patients (Varney and Thompson 2016:24).

By the middle of the nineteenth century, physicians also had at their disposal a number of new tools that proved appealing to those wealthy, usually city-dwelling white women who could afford them. As religious arguments against pain relief in childbirth waned, physicians began experimenting in 1847 with ether, and then chloroform, as anesthetics (Varney and Thompson 2018:27). The professional field of medicine and the discipline of obstetrics and gynecology grew concurrently with the development of these pharmaceutical interventions. By the turn of the twentieth century, the American Medical Association and the use of anesthetics in labor were both a half century old, the American Gynecological Society was a quarter century old, physician-attended births outstripped those attended by midwives, and ether or chloroform were used in more than 50% of those births (Rooks 1999:22, Leavitt 1986:117, Varney and Thompson 2016:26-8.) The turn of the century also saw the advent of the use of scopolamine and opium in labor, first developed in Germany in 1902. The semiconscious "twilight sleep" these drugs induced eliminated memories of the pain of labor, but it also rendered patients unable to control their movements to a dangerous degree. Large teams of hospital staff used elaborate systems of mechanical restraints, hoods, screens, and soundproofing to keep patients

[6] North American physicians became interested in normal obstetrics in the 1760s (Starr 1982: 49, Kline 2019:2).

from injuring themselves and their husbands from seeing the distressing condition of their hooded, straitjacketed, thrashing wives (Varney and Thompson 2016:44-5). Many historians note that while the safety of twilight sleep was the subject of some controversy, the demands of women to "take control" of their births through access to the drugs were welcomed by physicians, as twilight sleep, unlike chloroform and ether, could not be administered at home or by a single practitioner and therefore necessitated the move to a clinical setting (Leavitt 1986, Varney and Thompson 2016:47). As North American medical practice and education consolidated, some historians contend, physicians' understandings of their relationships to midwives shifted too. Where many had understood midwives to be their collaborators, attending uncomplicated births and sending for physicians in the case of complications, the centralization of the field of obstetrics introduced for the first time the sense that midwives were threatening competitors to physicians.

United States-based training for birth attendants—both midwives and physicians—began to be formalized around the same time. Both the private midwifery schools training nurses and non-nurse caregivers in midwifery (see Varney and Thompson 2016) and the one public midwifery school, the Bellevue School for Midwives in New York City, that formed in this period emphasized midwives' practice under physician supervision and with a narrowly defined scope of practice that left most complicated care to physicians (Borst 1995: 25-33, Leavitt 1986, Varney and Thompson 2016:41-4). Though hospital birth rates, which rose with the increased use of anesthesia in birth, did not overtake homebirth until about 1938, those births that continued to occur at home were increasingly attended by physicians, too (Wertz and Wertz 1989, Leavitt

1986:117).

These changes to birth location and attendance occurred earliest in urban settings in the northeastern regions of the United States and among white, middle- and upper-middle-class US-born women (Leavitt 1986:39, Starr 1982: 49). The southeast, on the other hand, led the country in homebirth and midwifery rates through much of the 20th century, due in large part to extremely poor access to physicians in the rural south and the fact that most Southern states did not regulate midwifery at all (Borst 1995: 7). By the middle of the twentieth century, most US births to white women—and most US births overall—occurred in hospitals attended by physicians subject to obstetrical standards, but rural women and Black women continued to give birth at home and with midwives as attendants at significant rates through the 1970s.

Between the turn of the twentieth century and about 1920, "the midwife problem" became the subject of what Helen Varney and Joyce Beebe Thompson have described as "a contrived hostile debate…fueled by wretched maternal and infant mortality and morbidity rates, a serious concern about what to do about them, the drive of physicians for control of childbearing women and female practitioners of midwifery, the developing specialty of obstetrics, the need of physicians to elevate the status of obstetrics, and the need for sufficient clinical 'material' for medical student experience" (Varney and Thompson 2016:34). The debate centered around the question of what to do with midwives: should their practices be "upgraded" with training, state oversight, and physician supervision? Or should the practice of midwifery be eliminated in favor of obstetrics? Perhaps unsurprisingly given the predominance of midwifery care among Black, indigenous, Latinx, and racialized immigrant communities, the legal regimes—

and professional debates that initiated their formation—that emerged to surround midwifery over this period, as anthropologist Gertrude Fraser has written, "mixed arguments about the need to reduce maternal and infant mortality and to improve healthcare with those confirming the importance of maintaining the racial and social order" (Fraser 1998:72, see also Rooks 1999:25). For those physicians, nurses, reformers and philanthropists guided by the principles of emerging public health movement, midwives appeared as possibly critical figures to conscript in a project of population health improvement; for those whose project was the promotion of the nascent profession of obstetrics, midwives appeared as frank competitors, who would need to be either eliminated or subordinated in order for a successful professional monopoly to be secured (Rooks 1999:24, Varney and Thompson 2016:40-1, Kobrin 1966). Crucially, many midwifery advocates and historians emphasize that debates over the "midwife problem" depended on debates over cultural understandings of childbirth. Varney and Thompson, nurse midwives, nurse-midwifery educators, and authors of the germinal *The Midwife Said Fear Not: A History of Midwifery in the United States*, describe physician members of the American Association for Study and Prevention of Infant Mortality as "concentrat[ing] on efforts to 'elevate' the status of obstetrics by insisting that childbirth was a complicated medical specialty fraught with danger that required the knowledge, the skills, and the specialized services of a physician." These physicians, they emphasize, understood that they would need to "educate" members of the public about the dangers of childbirth and the indispensability of the obstetrician's services—thus also preparing laypeople to support legislative action banning purportedly dangerous alternatives, chiefly midwives, from practice (Varney and Thompson 2016:34-5). The emerging field

of obstetrics also sought to limit the practices of midwives for another pragmatic reason: physicians recognized that many of the births that could be attended by trainees were being attended by midwives. The professional and public-health trajectories of midwifery abolition collided around the issue of obstetrical training. To successfully capture midwifery clients as obstetrical patients and, at least ostensibly, raise the standards of obstetric practice and training, physicians sought to both end midwives' practices—or absorb them into physician-administrated nursing and hospital programs—and establish obstetrical charities in their stead (Varney and Thompson 2016:37). By the turn of the twentieth century, both statutory and judicial state bans on midwifery practice--often arising in response to cases questioning whether midwives were practicing medicine without a license—had begun to take effect (Varney and Thompson 2016:39-40).

The midwives and midwifery educators who have served as many of the most foundational historians of midwifery narrate the decline of midwifery as the victory of obstetricians in their concerted effort to eliminate competitors (Rooks 1999:22-30). But historians of childbirth, obstetrics, and midwifery have advanced several other key arguments about what spurred the overwhelming changes to the unfolding of the typical American labor and birth in the twentieth century. Many note that whether or not dying in childbirth was a pressing risk, women perceived it to be one (Wertz and Wertz 1989: 19, Leavitt 1986) and embraced technologies they hoped could attenuate the danger they felt. Turning to experts and scientific knowledge during the Progressive Era, some historians argue, women's choices in childbirth also constituted part of a larger American cultural turn (Borst 1995) towards increased interest in professional advice and away from interest in "popular autonomy in healing" (Starr 1982: 140-1). Crucially, historians

generally agree that "birthing women themselves played a crucial role in bringing about these transformations" (Leavitt 1986: 196), and that the transition away from midwives and toward physicians occurred as a result of a change in who women sought out to attend their births and what technologies they hoped to use to alleviate pain, discomfort, and danger (Borst 1995:154). Other historians have argued that bans of midwifery were spurred more by midwifery's association with abortion and Progressive-era anti-vice campaigns than by the medical community's monopolistic impulses (see, for instance, Borst 1995).

Regardless of whether the growing medical profession set out to seize control of birth from women, many historians also note that all of these developments had the effect of turning birth into an event managed mostly by men in institutional settings by the middle of the twentieth century. All of the non-nurse midwifery programs founded in the earlier part of the century had closed, and with the exception of the New York's Downstate and Kentucky's Frontier Nursing Service, most nurse-midwifery programs had also shuttered by the late 1960s (Varney and Thompson 2016:103-117). The "midwife problem" had come to a twofold settlement: lay or community midwives were increasingly heavily regulated and supervised by state public health authorities throughout the middle decades of the twentieth century, particularly under the Sheppard-Towner Act, and non-nurse midwifery as it had been practiced was, by 1970, effectively illegal in all fifty states. A small number of lay or granny midwives were able to continue practicing under the supervision of public health programs, and a small number of nurse-midwives were able to keep training as advanced practice nurses and practicing under the supervision and regulatory authority of physicians in a compromise struck by public

health reformers in the professionalizing field of nursing (Rooks 1999:31, Varney and Thompson 2016:48-9). These nurse-midwives were complicated figures: many entered midwifery as public health nurses, trained in midwifery for the purpose of preparing for missionary work, and, before the founding of the American College of Nurse-Midwifery in 1955, institutionally found themselves caught between midwifery-friendly national public health nursing organizations and more narrowly defined nursing organizations (Varney and Thompson 2016:157-9). They were frequently tasked by state health departments with the supervision and education of Black lay or granny midwives—even as their own supervisors sometimes understood them as "in competition" with those midwives. Their clinical practices, however, were restricted to care services associated with educational programs, demonstration projects, and missionary settings, where, as many historians emphasize, they were unlikely to compete with obstetricians for patient fees (Varney and Thompson 2016:90-5, 125).

Meanwhile, the expansion of protocols at least ostensibly aimed at reducing infections and contamination meant that the experience of birth for the vast majority of women birthing in hospitals was radically different from both that of the small number of women under the care of midwives, and that of their mothers. Women birthing in hospitals were, as a matter of course, shaved, given enemas and vaginal douches, and restrained on their backs during their labors and births, and they were alone, as visitors were generally still not allowed. Historians frequently note that these protocols rendered the birthing woman, in Varney and Thompson's description, "helpless and vulnerable, unable to control what was done to her in the way of anesthesia and instrumentation" (Varney and Thompson 2016:95). By the 1940s, these protocols had their critics. New

directions in both expert opinion and popular preferences emerged with the rise of methods, such as those popularized by Grantly Dick-Read and Fernand Lamaze[7], intended to reform hospital childbirth practices to increase the presence of fathers and other family members in the scene of birth, manage pain without medication, and decrease the use of general anesthesia (Rooks 1999:32-3, Leavitt 1986: 214-215, Katz Rothman 1981, Borst 1995: 158). Dick-Read's 1933 *Natural Childbirth* and 1942 *Childbirth Without Fear*, first published in the United Kingdom, theorized pain in childbirth as the result of musculature tension caused by fear, and prescribed knowledge of the physiology of birth and the company of family as the solution to that fear (Dick-Read 1933, 1942). Dick-Read, who has been described as "articulat[ing] what nurse-midwives practiced," was warmly embraced by US-based nurse-midwives, who had included father-involvement in their maternal education courses since the 1920s and were themselves key advocates of "family-centered maternity care" (Varney and Thompson 2016:96-7). Once again, white women turned to a new model of ideal birth in the greatest numbers, this time turning away from the use of medical technologies. Women of color continued to have their babies in this period without ever having had access to or used the technologies rejected by midcentury natural birth advocates in large numbers[8] (Borst 1995).

Another challenge to physician-attended, medicated hospital birth emerged several decades later with the advent of new homebirth practices arising from both

[7] Barbara Katz Rothman has emphasized the differences between these models (1981:167-9)

[8] In 1940 only 26.7% of births to nonwhite women occurred in a hospital; nearly half of the babies of nonwhite American women and over 70% of the babies of rural nonwhite American women were delivered by midwives (Borst 1995: 157)

multiple predominantly white locations: middle-class breastfeeding and consumer advocacy, feminist health activism, and back-to-the-land countercultures (Kline 2019: 6, 35, 64; Rooks 60-64, Borst 1995:158, Morgen 2002). Sometimes dated to the 1960s and sometimes to the 1970s, the emergence of the new homebirth doubled the then-historically low rates of out of hospital birth over the decade of the 1970s (Kline 2015:530). Influential authors and practitioners reflected broader themes of those rising US countercultures and political movements: encouragement to "relax, live in the moment, simplify your life" (Kline 2015:533), a high value on "womanly wisdom" (Kline 2015: 538), and a desire to "reassert women's power to make their own choices" (Morgen 2002: 71, see also Kline 2019: 10). Feminist health groups undertook homebirth work as part of a broader project of feminist self-help movement combining public advocacy with service provision and political education. However, they shared with back-to-the-land countercultural figures such as midwife and author Ina May Gaskin an interest in "demedicalizing" birth, comfort with the frank presentation of information about anatomy (Kline 2015: 539), and a desire to reclaim birth-related work and knowledge from the field of obstetrics that was, at the time, dominated by men (Morgen 2002). Many proponents argued that this new homebirth approach was both more "natural" and offered more autonomy to women than the natural childbirth techniques dating to the 1940s. They argued that in the decades following their publication, Dick-Read and Lamaze's techniques had been "coopted by institutionalized medicine to work within the system" (Romalis 1981:26, Katz Rothman 1981: 169). Arguing instead for "reinstating the midwife to her rightful place" (Romalis 1981: 26), these advocates hoped to address dissatisfaction with obstetrical and hospital approaches not by reforming them,

but by increasing the availability of alternatives.

Partially for this reason, the midwives who emerged in the 1960s and 1970s were not, at least initially, mostly formally trained nurse-midwives. Instead, they taught themselves from obstetrical and midwifery textbooks, apprenticed with the handful of community midwives, nurse midwives, and family physicians still attending births at home, or attended the births of their friends (Leonard 2008, Rooks 1997:46, 61, Kline 2015, Kline 2019: 78, 104, 115, Varney and Thompson 2016:126-7). By the 1970s and 80s, some midwives began teaching others in apprenticeship-style training programs, such as those run by Ina May Gaskin at The Farm, a Tennessee back-to-the-land community, or by Shari Daniels, Rahima Baldwin, Raven Lang, and Kate Boland at birth centers in Texas, Michigan, and California.It was common for those attending births as self-taught care providers not to call themselves midwives or seek payment for their work, and many worked in relatively isolation, unaware of others doing similar work (Rooks 1999:60, Varney and Thompson 2016:128-9). They passed around books, pamphlets, and "how-to" materials by Grantly Dick-Read, Ferdnand Lamaze, CNM Kitty Ernst, sociologist Barbara Katz-Rothman, and midwives Raven Lang, Ina May Gaskin, and Rahima Baldwin, a literature that historians have argued played a key role in "translating home birth to a wider audience who did not necessarily identify as 'countercultural'" and "reshaping expectations about the birth experience" (Kline 2015, Varney and Thompson 2019:126-7). Many influential figures and institutions from various corners of the 1970s homebirth community remain active today, including Ina May Gaskin and her midwifery practice and training center at The Farm in Tennessee and many of the birth centers founded by the feminist health movement. Between 1970 and

1977 the United States out-of-hospital birth rate more than doubled from .06% to 1.5% as the new homebirth's vision was embraced by a small and rapidly growing share of mostly white women (Kline 2015, Rooks 1999: 60). By the early 1980s, then, hospital-based, physician-attended birth had a viable challenge.

Institutionalizing Homebirth and Midwifery

Historians of the women's health movement also note major shifts in the 1980s and 90s (Weisman 1998, Morgen 2002, Kay 1988), many of which they attribute to the rise of managed care and changes to the state funding structures upon which many clinics had relied with the right-wing retrenchment of the 1980s. These included the increased commodification of women's health care and a decline in the advocacy, political mobilization and political education that had accompanied feminist clinics' care provision (Morgen 2002: 163). Meanwhile, new institutions focused solely on birth and birth attendants, rather than on communal living or other aspects of counterculture or women's health began to be established, from the Midwives' Alliance of North America (1982) and DONA (1982), the first doula certifying organization, to midwifery schools like the Maternity Center at El Paso Training Program (1976), Seattle Midwifery School (1978), Heart and Hands (1982), the National College of Midwifery (1989), the Midwives' College of Utah (1980), and Birthwise (1994). Some of these schools were founded by midwives who had come to midwifery from the feminist women's health movement, and/or were the outgrowth of partnerships between groups of midwives and state education or licensing commissions and departments in states where homebirth and midwifery had never ceased. When many of these schools were founded in the late

1970s and early 1980s, licensure laws from the early part of the century remained on the books, and some Japanese and European-trained midwives who had arrived and begun practicing a half-century before were in fact still in practice. Midwives in the new home birth and midwifery movement used this legal and practical continuity, alongside material from other key institutions such as the World Health Organization, to justify the establishment of their new training programs, and in some cases, to initiate reviews of early twentieth-century licensing laws that enabled state accreditation of new schools (Rooks 1999:76-8, Varney and Thompson 2016:142-146). Many of these schools persist today, having transitioned from local training programs to schools open to midwifery trainees across the United States.

The 1970s and 80s saw some fruitful collaborations between midwives and obstetricians and midwives and state agencies, but the American College of Obstetricians and Gynecologists also publicly condemned home birth. Physicians, many of whom were threatened with loss of their licenses and hospital privileges if they collaborated with homebirth midwives, often followed the lead of their professional organizations in urging law enforcement to prosecute midwives (Rooks 1999:66). Midwives consequently found themselves the targets of sometimes hostile investigations by licensing agents and many were charged with practicing medicine without a license (Varney and Thompson 2016:128, 207). Midwives seeking mutual support with these and other challenges of practice found that they needed to create alternative gathering spaces to those furnished by the American College of Nurse-Midwives, which did not admit non-nurse midwives as members. After two International Conferences of Practicing Midwives in 1977 and 1978 and the foundation of a newsletter and short-lived

National Midwives' Association, an agreement was reached at a formal meeting between CNMs and non-nurse midwives[9] to form a separate, self-regulating organization of all United States midwives for the purpose of setting competency standards, developing educational guidelines, facilitating communication between community midwives and CNMs, representing professional midwives in public, and speaking for the need for midwifery care (Rooks 1999:241, Varney and Thompson 2016:211). By the middle of the 1980s, MANA was a bustling professional organization—if one marked by the leadership of what one former president, Geraldine Simkins, called "counterculture feminist-types"—that had adopted organizational positions on the standards, qualifications, and core competencies of midwives (Simkins 2011:303, Varney and Thompson 2016:221-224). The organization was primarily made up of the generation who had come to midwifery during the 1970s and 1980s, rather than of the immigrant and lay or granny midwives who had been in practice during the forty or fifty years before the later twentieth century resurgence of homebirth[10].

MANA did not ultimately take up the work of setting practice standards, credentialing midwives, or determining educational guidelines. Instead, three key organizations emerged from MANA's membership and leadership to take up this work during the 1990s and early 2000s. The North American Registry of Midwives (NARM), born of MANA subcommittees in the 1980s, spent the early 1990s pooling test questions from direct-entry or non-nurse midwifery schools, state midwifery associations that

[9] the term "non-nurse midwife" was actually agreed upon at this meeting (Varney and Thompson 2016:211)

[10] MANA members survey, Feburary 1985: "The average age of members was 35 years with an average of 4 years of college education and an average of 6 years since completion of basic midwifery preparation." Varney and Thompson 2016: 225

administered exams to midwives who hoped to be members, and states that licensed non-nurse midwives, and field-testing exams with midwives in practice in certified states serving as volunteer test-takers. With the addition of a clinical skills assessment and standards for documentation of training, NARM created the Certified Professional Midwife credential. CPM credentials began to be awarded in 1995 (Rooks 1999:248-253, Varney and Thompson 2016:331-2). By the late 1990s, the NARM written exam had been widely adopted across the continent, with 21 US states and two Canadian provinces using the test in their licensing or certification (Varney and Thompson 2016:334). Meanwhile, the Midwifery Education Accreditation Council (MEAC), established in 1991, began to evaluate and accredit some midwifery programs training programs, eventually receiving federal recognition as an accrediting agency from the United States Department of Education in 2003 (Varney and Thompson 2016:319). Another new organization was also born on the basis of the CPM credential: the National Association of Certified Professional Midwives (NACPM). NACPM came into being as the result of a 2000 bid for non-nurse midwifery licensure in Massachusetts. When legislators considering a bill that would have created a Board of Midwifery to license both CNMs and CPMs requested CPM-specific standards of practice, a group of CPMs who felt that a Midwives "Alliance" did not constitute a professional association comparable to ACNM in its credibility to legislators founded a new organization (Varney and Thompson 2016:236-8). All of these credentialing projects and bids for institutional recognition were the subject of great internal controversy among non-nurse or direct-entry midwives in this period (Rooks 242, Varney and Thompson 128).

Trends in Social Scientific Treatment of Homebirth and Midwifery

The emergence of the new twentieth century homebirth coincided with a surge of social scientific interest in birth and reproduction. Writing about homebirth from this time is characterized by a focus on identifying, characterizing, and explaining hospital and physician-assisted birth as a distinctive cultural practice. This new social scientific field was heavily influenced by—and sometimes cited (Romalis 1981, Simonds, Katz Rothman, and Norman 2007:xxi)—a trajectory of 1960s and 1970s anthropological work that examined reproduction and birth in "primitive societies" (see Mead and Newton 1967) and contrasted these approaches with those found in obstetric practices in hospitals (Jordan 1980). Katz Rothman (1982), for example, identifies a "medical model" of childbirth produced by a "patriarchal" and "technological" society that regards the body mechanistically and employs Cartesian dichotomies of mind/body and mother/infant (Katz Rothman 1982: 48, 34); defines the pregnant and birthing body as diseased by virtue of both sexual difference (its divergence from the male body) (Katz Rothman 1982:37) and, via medicalization and the invocation of the sick role, dependence upon medicine and physicians (Katz Rothman 1982:39).

A project of critically taxonomizing hospital and physician-assisted birth persists in the literature over the next several decades. Nearly twenty years after Katz Rothman, Robbie Davis-Floyd expands upon her medical model to argue that patient objectification, alienation of care providers from patients, mechanistic "treatment from the outside in" of pregnant and laboring bodies, and an organization of care on the basis of hierarchy, standardization, and a "supervaluation" of science and technology (Davis-Floyd 2001 S8-9) constitutes prevailing "technocratic" model of birth. These texts "make

the familiar strange," in Mills' words, asserting not only that there is analytical value in this move, but that medicalized or technocratic childbirth ought to be regarded as strange or unnatural. Alongside critiques of medicalized birth, these authors also tend to envision and profile those who work in what they identify as other more viable models. These models include Katz Rothman's "midwifery model"[11] and Davis Floyd's "humanistic" and "holistic" models. Katz Rothman describes the midwifery model as emphasizing "pregnancy as a healthy and entirely normal condition for mammals" (Katz Rothman 1982: 139), relying less on routine and standardized care than on making "the attendant fit the birth" and uniting fetus and mother in an "organic whole" (Katz Rothman 1982:179, 276). The birthing woman appears as less passive and more active (Katz Rothman 1982: 277), and the approach is centered on woman as norm, and women's bodies as "meant to bear children" such that the act of doing so is no more "stressing the system than…digesting a nutritious meal [is]" (Katz Rothman 1982:24). Davis-Floyd's "humanistic" and "holistic" models describe women as relational subjects or "whole people" with minds and bodies connected or united in a single "energy field," emphasize care and healing "from the inside out" over diagnosis and treatment, and embrace alternative modalities, prevention, and mitigating inequality as routes to improved population health. (Davis-Floyd 2001: S10-S17).

Many of these texts, especially those published before the early 2000s, treat concepts like technology, science, and nature as relatively transparent and possessed of inherent normative values (Leavitt 1986: 38, 174). Some ways of knowing the body—

[11] While Katz Rothman uses this terminology before the advent of certification for CPMs (Certified Professional Midwives), her definition is not to be confused with (though it is certainly related to) the "Midwives' Model of Care" towards which contemporary professional midwifery training and certification is oriented.

those associated with the "midwifery," "humanistic," or "holistic" approaches—appear as both better and less constructed than the medical or technocratic models of birth, reclaimed from a natural, female-centered world of tradition under attack by patriarchy. These texts do not dispute the history of childbirth literature's conclusion that the shift to midwifery happened initially because women themselves began to seek out physician attendants, but they are also keenly attuned to the costs of the rising cultural authority (Starr 1982: 14) of medicine that led women to do so. They are specifically attuned to the fact that birth was, in the past, defined as a nonmedical and routine life event, and has come to be defined as a medical problem. They frequently use the term "medicalization" to describe that process. In so doing they invoke Conrad's definition of the term, which is both cultural in that it highlights a shift in the meaning of a problem and structural in that it points up the ensuing opportunities for increasing medical jurisdiction (Conrad 2008: 4). Social scientists of homebirth invoke both elements of this term and see birth as a key moment in which power and authority were taken from women by men through the vehicle of medical institutions such that midwifery appears as a lost treasure to be rescued (Davis-Floyd 2001:S8, Katz Rothman 1982:95, Leavitt 1986, Jordan 1980). These authors routinely distinguish between kinds of knowledge that are "authoritative" and those that are "suppressed" (the medical/the experiential or traditional) and often assess medical knowledge as "fiction" or even poor application of "science" (Jordan 1997: 62-65, Davis-Floyd 2001:S9). Rather than midwifery as dangerous lies, these texts tend to identify obstetric medicine as dangerous lies—but these authors, too, make truth claims about risk and safety.

These scholars self-consciously take a side: Romalis describes pregnant women as

"trusting human subjects" upon whom "unnecessary surgery, harmful drugs, and tests that are still unproven" have been tested (Romalis 1981:4). Katz Rothman's index contains entries under "hospitals" for "dangers of," "infections in," and "natural childbirth thwarted by," while the same section for "midwives" lists "mothers cared for by," "instruments forbidden to," and "restrictions imposed on" (Katz Rothman 1982: 315-317). I point this out not to dispute the claim that hospital practices frequently impede labor and threaten maternal and infant health and safety, but to note the embattled-hero status attained by midwives in such writing. Above all, these texts value the "natural" and are suspicious of or critical of the "technological," "technocratic," or "cyborgifying" (Davis-Floyd 2001:S7).

Most key texts in this literature from the 1970s to the present share a distinctive rhetorical style of foregrounding personal birth narratives. These texts might not cite Nancy Hartsock or Sandra Harding, but their turn to personal experience marks them as late twentieth century feminist academic writing. Katz Rothman's *In Labor* opens with the story of her own first pregnancy, during which she learned "that hospitals have never been demonstrated to be the safest place for a woman to give birth" and "that hospitals pose unique dangers for birthing women and their babies, including the overuse of medication, higher risk of infection, and numerous obstetrical interferences in the physiological process of birth." She watched a Lamaze film and a "film of a down-South black midwife at work" who "dealt with [the black woman giving birth] as an entire person", and sought out a way of "having a baby with dignity and joy—as a feminist, not in spite of being a feminist" (Katz Rothman 1982:11-13). Katz Rothman narrates the process by which she decided to have her baby at home, including her realization that

what mattered to her was about "control, power, and authority." "At home, I would have them," she writes, "in the hospital, they would be handed over to the institution" (Katz Rothman 1982:15). Katz Rothman walks the reader through the commitments that lead her to home birth: her belief that birth is "a condition of healthiness, not of illness," and her sense that others would form their understandings of risks she took not on the basis of whether or not she was able to eliminate risk, but instead on the basis of whether and how the risks she selected were socially acceptable (Katz Rothman 1982:15-17). The prologue's identification of a "midwifery model" of care comes on the heels of a vivid description of the experience of birthing her child at home, the "peaks and, blessed be, valleys" of her contractions, the rocking chair and kitchen chairs in which she labored, the family members' entrances to the room, the feelings in the moments of birth of "sitting on the head," "beautiful, total, sense of opening and roundness," "slurp, wriggling, warmth, wetness, and…a baby" (Katz Rothman 1982:20-1). Romalis' 1981 collection is similarly credentialed with an introduction that identifies its chapters as having "emerged out of experience", and as "the result of the merging of observational data and literature with our own experiencing of childbirth" (Romalis 1981: 5). First-person narratives of birth are often cited alongside data collected through interviews, reviews of medical literature, and archival material and treated evidence that is at least as—if not more—authoritative.

Twenty-five years later, personal narrative remains firmly installed as a rhetorical device embraced by social scientific scholars of birth—and indeed by natural and homebirth practitioners. A 2007 collection examining the proliferation of midwifery, labor-and-delivery nursing, doula work, and other "birth work" in the twenty first century

begins with two introductions. In the first, Barbara Katz Rothman tells the story of her own evolving understandings of birth before the publication of *In Labor* and afterwards. In the second, Simonds narrates her labor and birth in hospital with Pitocin and an epidural she hadn't wanted but had acquiesced to in a "negotiation process that had been stacked against me" (Simonds, Katz Rothman, and Norman: xxix). These personal narratives emphasize "what I learned from the midwives" or "what I learned from my own birth," and they feature the analyst's body prominently: we learn of the sociologist's waking with cramps and diarrhea, playing with her nipples, squatting in an attempt to release the rim of her dilating cervix (Simonds, Katz Rothman, and Norman: xxvii). Midwives, the process of birth, and the birthing sociologist's body are identified as sources of truth whose authoritative knowledge will be restored as a corrective to the harmful effects of the rise of expert medical interference in birth in the analysis that follows. Analyses like these constituted a kind of meta-intervention in the academy about expertise, locating the sociologist's authority as at least in part produced by the expertise of her experience; they also served as a vehicle through which non-academic audiences encounter and sometimes take up that intervention.

Many active social scientists publishing about midwifery and homebirth in the 2000s and 2010s are also themselves practitioners of homebirth and other forms of alternative birth or have close relationships to and collaborations with care providers and care providers' organizations. Ethnographer Christa Craven, for instance, was a contributing author to *From Calling to Courtroom,* a midwifery-facing guide to navigating the law in practice. The often-cited volume *Birth Models that Work* was edited by Robbie Davis-Floyd in collaboration with Jan Tritten, editor and founder of the

magazine and conference *Midwifery Today*, and midwives and midwifery educators Betty-Ann Daviss and Lesley Barclay. Some of the empirical research establishing the midwifery community's assessment of the risk profile of home birth (e.g. Cheyney 2014) has been conducted by social scientists who study birth and advocate for homebirth—some of whom are themselves midwives. Others (see, for instance, Freeze 2008) write extensively in popular settings about their own birth choices.

Literature on midwifery care shifted in focus towards considering mainstreaming, professionalization, cooptation, and legalization during the 2000s as both nurse-midwives and homebirth midwives grew more prevalent and established themselves as accepted options for birth care in at least some of the country (Craven 2007, 2010; Bourgeault 2006, Davis-Floyd 2004). Early 2000s texts examine, for instance, the growth and costs of the "consumer" as a model for framing women seeking state support for midwifery care (Craven 2007) or the dynamics of groups lobbying for midwifery licensure and funding (Craven 2010, Bourgeault 2006). The later 2000s and early 2010s also saw an increase in publishing of a distinct literature about birth justice and midwives of color, as well as critical scholarship about the trajectory of birth work in communities of color (e.g. Fraser 2009, Oparah and Bonaparte 2015). All of the earlier central texts of this literature have both been written by and focused on white women, sometimes self-consciously (Leavitt 1986: 8). Some twenty first century authors also began to treat those who choose homebirth and unassisted birth as members of a distinct group or community possessed of practices and meanings that could be studied using the conceptual and methodological tools of cultural anthropology and sociology (Miller 2007, 2009, 2012; Cheyney 2011, Klassen 2001). These authors investigate 21st century homebirth as ritual

performance (Cheyney 2011) or the site of collective gender identity formation (Miller 2007, MacDonald 2008), narrative writing (Miller 2009) and stigma management (Miller 2012) and investigate meanings of spirituality and the "natural" in practitioners' talk (Klassen 2001a, b, MacDonald 2008).

One major source of commonality between earlier and later literatures is a heavy focus on issues of professional monopoly. Historians of midwifery, many of them midwives themselves, narrate the question of where United States babies are born and with whose assistance as an expression of cultural struggles about expertise, authority, and knowledge. One prominent group of commentators has argued that the eventual near-disappearance of midwifery in the United States was the result of a concerted nation-wide effort by physicians and lawmakers to eliminate the practice of midwifery through increasingly restrictive regulation and physician supervision and, in some states, statutory practice bans (Craven 2007: 705). These analysts argue that laws aimed particularly at the practices of African American, immigrant, and poor white midwives were as much gender and racial projects as they were attempts to improve health outcomes, "mix[ing] arguments about the need to reduce maternal and infant mortality and to improve health care with those confirming the importance of maintaining the racial and social order" (Fraser 1998:72). Echoing sociologist Eliot Freidson's understanding of the medical profession's monopolist ambitions as enabled by state power, Craven describes Virginia as a state in which "physicians and lawmakers colluded in legislative efforts to eliminate midwives" in the early 1900s (Craven 2007:405). Fraser, meanwhile, describes the activities of both individual physician-regulators of midwifery and the legislatures and state agencies that enabled their projects of midwifery

supervision, describing such projects as the product of a "consolidation of legislative, medical, and bureaucratic power" (Fraser 1998:66). For Katz Rothman, the "attempt simply to abolish midwifery altogether" reached a critical point with the 19th and 20th century when, as medical training became increasingly clinically oriented, physicians found themselves in competition with midwives not only for client fees but also for the opportunity to attend the births of immigrant and poor families for teaching purposes. Katz Rothman also describes physicians as securing the monopoly they sought through state power: "physicians," she writes, "unlike the unorganized, disenfranchised midwives, had access to the power of the state through their professional associations. They were thus able to control licensing legislation, in state after state restricting the midwives' sphere of activity and imposing legal sanctions against them" (Katz Rothman 1987:57). Fraser's 1998 study of African American midwives in Virginia and Smith's 2005 history of Japanese American midwives each describe even a single physician as able to harness the power of state-level public health authorities to initiate attempts to restrict or eliminate the practice of midwifery (Smith 2005:122, Fraser 1998:65). Historians of midwifery often look to the literatures on the contests surrounding the rise of medicine to describe continuities between medical countercultures across historical periods: "Paul Starr describes a counterculture to organized medicine in the early 19th century as lay healers 'saw the medical profession as a bulwark of privilege, and they adopted a position hostile to both its therapeutic tenets and its social aspirations.' Lay medicine, however, was passed from generation to generation, building on the wisdom, remedies, and traditions from elders and from reading authoritative sources, thus sharing many common roots to the evolving 'profession' of medicine (as well as midwifery) in the Americas.

This popular health movement is similar, in part, to what happened during the 1960s and 1970s surrounding changing childbirth practices in the United States" (Varney and Thompson 2016:139).

Social scientists in the late twentieth century were involved in a project of locating or recovering de-medicalized birth, homebirth and other demedicalized birth practice, either by turning to midwives and births of the past, as Barbara Katz Rothman does, or by turning to cultural settings other than those of middle-class white Americans, as Katz Rothman, Brigitte Jordan, and Robbie Davis-Floyd do. By the 2000s, however, such practices emerge as enough of an established site in this period to fruitfully be considered their own "dynamic, necessarily contested, cultural system" (MacDonald 2008:24) from which to consider dynamics of market and identity. These 21st century texts reflect an early 2000s academy interested in the emergence of neoliberalism as a conceptual structure for considering linkages between commodification and governance (Katz Rothman 2004, Davis-Floyd 2004, Craven 2010) and somewhat more attuned to race and class. The emphasis is less on the reclamation of midwifery care as "lost" art by this point, but many of the patterns of the 1980s and 1990s literature continue. Critique tends to focus on social movement and market dynamics while homebirth practitioners appear as engaged in a political "resistance" of a "biomedical habitus" (Klassen 2001:781), sources of "new stories to serve as counterpoints to hegemonic biomedical stories" (MacDonald 24), or illuminators the historical contingency of—and demonstrating the possibility of viable alternatives to—hospital birth (Klassen 2001:802-3, Davis-Floyd 1992:299). However, authors in the 2000s also begin to question the success of that resistance, considering the costs of the strategy of breaking the medical

profession's monopoly on perinatal care through the professionalization and institutionalization of resurgent midwifery. Historians of midwifery noted division among community midwives in the 1980s and 90s, as Varney and Thompson put it, "on whether official recognition was a positive move forward, or another attempt to control the practice of midwifery by non-midwives." They described the highly personal stakes of those divisions: "some of the community midwives were ignoring legal barriers to practice as they valued their freedom to do their own thing and thought hat licensure was the patriarchal attempt to control and then eliminate their practice. On the other hand, many community midwives wanted some form of legal recognition and protection, and some spent years trying to fight state agencies that harassed them for ostensibly practicing medicine without a license" (Varney and Thompson 2016:128). As some commentators would argue, midwives on both sides of that argument were crucial to the field. Those who courted officialdom enabled care collaboration, but professionalization also lent particular importance to the work of those who pushed scope-of-practice limits to sustain knowledge and availability of increasingly marginal care practices (Davis Floyd and Johnson 2006). Professionalization, others would note, was also about race and class. Christa Craven argued that as professional midwives increasingly framed birthing people as "consumers" of perinatal care and adopted the language of a "right to choose" midwifery care, divisions between wealthier "homebirthers", who frequently felt more able to claim a consumer identity, and low-income homebirth parents, who feared state intervention in their families as a result of their choices. Writing in the Canadian context, meanwhile, Sheryl Nestle argued, as Margaret MacDonald put it, "the incorporation of midwifery in Ontario was a racist process that systematically excluded

hundreds of foreign-trained and immigrant women of color in order to preserve midwifery as 'a new profession for the white middle classes'" (Nestel 1996, MacDonald 2008:21). As Varney and Thompson and others have noted, these debates over legal recognition, credentialing, and relationships to institutions have continued into the 21st century, setting the stage for the focus of this dissertation.

Twenty First Century Homebirth and Midwifery

This dissertation focuses on a contemporary period of homebirth and natural birth that is marked by both significant differences from and continuities with the late twentieth century period. After a relatively steady rate of out of hospital birth in the 1980s,[12] the 1990s and early 2000s saw a slow decline in home births followed by an accelerating increase beginning in 2004 (MacDorman 2012). Following a 29% increase in the home birth rate between 2004 and 2009 (MacDorman 2012), the three years between 2009 and 2012 saw an increase of 89% in the home birth rate (MacDorman 2014). By 2015, the number of births occurring at home—38,542—was the highest reported since CDC place-of-delivery data collection began (Martin et al 2017:9). Centers for Disease Control and Prevention reporting about homebirth began to note the potential macrosystemic effects of this shift in 2014 with the release of 2009-2012 data.

[12] Changes to the US Standard Certificate of Live Birth make distinguishing between out-of-hospital births occurring at a birthing center or clinic from those occurring at home possible for the first time; in the remainder of this paragraph I refer to rates of *home* birth, which were only a share of the out of hospital birth rate figures I reported previously (MacDorman 2012). Furthermore, while the dissertation is interested more broadly in those individuals who seek to have less medicated births *whether at home or in the hospital,* it is yet more difficult to quantify those births that occur in hospitals but are assisted by doulas or in which parents have participated in extensive research and conversation about minimizing medical intervention. I therefore take the sharp rise in the homebirth rate as one important indicator of increased interest in the United States in alternatives to standard hospital birth.

While still reporting that out of hospital birth is "rare" in the US, the agency newly noted its potential to "affect patterns of facility usage, clinician training, and resource allocation, as well as health care costs" (MacDorman 2014:1). Like earlier changes to United States childbirth practices, the CDC reports that this 21st century surge in homebirth is driven by married white women (MacDorman 2012, 2014), and that once again the southeast is the slowest region to see changes. Some researchers in the early 2000s reported that while traditional (unlicensed and apprenticeship-trained) Black midwives continued to practice in this period, they were much more likely to attend the births of white women seeking alternatives to hospital birth than to predominantly serve Black parents (Fraser 1995).

Both the late 20th century and current early 21st century homebirth resurgences have been the subject of much criticism from the field of obstetrics and gynecology. Despite the lower risk profile of home births reported by the CDC (MacDorman 2012) and the proliferation of various studies in the US and Canada finding that homebirth outcomes for low-risk mothers and infants are similar to or better than those in hospital (see, for instance, Cheyney et al 2014, review in Armstrong 2010), the American College of Obstetricians and Gynecologists (ACOG) continues to classify homebirth as risky and opposes affiliated physicians including homebirth attendance in their practices. Contrary to the findings of studies such as those undertaken by the Midwives' Alliance of North America's Division of Research (Cheyney et al 2014 a, b), ACOG reports[13] that

[13] This debate over homebirth safety is the subject of a great deal of conversation in both research and practice communities surrounding homebirth. One often-cited assessment of evidence quality, conducted by Saraswathi Vedam and collaborators, lists a number of factors that homebirth advocates often argue are ill-considered in assessments of homebirth safety such as ACOG's. These include: whether planned and unplanned homebirths are differentiated from one another; whether studies adjust for differences in selection criteria for homebirth and care

homebirth is associated with much lower rates of medical intervention, but much higher rates of perinatal mortality ("Committee Opinion 697").

Meanwhile, standard hospital practices—including high rates of chemical induction and resulting complications, cesarean sections, episiotomy, mobility limitations, and what many women describe as belittling, coercive, and choice-limiting treatment by obstetricians—have been examined in a burgeoning genre of films, books, and long-form journalism (see Block 2007, Wagner 2006, Lake and Epstein 2008). These publications echo the sentiment of many 1980s homebirth texts that described most low-risk birth as a reliable natural process mostly interrupted and made more dangerous by the definition of birth as illness and the introduction of technologies such as medication, monitoring, and surgery (Kline 2015). Some attribute the rise in medical intervention to constraints imposed by liability or provider convenience, blaming medical malpractice insurance and obstetricians themselves (Morris 2016, Block 2007, Lake and Epstein 2008). others focus more specifically on their results in the United States' high rate of maternal mortality (for more recent reporting on this matter, see articles such as Belluz 2017, Martin and Montagne 2017, Gallardo 2017). Research examining why birthing parents choose homebirth has found that all of these themes appear in the reasons respondents give for wanting to remain at home for their labors and births: one such study found that "women equated medical intervention with reduced safety and trusted their bodies' inherent ability to give birth without interference" (Boucher et al 2009: 119). Religious and spiritual reasons for embracing homebirth are also common, and research

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management; whether research designs control for differences in hospital transfers, including both decision criteria and processes; how researchers define morbidity and mortality. See Vedam et al 2012.

on homebirth and other alternative birth practices frequently highlights the centrality of a sense of birth as sacred to both religiously affiliated and unaffiliated practitioners' narratives (Klassen 2001a, 2001b, Duncan 2017). The non-nurse homebirth midwives this dissertation followed are often identified as the providers most likely to provide the extensive preventative attention and minimal intervention or interference that parents seeking a demedicalized birth experience want.

Homebirth Midwifery Practice Now

It is morning, or afternoon, or even early evening. The midwife and I, or the midwife, her kid, and I, or the midwife, her apprentice or student, and I are sitting in a therapist's office, or in a massage therapist's office, rented several days each week to be used for prenatal and postpartum visits. Or we are setting out the pitcher of water and stacks of high-protein granola bars and childbirth education books for clients to stay hydrated, fed, and learning while they wait for their appointments, and sitting in the bedroom of her home that, with the addition of a massage table for more comfortable exams, large baskets of toys for clients' kids, a bookshelf full of the pregnancy-related library from which clients borrow, and totes full of fetuscopes and blood pressure cuffs and tubes of pee-sticks, has been turned into a clinic space. Or we are settling into one of the rooms of an independent birth center, turning on the heat because there haven't been any births today and the building is chilly, the midwife pulling charts out of her bag to prepare for the client who will soon arrive with their partner and their toddler and their friend, or her husband and their two kids, or on her own. Or we are pulling up to the client's house, carrying in bags bulging with supplies, hastening into the kitchen to wash our hands

while calling back to the client to please not stand up, to stay right where she is, nursing her week-old-baby on the couch. We will be in this appointment for a long time. A student or apprentice might lead the visit, performing most of the tasks of the visit under the midwife's supervision—asking questions, palpating, listening to fetal heart tones—with the midwife following along, confirming answers, and documenting the student's tasks. Or a second midwife might join us, giving the family an opportunity to meet someone who will be with them when their baby is born. We might leave with a half-gallon jar of yogurt, or a check, or a new quilted pillow, as part payment for this course of care.

This midwife may have trained in any number of ways. Some midwives apprentice directly with a practicing midwife, forgoing formal didactic training through a schooling program entirely. Others complete this kind of apprenticeship while pursuing didactic training through an unaccredited school: Ancient Arts Midwifery, WomanCraft, The Matrona. In both cases, some students begin practicing as uncredentialed traditional or community midwives, while others who wish to obtain the CPM credential complete the "PEP" or Portfolio Evaluation Process through NARM and sit for an exam. Other students attend midwifery schools accredited by MEAC, complete preceptorships in compliance with their school's requirements, and sit for the exam. Both accredited and unaccredited midwifery schools include distance and in-person programs, with many schools offering both options.

This appointment will last somewhere between forty and ninety minutes, not counting the time we spend—anywhere from a few minutes to an hour or two—driving to the client's house. The time-intensive nature of homebirth midwifery care is one of the most

immediately apparent ways the model departs from its others. This also means that homebirth midwifery practices are necessarily relatively small. Most homebirth midwives I interviewed or shadowed attend about 2-5 births each month, or 24-60 births each year, though some in group practices who follow rotating call schedules attend more births, and some with particularly small practices attend fewer. Midwives are on-call for each client for what is often called a "due window"—the range of dates during which the midwife would attend an out of hospital birth should the client go into labor—for approximately four to six weeks. In order to be off-call—and thus able to travel more than a couple of hours away, "unplug" from availability by cellphone or pager, drink alcohol, or do many other things that many of us take for granted—most midwives in solo practice must take significant steps. Some arrange for another midwife to be on call for their clients, but given the deep commitment to relationships between providers and clients, this usually requires that midwives arrange for clients to meet the substitute midwife one or more times—and sometimes involves seeking additional substitute midwives if clients find the first possible substitute midwife is not a good fit. Others simply do not take any clients at all for a given month, effectively giving up a month of income in order to be able to visit far-away family for a week or two. All of the midwives in whose practices I conducted participant observation make themselves available to clients for questions at any time of the day or night during that due window.

While many homebirth midwives contract with midwifery-specific billers to manage the process of billing insurance, including Medicaid in those states where midwifery is covered, managing billing still consumes a great deal of midwives' time. Billing in homebirth midwifery is complex. The majority of clients are private pay. Others pay

their midwives directly, but file claims with their insurance companies, and midwives and their billers work together to prepare a superbill for that purpose. Even in cases where Medicaid covers homebirth midwifery care, clients often do pay some out of pocket costs, which vary from practice to practice but frequently include expenses such as supply costs for a birth tub liner, charges for placenta encapsulation, and the fee paid to the second or assisting midwife, which is often around $500.

Midwives often seek ways to lessen the financial burdens on their clients. Many offer discounts: for clients paying their full fee up front or by a particular date, for clients whose appointments will all take place at a clinic or birth center, for queer clients, clients of color, and/or clients who qualify for Medicaid, even if they cannot use their benefits to pay for homebirth midwifery care in their state. Many select a number of no-cost births and courses of care to perform each year. It is also common to offer barter arrangements: in one practice I shadowed, the midwife bartered for vegetables, eggs, cheese, milk, and yogurt from farmers; liquor for use in making herbal medicine tinctures from a bartender and caterer; and artwork by both parents from a third family. Others bartered for home improvement work, childcare, or administrative work benefiting the practice. Long-term, interest-free payment plans are also common.

Homebirth midwives also work in collaboration with extended networks of care providers. "Identifying and referring women who require obstetrical attention" is one of four elements of midwifery care listed in the Midwives' Model of Care. For all of the midwives I shadowed, being an "expert in normal" demanded managing relationships with area hospital staff, obstetricians, Maternal-Fetal Medicine specialists, endocrinologists, psychiatrists and therapists.

The profile of these collaborations varied widely from place to place, institution to institution, and provider to provider: some midwives had the cellphone number of a friendly nearby obstetrician and could reach out at any time to consult. One homebirth midwife had a robust collaborative relationship with a Maternal-Fetal Medicine specialist, enabling the practice to accommodate some clients with risk factors like Type I Diabetes most midwives otherwise found incompatible with homebirth. In one area, the nurse-midwives on staff at one hospital, some of whom had trained with homebirth midwives, offered co-care with homebirth midwives, making transfers of care to hospital-based providers much smoother. Another hospital had a nurse-midwife on staff who had practiced as a homebirth midwife in the past, and midwives often said parents transferring care to those hospitals were more easily able to make their desires for a family member catching the baby, low lights, very minimal provider touch, and more known to someone familiar with homebirth. In other settings, midwives told me hospital-based providers were hostile to them or their clients, refusing to speak with midwives, yelling at parents, or giving them punitive treatment in transport scenarios. In still other institutions, providers were simply unfamiliar with the scope of homebirth midwives' care, their surprise at its comprehensiveness revealing what often felt to midwives like a rather low opinion of them and their work. In still other settings, providers had worked hard to create collaborative dynamics: the Northern New England Perinatal Quality Improvement Network (NNPQIN), for instance, had served as a platform for relationship building and protocol development for hospital- and home-based perinatal care providers, producing transfer protocols, shared professional development opportunities, and more. In *all* settings, however, the work of managing, maintaining, building, and/or mitigating

the harm to clients arising from the encounters between these two systems of care demanded time and attention of midwives, and was often quite stressful.

The day-to-day work of homebirth midwifery, in other words, includes work done by multiple care providers and staff members in most institutional perinatal care settings. Homebirth midwives answer the questions from clients whose contractions are getting closer together that would be answered by a night nurse on call; they secure the supplies that would be obtained by a purchaser; they compile and fax the records to consulting physicians, billers, and insurance companies that would be handled by an office administrator. Their jobs are enormous. It is taxing to fulfill these multiple roles, to attend multiple multi-day births in the same week without the kinds of shift breaks that hospital-based providers can count on, to manage challenging relationships with other care providers. Homebirth midwives often told me they were considering taking breaks from their practices or ending their practices altogether. Some planned to begin assisting other midwives or using their skills to work as birth educators or lactation consultants. Many midwives emphasized to me that their jobs were profoundly rewarding. Yet I also saw the ways their vocation was deeply challenging.

Core Commitments and Model of Care

The model of care practiced by contemporary homebirth midwives is guided by a number of commitments, perhaps most prominently including those to physiologic birth, individualized and holistic care, and informed choice. In this section, I will introduce each of these commitments, outlining some of the ways conflict about each unfolds within the homebirth midwifery community of practice.

Physiologic birth, normal birth, or normal physiologic birth[14] is also sometimes more colloquially called "undisturbed" birth. As defined by ACNM, MANA, and NACPM in a 2013 consensus statement, "a normal physiologic labor and birth is one that is powered by the innate human capacity of the woman and fetus," rather than by the use of pharmaceuticals, instruments, or surgical techniques (ACNM, MANA, and NACPM 2013:1). Advocates of physiologic birth are adamant that in most cases—hence the use of "normal" or "typical"—this is the safest way for birth to unfold for all involved. Citing the World Health Organization's 1996 call for the elimination of unnecessary intervention in childbirth, this consensus statement, for instance, continues as follows: "this birth is more likely to be safe and healthy because there is no unnecessary intervention that disrupts normal physiologic processes. Some women and/or fetuses will develop complications that warrant medical attention to assure safe and healthy outcomes. However, supporting the normal physiologic processes of labor and birth, even in the presence of such complications, has the potential to enhance best outcomes for the mother and infant[15]." For this reason, many homebirth midwives speak of themselves as "experts in normal birth," highly attuned to complications as deviations from the norm by virtue of experience with normal birth that, many argue, is impossible for hospital-based midwives to obtain.

This is in part because normal physiologic birth, by this definition, is more than just unmedicated vaginal birth. In addition to induction or augmentation of labor and "operative vaginal (vacuum, forceps) or abdominal (cesarean) birth," "opiates, regional analgesia, or general anesthesia," and "induction or augmentation of labor," the

[14] "Normal physiologic birth" is the terminology used by NACPM and many researchers
[15] see ACNM, MANA, and NACPM 2012

consensus statement lists the following disruptions to normal physiologic childbirth: “an unsupportive environment, i.e., bright lights, cold room, lack of privacy, multiple providers, lack of supportive companions, etc.”, “time constraints, including those driven by institutional policy and/or staffing”, “nutritional deprivation, e.g., food and drink”, “episiotomy,” “immediate cord clamping,” “separation of mother and infant,” and “any situation in which the mother feels threatened or unsupported” (ACNM, MANA, and NACPM 2013:2). Of course, it is standard in many hospitals for many of these factors to be present, even as institutions have adopted so-called “baby friendly” policies such as delayed cord clamping: overhead lights are standard in many hospital rooms, care providers frequently work finite shifts shorter than the length of many labors, food and drink restrictions are common when providers wish for patients to be ready for anesthesia in the event of a cesarean. The notion that “leaving home is the first intervention” in labor and birth points to the significance of environmental factors like these. Indeed, homebirth midwives take steps to avoid these disruptions: overhead lights are off and curtains drawn in labor most of the time. Sometimes the room is entirely dark and sometimes it is slightly lit with candles, string lights, or small lamps. Homebirth midwives commonly carry headlamps so that they can perform clinical tasks without disturbing this darkness, and the one time I ever saw overhead lights switched on at a birth was when a midwife suspected prolapse and Emergency Medical Services were called. Midwives begin encouraging clients to purchase and prepare snacks and beverages for labor, such as popsicles, ice cubes made of honey-sweetened tea for electrolytes, in prenatal visits weeks ahead of their due windows. During the home visits that happen for clients whose prenatal visits have mostly occurred away from the client’s

home, midwives discuss with parents which room or rooms they'd like to use for the labor and birth, identifying spaces to which the midwives can retreat to give the family privacy.

While many of these practices are fairly standard for out-of-hospital midwives, significant boundary-work (Gieryn et al) also accompanies the identification of normal physiologic birth. Just how anti-interventive practitioners should be is the subject of great internal conflict in among homebirth midwives, and parents seeking homebirth midwifery care differ widely in the degree of interventiveness with which they wish their midwives to approach their care. Many told me they do not understand themselves to provide "noninterventive" care, but instead seek to use early, "gentle" interventions: iron or herb supplements to prevent the need for more interventive blood loss treatment later; probiotic foods and probiotic supplements to reduce the likelihood of Group B Strep later; Spinning Babies exercises to encourage optimal fetal positioning, and more. "Anything is an intervention," one told me, even "a position change, or herbs. I try to use interventions with the fewest side effects first." As clients neared the end of their "due window," this midwife generally offered what she called "gentle encouragements" to labor: using a breast pump for nipple stimulation, acupuncture, or chiropractic adjustment. If labor didn't start with these measures, she would offer what she called "things that feel like interventions even as they are gentle," such as homeopathic blue and black cohosh. Later still, she offered clients the option of using castor oil and/or membrane sweeps to encourage labor. While this was a common approach to encouraging labor, for some, more anti-interventionist midwives, calling these measures "encouraging labor" was at odds with their understandings of physiologic or undisturbed

birth. “An induction is an induction,” these midwives frequently told me. Often, these conversations were framed with respect to state regulations prohibiting midwives from attending births past a particular gestational age, often 42 weeks. “Induction! [Thumbs down emoji] Babies should NOT be forced out even in the most ‘natural’ or ‘gentle’ means,” read one Facebook post on the topic by Indiebirth, a particularly uninterventionist organization. “Herbs, castor oil, breast pumping…when there is NO problem but simply a matter of dates and midwives working under strict regulations that prohibit them from attending births past a certain point.” For Indiebirth, the same dangers of induction applied for so-called “natural” or “gentle” inductions: “Succumb to this,” the post continued, “and you will be a mama in stress, with likely a wonky labor…and don’t be surprised if your baby has trouble breathing at birth and/or you bleed a lot, too! …the hormonal flow of birth is perfect when left alone, and when we mess with it we should expect problems that need to be solved.”

The question of how to define physiologic birth is related to the question of where to draw the line about what is typical or normal in pregnancy and birth. Many midwives told me they worked to “hold a wide range of normal,” understanding various bodily states in pregnancy as “variations of normal.” Post-dates pregnancy, or pregnancy continuing past 42 weeks gestation, was among these, along with others such as breech birth. But where does that wide range of normal end? For some, the answer was at 42 weeks. Others argued that 43- or even 44-week pregnancies were rare but non pathological variations of normal. Likewise, some were adamant that breech was a variation of normal, and that as such, breech births belonged at home with all other normal births—a belief upheld in some state licensure regulations, but at odds with

others. One midwife who had trained in breech birth in order to have ready-to-hand skills in case of surprise breeches told me she understood this position, but as breech positioning was, she noted, present in less than 4% of births, she wasn't eager to add regular breech to her scope of practice. Differences in understandings of physiologic birth or normal ranges were frequently identified to me as generational—in multiple directions. Older midwives who practiced in a more hands-off fashion and had long attended breech or twin births sometimes told me they found that younger midwives, trained in an era of state standards written with an eye to collaboration with physicians and nurse-midwives who tended to wish for more cautious practice styles in home birth, were losing their faith in birth—their trust in the body's ability to birth safely. Meanwhile, some told me they found that the desire for radically undisturbed labor—labor with minimal or fetal heart tone monitoring, for instance—was new, a trend spurred by engagement with the media and conversations surrounding freebirth, sovereign birth, and unassisted birth.

For many midwives, the question of how to define a range of normal or what physiologic birth meant depended on another core value of contemporary homebirth midwifery: that of individualized care. Midwives often emphasized to me that they were interested not just in identifying whether clients were in a standard normal range, but whether what was happening was normal *for that person*. Alex mentioned to me after a prenatal appointment, for instance, that given the headaches the client was reporting, she wanted to keep an eye on her blood pressure. If it rose at all from her past levels, she explained, she'd want to further investigate the possibility of pre-eclampsia, even if her levels remained within a normal range. Alex similarly drew on her knowledge of clients'

life circumstances to inform clinical care: for clients who she knew were struggling to feel connected to a partner, she suggested using the exercise of writing the birth plan as a time to come together and talk about their anticipations. For a client who had recently made a painful decision not to have any more babies after some challenging medical news, she paid additional attention to postpartum depression screening and began to brainstorm possible tailored ways to screen for postpartum depression, considering asking the client's partner to check in with her using a set of screening questions. Many emphasized to me that this kind of individualized risk assessment, close and lengthy attention, and what one midwife called "reading the subtle signs" of each idiosyncratic person results in *safer* care then that provided in hospital settings characterized by standardized screening instruments and distributed care teams working under enormous time pressure.

Alex and others also frequently told me about other ways they were paying attention to a client's individual preferences: one client preferred to make nutritional changes rather than use herbs or supplements, and when she did use herbs, she preferred to use teas, rather than capsules or tinctures. Midwives were careful to mirror clients' language, calling a parent Papa if they used that term rather than Dad, or using a baby name if one had been selected prenatally rather than simply referring to "the baby," or using terms like "surge" or "wave" for contractions if parents were using systems such as Hypnobirthing for labor preparation that included specific terminology. These measures also support a commitment in homebirth midwifery to holistic care, or care that addresses not just physical but also emotional and social needs for birthing parents. Midwives frequently have long conversations with clients about their emotional lives: their school

finals; their relationships with their children, their parents, partners, and friends; their dreams; their jobs. Some of these conversations were highly practical: with one client whose job as a chef kept her on her feet much of the day, Alex brainstormed specific shoe options that might be comfortable late in pregnancy. Other conversations could sound a bit like counseling sessions: Sylvie, for instance, frequently used silence to give clients the space to say more about their feelings. "It sounds like you're feeling good about [your older kid]," she said in one prenatal visit. Yes, the client replied, despite feeling a bit cooped up lately. Sylvie stayed quiet. The client elaborated a bit: she and her older kid had been showering together, and it had prompted some memories that felt sweet about bathtimes when he was much younger. Sylvie stayed quiet. "I'm realizing," the client said, "I'm going to do it all again with another baby." Sylvie stayed quiet. "I'm just so excited to meet her," the client said, describing the flow of her feelings: she'd feel some worries, and then they'd pass and she'd feel excitement. Alex, similarly, sat with one client, affirming her feelings about transition as she talked about her third birth. "I know that birth is beautiful," the client said, "but I also know it's ugly." She thought, she said, about a seedling coming out—"well," she said, "maybe that's painful, too." With another client whose social world didn't include many parents, Alex brainstormed possible ways to connect with a partner and to strengthen relationships with those acquaintances who did have children. These were somewhat lengthy conversations, with some significant specificity: was there a particular hiking trail that the two of them could establish a routine of taking together?

For clients with older children, midwifery visits often included the children: kids were invited to squeeze blood pressure cuffs, listen to fetal heart tones, or look at

diagrams of fetal growth. Preparing older siblings for the arrival of a new baby was also a part of midwives' care: they frequently advised clients about introducing overnights with grandparents or refraining from lifting children partway through pregnancy so as to avoid a rude shock with the arrival of a new baby, for instance. Midwives also prepared kids for the event of labor itself. When Alex added a short childbirth education conversation to a prenatal visit for a client who was not going to take a childbirth education course, for instance, the client's toddler was part of the action. Alex demonstrated some labor vocalizations for the toddler, aiming to prepare her so that her mother's unfamiliar sounds might be less shocking. She explained that when people do hard work they sometimes need to make a sound, demonstrating by picking up her own toddler, pretending that he was extremely heavy, and groaning. The client's kid responded by picking up a pillow with exaggerated effort and groaning. Everyone in the room cheered: "Yes! Like that!" "When people are having a baby," Alex continued, "they sometimes need to make sounds like this." She got down on her hands and knees and made some loud, labor-like sounds, and the toddler climbed on her back. Alex ignored her, continuing to moan. "See," she said after the toddler climbed off, "I was concentrating really hard and couldn't stop when you climbed on me!" Support for sibling relationships also continued postpartum. At one postpartum visit with a client of Daniella's, for example, clinical action stopped when client's partner passed around his phone to show us all a video of their older son meeting the new baby. Everyone exclaimed as the toddler wrapped his arms around the baby, kissing her again and again, about how smitten he was with his sister, showing him the video of himself, and affirming to him that he was showing his love for the baby in all the right ways. Sharing

clients' joy in their families and lives, empathizing with and brainstorming strategies to address challenges, and witnessing their feelings at length occupies a great deal of *time* in homebirth midwifery—and rightly so, many homebirth midwives would argue, as babies are born to parents who have jobs, relationships, fears, dreams, narratives, and metaphors. Indeed, the emphasis in homebirth midwifery communities on holistic or whole-person care means that midwives generally understand birth to be a significant moment not simply physiologically but also spiritually, sexually, emotionally, and socially. Providing care that addresses needs arising from many facets of a client's life and identity is thus at the core

Delia, a midwifery student, emphasized to me that this emphasis on holistic and individualized care prepared home birth midwives well to offer trauma-informed care. "We're gonna say whatever words we have to," she said, and adjust behavior in care in order to help a client feel as comfortable as possible. She related options she routinely offered to clients: turning her back or leaving the room in order to put on gloves, avoiding hands and knees positioning, and more. Alex, similarly, adjusted appointment times for one client whose history of trauma made pregnancy and birth particularly complex, allowing a full ninety minutes to each visit in order to discuss in detail how communication could go best during the birth: this client needed a clear statement of why the midwife wanted to do something, clear consent to begin, and then to pay relatively little attention to what was happening.

The emphasis on trauma-informed care in homebirth midwifery carries particular weight because of the abuses and utter lack of choice or autonomy that many birthing people experience in the contemporary United States perinatal health system. One recent

study investigating the frequency with which doulas and labor and deliver nurses in the United States and Canada observed care providers providing disrespectful perinatal care found that over 65% had either occasionally or often witnessed care providers beginning procedures before giving the patient a choice or the chance to consider the procedure, and 18% had occasionally or often witnessed care providers engaging in procedures against the explicitly stated wishes of the patient. Moreover, over 11% of respondents had heard care providers "mention a laboring woman's racial or ethnic background in a way that was demeaning," and 8.5% had occasionally or often "witnessed a care provider use sexually degrading language with a laboring woman." One third, moreover, had witnessed care providers threatening infant death if a laboring patient did not agree to a proposed procedure (Morton 2018 Bearing Witness). The prevalence of this kind of coercion and abuse—what many midwives referred to as a complete lack of informed consent—in mainstream, hospital-based perinatal care lends particular urgency to homebirth midwives' commitments to informed choice. Indeed, one midwifery educator told me she believes that the reason informed choice has become such a core value in contemporary midwifery care is that it has been so lacking in obstetrical settings, from the twentieth century routines of rendering birthing people either unconscious or physically restrained such that they could not participate fully in their own births or the choices surrounding them to the present.

When, in 1984, the Midwives Alliance of North America first adopted "Functions, Standards, and Qualifications for the Art and Practice of Midwifery," Informed Choice was listed as the seventh skill (Varney and Thompson 223). It remains

in the most recently updated version of that document, adopted in 2005[16]. Interestingly, however, more many more recent documents, including MANA's own Core Competencies for Basic Midwifery Practice[17], revised in 2011, and NACPM's Standards of Practice for NACPM Members[18], Scope of Practice[19], and Philosophy and Principles of Practice[20] do not use the specific term informed choice, referring instead more generally to the rights of birthing people to make their own decisions in pregnancy and birth and midwives' work to facilitate "informed decision-making " or even "inform, educate and support women in making choices about their care through informed consent" (NACPM Scope of Practice). Their standards of practice are yet more careful. Standard Three, "The midwife supports each woman's right to plan her care according to her own needs and desires," continues to describe the NACPM member's responsibility to "respect…the woman's right to decline treatments or procedures and properly document…her choices," but also describes care planning as done "together," and notes that an NACPM member must "clearly state…and document" both "when her professional judgment is in conflict with the decision or plans of the woman" and "when a woman's choices fall outside the NACPM member's legal scope of practice or expertise." The midwife may, the document stipulates, "refuse to provide or continue care and refers the woman to other professionals if she deems the situation or the care requested to be unsafe or unacceptable." Meanwhile, homebirth midwives who eschew state licensure, practice with an extremely wide range of normal, attending post-dates,

[16] see MANA 2005
[17] see MANA 2011[1994]
[18] see NACPM 2014, "Standards of Practice"
[19] see NACPM 2014, "Scope of Practice"
[20] see NACPM 2014, "Philosophy and Principles of Practice"

twin, and breech births, often approach informed choice quite differently: as an individual and not shared decision-making process. "Every tool has an appropriate and sacred use and it's up to the woman to decide when that is," one Indiebirth Instagram caption reads.

Informed choice has, then, been at the heart of the resurgence in midwifery since it began. The question of how to understand informed choice—and, indeed, whether to continue to use the term at all, or to replace it with informed decision-making or the right to plan care—correlates closely with many of the other internal conflicts over core values in midwifery described in this section. The chapters that follow will trace this central and contested idea: informed choice.

Chapter Two

Informed Choice: The Ideal and In Action

Introduction

The road to Tania's house wound along a small stream, passing the post office where her mother-in-law worked and a few other houses as snow-blanketed as hers. There were four of us in the car, all squinting against the sunlight that flickered through the still-bare early March trees. Alex, the midwife, was driving. I rode in the front seat, my feet splayed around her canvas prenatal bag stuffed to bulging with blood pressure cuffs, fetoscopes[21], Pinard horn[22], pee-strips[23], portable Doppler ultrasound machine, Leff[24], measuring tapes, fetal growth illustrations, and charts. Elana, the "second" or assisting midwife, rode in the back. This home visit was her chance to meet Tania before the birth. In between all of our attentions to Alex's nine-month-old, Elana and Alex conferred about Tania's pregnancy and care. Alex reminded Elana that it had been a tough week for Tania. Her dad had just died, and everyone in the family—Tania, her partner, and her toddler—had all had the stomach flu. Tania was also hoping that this birth would go differently than the birth of her toddler had gone. She'd had an atonic postpartum hemorrhage[25] after her first birth that had resolved only with the full

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[21] specialized stethoscope made for listening to fetal heart tones

[22] hollow wood horn also used for listening to fetal heart tones

[23] Chemically treated paper allowing urine screening. Midwives commonly use these strips to check for platelets or protein in urine as one diagnostic tool in evaluating clients for preeclampsia or urinary tract infections.

[24] The weighted bell of this type of fetoscope amplifies the fetal heart tones and makes it useful for listening without the Doppler early in pregnancy.

[25] In an atonic postpartum hemorrhage, the uterus does not contract to stop the flow of blood, leading to frequently dangerous blood loss.

complement of available treatment at home: two doses of Pitocin, plus both methergine and Cytotec, and uterine massage. The sheer amount of blood Tania lost made for a a rough postpartum period with a lot of exhaustion for her, Alex said, and Elana nodded. "Makes sense that it would be," she said. She and Alex brainstormed a bit and decided to offer Tania active management of her third stage of labor, or the birth of her placenta.

Alex introduced the idea of active management during the portion of the visit when they were checking in about other care decisions Tania was still deciding about, like pulse-oximeter screening[26], Vitamin K injection, and antibiotic eye ointment. She described active management, which involves the midwife giving a shot of Pitocin, the first-line drug used to treat hemorrhage, prophylactically. She explained that active management of third stage is standard in hospital protocol, telling Tania that the evidence shows that it is effective at reducing the incidence of hemorrhage and thus the use of drugs, so it can be a way to avoid further interventions like the ones Tania experienced. Physiologic management, Alex said, has been shown to be effective too, but the kind of history of a big bleed and challenging postpartum experience afterwards that Tania had at her first birth makes active management a good tool to consider. "You don't have to make a decision right now," she told Tania, offering to check in about the decision at the next visit or during early labor should Tania's labor start before they saw one another again.

By the time she went into labor, Tania was sure she wanted active management. Tania generally tended to avoid care options she found invasive. She planned to decline both Vitamin K supplementation and eye ointment for the baby, but she'd been surprised

[26] used for critical congenital heart screening

to hear some other mothers talking about going to the pediatrician's office a couple of weeks after their babies were born. There was no way she could have done that, she thought. She really didn't want to feel so *flat out* again. Alex and Elana both told me later they were happy she'd made that choice—but Alex also emphasized that she would have been equally prepared to affirm another choice.

The process Tania, Alex, Elana undertook together about the management of Tania's third stage of labor is referred to as informed choice. This chapter examines the ideal and the scene of informed choice. The chapter will describe informed choice as an ideal and informed choice in action, examining its difficulties and contradictions.

Informed Choice: The Ideal

Since at least the 1960s, the ideal of informed choice has been at the heart of the resurgence of homebirth and homebirth midwifery—indeed, in a 1992 community history of the Midwives Alliance of North America, prominent midwifery educator Betty-Ann Daviss identifies "the saving of a woman-centered, informed choice approach to midwifery care" as one of the core issues for midwives across the United States and Canada (Schlinger 1992:71, see also Varney and Thompson 2016:130, Litoff 1978:145-6). At its simplest, informed choice is defined as the recognition that "the woman [or birthing person] is the primary decision maker in all matters regarding her own health care and that of her infant," the expectation that the midwife "respects the woman's right to decline treatments or procedures and properly documents these choices," and the requirement that the each midwife will "present accurate information about herself and her services" (MANA 2005). Informed choice was often described to me as an ideal to

which parents and providers were drawn in their search for alternatives to failures of the informed consent processes that are typical in hospital-based perinatal care. Indeed, many parents needed to discuss in homebirth prenatal visits the experiences of informed consent gone wrong that they had experienced in previous hospital births. Fiona was one such client. She was a client of Daniella, a homebirth midwife who attended a large number of VBAC clients due to the high rate of cesarean sections in her area. Fiona told me about her first birth within minutes of our meeting at a home prenatal visit with Daniella. During a vaginal exam at a prenatal visit when she was 38 weeks pregnant, her obstetrician had surprised her by inserting his finger into her cervix to perform a membrane sweep. "I had no *idea* he was going to do that," she said, shaking her head. Fiona was angry not only because she had to avoid interventions like this in her pregnancy and birth and not only because she hadn't consented to the sweep itself, but also because the experience that followed had been a classic example of a "cascade of interventions." Her labor had started soon after the sweep, but had progressed in fits and starts and ended in a cesarean that she had not wanted and, both she and Daniella now believed, she almost certainly would not have needed had her obstetrician not urged her into labor before her body or her baby were ready. Research has demonstrated that experiences like Fiona's are relatively common and the phenomenon of obstetricians performing procedures without discussion or consent is relatively widespread: one 2013 survey found that 25% of participants whose labor was induced—either pharmaceutically or through means like the membrane sweep— experienced some form of pressure to consent to inductions, and for some other interventions in labor and birth, such as episiotomy, it is more common for parents to report having *no* part in the decision-

making process than to report having participated at all (Declercq et al 2013:16, 36). Other parents used the terminology of "obstetric violence" (Diaz-Tello 2015, Sadler 2016) or "birth rape" (Kitzinger 2006, Elmir et al 2010) to describe the bodily violation and loss of agency they experienced.

While experiences like these are often described as the worst foils for a good informed choice process, homebirth midwives and parents frequently characterized informed choice to me by way of comparisons to "good" hospital choice. Meg, a midwife with a birth center and homebirth practice in New England, described the distinction this way:

> *Informed consent is basically making sure that you're giving people information that they will ultimately consent to, whereas informed choice is giving people the information they need to make a choice on their own. So it's not implying that if I tell you about this you're going to consent.*

This was a common sentiment: that even when nothing is done secretly or against the expressly stated wishes of a client—even when informed consent is practiced in such a way as to fulfill its own requirements and the requirements of the law--informed consent still limits parents' role and agency in the scene of decision-making about their own care. In informed consent, as Meg explains, the work of identifying what factors are relevant to the choice at hand, synthesizing information, and formulating a plan of care are delegated to the provider. The parent's role is limited to a binary choice, accepting or rejecting the vision of the care provider.

Informed consent itself is a twentieth century artifact. The requirement that a care provider obtain a patient's voluntary consent before proceeding was first legally codified

in 1914, and requirements that providers disclose the risks and benefits of procedures in question began to be upheld by state Supreme Courts in the middle of the 1950s (Berg et al 2001:43-4). The term "informed consent" was first used in full in 1957. By the 1980s, the American Medical Association, which rewrote its code of ethics as the field of bioethics expanded, had adopted an official statement recognizing informed consent as a "basic social policy, " one "necessary to enable patients to make their own choices even if the physician disagrees" (Faden and Beauchamp 1986:96). The notion of informed consent, first legally defined in 1957, was fraught from the start (Berg et al 2001:48). How much information should physicians provide? Enough to satisfy a patient's desires and questions, or a physician's? If different patients might desire more or less information, how might a court or professional determine what constituted adequate standard information?

Like Meg, analysts have argued that the informed choice approach used in the direct entry midwifery practices I shadowed is meaningfully different from informed choice. Informed consent, as they emphasize, is imbricated with liability (Beauchamp 2011), aims to protect both patient and provider, entered the scene of practice after the emergence of the medical profession, and is constrained by other institutional features of medical care, such as hierarchical relationships between doctors and patients and the circumscribed provider-patient relationships produced by short appointments and poor continuity of care (MacDonald 2018: 287). Informed choice, as MacDonald argues, is not a later addition to a model of practice, but instead integrated with presumptions horizontality and longevity of relationships, a high value on multiple kinds of knowledge, and a vision of patient "autonomy" (Handa and Sharpe 2015, MacDonald 2018).

In practice, this means that informed choice assumes a much wider role for parents. Alex described herself and her clients as "partners in care," bringing two different crucial perspectives to a joint research and decision-making process. It was Alex's job to generate care options that she would offer to Tania, such as active management, but that job was impossible without Tania's role in identifying her own wishes and priorities, such as a better-feeling postpartum period, even at the expense of avoiding intervention. This arrangement of roles in prenatal care is often described as uniquely suited to out-of-hospital birth because it prefigures the physiological process of unmedicated labor and birth. Meg, for instance, further differentiated informed choice and informed consent this way:

> *[They're] so different, and I think in preparing for a natural birth that distinction is so important. Because if you're going through our pregnancy and I'm saying* now it's time for this, and now it's time for this*—whether or not I'm getting your consent—when you get into the setting of labor, if I'm doing stuff through your whole pregnancy, then when you're in the labor setting it almost feels like your labor is being done to you. And that's not what's happening. Your body is working to get your baby out, and so treating somebody in that way throughout their pregnancy is absolutely crucial for the outcome that they want.*

Using an informed consent model would, in other words, give a client a sense of what to expect during labor that was wrong for a setting in which getting the baby out must be done by the parent, not the provider. Midwives often emphasized to me that this division of labor was one of the distinctive features of the out-of-hospital setting. Unlike in a hospital, where a nurse-midwife or obstetrician might have induction drugs, forceps,

vacuum extractors, or the option of performing a cesarean section, the person in labor must push the baby out—or transport to the hospital to seek another model of care. The job of midwifery, homebirth midwives often emphasized to me, is thus *not* to get the baby out. That's the parent's job—and it is the parent's job to decide how they want to navigate that process, too. The midwife's job is to support the parent's work of pregnancy and labor. The midwife can provide information about what might help that happen in the most uncomplicated way possible, offer an extra pair of skilled hands to help gather that information by monitoring fetal growth or fluid levels during pregnancy or fetal heart tones during labor, alert the parent to approaching decision points, help a parent think through their own desires and priorities, provide the emergency care parents want should something unexpected like a hemorrhage arise. But the work of moving the baby out into the world must be done by the parent, or, as many say, by the team of parent and baby. Prenatal care is then ideally a rehearsal for labor, and the provider can no more discern what gestational diabetes screening approach is right for a parent than they can push that parent's baby out for them.

One parent in an online forum was upset with her hospital birth because, as she said, "I was told how it was going to go and what I was going to do." But out-of-hospital midwives often emphasize to their clients that they cannot say how things are going to go, or what the parent will do. Indeed, some said that helping clients shed that expectation was an important part of prenatal care, lest a parent expect to look to the midwife to direct the experience of labor in a way that simply is not possible in the home setting. I was only ever at one birth at which the midwife felt this happened. It was late at night. Sylvie had helped her client try various positions to open her pelvis, use the

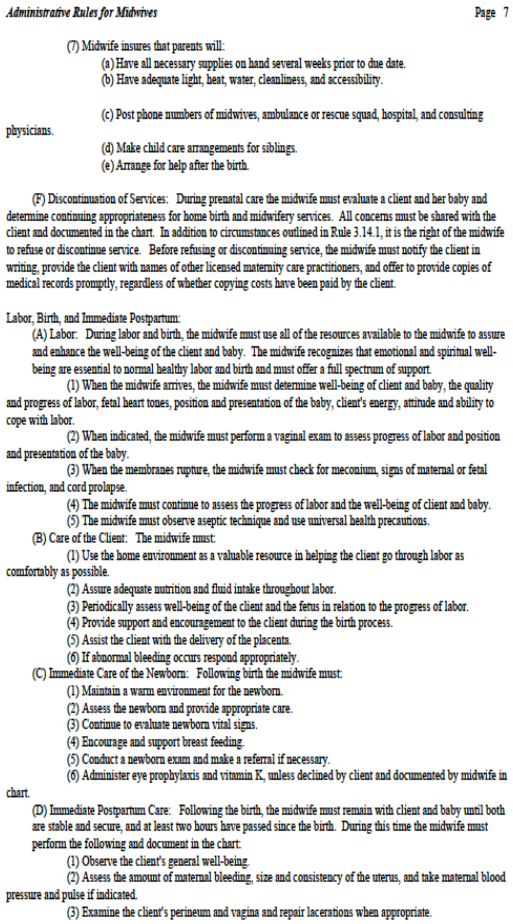
birthing pool to rest between contractions, use the bathroom in case a full bladder was in the way, and more. Now, Sylvie felt she had existed the measures she could offer to help remove impediments to progress or make things more comfortable. But the laboring mother and her family continued to ask her to *do* something to move labor forward. Sylvie pulled me into a side room. "I can't have this baby for her," she whispered to me. "She's going to have to push the baby out." Turning to the body provides a common-sense explanation for both the arrangement of work and the arrangement of decision-making and expertise in out-of-hospital midwifery. The provider cannot know best if "knowing best" means sensing and understanding one's own priorities and desires, but also if "knowing best" means feeling the sensations of unmedicated birth. The ideal of informed choice thus does more than reject or construct an alternative to what feminist critics have long diagnosed as the paternalism and coercion of obstetric care (Ehrenreich and English 1979, Romalis 1981, Katz Rothman 1982). Taking the individuality of the body as a point of departure, it constructs the work of unmedicated labor—and the knowledge work of preparing for that labor in pregnancy—as properly done by parents, and parents as therefore properly the experts in their own performance of that work.

Informed Choice in Action

Prenatal Informed Choice

Accountability to the mandate of informed choice inflects every aspect of the practices I shadowed. That inflection begins before any particular care decision has arisen about which a formal process of informed choice might occur. The midwives whose practices I shadowed begin to set the scene for the client as decider and midwife as

support and resource-provider in the opening lines of their appointments. They do this despite the fact that they certainly have an agenda: most, in fact, use a checklist to guide each prenatal visit that is attached to the back of a client's paper chart or appears as one of the landing pages in their electronic record, and in states in which CPMs are licensed, regulation frequently stipulates required assessments and components of care (for instance, a sample page of the Vermont Administrative Rules for Midwives appears in Fig. 1).



Administrative Rules for Midwives Page 7

(7) Midwife insures that parents will:
(a) Have all necessary supplies on hand several weeks prior to due date.
(b) Have adequate light, heat, water, cleanliness, and accessibility.
(c) Post phone numbers of midwives, ambulance or rescue squad, hospital, and consulting physicians.
(d) Make child care arrangements for siblings.
(e) Arrange for help after the birth.

(F) Discontinuation of Services: During prenatal care the midwife must evaluate a client and her baby and determine continuing appropriateness for home birth and midwifery services. All concerns must be shared with the client and documented in the chart. In addition to circumstances outlined in Rule 3.14.1, it is the right of the midwife to refuse or discontinue service. Before refusing or discontinuing service, the midwife must notify the client in writing, provide the client with names of other licensed maternity care practitioners, and offer to provide copies of medical records promptly, regardless of whether copying costs have been paid by the client.

Labor, Birth, and Immediate Postpartum:
(A) Labor: During labor and birth, the midwife must use all of the resources available to the midwife to assure and enhance the well-being of the client and baby. The midwife recognizes that emotional and spiritual well-being are essential to normal healthy labor and birth and must offer a full spectrum of support.
(1) When the midwife arrives, the midwife must determine well-being of client and baby, the quality and progress of labor, fetal heart tones, position and presentation of the baby, client's energy, attitude and ability to cope with labor.
(2) When indicated, the midwife must perform a vaginal exam to assess progress of labor and position and presentation of the baby.
(3) When the membranes rupture, the midwife must check for meconium, signs of maternal or fetal infection, and cord prolapse.
(4) The midwife must continue to assess the progress of labor and the well-being of client and baby.
(5) The midwife must observe aseptic technique and use universal health precautions.
(B) Care of the Client: The midwife must:
(1) Use the home environment as a valuable resource in helping the client go through labor as comfortably as possible.
(2) Assure adequate nutrition and fluid intake throughout labor.
(3) Periodically assess well-being of the client and the fetus in relation to the progress of labor.
(4) Provide support and encouragement to the client during the birth process.
(5) Assist the client with the delivery of the placenta.
(6) If abnormal bleeding occurs respond appropriately.
(C) Immediate Care of the Newborn: Following birth the midwife must:
(1) Maintain a warm environment for the newborn.
(2) Assess the newborn and provide appropriate care.
(3) Continue to evaluate newborn vital signs.
(4) Encourage and support breast feeding.
(5) Conduct a newborn exam and make a referral if necessary.
(6) Administer eye prophylaxis and vitamin K, unless declined by client and documented by midwife in chart.
(D) Immediate Postpartum Care: Following the birth, the midwife must remain with client and baby until both are stable and secure, and at least two hours have passed since the birth. During this time the midwife must perform the following and document in the chart:
(1) Observe the client's general well-being.
(2) Assess the amount of maternal bleeding, size and consistency of the uterus, and take maternal blood pressure and pulse if indicated.
(3) Examine the client's perineum and vagina and repair lacerations when appropriate.

Fig. 1

At one 36-week prenatal visit, the midwife settled herself into a cross-legged position on the floor of the client's living room and opened the chart to a blank page. After a few minutes of chatting—an update on the client's partner's work schedule, some happy announcements about progress on the client's recent move—the midwife opened the visit: "I'd love to hear what you'd like to talk about today, and then I have some things I think it would be lovely to talk about," she said. Another midwife started each visit by perching on a small stool in the bedroom in her home that she uses as a clinic space, turning on her iPad, pulling up the client's electronic record, and asking, "So what do you want to talk about today?"

These moments are striking in their uniformity. In each case, the midwife both explicitly told the client that their concerns would drive the unfolding of the visit and signaled as much by readying the chart itself to record and respond to those concerns before imposing the agenda of the provider. One midwife did mention her own agenda, but cast it as a happy suggestion, not a mandatory requirement—"some things I think would be lovely to talk about." Even the midwives' body language and use of space signaled horizontality and the authority of client as decider: rather than flipping to their checklist and beginning to ask the questions it stipulated, the midwives, poised with pen and blank page or iPad, positioned themselves as stenographers and listeners first, contributors to the agenda second. The typical schedule of a visit also privileged the client's concerns by not only collecting but addressing them first. In another prenatal visit, the midwife and client discussed the client's feelings of physical discomfort while spending long hours on her feet as a bartender, her concerns about her remaining cervical scar tissue from a previous procedure, and the thoughts and fears about her upcoming

birth that were racing through her head and making sleep difficult. All these conversations unfolded in full, the midwife listening, empathizing, asking follow up questions to make sure she understood, and offering information, resources, or ideas of strategies to help, before she removed so much as a fetoscope or pee-strip from her bag. Elements of clinical visits that might appear the most mandatory (by dint of both insurance policy, which sometimes allows payment for visits only if they include three vital signs, and of standard of practice for professional homebirth midwifery) like taking vital signs, assessing urine samples for preeclampsia and other conditions, measuring the fundus and listening to heart tones, frequently occurred near the end of the visit. They were also preceded by explicit language positioning the client as decision-maker. This language ranged from asking for consent—"may I take your blood pressure?—to offering choices: "are you interested in weighing yourself today?" Even payment was usually raised as a question about what a client would like and what would work for a client, with midwives asking clients whether they "would like" to make a payment at any given visit and "what would work for them" when following up about lingering payments owed after a birth.

Of course, the midwives I shadowed were paying close attention to the items on those checklists. This attention was often filtered through the particulars of an individual parent: midwives were frequently monitoring not only whether a client's vital signs or lab work not only looked normal but was typical for them, and they were thinking about possible courses of action that might fit with what they knew about that person's desires and preferences. As we drove up to a client's house or straightened up the clinic space between appointments, they'd mention to me that they'd noticed that though the previous

client's blood pressure had been well within the range of normal, it was higher than it generally had been for that client during pregnancy, and they'd tell me about their plans to review records from a previous pregnancy to see whether this was typical for that particular person at that particular gestational age. They would tell me days before someone's appointment that they were thinking about the person's postpartum bleeding lasting longer than usual, and that their attention was particularly grabbed by the situation because they knew that client didn't typically like to take supplements or because they knew she followed a diet that did not include common sources of iron like red meat. The standardization of the checklist, in other words, did not overdetermine its use.

Homebirth midwives thus use their own bodies, the physical space around them, and the arrangement of time and documents during prenatal visits to signal their intention to redistribute what Steven Lukes would call two different "dimensions" of power: both the power to make decisions and the power to set agendas (Lukes 2005). By assuming that the client's concerns and preferences about how to spend the time of the visit literally come first, midwives set the scene for the notion that time and attention will be allocated in accordance with client, not provider, preferences, perceptions, and desires, and that parents will determine what elements of their lives are relevant to their perinatal care (Zerubavel 2015: 70, 79). Facilitating informed choice appears not as an isolated task, but as an inflection of all aspects of care.

Of course, as individual care decisions arise in each course of care, the work of facilitating informed choice does then become discretely visible. Some of these choices are relatively standardized: practices maintain formal documentation for a list of conditions and care options about which all clients are asked to formally make an

informed choice. While this list certainly varies by state and region, the conditions in question typically include first trimester quad screening, Rh sensitization, Group B Streptococcus testing and treatment, gestational diabetes screening, and, for newborns, Vitamin K supplementation, antibiotic eye prophylaxis, metabolic and hearing screening, and others. These documents are written by each individual midwife or midwifery practice and are intended to present the facts about health conditions and care options for both parent and infant, describing available tests, screening methods, and treatment plans, their risks, and their benefits. The ubiquity of these documents is in part an artifact of their inclusion in the requirements for obtaining the CPM credential, but some traditional midwives or midwives who practice without the CPM credential who I interviewed did use such documents as well. The documents themselves generally present a definition of the condition in question, a summary of relative and absolute risks, and a description of options for screening and care. Many describe both the standard of care in hospital-based practices or "the medical model" as well as standard of practice in "the midwifery model" or homebirth midwifery community in the area.

The wording of these documents highlights the invitation to client choice even when the specifics of the care made available overlaps significantly with the care typical in a hospital setting. For instance, Alex's informed choice documents describe the standard of practice with regard to Group B Strep in hospital-based perinatal care and its stipulation of *universal* screening by vaginal and rectal culture and treatment with intravenous antibiotics during labor in each case of a positive screen:

Informed Choice for Group B Streptococcus Testing Options

fiddlehead
MIDWIFERY

Group B Streptococcus

Group B Streptococcus (GBS) is a strain of the streptococcus bacteria that is commonly found in the gastrointestinal tract, rectum, vagina or urinary tract of many adults. It is generally asymptomatic in people with healthy immune systems., although it can cause UTIs Approximately 10-30% of pregnant people have the GBS bacteria in their vagina/rectum. It is tested for in pregnancy, because although adult bodies can handle GBS colonization, newborn bodies are less able to fight off bacterial infection. Newborns can contract GBS during a vaginal birth, or a Cesarean birth in which membrane ruptured prior to birth. Serious complications, including systemic infection, meningitis pneumonia, respiratory distress, cerebral palsy, or death can result from an infection. Newborns can contract GBS either in the first days after the birth (early-onset disease), or late-onset disease, occurring 7-90 days after the birth.

Risks to the newborn associated with GBS

In a GBS-positive mother (one who has colonizing bacteria in the vagina or rectum) the risk of neonatal infection is 1 in 200 without any kind of treatment. With the medical standard of care, IV antibiotics in labor, the likelihood of transmission reduces to 1 in 4,000. In those infants that do become colonized with GBS there is a 10-20% chance that that newborn will develop serious complications, and 2% of all infants who are infected die. This translates to a 0.025-0.1% chance of serious illness with GBS infection, if the pregnant person receives no treatment. Risks of GBS infection and transmission go up if

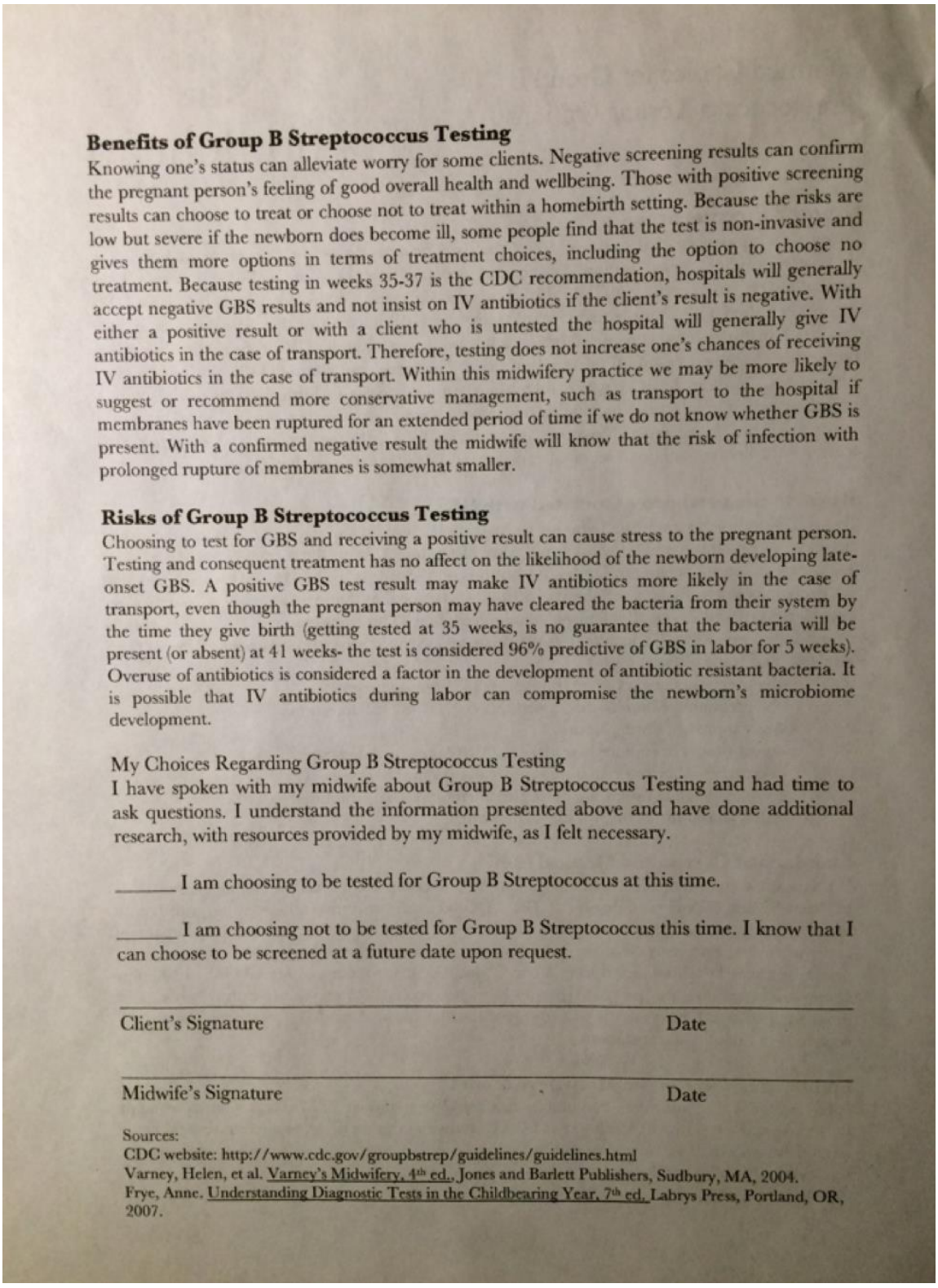
- -the pregnant person has a GBS-caused UTI during pregnancy
- -the pregnant person has had a previous baby with GBS infection
- -fever is present during labor
- -membranes are ruptured for more than 18 hours prior to birth
- -premature labor or premature rupture of membranes occurs
- -frequent vaginal exams are done after membranes have ruptured
- -artificial rupture of membranes is performed

Standard of Care in the Medical Model

It is customary in the medical standard of care to universally test for GBS in all pregnant people between 35 and 37 weeks of gestation. The CDC recommends universal screening, with both a vaginal and rectal culture, where a cotton swab is inserted in to the vaginal and rectal openings and then tested for presence of the GBS bacteria. If the test comes back positive the pregnant person receives IV antibiotics during labor, if possible at least 4 hours before birth. If the test comes back negative the pregnant person does not receive IV antibiotics during labor. If a pregnant person's GBS status is unknown, within the medical model of care, the person will receive IV antibiotics during labor.

Standard of Care in the Midwifery Model

It is standard in the midwifery community to offer GBS testing at 35-37 weeks. Clients who opt for testing and test positive can choose to use IV antibiotics during labor, or alternative treatments offered by midwives at home, or not treat the Group B Strep. These treatment options are outlined in the following document.



Benefits of Group B Streptococcus Testing

Knowing one's status can alleviate worry for some clients. Negative screening results can confirm the pregnant person's feeling of good overall health and wellbeing. Those with positive screening results can choose to treat or choose not to treat within a homebirth setting. Because the risks are low but severe if the newborn does become ill, some people find that the test is non-invasive and gives them more options in terms of treatment choices, including the option to choose no treatment. Because testing in weeks 35-37 is the CDC recommendation, hospitals will generally accept negative GBS results and not insist on IV antibiotics if the client's result is negative. With either a positive result or with a client who is untested the hospital will generally give IV antibiotics in the case of transport. Therefore, testing does not increase one's chances of receiving IV antibiotics in the case of transport. Within this midwifery practice we may be more likely to suggest or recommend more conservative management, such as transport to the hospital if membranes have been ruptured for an extended period of time if we do not know whether GBS is present. With a confirmed negative result the midwife will know that the risk of infection with prolonged rupture of membranes is somewhat smaller.

Risks of Group B Streptococcus Testing

Choosing to test for GBS and receiving a positive result can cause stress to the pregnant person. Testing and consequent treatment has no affect on the likelihood of the newborn developing late-onset GBS. A positive GBS test result may make IV antibiotics more likely in the case of transport, even though the pregnant person may have cleared the bacteria from their system by the time they give birth (getting tested at 35 weeks, is no guarantee that the bacteria will be present (or absent) at 41 weeks- the test is considered 96% predictive of GBS in labor for 5 weeks). Overuse of antibiotics is considered a factor in the development of antibiotic resistant bacteria. It is possible that IV antibiotics during labor can compromise the newborn's microbiome development.

My Choices Regarding Group B Streptococcus Testing

I have spoken with my midwife about Group B Streptococcus Testing and had time to ask questions. I understand the information presented above and have done additional research, with resources provided by my midwife, as I felt necessary.

_____ I am choosing to be tested for Group B Streptococcus at this time.

_____ I am choosing not to be tested for Group B Streptococcus this time. I know that I can choose to be screened at a future date upon request.

Client's Signature Date

Midwife's Signature Date

Sources:

CDC website: http://www.cdc.gov/groupbstrep/guidelines/guidelines.html
Varney, Helen, et al. Varney's Midwifery, 4th ed., Jones and Barlett Publishers, Sudbury, MA, 2004.
Frye, Anne. Understanding Diagnostic Tests in the Childbearing Year, 7th ed. Labrys Press, Portland, OR, 2007.

Fig. 2

The midwifery model, according to her documents, *offers* such testing and, in her practice, *offers* intravenous antibiotics during labor for treatment of a positive screening result during labor should a client wish to use them. However, intravenous antibiotics are but one treatment option for GBS in this and other practices: many midwives offer options including probiotic protocols early in pregnancy to reduce the likelihood of GBS colonization, Chlorhexedine vaginal wash or herbal suppositories in the event of a positive screening result, and limiting vaginal exams during labor. In other words, they offer more than a binary choice at the point of both testing and treatment. Alex's practice documents also take a broad view of the notion of risks and benefits of testing. They highlight the CDC's recommendations and the "low but severe" health risks to newborns who are colonized with GBS, noting that "some people find that the test is non-invasive and gives them more options in terms of treatment choices, including the option to choose no treatment." But they also alert clients to the midwife's approach of "suggest[ing] or recommend[ing] more conservative management…if we do not know whether GBS is present" and to the likelihood of treatment with antibiotics in the event of a transport to the hospital during labor. While the documents note some risks associated with IV antibiotic use during labor, it is not only the tradeoff between risks of harm associated with untreated GBS and risks of harm associated with antibiotic use that are highlighted in this analysis. Instead, possible limitations on autonomy and choice—from a homebirth midwife's recommendations to transport to the hospital once membranes have been ruptured to a hospital's automatic treatment of GBS with intravenous antibiotics, without the chance to choose another form of management or treatment—are treated as risks in and of themselves. Informed choice documentation in home birth

midwifery practices thus considers risks and benefits *to autonomy and choice*, not only of parental or neonatal morbidity or mortality. The ideal they represent thus presumes that good care guards against not only disease or bodily injury, but also against incursions on autonomy and individual choice.

The presentation of both options is crucial to many midwives: they emphasize the importance of comprehensively presenting the risks associated with standard of practice in the medical model, such as the risks of intravenous antibiotic treatment during labor, given the frequency with which, many told me, mention or serious discussion of such risks is omitted from "mainstream" pregnancy resources and even from informed consent conversations in hospital settings. But many also told me they felt it was important to include the hospital standard of care so that clients would be informed about the divergence of their own choices from the typical course of care when they chose something different—in other words, that they would be informed about that their choices had an outlier status relative to typical perinatal care. At other times, they said, the standard of care used in hospitals might be right for their clients: for many clients of a birth center-based practice that serves a relatively higher volume of low-income families and families of color than many out-of-hospital midwifery practices, opting for the laboratory Glucola drink gestational diabetes screen instead of the options offered in out-of-hospital but not hospital-based practices felt like the right choice, as it made their charts more legible to hospital staff in the event of consultation or transport with relatively little discomfort. Finally, many described the avoidance of "bias" in the presentation of this information as the most important value. Many critics characterize hospital-based informed consent as biased in its presentation of information about

interventions such as cesarean and induction that are likely to increase convenience or payments to providers. Indeed, research about parents' experiences of perinatal care decision-making has found that many parents found the information they were given incomplete or insufficient in its discussion of the risks of or reasons one might not choose possible interventions, and that they were left with incorrect information about the impact of many significant interventions (Declercq et al 2013: 40-1). Devoting attention to accurately representing the risks of practices common to out-of-hospital midwifery but not to hospital-based perinatal care aims to rectify not only the gaps in knowledge presented but the experience of receiving partial information and being led to agree with one's provider on the basis of a lack of knowledge.

When the midwife offers this handout or packet of information about the decision at hand, the invitation to the client is generally to read the packet and think about the issues involved in the decision in preparation for a fuller conversation later in care, usually at the next visit. Midwives encourage their clients to talk about their decisions with family at this time, and often ask their client's partners, if they are present, whether they have questions. The presentation of these documents, like their preparation, is also designed in such a way as to encourage choice and avoid coercion or bias: clients are often encouraged to take their time, consult family members or friends, discuss their decisions with partners, and read other sources, qualifying the completeness or authority of the document itself in the moment of its presentation by signaling that more might be necessary to arrive at a truly informed choice than just considering the facts in that document.

The follow up conversation at the next visit usually opens with the midwife

asking the client whether or not they have had a chance to read over the information, or with the client saying the issue was one of the things they wanted to discuss at the beginning of the visit. Midwives then frequently verbally talked through some of the issues in the packet. In Alex's practice, she generally began with explaining that Group B Strep is a bacterium that many of us have in our guts along with lots of other flora. "Like E. coli?" one client asked at this point in the conversation. Yes, Alex said, not unlike E. coli, where the problem is that some strains are really good competitors and can crowd out other flora. GBS, she would go on to say, is a good competitor like that. It can colonize the vagina in pregnancy and when it does, it can then be passed to newborns during labor and birth once the membranes of the amniotic sac are ruptured. Because babies are born with sterile guts, she would explain, exposure to a good competitor like GBS can be really dangerous. Alex would then talk through both the absolute and relative risks associated with GBS, explaining that of the babies whose mothers have Group B Strep present in the vagina, some will contract the infection. Of those babies, some will get sick, and of those babies who get sick, some will develop sepsis, and some of those who develop sepsis die. "So it's relatively rare, but when it happens, it's really serious," she'd say. Another client stopped her here, asking, "How would that show up in labor?" "It could show up in an increased heart rate," Alex said, and explained that if the client wanted to test and received a positive result, they use IV antibiotics in labor. Or they could do other things: Alex said she might recommend "gently interventative" things like getting up and moving around, herbs or homeopathics earlier in labor if she knew someone was GBS positive—or if she didn't know, she'd treat the situation as though someone was positive. A third client stopped an informed choice conversation there,

asking to do the test that day instead of waiting until the next visit. If her labor began in the next week, she was thinking about going to a friend's house in a neighboring state whose regulations allow midwives to attend births at an earlier gestation than the regulations in her own state allow, and she wanted to know her GBS status before labor. With another client, the midwife brought up GBS status again later in pregnancy when the client asked whether she would do a cervical exam to measure dilation. "I can if you want," the midwife said, "especially if you remain GBS negative."

Not only do informed choice conversations involve discussion of different issues for different clients, they also last dramatically different lengths of time. In one visit, a client who was having her third baby with the midwife and was near her due date laughed as Daniella pulled out the informed choice forms for vitamin K, antibiotic eye prophylaxis, and metabolic and hearing screenings. "You know I'm not doing any of that stuff," she said. I had just begun fieldwork with Daniella, and she turned to me, clearly concerned with emphasizing that this was *not* usually how things unfolded. "This is her third baby, so she already knows all the risks and benefits," Daniella told me. The client laughed again. "I sure do," she said, "and I'm not doing any of that stuff." Daniella passed her the signature portions of the forms to sign and the conversation moved on to the pelvic discomfort and birth tub location concerns the client wanted to discuss.

At other times, the conversations are quite lengthy and the midwife is deeply involved in the client's process of discernment. Kayla, one of Alex's clients, described herself as anxious about her first pregnancy. She often brought extensive lists of questions and issues she was nervous about to visits, and she usually wanted to discuss each issue several times. When Alex brought up gestational diabetes screening, the

conversation was characteristically long. Alex told her in detail about all four of the screening options offered in her practice. Kayla had many questions: what would an atypical screening result indicate? Would different screening methods' results mean different things? What would come next if she received an atypical result? Would different screening methods leave her with more or fewer choices in the event of an atypical result? How long would it take to complete a screen with each method? How would she find out the results? Alex answered all of her questions. Kayla wasn't sure what she wanted to choose, and Alex helped her sort out her desires by pointing out when Kayla was articulating a desire or priority about her care and sometimes reminding her of other care priorities and reflecting those desires back to her: "it sounds like the speed with which you'll know results is really important to you." Kayla thought aloud about each option. She liked the idea of getting the test over with, and that speed would be afforded by picking the standard Glucola drink and blood draw in the lab or the "breakfast challenge" blood draw Alex could do at home after a carbohydrate-heavy meal. But, she said, as she thought about the experience of waiting to find out whether she had had a normal screen, that felt like the most anxiety provoking thing about the process. She decided on testing with a home glucose monitor several times a day for a few days, so that she could know immediately whether she was getting a lot of high readings. Alex made no attempt to hurry her, but she also made no suggestions that Kayla ought to do this work of thinking through options and identifying priorities and desires on her own.

Robust informed choice, many midwives emphasized to me, involved more than just talking about the specific clinical issues at hand. One midwife, Hannah, told me she

frequently began conversations without talking about anything so specific as group B strep. "Sometimes I start with just asking them…When they're making decisions, do they feel better knowing they did all the preventative things they possibly could, even if some of those preventative things could have a negative impact? Or do they feel better trusting that everything's going to be okay and if something does go wrong, we know that was a really low chance that it was going to go wrong in life, and we took our chances?" She'd ask about other choices: "Do you always wear your seatbelt? Do you always wear a bicycle helmet? Do you abide by expiry dates on your yogurt?" She wanted, she told me, for clients "know the risk cultures[27]" of their own families. She found that through these conversations, parents sometimes discovered they disagreed with one another. "What's difficult is when one party feels really differently than the other. More often than not, the non-gestational parent is like, 'Not my body. Whatever, make your decision.' But sometimes, they're like, 'No, these antibiotics are really important. I know you don't want to take antibiotics but they're really important [to me].'" Hannah emphasized that legally, she knew she was supporting a decision to be made by the gestational parent. "But in reality," she told me, "it's a conversation in the context of the family, and it's in the context of making decisions for this person that's not even born yet." For Hannah and others, informed choice needed to not only settle the questions of which clinical options to elect, but also directly engage more abstract patterns in families' choices—and the gaps or conflicts between parents' preferences.

Prenatal informed choice, then includes all of these elements: detailed

[27] The term "risk culture" is also associated with social scientific debates about how to conceive of risk. The term was introduced by Douglas and Wildavsky (1983) to explain how groups choose which risks to avoid, work to prevent, ignore, or prioritize.

explanations and quick check-ins, supporting parents in matching clinical care to regulatory realities in order to facilitate the birth experiences they want, "unbiased" or value-neutral presentation of complex information, descriptions of the ways it might look or feel to select a particular course of care, support with self-reflection, identification of priorities, and negotiation of those priorities between partners. These prenatal informed choice conversations treat truly free and informed choice as a process that not only requires different conversations for different people, but that takes skilled, complex work on the part of the provider to accomplish. This work appears in perhaps its simples form in the prenatal visit, when the model of the lengthy appointment can help relieve the soft coercion of time pressure. Choice points during labor and birth, of course, present an additional set of challenges.

Informed Choice During Birth

Time pressure and the presence of additional institutions—notably hospitals to which a client might transport--change the scene of informed choice during labor and birth. A birth story from Alex's practice[28] illustrates this difference: Kelly was in labor with her second baby. Things had been progressing relatively typically. Kelly was feeling an urge to push, but she was blowing throug her contractions, avoiding pushing to keep from irritating a cervical lip and a bit of anterior cervical swelling that Alex had felt in a cervical exam. Alex, meanwhile, was listening through a contraction, monitoring the fetal heart tones, when she heard a single deceleration in the baby's heart rate. "It was possible that that was related to the baby's head being squeezed as it passed the pubic

[28] This birth occurred during a break in my fieldwork. While I was present for some of the parent's postpartum care, Alex told me the story of the birth itself.

bone," Alex said, describing a fairly common pattern in fetal heart tones. "But it was low enough that even if that was the explanation, we kind of wanted to do more." She and the other midwife helped Kelly get on her left side, allowing maximum oxygen to pass through the placenta, and they gave Kelly oxygen, and then the other midwife called 911. "We didn't hear any more decelerations from then on through the birth of the baby," Alex told me. "But we didn't know if there were going to be any more. And we would always call in that scenario." They also phoned the nearest hospital to let them know what was happening, and what Alex called a game of telephone ensued: the midwife was put on hold, transferred between general switchboard, clinic receptionist, and obstetrician. The conversation with the obstetrician was fairly calm, and she and the midwife agreed that the care team at home would keep the obstetrician posted about whether the baby was born quickly or they were coming in. Alex did another exam, finding that the baby's head was two stations[29] closer, "very, very much right there," as she put it. Kelly wanted to stay home, and it seemed clear to everyone that the baby would be born soon enough that transporting would complicate the situation rather than helping. Kelly started to push.

Meanwhile, EMS had arrived outside. Two fire trucks, two ambulances, and a small crowd of people were parked outside the family's house. Alex and the other midwife explained the situation to the EMS team, describing Kelly's efficient pushing and stable vital signs and the baby's reassuring heart tones following that single deceleration. As Kelly pushed, the EMS team seemed to "get more and more interested,"

[29] Fetal station is a measurement of the fetus's descent through the parent's pelvis during labor. It refers to the proximity of the head or other presenting part of the fetus is to the ischial spines, or sit-bones, of the parent.

as Alex put it, coming further and further into the room and asking questions that weren't terribly relevant to the moment of labor Kelly was in: was she effaced? Was there a cord around the baby's neck? They seemed eager, Alex said, to transfer care to the hospital, and phoned the labor and delivery team at the hospital, telling Alex and the other midwife that the hospital wanted them to transport right away.

At a certain point, Alex told me, the way Kelly's tissues were stretching, along with the fact that there had been one deceleration and the baby might be getting stressed, made her think it made sense to cut an episiotomy. Episiotomies are quite rare in homebirth midwifery practice: Alex had never cut one in five years of her own practice. Other midwives told me they could count on one hand the episiotomies they had cut in decades of attending births. And many parents choose homebirth because they want to avoid interventions like episiotomy. Yet Alex and the other midwife felt this decision could not be afforded a lengthy conversation given the time pressure generated by both the possibility that the baby was stressed, indicated by the deceleration she had heard, and the EMS team's urgency. Alex told me she consulted with the other midwife, a trusted colleague, and while prenatal consultation with another midwife might involve a lengthy phonecall or research, this consult looked quite different. The other midwife offered the birth tray of instruments and medications to Alex, and Alex held up the scissors. The other midwife nodded, and Alex told the family what she was going to do.

Alex and I talked about this moment for a long time. It was different, she said, from the way she'd approach a choice prenatally, and really only applied to a few very urgent scenarios: episiotomy when tissues seemed to be the only impediment to progress of a baby who had previously showed signs of distress, use of medication to stop a

hemorrhage, and resuscitation of a newborn. "We talk prenatally about those kinds of things—that there are certain interventions and moments when I'm going to make a clinical call, and I'm going to tell them that that's what I'm doing, and it's less of a conversation and less of a negotiation if it's an urgent and complex situation." To an outside observer, this might appear to be a moment in which informed choice drops away as the provider "makes a clinical call" with less collaboration. But Alex emphasized that she took steps both prenatally and in the moment to mitigate the extent to which this loss of choice occurred. Prenatally, she explained, she had conversations about these possible scenarios, allocating time to "process" their feelings and preferences. For a client who tells her in this prenatal conversation that they would prefer herbs to medication as hemorrhage treatment, she said, she could "have her own algorithm" of what seemed like the right tool and what the person's preferences were, and would reference both her judgement and the person's preferences as she discussed the choice point in the moment and actively seek out ways to offer parents their first choices of treatment. "I know you would like to use yunnan bai yao if possible for this," she might say, "and to me, this looks like a situation where Pitocin is more warranted. I'm going to draw up this dose right now, and if you want to take this capsule, we can see what happens in the next 30 seconds while I draw it up." And, she said, as she had in the case of Kelly's episiotomy, she'd make sure to "really make eye contact" with the parent and be certain they were hearing her, then pausing to "give them an opportunity to say, 'I really don't want that,' or 'Woah, can we talk about that.'" Reflecting on her in-the-moment communication at Kelly's birth, Alex told me, "I'm aware of the fact that she's doing really, really hard work in that scenario."

The moment of birth—or even the moment of somewhat complicated, urgent treatment in birth—is not a state of exception to informed choice. But given the fact that an urgent, complex situation in which one is working exceptionally hard might be a difficult time to discern one's own desires and priorities, informed choice in birth demands preparation. In addition to prenatal monitoring, retaining the greatest possible choice for parents demands specific management of time during labor and birth, or what Alex monitoring labor with an eye to "pink flags" rather than "red flags." Noticing a "pink flag," she explained, allows her to have a conversation about possible interventions "before they are a necessity." An earlier conversation allows her to present more options. "Almost always, when I think something needs to be done," she said, "I will say, 'There's a number of options right now, here are some of them.' And then if I think something needs to be done, I will say, 'I think something should shift right now…I think we should choose one of those things at this point, or if you have a different idea, that's great.' " Extremely attentive monitoring, in other words, allows for more choice points, and for choice points in which options are multiple rather than binary. While midwives often emphasize that more attentive monitoring and earlier intervention allows for gentler intervention, this combination is also prized for its ability to maximize choice.

Alex also told me that she uses the language of "clinical recommendation" very rarely. "I don't take that lightly," she said. "And I don't usually use the word recommendation without saying 'clinical recommendation' because I want to be super clear that it's not my opinion, or my preference. It's that my clinical picture is suggesting this." Certainly the language of clinical recommendation might be echoed by any healthcare provider. However, Alex—and most other midwives whose practices I

observed—used this language very rarely, more commonly turning to extremely value-neutral language, “one thing people sometimes find useful in this situation,” “a couple of approaches people sometimes take are,” “my clients have had a lot of success with this.” In general, midwives were committed to this language because it skirted the issue of the soft pressure to defer to expert opinion. But many also told me that they felt this pattern of prenatal communication served to set a reference, meant that clients recognized the use of terms like “clinical recommendation” during labor, birth, or the immediate postpartum period as a signal that something had shifted or become more urgent. Establishing a pattern of communication that is consistent enough to make deviations recognizable serves as a tacit kind of prenatal preparation for informed choice in birth.

This kind of communication, some midwives emphasized, could lead not only to different emotional outcomes but to different birth outcomes. “I really think,” Cheryl, a retired midwife, explained to me, “that when, say, the woman really needs to push harder because the baby's in distress and they're on the cusp and *you've got to do this now*—they hear the change in my voice and they do it and everybody's fine. And I'm not saying that it's always that way, but it was in my experience.” By contrast, when she worked as a doula, Cheryl said, she saw providers who did not practice in the kind of deep relationship she fostered with clients handle those moments very differently. “That’s the moment where they give a shot or cut an episiotomy or now we're going for a c-section,” she told me. “It kind of makes you realize, in some ways , the outcomes are created.” Building relationships that enabled that level of subtle communication, Cheryl suggested, facilitated choice by keeping available options such as unmedicated or vaginal birth. Cheryl and others did not dispute that there were times that a midwife needed to assess

the situation and be more directive. However, they emphasized that even the ways in which they did that preserved more choice—more options, and more chances to make choices—for parents than were possible in a medical model of care.

Another part of that necessary preparation for informed choice in birth is institutional, as midwives must often inform and support clients about not only the realities of their body's progress through labor but also the regional healthcare context, including those elements of that context that midwives and parents find profoundly objectionable. For Daniella, a midwife in Louisiana, clients could not be fully informed unless they knew how were likely to be treated by hospital staff in the event of a transport during labor or transfer of care. I saw her discuss this many times during prenatal visits, but the issue was even more marked in a story she told me of a time she was surprised to discover a baby in breech position toward the end of labor. Breech delivery is out of scope for Louisiana licensed midwives, so Daniella was required by regulation to initiate a transfer out of her care for the client—despite the fact that the baby's arrival was imminent. But she knew that the hospital near the client's home had a terrible record of patient mistreatment.

> *I had to give her the choice, and I did give her the choice. I was like, I can take you in now, we can initiate transport in private vehicle. We can be there in 10 minutes, that's the quicker way. Told her the risks, the benefits. Or I can call EMS and you can push your baby out. It's up to you…And so she chose the C-section, just like, no, I want to take it. And that's her right. That is her right to choose. But I let her know that was going to get treated poorly. She's like, it doesn't matter. I don't want to take the chance. I was like, that's fine, and so we did [the transport].*

She probably regrets that now!

I told her the risks, the benefits. The midwife approached the question of what kind of treatment the client could expect to receive if they chose to transport similarly to the way informed choice packets include the risks and benefits of antibiotic prophylaxis for screening and treatment options like Group B strep. She had carefully worked to present all the information she had available, without inflecting her delivery with her own preferences or "biases." The transport had, in fact, gone poorly: the midwife told me that upon arrival, the obstetrician on call had become irate. Red-faced, he yelled at the patient, "you're at the hospital right now, you have to do whatever we say," and then "forcefully checked her"—gave her a vaginal exam without consent or warning. Daniella told me that the client was, months later, struggling with PTSD, and the midwife was struggling with the question of how to adequately incorporate the risk of harmful treatment by hospital staff into her informed choice process.

The complexity and urgency of birth could be cited as a reason to simplify matters by delegating decision-making to the experts or routinizing care. Instead, the ideal of informed choice guides homebirth midwives to find ways to retain collaborative decision-making and individualization. Informed choice thus emerges as a process that develops over time, cannot be carried out momentarily, and is conditioned on relationship. It also cannot be carried out in the absence of deep mutual knowledge: the client's knowledge of what language is typical for the provider to use and what language indicates a new level of urgency; the provider's knowledge of the client's desires and priorities about communication, particular care options and ways of proceeding through decisions, and institutional context. Informed choice in birth is thus dependent on the

structure of prenatal visit, including its conditions of unhurried time and undivided attention on the part of the midwife.

Difficulties and Contradictions

Of course, in practice informed choice does not always unfold without difficulty or contradiction, even when providers prize its value and orient their practices towards the goal of achieving it. The story of the bad breech transport was not an anomaly: while it usually took some significant time and trust, midwives frequently told me they struggled with various dynamics of living out the mandate of informed choice in their practices. Informed choice processes could become difficult when informing clients conflicted with other core commitments of homebirth midwifery, when clients' wishes did not provide a clear roadmap for midwives to follow, when clients and midwives disagreed about what information was good information, and when, relatedly, midwives were uncomfortable with clients' desires.

One conflict between informed choice processes and other guiding principles of homebirth or community midwifery concerned the difficulty of giving clients good information without provoking fear. The notion that the experience of fear interferes with the physiological process of birth features prominently in common sense of the wider conversational space surrounding natural birth or alternatives to standard obstetric care. This notion was made famous with the midcentury publication of Grantly Dick-Read's *Childbirth Without Fear*, which famously popularized the idea that "the natural tension produced by fear influences those muscles which close the womb and oppose the dilatation of the birth canal during labour" (Dick-Read 2006 [1942]: 39). "Fear, Tension,

and Pain are three evils opposed to the natural design," Dick-Read wrote, recommending that "if fear, tension, and pain go hand in hand, then it must be necessary to relieve tension and to overcome fear in order to eliminate pain"—and thus to facilitate the progress of labor and birth. Particularly in the out-of-hospital setting, where pharmaceutical pain relief is unavailable, avoiding fear is frequently described as a matter of safety. Fear also appears as an impediment to free choice. Obstetricians are sometimes described as "scaring" parents into cooperating with their preferences or encouraging parents to make what Cheryl, a retired CPM, and Ellie, a parent who had chosen homebirth with an unlicensed traditional midwife, called "fear-based" decisions. Yet even providers who are deeply committed to avoiding scaring parents into particular care options and to facilitating opportunities for parents to confront their own fears during their perinatal care experiences sometimes found themselves having to deliver news that could be frightening in order to ensure that their clients were fully informed. For instance, a client who was 39 weeks pregnant with her third baby arrived for a prenatal visit one day. After the usual conversation—for this "multip," or parent who has given birth before, preparations for childcare for her kids during the postpartum period were a paramount concern—she leaned back on the brocade couch for the midwife and student to "check on the baby." The midwife slid a tasseled pillow under the client's knees and began the Leopold's maneuvers, palpating the client's belly and narrating what she felt, as usual. "I feel a back here, I think," the midwife said, "and I think this is a butt. I think a feel a butt over here." Her hands traced a horizontal line across the client's abdomen and the room grew quiet. The baby and turned and was now transverse—lying horizontally across the uterus.

The midwife calmly told the parent that the baby was lying side-to-side, perching next to her on the couch and mapping the baby's shape on her belly. Then she began to talk softly about the implications of that fact: that she couldn't have a homebirth if the baby was transverse, or a vaginal birth at all; that she had some options for encouraging the baby to turn, but that there wasn't much time left in which to do that. The midwife told her about specific doctors who might be able to perform a procedure called an external cephalic version that might help the baby turn. Everyone moved slowly, taking lots of deep breaths, and both the midwife and the student kept their body language and their tones of voice sympathetic but not urgent. The client cried quietly for a while, and the student offered her tissues. "We know this really isn't what you were hoping to hear," the midwife said. Then they reassured her that the baby's heart tones sounded great, and she took a couple of deep breaths and left to think with her husband about the question of which providers she might try to see for a version. A few hours later, the other midwife in this group practice returned from a break and the team sat down to talk about the case together. As they talked, they all began to express more discomfort with the situation. The midwife and student who had conducted the visit worried that they hadn't conveyed the urgency of the situation well enough. They wondered if the client was really fully informed. "But I didn't want to scare her," one said, and everyone agreed.

Informed choice also became difficult to practice when clients' wishes were themselves in conflict. At one birth in Alex's practice[30], a client who had maintained a strong preference for avoiding all medications and minimizing testing during her pregnancy had a significant, fast hemorrhage or bleed following a dystocia. As Alex told

[30] This birth was one I missed when my car wouldn't start!

the story during a regional peer review, I remembered from prenatal visits that this client had declined the part of the blood work schedule that generally checks iron levels later in pregnancy. Without knowing whether the client was anemic, Alex didn't know just how risky significant blood loss would be for her. Yet she knew the client wanted treatment for any significant postpartum hemorrhage, because they'd talked about it prenatally, and the client had been clear that she would want medication and to avoid the difficulty of a postpartum period marked by severe anemia. Alex wanted to give her the care she wanted. She also knew the client knew her care would be more conservative in the absence of testing. She approached the woman, holding out the syringe of Pitocin she'd drawn up. But the woman shrank from her, scooting her hips backwards and leaning away. Alex demonstrated as she related the story to the assembled midwives in the peer review. The midwife next to me let out a long sigh.

Alex said the moment felt incredibly difficult: she wanted to honor the informed choice the client had made prenatally. She also knew that the hemorrhage might have particularly severe effects on the woman's blood iron levels—a possibility she could not rule out given that the client had declined blood work. But, she said, the client's body language in the moment was not that of a person choosing Pitocin. It screamed "no." The assembled midwives in the peer review shook their heads sympathetically, agreeing that she'd done the right thing—but they also all agreed that this kind of moment felt awful and wrong, and often demanded extensive conversation with a client during the postpartum period.

Something similar unfolded during Tania's birth. When she had been in active labor for several hours, Alex began to think about whether additional measures might

make sense to guard against the kind of atonic uterus and hemorrhage she had experienced with her first birth. Alex and I debriefed what happened next as we drove away later that morning after Tania's son's birth. "Everything felt normal in terms of progression, and things still felt safe," Alex said, "but I was aware of the fact that [these were] possible complications that could come up, and of the fact that she was concerned about that." When Tania began to say, "I don't know what to do," Alex started to offer options: she could change positions to help increase pressure, which might help with dilation and could encourage her water to break. Or Alex could even artificially rupture her membranes.

Alex felt somewhat uncomfortable introducing these possibilities: Tania had been incredibly clear in her prenatal visits that she wanted her labor to be "as unassisted as possible," artificial rupture of membranes was certainly not in her birth plan, and it certainly wasn't in line with Alex's sense of what she called Tania's "general way of making choices." Alex felt torn between wanting to avoid even a sense of pressure to accept the interventions she was offering and wanting to make sure that Tania had all the information and knew about all the options. "It felt a little like when nurses come into someone's room—when they are very clear that they want to have an unmedicated birth—and just keep offering pain medication in a way that feels pushy, or to the people within the experience [of the birth] feels like a vulnerable moment to have someone suggested something," Alex said. "And that said, [artificial rupture] was an option. And it was one of the things that felt relevant to bring up based on the fact that, for a multip who had a pretty speedy first birth, this was not a super fast active labor and was not a fast transition. And there's like a lot of possibility—even when someone's reserves are

strong—for getting exhausted in that scenario. It didn't feel like it was like close to the point of clinical maternal exhaustion. But that you know, certainly was one of the kind of things on my differential diagnosis radar." In other words, an internal tension between the *informed* and *choice* elements of the informed choice notion emerged during Tania's birth. In a setting in which even repeated mention of a possible intervention can feel—and is often understood to be—coercive, fully informing a parent about their options can become difficult. The job of the midwife during labor involves the management of multiple, sometimes competing priorities: parents' desires, priorities and the conflicts between them, as well as the conflicts between informing parents and avoiding soft coercion or the feeling of pressure. As Alex said, "'as unassisted as possible' doesn't mean no intervention is necessary. And so that is my job: to make that call."

Conclusion: Informed Choice or Shared Decision Making?

In 2018, I was sitting in a Maine conference room listening to a presentation by Courtney Everson, who was at the time a faculty member at the Midwives' College of Utah. The workshop I was attending was part of a cumulative annual series of workshops aimed at supporting practicing midwives' skills at "evidence-informed practice," abbreviated in the workshop as "EIP," with both abstract principles and specific tools and workflows. Everson opened the workshop with a review of past sessions: this workshop, which focused on integration of research evidence with midwifery practice workflow, followed one about integrating EIP in professional communities. But the first workshop, held in 2016, had made specific reference to midwifery's clinical decision-making style. "Walking the Labyrinth: Research Literacy, Evidence-Informed Practice, and Shared

Decision-Making," Everson read aloud, and I noticed the conspicuous absence of a phrase I might have anticipated I'd hear: informed choice. I decided to keep track, and at the end of the workshop, my notes featured the phrase "shared decision-making" three times. Informed choice, on the other hand, hadn't come up at all. What Everson referred to as "practice documents" would, in most of the practices where I worked, have been called "informed choice documents," and where she described workflows for to responding to client concerns or questions with research, I saw what I would have expected midwives to call informed choice processes.

A few months later, I was on a long walk with Penelope, a midwifery student at a prominent independent midwifery school—a midwifery school whose director, in fact, had emphasized the centrality of informed choice to their curriculum in conversations with me several months earlier. The binary between "only birthing people know what's right for them" and "the doctor knows best", Penelope told me, had begun to seem not terribly useful. "Does this mean that as long as someone is fully informed about risks and benefits that we should let people do what they want? What are *our* boundaries and what is the role of *our* clinical judgement?" Penelope wondered aloud, relating a story she'd heard from another teacher about leaving a birth after realizing that the family was ignoring her clinical advice and making choices with which she was not comfortable. "This profession, in its newest formation," she said, "grew out of a real desire to support people's autonomy. But how much are we actually supporting their autonomy when we're letting them do things under our care, under our supervision, that we don't actually agree with?"

Partway though the workshop at MANA, Everson had asked midwife participants

to call out some reasons they found it difficult to integrate research into clinical care. It's hard to gauge a client's understanding of the research, one participant had offered. It's hard, another had chimed in, to gauge a client's *readiness* to receive the research. I watched one midwife, Sylvie, navigate these challenges one day during a prenatal visit. Sylvie and the 38-weeks-pregnant client chatted for a few minutes about making time to do some journaling in response to the prompts from the book *Birthing From Within* before labor before Sylvie began to ask about a few remaining care decisions. "Did you think more about Vitamin K?" The client responded, rather cheerfully, that since she didn't plan to circumcise, she planned to decline all Vitamin K unless she "felt it was necessary after birth" because of something like bruising. Sylvie kept her voice even. "There's some potential that even without those things, the baby could have [Vitamin K deficiency] bleeding," she told the client. The client and Sylvie's student Becky talked for a few minutes about the client's concerns: she didn't like the high dose, or the fact that it was synthetic, and she knew some people said there was a connection to jaundice. Becky asked if the client had read the Evidence Based Birth article that she and Sylvie had recommended. "I've been doing a lot of reading," client said, and laughed that she didn't know if that was a good thing. Sylvie chimed back in. "I think doing at least the oral is a good idea," she said, so gently that had I not been in the field for over a year at that point, I might not have caught that I'd just heard a clear clinical recommendation. She explained why infants need Vitamin K supplementation physiologically, telling the client, "I don't want you to feel pressure from us. If you were circumcising, I'd strongly recommend it." By the end of the conversation, the client had mentioned doing oral supplementation, and was chatting about making it out of Scorpio and into Saggitarius.

When clients seemed to take risks relatively lightly, to be relatively disinterested in engaging with the proffered evidence, or to misunderstand its significance, the notion that "only birthing people know" what decisions are right becomes challenging. Penelope related a story about a teacher. Informed choice, the teacher had said, is often "throwing a bunch of information into this unreliable machine—our brains—and expecting a rational result." Penelope emphasized that she didn't mean to be offensive about anyone's brains—but she just wasn't sure that clients arrived at the best choices without more guidance. "Ask any person, 'can you tell me right now everything that's best for you?' You don't know! It' a process of finding that out," she told me. She called the informed choice approach that made her uncomfortable "I'm going to empower you and you have to make this decision and I'm going to give you great information and you have to do it yourself," arguing that instead, the skills of finding good answers, asking the right questions, and avoiding universal cognitive biases in decision-making were challenging ones to learn. Like Everson, she'd begun to focus on the notion of shared decision-making. She'd read a controversial editorial by Tekoa King, a prominent nurse-midwifery educator. King and others had argued in this editorial that midwives were too frequently using models of patient-centered care such as informed choice and shared decision-making that are premised on equipoise, in which multiple options are clinically appropriate, in situations in which evidence does not actually clearly establish equipoise, or in which evidence actually indicates that "outcomes of treatment outweigh possible harms associated with receiving or declining the treatment" (King et al 2018). "Equipoise in clinical care is actually fairly rare," King and her coauthors had contended. And, Penelope underscored, the research she'd read on what birthing people want from

their providers suggested that knowing about providers' clinical recommendations—"what their midwife thinks"—in situations of *non*-equipoise was in fact a high priority.

Penelope also emphasized that she felt that a shift away from the models of birthing-person-knows-best shared decision-making that I'd observed might be crucial for professional sustainability. Midwives who were considering leaving the field often told me similar things. One midwife who had worked for several years in a group midwifery practice was leaving the field in part because she'd found she simply couldn't square her approach to shared decision-making or informed choice with the approach of the midwife who had established the practice. She found the forms she was expected to use challenging. If she wrote them herself, she said, she would spell out what could go wrong more clearly, and think more specifically about how to communicate risk. Instead, she felt she was "being asked to take on that responsibility"—without the kinds of institutional arrangements used in hospitals to clearly delineate responsibility. "It doesn't feel good," she told me. "It feels like too much responsibility for me. So that's why I'm exiting the profession." Penelope, at the beginning of her career, put it similarly. "At the end of the day," Penelope told me, "if there's a bad outcome, your ass is on the line, and that's a real thing for your career—and I mean that [then] you can't serve all the people who want the care you provide."

The field of professional homebirth midwifery stands, then, at a crossroads about this ideal of informed choice. Providing care guided by notion that "the woman [or birthing person] is the primary decision maker in all matters regarding her own health care and that of her infant" (MANA Functions, Standards and Qualifications 2005) might, on its face, seem both obvious and relatively simple. Yet the provision of informed

choice in practice can be challenging enough that midwives find its weight unbearable. As more and more midwives encounter its limits, contradictions and difficulties, models of shared decision-making may rise. Meanwhile, these models, unlike informed choice, are beginning to be embraced in various ways by a wide range of healthcare providers, including medical perinatal care providers (see Pieterse, Stiggelbout, and Montori 2019, Gee and Corry 2012), though some analyses of the quality of shared decision-making processes in routine care have found poor implementation (Scholl, LaRussa, Halweg, Kobrin, and Elwyn 2018). As shared decision-making increasingly becomes a concern in obstetrics, will the gaps between the ways obstetricians and homebirth midwives describe their work narrow? Will their clinical practices come to look more similar? Questions such as these will be key in the study of medical and demedicalized perinatal care—and the relationship between them—in the future.

Chapter Three

Counterprofessional Expertise: "A View From Somewhere"

Introduction

This chapter analyzes the distinctive approach to knowledge employed by the contemporary professional homebirth midwives with whom I conducted clinical ethnographic research. It also coins two terms with which to analyze professionalization and the contemporary politics of expertise. First, I show how the commitment to individualized care at the heart of the occupational mandate of professional home birth midwifery is frequently expressed in a commitment to informed choice, and argue that this practice of individualized care is a key marker of the professional jurisdiction contemporary non-nurse midwives have attempted to claim. Next, departing from homebirth midwives' high value on a distinctive understanding of what it is to "be unbiased" in guiding decision-making processes, I characterize informed choice as a kind of abstract knowledge upon which homebirth midwives distinctively draw. I demonstrate the approach to knowledge informed choice employs, including its central aims of mitigating the power of expert knowledge and its distinctive epistemic multiplicity, and I describe its affinities—and active exchange—with feminist and critical social scientific approaches to epistemology. Arguing that informed choice is an example of a *normative epistemology*, or an approach to how knowledge should be recognized, made, and deployed, I examine the use of social scientific knowledge in credentialing the normative epistemology of informed choice—and the perinatal care shaped by its application. After tracking patterns in when claims to objective truth appear as *appropriate* in community

conversation, then explore a key challenge of the normative epistemology of informed choice: that of constraining knowledge, or identifying falsehood. Finally, I characterize contemporary professional homebirth midwifery as a *counterprofession*. I define this new concept and argue for its utility in the study of the contemporary landscape of expertise and professions.

Doing My Job Right: Informed Choice as Occupational Mandate

The informed choice approach to perinatal care is radically particular, especially in comparison to the rule-bound, routinized and mechanized understandings of birth that many commentators have noted predominate in obstetrical texts, training and practice (Morris 2016, Martin 2001: 54-7, Katz Rothman 1982). This personalization is also often explained in terms of physiology and the individuality of body and desire, as the goal of this turn towards the physiological is not to extrapolate general recommendations from many cases, but to privilege what makes each case different and present a broad range of possible physiological states and measures to support or alter those states that are ultimately mediated by individual instinct, feeling and desire rather than some kind of aggregate trend. I sometimes tried to prod midwives about whether they believed there was a right way to understand the issues informed choice processes target, or a right decision to make—whether some form of gestational diabetes screening was just better than others, for instance. Though homebirth midwifery practice was characterized by routines, and though midwives sometimes shared at other times that there were approaches to pregnancy they felt were unsafe, in response to these questions, they patiently and repeatedly explained to me that there simply was no right answer and that

they simply could not know what was best for any individual client. Then they'd often explain to me why different answers were right for different clients: for a client who is concerned about a family history of gestational diabetes, for instance, the option of monitoring blood sugar throughout the day with a glucometer and keeping a diet diary to closely track one's body's response to particular foods or combinations of food, rest, and activity might be best because it offers by far the most fine-grained information. But for a client who has a powerful needle phobia, that option might introduce more needle anxiety than the gestational diabetes anxiety it would quell, and a single blood draw following a meal or glucose drink in action might be better. For the client who fears retaliatory treatment in the event of a possible hospital transport, it might be the best choice to opt for the Glucola drink and blood draw that is typically used in obstetrical practice for the sake of avoiding multiple needle sticks and making the prenatal record easily legible to hospital staff. Because the particulars of body, institutional context and feelings combine to produce an endless array of possibilities, many midwives frequently told both me and their clients that they felt that variety in the decisions clients made about the various options during prenatal care was a sign that things were going right. "If all of my clients chose the same things," Alex would say, "I'd know I wasn't doing my job right, because different things are right for different families. Everyone needs a different birth."

The logic of the ideal of informed choice turns to the body's individuality in order to reject the arrangement of expertise in medical prenatal care in favor of a radically personalized and individual approach that operates against the idea that the provider knows best. Instead, the value of individualized care—most frequently expressed in the

practices where I conducted research as a commitment to informed choice—is at the core of the occupational mandate imagined by out-of-hospital or direct-entry midwifery. An occupation's mandate, according to scholars of work and occupations, serves as the "cultural underpinning" of its legitimacy (Fayard et al 2017: 270) and has an essentially normative or moral character (Hughes 1993 [1971]: 288-9). To borrow Alex's terminology, the content of an occupation's mandate answers the question of how one knows if one is "doing one's job right," with its definition of the occupation's abstract values, "proper conduct", and "beliefs" (Hughes 1993 [1971]: 287, Fayard et al 2017). That proper conduct can, of course, include the technical elaboration of proper task performance, but the term is particularly useful in the case of homebirth midwifery because in its attention to the more inchoate "orientation" to work (Faulkner 1978: 99), it reveals what *is* standardized in an occupation that prizes particularism and individualization. In a domain of work in which prenatal visits might look to an observer like a lot of chatting and care during birth often looks like waiting and watching, attention to action that is guided by this occupational mandate also helps make visible the knowledge, tasks, and skills associated with informed choice.

Informed Choice Professionals

Informed choice is a hallmark of contemporary out-of-hospital midwifery care: as one director of an independent midwifery school told me, it is the key guiding commitment by which contemporary direct-entry homebirth midwifery distinguishes itself from its others. These others include both the typical hospital-based obstetrical care, but also hospital-based nurse-midwifery care and the midwiferies that preceded or

developed independent of obstetrics. As such, the work of facilitating informed choice processes constitutes the core of contemporary professional midwifery's occupational mandate[31].

That is my job: to make the challenging decisions about how to present information to avoid coercion and facilitate choice, to balance the internal contradictions between fully informing a parent and frightening them or pressuring them, to manage parents' conflicting desires and wishes, to arrange time, physical space, and language in ways that organize the scene of prenatal care and birth to cast parents as agents and prepare them to do the work of labor and participate in informed choice in birth. The job of professional homebirth midwifery is distinguished by its accountability to an occupational mandate of individualized informed choice. It is the tasks and knowledge associated with with that mandate that distinguish professional homebirth midwifery from its occupational neighbors, including hospital-based nurse-midwifery, obstetrics, and even traditional midwifery. They form what Andrew Abbott calls the "core heartland of work" (Abbott 1988: 71) for which the profession of homebirth midwifery "aims:" in his terms, its "jurisdiction" (Abbott 1988: 9, 33). Alongside earlier analysts' emphases on professions' state-sanctioned control of one another—other professionals' activities, training and credentialing (Freidson 1974: 45-7, Larson 1979: 47)—Abbott stresses a focus on the question of which areas of work a profession seeks to dominate, and which

[31] I am not the only analyst to note the centrality of informed choice to the professional formation of contemporary midwifery. As MacDonald (2017) has highlighted, while the institutionalization of the midwifery that rose in 1960s and 1970s Canada unfolded differently, midwives in Ontario "strategically foregrounded" informed choice as they began to integrate a social-movement-based model of care into the mainstream healthcare system. MacDonald argues that foregrounding informed choice served to make midwifery care legible to a broad range of actors: "a skeptical medical profession, conservative law makers, and a mainstream clientele" (MacDonald 2017: 279).

areas of abstract knowledge a profession distinctively applies to the case it considers (Abbott 1988: 6-9, 315).

What, in other words, do these professionals do that others don't? This question is particularly useful in the case of homebirth midwifery because so many of the tasks midwives perform are not exclusive to the practice of homebirth midwifery. Medical assistants take pregnant parents' vital signs; labor and delivery nurses monitor labor progression; doulas and nurses suggest position changes or counter-pressure to make labor speedier or more comfortable. Obstetricians monitor fetal growth, iron levels, and more prenatally, and they resolve shoulder dystocias, treat hemorrhages, or suture tears during labor and immediately after birth. Social workers help parents get FMLA leave; lactation consultants provide postpartum nursing support.

Certified Nurse Midwives (CNMs), of course, have perhaps the greatest overlap in both tasks and abstract knowledge with CPMs and traditional midwives. Yet many contend that practice in the medical setting fundamentally alters the work of midwifery. Of course parents and homebirth midwives avoid hospital settings for birth for all sorts of other reasons, including infection risk and religion. But "the first intervention is leaving home" is also a common aphorism in homebirth conversations (see also Hazen 2017). The hospital or clinical setting, with its fluorescent lights and unfamiliar electronic monitors is understood by many to function as a disturbance to physiologic birth and the hormone cascade many midwives and parents seek to protect and facilitate as engine of labor. Many explained to me that, should that hormone cascade be interrupted, birth without the augmentation available in the medical setting becomes less likely—and labor augmented with medication renders the parent physiologically less agential, as well as

more dependent upon the expertise of the prescribing care provider. The tendency to medication introduced by the hospital setting, in other words, interferes with providers' impartiality and with the parent-as-expert, parent-as-decider model of informed choice. Robbie Davis-Floyd and Judith Rooks have also argued that CNMs' autonomy as providers is compromised by dint of their "nursing role," the significant medical inflection of their training, and their frequent use of more interventive models of care, including the use of pharmaceutical pain relief and induction drugs (Davis-Floyd 2006: 37, Rooks 1999:45). And when CNMs' autonomy is compromised—either by licensure structures that require reporting to a supervision physician, or by hospital protocol or liability insurance policy—limits appear to their ability to provide care that is guided by clients' understandings of evidence, clients' approaches to risk, and clients' priorities and desires. As parents and homebirth midwives frequently explained to me, CNMs' ability to provide care on the basis of informed choice, is, in other words, compromised. Informed choice thus appears as the occupational mandate of homebirth midwifery and also as the distinguishing feature of its jurisdiction. What do homebirth midwives do that others don't? What do they know that others don't? The answer, at least according to the perhaps-idealized sense of my informants, is that they order their practices around informed choice.

Indeed, both preceptors and midwifery school leaders told me that pre-existing comfort with the abstract underpinnings of informed choice was perhaps their major selection criterion for midwifery trainees. "We're living and breathing it," Marcy Andrew, President of the National College of Midwifery, told me of informed choice. "And even on our application form, that's one of the main things we look at. We ask,

'what have you had to do in your life that you've had to self-initiate, and self-start, and be really organized and independent around?' That's really what I think makes a good candidate…[because] that's the basis of informed choice: the recognition that I'm the expert of my situation, so I'm going to be the self-initiator in my life and I'm going to facilitate other people to do the same." The rest of what's required to be a good midwife, she said, can be taught. That includes both the subjective process of discerning one's own limits, as well as the mechanics of how to organize a prenatal visit in order to mitigate the risks of incursions on client autonomy posed by the authority of the care provider as expert and make sure client decisions are not swayed by the midwife's opinions or preferences. But the midwifery students must bring to their education a lived experience of independence and of "being the expert" of their own situation.

Alex said something similar as she began to consider, late in the time I spent in her practice, taking on students. She told me one day that she had received two messages from people who wanted to be her students. Neither one, she said, was likely be a good fit: one just wanted to start an apprenticeship but didn't have any plan for school or structure for an apprenticeship process and Alex didn't feel prepared to be a sole clinical skills teacher. The other, she said, "post[ed] a lot of Bible verses on Facebook" and hadn't been able to make it to any of the meeting times Alex had proposed because she'd been working, which, Alex said, was reasonable but unworkable for an apprenticeship. Was posting a lot of Bible verses on Facebook a problem for Alex's mostly relatively non-religious clientele, I asked? Not necessarily, Alex said. She told me she's worked with lots of religious and conservative people and wants to extend the same benefit of the doubt to them that was extended to her, and the thing that would matter most is whether

she gets the *feeling* that someone is actually chill with people making decisions they wouldn't make, and has experience being chill with that. Some examples were obvious: she'd need an apprentice to be comfortable with a client's choice to terminate a pregnancy on the basis of a genetic screen, regardless of their own beliefs on the matter. And she'd need them to be comfortable with family arrangements like queer families that aren't the same as what the person is accustomed to. But, she said, she'd need to have that sense about someone even if they were, as she put it, "demographically similar" to her.

Serving and supporting queer families is not a hypothetical in Alex's practice. She is one of the few queer midwives in her area and provides care to many queer families at discounted rates, and also has been providing trainings for other midwives about how to provide better care to trans clients for over a decade. But she was *not* looking an apprentice who resembled her in either what she called "demographics"—an apprentice who was queer, perhaps, or a self-identified leftist—or in opinions. Far more important was the ability to "be chill with people making decisions [the apprentice] wouldn't make." In practice, these decisions exceeded matters such as abortion and sexuality that might be predictably hot-button concerns to include decisions about issues such as how long after 40 weeks gestation to continue homebirth midwifery care. Being a good midwife—to practice good informed choice—meant consciously cultivating comfort with clients' decisions as drivers of care, even when those decisions were not ones the midwife herself would be comfortable making. Midwives often called this "holding space." One midwife's writing describes this as working to remain neutral instead of suggesting that some decisions are right and others wrong, witnessing,

releasing "any notion that I have any control, or that there is any specific outcome to be expected other than a healthy mom and a healthy baby (Indiebirth, "Hold the Space and Nothing More")." Another writer defines "holding space" as being "willing to walk alongside another person in whatever journey they're on without judging them…or trying to impact the outcome" (Plett, "What it means to 'hold space' for other people and how to do it well.') Other midwives often called this "being unbiased."

"Being Unbiased": Objectivity, Local Expertise, Epistemic Multiplicity, and the Informed Choice Approach to Medical-Scientific Knowledge

The inability to remain unbiased—or the tendency to allow one's preferences or beliefs to sway a client's decision making—was one key meaning often associated with the phrase "being biased." A provider, family member, or other actor who is "being biased" is the great disruptor of good informed choice processes, and any number of things can constitute "bias." A provider might be biased by dint of their imposition of their own religious views that abortion is universally wrong on a client who is considering whether to do first trimester or quad screening. Alex told me at another time that of all informed choice conversations, she struggled most with remaining unbiased during the ones she had about the possibility termination following atypical results from first trimester or quad screening. Her personal belief, she said, is that it is eugenics to terminate a pregnancy because of Down's Syndrome. Providers often told me they took steps to intentionally mitigate the effects of their personal preferences of beliefs: because of that bias, Alex said, she works extra hard to present information "that represents the other side". She said something similar about circumcision: it is uncomfortable for her,

she said, that the only study demonstrating health benefits to circumcision is so methodologically flawed, because it confirms her own "bias" against circumcision.

How, then, do homebirth midwives attempt to control or mitigate "bias"? Writing and updating informed choice documents was understood by many midwives to be a key moment for *avoiding* bias in client decision-making. Alex was in the process of revising her informed choice documents to bring them up to date during the months I spent in her practice. We developed a routine in which I'd come over to her house and hang out with her and her toddler while she looked through articles from Up To Date, Evidence Based Birth, and Midwifery Matters, the journal of peer-reviewed out-of-hospital midwifery research started several years ago by Birthwise, the independent midwifery school she had attended. Afterwards, she'd show me the new and old versions of the document and point out significant changes she'd made given the new evidence she'd found. I asked Alex to tell me one day about how she hoped to present evidence as she revised the documents. Here are my notes on the conversation:

> *Alex said she tends to present both standard of practice—which, she noted, given that homebirth is 1-3% of birth, is going to be hospital practice—and what the evidence says, and if the evidence is mixed, she'll try to present multiple takes. She gave me another example: after [one client's] visit in which they discussed acupuncture, she sent [the client] several studies about acupuncture in pregnancy and labor and one published review of relevant literature, trying to aim for middle of the road studies as opposed to studies that would skew in the direction of her own biases and what she'd like the clients to do. She also said if there is an outlier opinion she'll include that, along with her take on the study's*

methodology…she will explain her take on what was and wasn't strong or convincing about the methodology.

Presenting multiple takes on mixed evidence, seeking out studies that challenge one's own opinions, aiming to include outlier opinions, and emphasizing methodological rigor: midwives turn to these measures to "avoid bias" in the presentation of information in their informed choice processes. Taken together with the emphasis in informed choice on individual parents making up their own minds about what is true and what is right, this approach reflects a distinctive orientation to scientific knowledge. It is one that accepts the notion of scientific evidence while rejecting the notion that only experts have the authority to interpret that evidence. Scientific research and the evidence it produces might well be the way to the truth, according to this view, but it is up to each individual to make their own way with that evidence. Furthermore, it decouples what the evidence says from what any individual ought to *do*. Informed choice presumes that it might be the right choice for a client to elect a course of care that all the evidence suggests presents distinct risks to parent and infant, and that so long as the parent is aware of that evidence and has been given the chance to engage with the methodological conditions of its production, that choice is the right one.

The notion that the midwife truly does not know what is right for a client thus has a number of corollary and interrelated epistemic principles: first, as I mentioned earlier, the belief that there simply is no universal right answer, and that all courses of care have benefits and drawbacks that can only be resolved idiosyncratically. The right answer or the right plan of care is, in other words, understood to be an inherently personal object, knowable relative only to the individual. Second, the project of making sure client

decisions are not swayed by the midwife's opinions or preferences presupposes the idea that the authority of the care provider as expert itself poses risks to be mitigated. Third, the informed choice approach departs from a distinctive set of assumptions about how to approach medical-scientific evidence. Its relativism is not about the question of whether objective science can be done or good evidence generated. Instead, informed choice departs from the assumption that good evidence could be correctly interpreted in any number of ways. The informed choice approach presumes relationship between power, coercion and truth-claims in which truth-seeking and right-seeking are inextricable from one another. The expert midwife does not avoid "bias" in order to arrive at a universal or objective answer to the questions that arise in the course of care. Instead, the aim of avoiding bias is the protection of the inherently *relative*—and somewhat fragile—entity that is the client's understanding and desire from the possibly generalizing authority of a professional's view of the matter.

In placing this high value on local knowledge and expertise and attempting to mitigate the power of expert opinion, the informed choice approach attempts to resolve some of the anxieties that have preoccupied feminist approaches to epistemology and social scientific treatment of quantification and objectivity since these fields emerged in the last decades of the 20th century. "There are some perspectives on society," Nancy Hartsock argued in 1983, "from which, however well-intentioned one may be, the real relations of humans with each other and with the natural world are not visible" (Hartsock 1983: 36-7). Arguing, as Sandra Harding put it several decades later, that "one's social situation enables and sets limits on what one an know" (Harding 1992: 443), Hartsock and others sought to expose the supposedly objective knowledge that men had long

produced as in fact limited by the same dominant position that had enabled them to make and distribute that knowledge. Hartsock suggested that women's lives made for a "particular and privileged vantage point" (Hartsock 1983:36) from which *better* knowledge might be generated. "Standpoint theories argue for 'starting off thought' from the lives of marginalized peoples", Sandra Harding wrote in 1992, distinguishing such theories from the perspectives of feminist researchers who she called "feminist empiricists," who contended that better, more rigorous application of scientific methods could right the wrongs of sexism in knowledge-making (Harding 1992: 445, 439). For standpoint theorists, sexism in knowledge-making was not the result of the misapplication of scientific practice, but of the limitations introduced by the social position of the doers of science, and more empiricism would not necessarily lead to knowledge that was more feminist . Instead, knowledge-makers would need both different questions and different methods. "Starting off thought from [marginalized] lives provides fresh and more critical questions about how the social order works than does starting off thought from the unexamined lives of members of dominant groups," Harding argued. Her contemporaries added that not only more complete information, but a different form of "thinking about the world" (Smith 1974: 22, 24) might be rediscovered from attention to what women know from experience.

For standpoint theorists and others interested in the promise of what Donna Haraway termed "situated" knowledge, knowledge-making that aims to be "universal," produced by an "unlocatable" or "transcendent" scientist's view of the world, is irresponsible and also false (Haraway 1988: 583-4). This sentiment is echoed in early feminist sociological critiques of midcentury medicalized childbirth. Barbara Katz

Rothman's 1982 *In Labor*, for instance, includes a detailed discussion of "Friedman's curve," a "graphicostatistical analysis" of the timing of labors introduced by Emanuel A. Friedman in the 1950s. "[Friedman] broke labor into separate 'phases,' and found the average length of each phase," Katz Rothman wrote (Katz Rothman 1982: 259-60). "He computed the averages, and the statistical limits...He uses the language of statistics, with its specific technical meanings, and jumps to conclusions about physiology…once the false and misleading conclusion is made between statistical abnormality and physiological abnormality, the door is opened for medical treatment. Thus *statistically abnormal labors are medically treated*" (emphasis in original). For Katz Rothman, the attempt to produce universal measures of labor timing made for knowledge that was both false and dangerous. Supposedly objective medical science becomes, in this analysis, the dubiously-valid bludgeon used to define women as needing intervention, and then subtly coerce them into doing things they don't want. In an analytical move that would prove foundational for the "alternative" birth world, Rothman analogizes length of labor and human height, arguing that atypical need not mean pathological. Instead, she quotes a "midwifery-oriented" approach to assessing length of labor as proceeding "in terms of the laboring woman's subjective experience" of exhaustion, endurance, difficulty, and progress (Katz Rothman 1982:261).

The argument against universalizing that advocates of physiologic birth make—and that undergirds the informed choice approach—thus echoes feminist epistemologists of the 1970s and 80s in its presumption that subjective experience and the idiosyncratic body make for better, truer knowledge than what Haraway calls the "God-trick," or the promise of a total vision of reality "from everywhere and nowhere" (Haraway 1988:

584). It also echoes sociological analysts of probabilistic statistics and quantification, who have argued that the authoritative nature of statistical knowledge rests on its reductionism, its exclusion of the individual and the subjective, and its normative character (Gigerenzer et al 1989: 9, Hacking 1990: 97, Porter 1995: ix). Rather than merely describing the world, sociologists have argued that statistical knowledge and quantification techniques make understandings of what is good, healthy, abnormal, or in need of intervention (Espeland and Stevens 2008: 412). "The normal was one of a pair," Ian Hacking writes, "its opposite was the pathological…the word became indispensable because it created a way to be 'objective' about human beings" (Hacking 1990: 160). The depersonalizing nature of methods aimed at objectivity is, for these analysts, precisely what has allowed such methods to achieve such a powerful association with "rationality and universalism" and such dominance (Espeland and Stevens 2008: 432, Alonso and Starr 1989:1). The informed choice paradigm rejects impersonal, universal quantification and statistical knowledge as sources of final answers to the question of how to proceed in clinical care, and it also rejects the assumption of expert authority to name the normal or abnormal, turning instead to the subjective, the idiosyncratic, and the particular. Informed choice aims for what Haraway calls a "view from somewhere": a view from the client's standpoint (Haraway 1988:580). Notably, the aim is *not* for a view from *midwifery's* standpoint: homebirth midwives do not seek to produce a different "graphicostatistical analysis" of labor timing to replace Friedman's. Much as Haraway was skeptical of the promise of objective knowledge from below, arguing that "the subjugated have a decent chance to be on to the God-trick and all its dazzling—and, therefore, blinding—illuminations" (Haraway 1988: 584), the informed choice paradigm

assumes that midwifery can no more generate a good universal answer to how clinical care ought to proceed than obstetrics can. Instead, as Haraway argued for the presumption of the partial nature of any perspective and for departure from multiple such perspectives, or as she put it, "the joining of partial views and halting voices into a collective subject position that promises…a view from somewhere" (Haraway 1988: 580), informed choice presumes that a practice that is offering good care will find that clients arrive at many different good answers.

Under the informed choice paradigm, for care to be free of "bias"—that is, value-neutral and non-coercive with respect to clients' decisions—it must proceed from the subjective, idiosyncratic reality of the client rather from any attempt to standardize, and it must turn the work of evaluating information over to the client. This entails a very particular epistemic approach to quantification: numbers, the approach suggests, can avoid depersonalization if they don't have to mean the same thing to everyone. Add interpretation back into the non-expert's interactions with scientific evidence, and the provision of care becomes paradoxically *more* disinterested, more objective. Objectivity, in this view, demands more subjectivity. Practicing good informed choice thus involves approaching a paradox: claims to objective truth are risky business. Sending a client a study means sending them a claim to authoritative knowledge, one that has ostensibly excluded the very subjectivity and individual interpretation that make for good informed choice. Yet in order for choice to be well-informed, clients must have information made available to them. Withholding studies from clients, such as the outlier opinions Alex notes above she made sure to include, was understood by many of the midwives I worked with to be just as much an instance of "bias" as sending them studies that might sway

their decisions. The task of facilitating informed choice thus also demands skill in fostering scientific literacy and integrating evidence into clinical care while upholding a relative epistemic approach to the evaluation of that evidence.

In fact, this core competency has been institutionally recognized by the Midwives' Alliance of North America, which has since 2016 hosted a progressive series of "evidence-informed practice" workshops for continuing education credit at its annual conference. This year's workshop was presented by Courtney Everson, an applied medical anthropologist who is a faculty member at the Midwives' College of Utah and team member of MANA's Division of Research. Everson opened the session by taking a poll. "Raise your hand if you've…read a research article? Thought research could be applied to a client? Encouraged a student to look something up? Said you were an evidence-based or evidence-informed midwife to a client? To a legislator?" Everson joked that though she was sure there was some selection bias at play—all the participants had, after all, chosen this session—she was happy to see that everyone raised their hands most of the time. She emphasized the importance of proceeding from "the best available research evidence" *alongside* clinical expertise and "client values, social identities, and individualized needs." Photographs of midwifery supplies flashed across a PowerPoint screen as she said, "We have prenatal bags and birth bags as part of our essential equipment and supplies, but we sometimes consider research resources like journal subscriptions to be extra. We need to change our mindset and add UpToDate, MANA Stats, the Journal of Midwifery and Women's Health, and your electronic filing system for research resources to your essential supplies." Good perinatal care, Everson's workshop emphasized, demands fluency with medical-scientific research evidence—but

it also demands turning over assessment of that evidence to clients. The shared decision-making model valued by midwifery care, the workshop handout explained, is "about providing clients their risks, benefits, uncertainties, and alternatives for an array of options," and in order to "fully flesh out" each of those categories, engagement with research is key (see Everson's handout 2019, page 5).

A qualified sense of what Ted Porter has called "trust in numbers" has thus become not only common but normative, institutionally sanctioned, and an essential part of professional training in the world of community midwifery. Porter famously argues that quantification operates as a "technology of distance" (Porter 1995:ix), settling the question of why officials ought to be trusted by appealing to recognizable norms associated with objective knowledge production. Decisions made on the basis of numbers appear as almost inevitable, made "without seeming to decide" (Porter 1995: 8). The qualified trust in numbers employed by contemporary professional community midwives treats quantification as indispensable—as essential as clinical equipment—but decisions as certainly *not* inevitable. There is, according to the informed choice perspective, a real world out there, and it is one researchers, practitioners, and pregnant parents themselves can and should strive to know objectively. Yet the informed choice approach attempts to break that link Porter identifies between apprehension of the quantitative data associated with objective knowledge and decision making, or between expert position, reader of numbers, and decision-maker. When clients are encouraged, for instance, to track their own blood sugars with a glucometer, midwives often suggest they try interpret and act on the numbers they read themselves before the midwife weighs in about what those numbers might mean or offers any possible course of action. In one

prenatal visit, for instance, a client reported to Carissa that she had noticed an atypically high blood sugar after one snack several days earlier, then showed us the route she'd walked with her daughter in order to ascertain whether she achieve a new, lower reading in a short period of time. Other ethnographers have also noted the significance of this question of who does the quantifying, contending that *self-quantification* can produce a "situated objectivity" (Pantzar & Ruckenstein 2017) in which quantified data are interpreted in light of "prior experiences, understandings, and shared expectations" (Ruckenstein and Schull 2017:266).

The informed choice approach also posits scientific evidence and quantitative data as resources *like any other* and only one critical tool or element in clinical decisionmaking. Other knowledges, home birth midwives insist, are *also* crucial to the process of making a fully informed choice. In this distinctively epistemically multiple view, informed choice is compromised if a midwife withholds a key study or does not give the client the chance to come to their own conclusions about scientific evidence. But the process of informed choice is also understood to be biased if midwives *only* use scientific knowledge—if they leave out the knowledge of experience, bodily sensation, intuition, faith, or family lore. One client in Alex's practice, for instance, was admitted to the local community hospital late in pregnancy with a placental abruption. [32]Alex visited her in the hospital frequently to offer support and collaborate with providers there, and after one of her daily checkins, she updated me. The client, who had lost a great deal of blood, had had another drop in hemoglobin that day. She was feeling "crummy" and

[32] In a placental abruption, the placenta separates from the uterine wall during pregnancy. Abruption is dangerous to both parent and fetus, as parents frequently lose a great deal of blood and the fetus's oxygen supply is compromised.

actively considering a blood transfusion. But, Alex told me, the client was feeling "unlucky," and was worried about a transfusion reaction. Alex told me she felt that intuition was important information to consider alongside the expectation that a transfusion could help her feel much better.

Stories also hold a distinctive place in homebirth midwifery. They are solicited in postpartum visits, shared in birth-story sharing circles like the ones for parents and birth attendants in which I participated, narrated in memoirs and interview collections like Peggy Vincent's *Baby Catcher,* Carol Leonard's *Lady's Hands, Lion's Heart,* and Geraldine Simkins' *Into These Hands*. "Birth stories are the real guts of how our families are made," a midwife told the camera in the promotional video for her one-woman birth-story-based show *Blood, Sweat, Baby, and Life after Orgasm: Stories from a Midwife*. "Why are we doing this? Why are we talking about birth?" Talking about birth, telling birth stories in venues such as her performance, she insisted, could bring stories "told in secret" into the light of a public audience, could "humanize and bring acceptance to what a baby's birth is really like."

As others (Spoel et al 2013) have noted, the seemingly "sociable" activity of storytelling also accomplishes clinical work, and stories are also sought after as evidence to inform clinical decision-making. Advising readers about how to interpret family birth stories, Peggy Vincent's "Pearls of Wisdom" cautions that "a woman will labor more like her sisters than like her mother" (Vincent 2002:327). At one birth I attended with Sylvie and her student Becky, the client, who came from a big, close family, spent much of the day laboring in her bedroom with her mom, her husband, her brother, a few cousins, and her five aunties. They all rubbed her back, held her hands, talked her through

contractions, fed her bites of food: a banana, a teacup full of albondigas, oatmeal. The room was unusually full for a homebirth. I had never been to a birth before where early labor happened with more than one or two people supporting the laboring parent, I knew the saying that *every person at your birth is an intervention*, and I'd read the stories in Carol Leonard's memoir *Lady's Hands, Lion's Heart* about kicking out visitors to encourage labor to speed up. And at times, Sylvie and Becky were concerned that there were too many people in the room. We began to hang out in the kitchen, keeping a cousin company while she wrote the baby a letter, chatting with the client's in-laws, and spending time with the aunties while they fixed snacks for the client. They'd check in with Sylvie and Becky (and sometimes me!), asking about their opinions about labor progress or seeking reassurance that things were going well. Many also shared, sometimes through tears, their memories of their own labors and births: a frank breech son they named Frank, a mother told she was fully effaced and dilated only to be checked again and told that her cervix had "re-closed." Many were, as Becky, Sylvie, and I began to note, "wild" labors. Almost a full day later, in the middle of the night, Sylvie and Becky were trying to make sense of some surprising exam results. Sylvie had done an exam at dinnertime, and had found the client five centimeters dilated, and another around 11 PM, after which she'd told me the client was almost complete with a small lip. But now, hours later, Sylvie was telling us agitatedly that the client was only at a three or four. Had she messed up the earlier exam? Felt the lower uterine segment, and misidentified it as cervical tissue? In the long night and day that followed, as the second midwife arrived, she, Sylvie and Becky worked to make sense of what was going on and generate good options to offer the client. These stories of the "weirdest labors," as Becky put it,

became resources in their conversations. Instead of relying on quantification to, as Porter put it,"go… beyond the boundaries of locality and community" (Porter 1995:ix), homebirth midwives then actively seek out local, familial, communal, and particular knowledges for use as resources with which to inform decision-making.

For Porter, quantification rests on the promise that "the struggle against subjectivity" will produce knowledge that is a trustworthy basis for decision-making precisely because it is generalized. "A decision made by the numbers," he writes, "has at least the appearance of being fair and impersonal" (Porter 1995:8). The informed choice approach, on the other hand, presumes that a decision "made by the numbers" might in fact be entirely unfair and entirely personal, or unfairly impersonal and not inevitable at all, but that a decision made *without* access to the numbers might easily be as well. Unbiased care demands the numbers—but it also posits that the numbers do not eliminate judgement from decision-making and cannot, alone, guide unbiased care. "Avoiding bias" in informed choice-driven care certainly includes measures we might recognize as commonly employed in service of attempts to mitigate cognitive bias for greater objectivity, such as seeking out studies that challenge provider opinions or presenting multiple takes on mixed evidence & discussing methodology at length. However, it also assumes that other knowledges—including other, non-generalizable knowledges like story and intuition—can and should affect the ways evidence is interpreted. If a midwife fails to include those kinds of knowledge in a decision-making process or assumes that quantification should override them, the process is "biased," too.

Indeed, claims to objective truth appear as a threat to horizontality and "unbiased" shared or client-directed decision-making. To claim to know the truth objectively,

certainly, or universally is, as Porter points out, closely tied to claiming to know what to do, and for midwives guided by informed choice, such a claim is problematic indeed. Another way that the homebirth and midwifery community's "trust in numbers" was qualified was by midwives' and parents' acute awareness of and active discussion about the lack of closure in the medical-scientific community—*and* the midwifery-scientific community—that characterized many of the questions associated with perinatal care. I ran into one nurse-midwife acquaintance who had had her daughter at home with a certified professional midwife at the thrift store one day when I was doing research in New England. As we sorted through clothing racks for a few minutes together, we made plans to have tea and chatted a little about obstetrics, homebirth midwifery, and nurse-midwifery. "Well of course, obstetrics is based on basically *no* science," she said. Perhaps paradoxically, embracing a lack of closure is a key way midwives address that void. In between reports of midwives' clinical experience, philosophies of birth, and knowledge of research, *we don't really know why* or *we don't really know how* peppered prenatal and postpartum appointments. This is no accident: indeed, during an elective course I attended that Alex taught at the midwifery school she attended, she reminded the students that "breaking down the medical provider/person receiving care hierarchy where the medical professional has all the answers" is a core value of midwifery care. "Saying you don't know," she told the students, "is a key tool as a midwife" in providing that care. Midwives did this all the time. Alex told clients she was happy to give them information about homeopathics to encourage labor to begin late in pregnancy that some people had seen to be clinically successful, but that she didn't know how homeopathics work. A midwife leading a workshop for midwifery assistant trainees told the

participants she knows a chunk of placenta in the cheek can stop a hemorrhage but that she didn't know the exact mechanism. An apprentice in the primary-under-supervision phase of her training told a client during an informed choice conversation about Group B Strep that it's impossible to know what point in the life cycle of the GBS bacterium a positive culture represents. These statements of not-knowing certainly all served a shared purpose of disrupting the notion that the care provider, as Alex said, "has all the answers." But they also served other purposes: they validated the notion that care options don't have to be well understood scientifically to be powerful and effective, and that the information one can obtain through laboratory tests is limited and need not be treated as decisive. If good informed choice requires "being unbiased," and "being unbiased" requires exercising caution about the authority mobilized by claims to objective truth, then "saying you don't know" or as Donna Haraway put it, "resist[ing] the politics of closure [and] finality" (Haraway 1988: 589) becomes a key element of providing unbiased care and facilitating client informed choice.

Normative Epistemology

Though parents and midwives often turn to homebirth and direct-entry midwifery seeking alternatives to experiences of hospital-based medical perinatal care that they find coercive, belittling, or disempowering, informed choice is more than just a rejection of obstetric violence or an affirmation of parental wishes in perinatal care. Instead, it is a programmatic enactment of what I wish to suggest we might call the "normative epistemology" of the field. A normative epistemology is an approach to how knowledge ought to be produced, recognized and deployed. Normative epistemology is a useful

category because it identifies a set of agreements that enables many of the underpinnings of professional power identified by previous analysts. For Eliot Freidson, for instance, a profession is defined by control over the substance or technical knowledge of its own work that has been deliberately granted by state authority (Freidson 1970: xvii, 72, 185). The autonomy of professions, Freidson contends, is facilitated by measures identified by earlier analysts (see Wilensky 1967) as key to professionalization, such as the adoption of educational standards and codes of ethics and the establishment of professional associations, procedures for licensure, a nd mechanisms by which peers might regulate one another' activity. However, those measures only meaningfully confer power to professions insofar as they are politically and legally supported (Freidson 1970:45-7). For Magalit Sarfatti Larson, meanwhile, professions maintain their power establishing "a monopoly of training and credentialing" that distinguishes the professional from the layperson, creating a "seller's market" marked by artificial scarcity in the supply of the service that profession can provide. By creating an "unequal distribution of knowledge" or a situation of cognitive exclusiveness (Larson 1979:48), professions are thus able to defend themselves from competitors and secure market dominance.

As others (see Whooley 2013: 5-8) have contended, professional contests are also epistemic contests, and these accounts rarely address the question of *which* knowledge a profession will aim to control. Yet before any public epistemic contest can occur over which knowledge should gain either institutional backing or the cultural authority (Starr 1982: 13-15) to have its "evaluat[ions] of reality" or "definitions of fact and value" integrated into laypeople' understandings of their own experiences and needs, an aspiring profession must hit on an internal agreement over what should count as knowledge

among practitioners. The identification of a standardized body of knowledge to treat as credible is thus a missing step in sociological accounts of professionalization. In other words, if professional groups "apply…abstract knowledge to particular cases," and if they seek to control those bodies of abstract knowledge alongside techniques or skills to be applied to particular problems (Abbott 1988:318, 8), identifying that body of abstract knowledge depends on at least some degree of consensus *within* the community of practitioners about what will count as knowledge.

In the case of contemporary professional homebirth midwifery, that normative epistemology is, as I have described, characterized by three things: first, it highly prizes local expertise and aims to mitigate expert power and the extent to which expert knowledge becomes hegemonic in the clinical scene. Second, it is distinctively epistemically multiple. Third, it is shares major epistemic and normative commitments with feminist, interpretive and critical social scientific arguments about birth and perinatal care, quantification, and objectivity.

Practicing informed choice, in other words, constitutes a distinctive way of *living with knowledge*, one that presumes that choice, autonomy, and freedom require the management of multiple knowledges: expert and situated, social and scientific. This normative epistemology—along with expertise in the work of facilitating informed choice that upholds it—is at the core of the abstract knowledge and skill that characterizes the professional jurisdiction of contemporary professional homebirth midwifery.

Credentialing a Normative Epistemology: Social Science for Midwifery and Choice

The normative epistemology of informed choice approach, I argued in the previous sections, is remarkably social-scientific. In this section, I will argue that this affinity is no accident: the kind of living with science that informed choice involves is also one that is distinctively in conversation with social scientific knowledge. Indeed, when I left Princeton to do fieldwork, social scientists followed me into the field. Books by sociologists, anthropologists, and social historians were often lying around in clinical settings. On the bookshelf at one independent birth center where I spent many days, copies of a major social history of midwifery and birth and of *Laboring On,* a volume about perinatal care work at the turn of the twenty-first century edited by sociologists Wendy Simonds and Barbara Katz Rothman, was sandwiched between guides to breastfeeding, prenatal nutrition and massage (see fig. 3). Midwives' deep engagement with social knowledge led to some interesting moments of reversal in the dynamics between me as a researcher and my informants. At times, my more naïve inquiries were met with suggestions that I ought to have read the social scientific literature as least as thoroughly as my informants. "I assume you've read Robbie Davis-Floyd," one midwifery student replied skeptically when I asked her about her take on why homebirth rates are rising. Then she suggested a couple of histories of birth to me and told me what to look for: a better understanding of how obstetrics courted state support and established control of knowledge about birth. Hospitals, she stressed, are *new* social institutions, and they represent a new kind of approach to birth. "Technological birth," she told me, referencing Robbie Davis-Floyd's analytic, only entered the equation with our mother's generations. "Birth wasn't so *medicalized* before that."



Fig. 3

Encounters with formal social scientific knowledge often temporally comes first in the origin stories informants told me: several homebirth midwives told me that Barbara Katz Rothman's *In Labor* or Robbie Davis-Floyd's *Birth As An American Rite of Passage* were required pre-reading for their midwifery schools, and other midwives and clients dated their interest in midwifery or homebirth to their experiences reading this material in anthropology or women's studies classes as an undergraduate. Others came to social science through birth and midwifery: Indiebirth, an organization that stakes out a particularly strong position on autonomy and which describes itself as providing "out of the box" information about midwifery, pregnancy and birth, held a webinar with Robbie Davis-Floyd that I attended during fieldwork. She introduced the concept of "authoritative knowledge", identified by Brigitte Jordan, defining it as "the knowledge

that counts in a given situation, the knowledge people use to make decisions and take actions, the knowledge of the authorities." Walking through the core of Jordan's book's argument (Jordan), she described her finding that "authoritative knowledge about birth in the Yucatan was considered to be held not just by the women but by every woman about birth." She drew a distinction between this "lateral" knowledge and the "top-down" knowledge of obstetrics, linking the question of women's agency in birth. Shifting to her own work, she described the notion of three paradigms or "models" of birth she had introduced in *Birth as An American Rite of Passage*. In the technocratic model, she said, authoritative knowledge is held by the physician. Images flashed across the screen of gowned women reclining in labor with legs spread, flanked by groups of men in surgical scrubs and masks. In the humanistic model, authoritative knowledge is shared amongst a team that includes the parent, she said, and in the holistic model, authoritative knowledge is inherent in the individual and in the intuition of a midwife about what a mother knows. A photograph of a family in a birth tub, surrounding a naked laboring woman, appeared on the screen as Davis-Floyd explained that the authoritative knowledge concept "makes visible the existence of lack of a woman's own perceived authority during birth, and the importance of women perceiving their own authoritative knowledge." Citing another study (Hodnett 2003), she told the assembled parents, midwives, and doulas that "the most important determinant of the outcome of a woman's birth" is the attitude or paradigm of the caregiver or practitioner. "We must strive for the lateral distribution of authoritative knowledge in birth," she concluded.

If informed choice is a programmatic instantiation of that aim, then the central relationship of this core care approach to social scientific research is not just an incidental

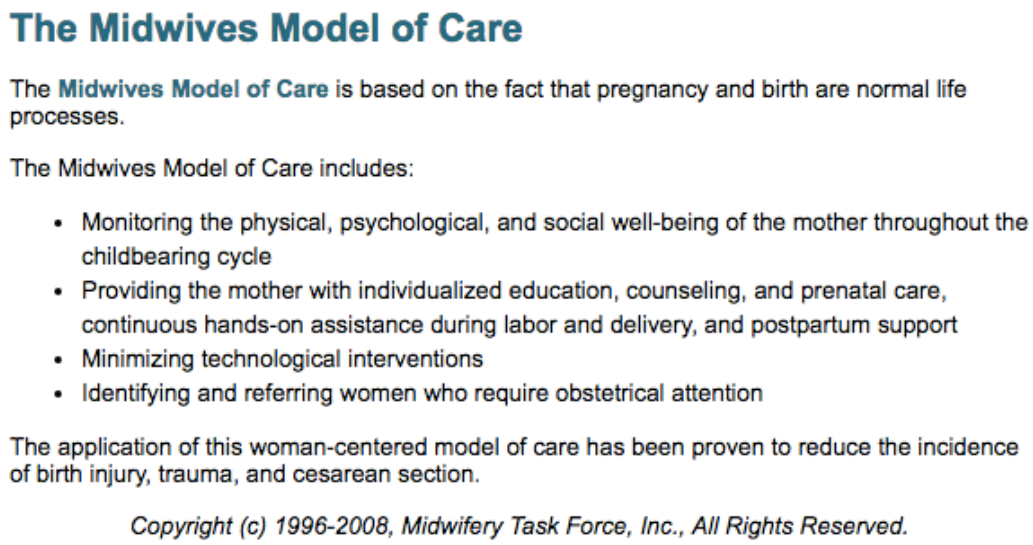
encounter but an institutional artefact of the ways midwifery organizations have formally relied on social scientific knowledge to credential the work they do. In fact, The Midwives' Alliance of North America describes its purpose in terms of the trademarked Midwives' Model of Care, defining this term with respect to its indebtedness to the social scientific ideal types of maternal care identified in sociologist Barbara Katz-Rothman's 1979 In Labor and Robbie Davis-Floyd's 1992 Birth As An American Rite of Passage[33]. Preceding Davis-Floyd and her "paradigms" of birth, Katz-Rothman described her search for alternatives to the "medical model" of obstetrical care she had identified. She writes that finding alternatives required "piecing together…ideas in the writings of eighteenth century midwives," "religious mothers of large families," "lay midwives living on communes," and the work and writings of Black and indigenous midwives who served communities into the 1970s who had never had access to hospital birth (Katz Rothman 1982 :24-5). "I have decided to call this other, no medical approach the midwifery model," she wrote, characterizing this ideal type as emphasizing "pregnancy as a healthy and entirely normal condition for mammals" (Katz-Rothman 1982: 25, 139), relying less on routine and standardized care than on making "the attendant fit the birth"and uniting fetus and mother in an "organic whole" (Katz-Rothman 1982:179, 276). According to Katz-Rothman, the birthing woman is less passive and more active in the midwifery model of care than in medical models of care (Katz-Rothman 1982: 277). The approach is centered on woman as norm; women's bodies appear as "meant to bear children" such that the act of doing so is no more "stressing the system than…digesting a nutritious meal [is]" (Katz-Rothman 1982:24). Women appear in these models as relational subjects or

[33] "The Midwives Model of Care," from https://mana.org/about-midwives/midwifery-model

"whole people" with minds and bodies connected or united in a single "energy field," emphasize care and healing "from the inside out" over diagnosis and treatment, and embrace alternative modalities, prevention, and mitigating inequality as routes to improved population health. (Davis-Floyd 2001: S10-S17). As Davis-Floyd described in her workshop, she and Katz-Rothman set these models of care against those they observed in the hospital, obstetrician-attended birth, which they (and many other commentators and parents) described as pathologizing, belittling, coercive, and instrumentalizing, simultaneously neglectful and so overzealous as to be injurious.

These ethnographic findings were codified by practitioners in 1996, when representatives of MANA, the North American Registry of Midwives (NARM, the organization responsible for granting the CPM credential), and the Midwifery Education Council (MEAC, the body that accredits direct-entry midwifery schools), and the advocacy organization Citizens for Midwifery collaboratively wrote a definition of a model of care to be used in advocacy efforts. The short paragraph they wrote (see fig. 2) was intentionally open-ended and aimed at characterizing the care already being given in midwifery practice. "The definition emphasizes the kind of care, rather than a particular type of provider," the authors wrote. "…By focusing on the model of care, we can avoid divisiveness over credentials and which categories of care-givers do or don't practice 'real' midwifery. The issue becomes the kind of care -- the evidence that supports its value, how to remove obstacles to its availability, how to make it available to as many women as possible, regardless of who is providing the care. The Midwives Model of Care then becomes a standard or ideal that all maternity care providers can attempt to meet".[34]

[34] "The Midwives' Model of Care", from http://cfmidwifery.org/mmoc/aboutdefine.aspx



The Midwives Model of Care

The **Midwives Model of Care** is based on the fact that pregnancy and birth are normal life processes.

The Midwives Model of Care includes:

- Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
- Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- Minimizing technological interventions
- Identifying and referring women who require obstetrical attention

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

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Fig. 4

In this site, in other words, the actors themselves frequently cited sociologists and made sociological arguments about concepts like medicalization, risk culture or professional monopoly. Social scientific texts become part of the backdrop of tacitly shared knowledge among homebirthing parents and community midwives, providing abstract guiding principles. As one midwifery educator mused, they "help us understand ourselves better." But they also articulate and validate the profession's values of individual choice and critiques of its others, naming the motivations and priorities that midwives and parents hold dear. Barbara Katz Rothman's critiques of obstetrics, descriptions of the strengths of midwifery care, and arguments about the implications of each for mothers and babies are often quoted on practice webpages (Fig. 5), turned into colorful memes reminiscent of inspirational quotations from motivational speakers:



Fig. 5

Likewise, Indiebirth cited Davis-Floyd's models of birth as a point of departure in discerning the right way to approach particular care choices, such as listening to fetal heart tones during labor, in an Instagram post (Fig 6):



Fig. 6

Social scientific texts also establish a narrative that makes sense of a re-emerging profession's origin story and its embattled, marginalized status. The same midwifery student who suggested I'd better read my Robbie Davis-Floyd more carefully pointed me to several other histories of midwifery and birth, telling me I could learn about "OBs [obstetricians] taking away homebirth from family practitioners, how hospitals came to be, and how homebirth has always been statistically safer."

Finally, social scientific texts and social scientists themselves guide the making of formal contemporary midwifery knowledge. Over the past two decades, homebirth midwives themselves have also been engaged in a project of turning the critical scientific literacy nurtured in the community of practice towards the production of evidence for practice through the MANA Statistics Registry or MANA Stats. Housed at the Division of Research of the Midwives' Alliance of North America, the team is led by Melissa Cheyney, a medical anthropologist at Oregon State University and certified professional midwife. A midwife and volunteer web developer, Ellen Harris-Braun, built the software for the data collection website before her death in 2016. In addition to Cheyney, the project is now staffed by Courtney Everson, an applied medical anthropologist who is faculty and director of graduate studies at the Midwives College of Utah; Marit Bovbjerg, an epidemiologist who is also on the faculty of OSU; and Bruce Ackerman, who manages data collection. Saraswathi Vedam, a nurse-midwife and professor who directs another prominent midwifery and perinatal care-focused researcher called Birth Place Labs at the University of British Columbia, serves as an advisor and collaborates on many of the division's publications.

The DOR aims to produce community based participatory action research that is of use in both clinical practice and in advocacy. At the "Research Roundup" presentation at the 2018 MANA Conference given to all participants over lunch, Cheyney described its goals as threefold: first, the DOR hopes to allow individual midwives and practices to track practice statistics, enabling out of hospital midwives to report rates of various outcomes to their clients in order to "support person-centered care and informed decision-making." Second, the division hopes to produce reports that can enable state and national level quality improvement. Third, the team hopes to "enable transformative research" through the collection of novel data and the investigation of novel research questions. Indeed, the division's research agenda is often shaped by concerns raised by homebirth midwives in practice, and in the 2018 Roundup Cheyney described several unpublished projects that had grown out of midwives' concerns. An investigation of the safety of placentophagy, for example, was hatched after a case in 2016 in which an infant had become very sick from GBS. After news that the mother had consumed her placenta came to light, the CDC recommended against consuming placenta because of the possibility of unidentified GBS in a placenta infecting an infant through breastmilk. Cheyney's introduction of the paper's research question was an indictment of the CDC's recommendation's basis in a single case, and it got a big laugh: "What if you evaluated the safety of placentophagy using a sample size of larger than one?" But the project, she noted, was one with serious implications for midwives' livelihoods: "many of us augment our incomes by doing placenta encapsulation[35]," she said as many in the audience

[35] Placenta encapsulation refers to a variety of methods of preparation of the placenta for ingestion, typically involving dehydration. Many midwives offer placenta encapsulation to their clients for an additional fee. Parents consume their placentas with any number of goals: increasing milk supply, avoiding postpartum depression, or increasing iron supply.

nodded. Similarly, a test of whether any particular Apgar score could be identified as a good predictor of poor neonatal outcomes was hatched as a plan to empirically validate generally held midwifery knowledge. "We've thought [the Apgar score] was nearly useless in practice, and now we know it," Cheyney reported. Cheyney made it clear that babies—and parents—are kept safe and healthy not by just any science at all, but by particular science.

She closed the presentation with a call to action. The evidence, she said, points overwhelmingly to the benefits of "culturally and racially matched midwifery care[36]," and decisive studies by the Lancet and the World Health Organization indicate that "future investment in maternal and newborn health should be on 'right care'" and not on medical obstetric or neonatal interventions. "Right care," she explained, would be tailored to individuals, allow people to weigh benefits and harms themselves, work "across the whole continuum of care," advance equity, and be informed by evidence. It would begin to address the binary between "too much too soon" care harming parents and infants in high resource countries and settings *and* "too little too late" care harming parents and infants in low resource countries and settings. "They coexist in the same country because of unequal distribution of resources such as money, power, and the right to self-determination and cultural determination about the right to give birth how we wish," Cheyney told the audience. "We call that 'stratified reproduction' in anthropology." She cited Donna Haraway, announcing that MANA Stats could "trouble," disrupt, or unsettle the idea that every birth ought to be a facility birth and that the

[36] One commonly cited source in conversations about culturally-matched midwifery care is the World Health Organization's recommendation of "culturally-appropriate" maternity care services (see Tunçalp et al 2015)

practices of hospitals are goals towards which all individuals or communities should strive. "Our focus on physiologic, community, culturally matched birth has more to say about global maternity reform than does advancing an often-violent, high-tech, US-style obstetrics," she announced, and the room applauded.

Social scientific ideas thus inform both the research agendas of contemporary midwifery and their methodologies. The intertwined trajectories of social scientific and midwifery knowledge move in a looping fashion: social scientific analysis of birthing practices codified midwifery knowledge, and midwifery practice now draws on that codified knowledge to guide practice and the production of the right of kind new research. These texts also serve to put a finger on the scale, articulating stances about which midwives feel embattled in terms that invoke the institutional legitimacy of official academic study even when they do not or cannot use the methodological apparatus of mechanical objectivity. The set of interlocking assumptions that forms the epistemic common-sense of homebirth midwifery walks a risky line: winning decriminalization, care partnerships, and state resources for homebirthing parents and midwives in the past thirty years has often rested on the basis of claims to the objectively empirically verifiable safety of physiologic birth and homebirth. Yet the care approach many seek and hope to provide care demands that any embrace of that kind of knowledge be highly qualified. Social scientific work—particularly that which is informed by contentions of feminist empiricism and standpoint epistemology—provides sources with the imprint of officialdom for the notion that all knowledge is partial and historically contingent, the product of always-biased human action, but that some knowledge is better than others. And it validates the notion that knowing the empirical truth cannot alone guide decision-

making and does not provide a universal right answer. Social scientific work on birth and midwifery provides citations for the idea that with or without closure, scientific knowledge and objective truth claims are necessary but not sufficient knowledge to guide perinatal care. In order to preserve choice and autonomy, they affirm, scientific knowledge must be deployed with a critical eye to the conditions of its production ("why you should take a quantitative methods course"), a sense of the power dynamics surrounding its use, and concurrent attention to modes of knowledge-production that privilege testimony and subjective first-person experience, interpret, honor not-knowing, emphasize meaning-making, and analyze inequities and institutional parameters.

The Right Time for Objectivity

Unsurprisingly, advocates of physiologic birth, including homebirth midwives, do often invoke scientific certainty and their claim to objective knowledge. Parents, midwives, doulas, and collaborating physicians are enormously aware of the dearth of official legitimacy for their arguments about what makes for safe birth and the dominance of approaches to perinatal care whose foundations they find spurious, and they are frustrated about it. This is a mostly tacit, mutually assumed frustration—part of the epistemic backdrop or common sense of the conversation. However, stories about coming to consciousness about that "legitimacy deficit" (Kempner 2014:13) were sometimes told when I asked interview participants how they came to midwifery or homebirth, often interwoven with stories of encountering social scientific and historical accounts of the marginalization of midwifery by obstetrics or with stories about harm experienced in hospital birth.

Addressing these stories when clients told them was also sometimes a part of prenatal visits. This happened one day with a client from Louisiana, who was seeing her midwife from Louisiana in Texas. Even this setting was the subject of a sort of meta-eyeroll: VBAC (vaginal birth after cesarean) was not part of the regulation-defined scope of practice for homebirth midwives in Louisiana, but it was in Texas, and so this VBAC client and her midwife were both driving across state lines to hold prenatals and the birth at the client's uncle's house. There was some joking as the visit began and we all pulled up to the client's uncle's house with our Louisiana license plates and similar trucks. Everyone seemed aware of a feeling of absurdity about the notion that VBAC was entirely safe five miles in one direction from the state border and entirely unsafe five miles in the other direction, the inconsistency of their conclusions casting some doubt on the epistemic authority of the boards of medicine who had made both sets of regulations. The first order of business in the visit extended that mood: the client had requested the records from her first birth, the cesarean section, and she and the midwife settled in on the couch to review them. She'd been told the day before her labor at a prenatal visit that her obstetrician believed she had a baby between ten and eleven pounds, and that she was unlikely to be able to give birth vaginally. Daniella, the midwife, read bits of the chart out loud. "Suspected CPD" (cephalopelvic dysfunction, or mismatch between the size of the baby's head and the size of the parent's pelvis), she read, and raised her eyebrows. "Hmmmmmm. I wonder how they could know *that*," Daniella said dryly. The client shook her head. "I definitely did not have a ten pound baby." Daniella read out another note about the obstetrician introducing his hand into the uterus and finding that the head was "tightly engaged in the pelvis," and she, the client, and the client's mother all

laughed. "Isn't it *always* tightly engaged in the pelvis?" the client mocked. Everyone agreed that there wasn't much space for an infant's head to engage any other way. "Well, he was smart to write that note," Daniella said, "it covers his butt because it gives him a reason to give you a c-section." The client agreed. "They told me my labor wasn't progressing because my baby was too big and my body 'knew it,' so my body was stopping me from giving birth vaginally," she said, and rolled her eyes a little. The midwife shook her head. "Your baby wasn't too big." The client agreed. But, she said, as easy as it was to roll her eyes and laugh now at the absurdity of the obstetrician's understanding of things, she'd been terrified at the time.

Out-of-hospital birthing parents and midwives often used this kind of reversal of the legitimacy deficit they self-consciously experienced relative to obstetricians and hospital staff skeptical of less interventive or physiologic birth (though not necessarily to those who were supportive.) One parent, a client of Alex's, became extremely frustrated towards the end of her pregnancy. She came to a prenatal appointment one day and said she'd been talking with a friend who was also pregnant but was receiving care from an obstetrician. The friend wanted to avoid induction, but her obstetrician had told her there was nothing she could do but wait. The client had been taken aback. Alex had told her about any number of things that might encourage labor, from a "mother's cordial" herbal tincture for uterine toning to acupuncture. The client's friend mentioned the mother's cordial to her obstetrician, who had never heard of it. The client said that the longer she was pregnant, the more dissatisfied she was with what she heard about obstetrical care, and part of the problem was about knowledge. "It's like you know everything they know, but they don't know anything *you* know," she told Alex. If someone's knowledge is

impoverished, the response to that perceived legitimacy deficit goes, it's *yours*, obstetricians.

Unsurprisingly, turning to attempts to scientifically validate existing midwifery knowledge was another common way parents, midwives, and others addressed the dearth of official legitimacy for their understandings about what makes for safe birth. Several midwives in practice in New England were involved with *Midwifery Matters*, a peer-reviewed journal of out-of-hospital midwifery published by the Birthwise independent midwifery school that publishes both original research and reviews by midwives of research relevant to the out-of-hospital setting published elsewhere. For example, one issue's research update section includes reviews of a study originally published in the *European Journal of Obstetrics & Gynecology and Reproductive Biology* of the effectiveness of the "windmill technique" for addressing retained placenta that avoids the need for manual removal, which must be done in an operating room; a trial published in the *Lancet* of the use of tranexamic acid as a new supplemental treatment for postpartum hemorrhage; and an update to waterbirth guidelines based on two cases of Legionnaire's disease published in the *Morbidity and Mortality Weekly Report*. Many midwives were themselves excited about the proliferation of fine-grained medical-scientific research applicable to their clinical contexts, and many told me that in general they wanted to have an evidence-based practice and they liked having evidence to guide their clinical judgements. But they were also conscious that turning rhetorically to medical scientific evidence addressed the credibility gap they faced. Studies that validate midwifery knowledge or prove midwives right are, as others (see Akrich et al 2014) have also noted, often heralded by midwives and midwifery advocacy organizations—a new study by the

University of Rhode Island identifying benefits of delayed umbilical cord clamping, for instance, was announced by the Vermont Midwives' Association in a Facebook post with a note saying, "standard practice in most midwifery practices. So glad science is leading the way to keeping babies safe and healthy!" Many touted the evidence-based nature of their practices to nervous clients and family members—Alex told the first client I ever met, in an initial consult in which the client whose labor and delivery nurse mother was nervous about homebirth, that "the statistics around here are very good in terms of outcomes," and "the steps we can take at home are really evidence-based."

The appeal to evidence-based practice and to empirical validation of midwifery knowledge is a more straightforward instance of "trust in numbers." "Objectivity," as Porter puts it, "lends authority to officials who have very little of their own" (Porter 1995:8). Invoking the power of objective knowledge to claim authority and legitimacy for a marginal and, many would argue, marginalized set of practices and knowledges at times includes not only heralding these findings but also embracing the conventions of mechanical objectivity as epistemic values (Daston and Galison 2007:16) guiding the approach to evaluating information in practice. One of the key resources often cited by parents seeking unmedicated birth without intervention—and recommended by homebirth midwives—is a website called Evidence Based Birth. EBB is beloved by midwives not only because it presents evidence that supports minimal intervention in birth, but also because its rigorous methodological evaluations deeply inform parents. "You should take a quantitative methods course [before writing bad blog posts]," an Indiebirth blog post advises, echoing this sense that true informed choice demands not only knowledge of studies' findings but also evaluation of their methodology, critique of

their sampling practices, and attention to what questions they asked in the first place.

It also requires that practitioners distinguish between right and wrong uses of claims to objective truth, or between times to resist and times to embrace closure. Claims to objective truth, by the epistemic norms of the informed choice model, ought to be used *only in such a way as to support informed choice*. This means they are generally of value in one of two situations: first, to borrow a phrase from stand-up comedy, when they are used to "punch up" to coercive doctors and medical institutions who don't trust physiology or parents' decision-making; second, when they are used to help providers and parents settle uncomfortably open questions or identify more options. Many of the studies in *Midwifery Matters* aim at this second goal: identifying new techniques for addressing retained placenta at home lets a midwife present more choices to a parent who wants a tool that is neither simply waiting, with all its attendant risks, nor leaving home to go to the hospital and undergo manual removal. Scientific knowledge, in this view, ought to be used in service of individuals' goals and desires. Closure is helpful because it clarifies difficult questions and identifies new options, but it is also risky because the line between claiming to know the objective truth and claiming to know the whole truth is a slippery one. The same is true of the line between claiming to know the whole truth and claiming to know what is right for someone else—what the best or safest choice is.

Constraint: The Limits of the Informed Choice Approach to Knowledge

Tracking what I have called the right times for claims to objective truth also helped reveal something else: constraint, or imposing *limits* on what could count as knowledge, was enormously challenging in homebirth midwifery practice (Vertesi

2015:192, Galison 1995:22, Pickering 1995:207). The informed choice approach to knowledge became difficult—and midwives sometimes felt they had reached its limits—when information quality was contested. Lack of closure often created particular opportunities for conflict over whose information was best, or good enough to use to make informed choices, and when, if at all, it was appropriate for a midwife to characterize something as falsehood or non-knowledge.

One clinical issue characterized by a lack of closure is the issue of gestational age. Many midwives are committed to maintaining what is often referred to as a "wide range of normal" about gestational age, assuming that not all pregnancies will be exactly 40 weeks long and that full gestation, for any individual person, might range from 37 to 42 weeks. It is common to refer to a "due window" rather than a due date, and midwives often told me they really believe that healthy pregnancies last different lengths of time because babies reach full development of the lung surfactant that enables breathing and initiates spontaneous labor at different gestational ages. They were frustrated with obstetricians who wanted to induce their clients before they felt that their babies were "ready." But most also told me, often privately, that they did not believe that the initiation of a hormonal cascade of labor worked perfectly every time, and they were not convinced that it was safe to count on a placenta continuing to function optimally in the tenth month of pregnancy. Many said they had seen placentas that "looked old" in post-dates clients, and that they did feel it was important to tell parents that post-dates pregnancy was not risk-free and offer "gentle encouragements" or home induction methods such as castor oil, herbs, or membrane sweeps to support getting into labor after 41 weeks. It was typical to offer the "longer listen" or home version of the non-stress test

used in hospital practices, and to refer clients for biophysical profiles[37] at a local hospital after 41 weeks or whatever gestational age was required by their state regulations.

Yet as parents approached the end of pregnancy, the issue of how to understand and intervene in longer pregnancies could become contentious. Parents were often finding information from parents' Facebook groups and pages, podcasts, blogs, and other internet sources. This information frequently "stretched," as one midwife put it, the clinical standards of homebirth midwifery practice. A good opportunity for comparison arose recently when posts in two Facebook groups I follow—one study group for homebirth midwives and one group for parents pursuing "unassisted" or "freebirth"—addressed the issue of postdates, or pregnancies without spontaneous labor before 41 weeks. The post in the midwifery study group inquired about practice protocols for post-dates pregnancy, and the midwives who responded offered relatively similar suggestions to those I observed. Some answers in the unassisted and "freebirth" group were quite radically different. The original poster had asked, "How far overdue is too overdue?" Some of the respondents agreed with most of the homebirth midwives I shadowed and interviewed, saying that whether or not "we know" exactly when or why it occurs, there comes a moment when most babies cannot survive in utero. "Placentas weren't made to function forever," one wrote. But others disagreed: "If your trust your body won't just stop working randomly then you can't go 'too far overdue'," one posted. "Personally, I don't really believe in 'too' over due. Baby comes when baby is ready," another posted. For her, midwives' cautions that amniotic fluid levels could in fact drop and needed

[37] The biophysical profile is an ultrasound evaluation that was the standard approach to assessing fetal well-being when gestational age exceeded 40 weeks among obstetricians consulting with homebirth midwives in the area where I conducted this research.

monitoring were just "scare tactics." "For me, it's absolutely not about numbers, it's how I feel (physically and intuition-based) and how baby is doing. If baby is still moving and I don't feel a concern (in my heart, not my head where fear lives), I would totally just keep going, 44, 45 whatever," another wrote, following her comments with the "shrugging woman" emoji. Others told her they had had babies at 44 or 45 weeks gestation, or directed her to a "ten month" group for parents declining induction very late in pregnancy.

Many midwives were extremely put off by this kind of approach to pregnancy and birth in which "it's absolutely not about numbers," or by an approach to a clinical issue about which scientific closure is elusive that treats the lack of scientifically confirmed danger as a lack of danger. Of course, when it came to the question of whether the right choice was to wait, seek medical induction, or use "gentle encouragement" methods at home, midwives reiterated to me that only a client can know how they want to weigh these competing priorities, that midwives might have their own preferences or "biases," but the midwife is responsible for making sure they do not posit these preferences as universal goods or allow them to sway the client's decision-making or override the client's idiosyncratic priorities. There are opportunities for midwives' wishes to be counted—but the time for that is before a conversation with a client, and comes when midwives write their practice protocols and informed choice documents and decide which options are "offered" in their practices. In all their endeavors to address client preferences and clients' information-gathering that did not match their own approaches or understandings of information and research, midwives struggled to continue to avoid "bias": they were delicate in noting small sample sizes in an attempt to continue to

uphold the idea that population-level patterns represent only one kind of good information. They were careful to phrase their invocation of state regulations with an emphasis on the notion that a client had reached a midwife's personal limit—sometimes phrased as the limit of the midwife's own comfort, and sometimes phrased as the limit of the midwife's comfort with pushing regulatory stipulations—maintained the notion that evaluating information was a personal matter, and there were no "wrong" choices.

The question of vaccination, which new parents often wanted to discuss with their midwives despite the fact that midwives do not themselves provide vaccines, was another frequent site for this difficulty. It came up one day when I was driving to an appointment with Alex. Alex told me the client had emailed her ahead of the visit with some questions, attaching some anti-vaccine material she had been reading online that Alex described as "so wingnut it's hard to tell what you're looking at." Alex found the question of how to discuss vaccines with her clients to be an incredibly difficult one. She truly believed that different choices were right for different families about vaccines, too, but she also believed in herd immunity, believed it was possible for most babies to safely receive all of their immunizations, and had fully immunized her own child. But, she said, if she shared what she thought about vaccines or her approach to vaccine information, much of her practice would stop trusting her.

Alex was usually fairly hands-on about providing research studies and her opinions about them to her clients: she told one client that a good new study had come out recently showing that Hebacleanse, a vaginal wash some midwives were using for GBS, was not terribly effective, and that she was no longer recommending that clients rely on it as a good way to prevent GBS transmission. She told another client that new

information about the use of blue cohosh herbal tincture suggested a possible link to heart problems in infants, and so she no longer recommended its use late in pregnancy or in labor. But she didn't feel she could have those conversations about vaccines. Instead, she found other ways to respond. From my fieldnote:

> *Then Alex said that when she saw [another family] last week, the client's husband had just seen that film* Vaxxed *and was newly concerned about vaccines. She talked about how she responded: she validated that there's a wild spread of information out there about vaccines and it's really tough to think through, and said she knows lots of people who have seen that movie and it's really affected them…then she focused on the role she could play in helping to uphold their decisions: [the client's husband] was very worried that in the case of transport, the baby might be given a vaccine, specifically Hep B. They'd also talked about using oral vitamin K instead of injectable, as they did with [their first child]. Alex affirmed that she will have the oral vitamin K and that her job will be to make sure that nothing is given without their consent if they do need to transport, and she said that she doesn't think any hospital they would transport to would do that, especially with a homebirth transport.*

The set of strategies Alex used here to sidestep the issue of conclusions or even information quality about vaccines was one I saw used relatively commonly: empathize with the difficulty of thinking about a charged issue and the experience of hearing about vaccine injury, and emphasize that you will help your clients get resources like oral vitamin K that would enable them to carry out their wishes about vaccination. Midwives who were themselves skeptical of vaccination--some of whom had chosen themselves not

to immunize their children--also did this in the opposite direction, empathizing with their vaccinating clients' experiences of concern and helping them find pediatricians who were willing to fully immunize on a delayed schedule. Vaccination was, in other words, an issue about which midwives retained their commitment to avoiding "bias," but was also a sort of exception zone from the element of evaluating information quality that was core to the informed choice process midwives applied to rest of their practices, and many said they were relieved not to have to take it on because they did not themselves provide vaccines.

These stories reveal one of the limitations of the informed choice approach to knowledge: its emphasis on epistemic multiplicity and on the importance of each individual parent's personal evaluation of information makes it very difficult for providers to tell clients when they think they are making risky decisions for themselves, their children, or their communities on the basis of bad information. If all kinds of things are treated as consequential knowledge—intuition, stories, experience, social scientific knowledge, the knowledge of how to mitigate expert authority and account for multiple knowledges, the knowledge of when to use claims to objectivity—what *isn't* knowledge? Midwives often struggled to figure out how to uphold their commitments to informed choice when faced with the distance between their own clinical judgements and clients' embrace of these kinds of radically anti-interventionist approaches to decisions in perinatal care. Pointing out the anecdotal nature of this information and telling clients about their differing experiences from the larger sample size of their practices was sometimes effective. Some displaced "drawing the line" onto a regulatory body, dodging the issue of whether or not they believed information to be good by telling clients that

unfortunately, they were required to refer clients for biophysical profiles and obstetric consultation after a particular gestational age and shifting the conversation towards empathy for the disappointment of having reached the limits of the midwife's scope of practice. Others sought, as I explore in the next chapter, to encode their understandings of what information was good in law. Ultimately, however, many told me they tended to suggest to clients who were extremely committed to care approaches they thought were founded on non-knowledge that they find a midwife who was a better fit. One midwife showed me an email from a prospective client who told her she wanted a midwife who wouldn't listen to fetal heart tones during labor much, and who would accept her request for few prenatal visits. The midwife told the prospective client she simply couldn't honor those requests, but she only privately told me that the woman simply had some wrong understandings of the risks of pregnancy and birth.

While these constraints were essentially imposed at the level of practice without open disagreements being explicitly litigated at the level of epistemology, constraining what could count as knowledge actually involved affirming epistemic multiplicity. They affirmed, in drawing the line around their practices, that client intuition did not provide enough kinds of knowledge for decision-making. Quantitative empirical evidence, along with the clinical experience of the midwife and the best practices identified by the community of practice, were also necessary kinds of information to account for in the making of good informed choice.

Counterprofessions, Power, and Social Science

As this chapter has described, contemporary professional homebirth midwives

base their practice on a set of commitments formalized *in response to* critiques of how existing experts were handling a set of concerns, in this case, perinatal health. Contemporary homebirth midwives have, in other words, constructed their work on the basis of a claim to a different kind of expertise from the ones we most readily recognize—without rejecting the idea of expertise as a whole.

This claim to expert knowledge and work is different from many of those examined in the extensive relevant literatures in both sociology and science and technology studies. STS studies of expertise, demonstrating the dynamism of lay-expert relationships (Fleck 1935, Collins and Evans 2002), have argued against the idea that laypeople have a knowledge "deficit" or that knowledge "trickles down" from scientists to populations (Wynne 1996, Benjamin 2013). These studies have illustrated the ways the appearance of credibility--the credibility of expert scientific findings to laypeople, or the credibility of laypeople seeking to shape scientific knowledge-making—is always contextual and contingent (Epstein 1996, Benjamin 2011, Hilgartner 2000). Sociologists, meanwhile, have been interested in the power of institutionalizing expert knowledge and the questions of what makes professions distinctive and what it means for some occupational groups to have the blessing of the state to control their work. They have identified both political and legal support and the significance of securing "cognitive exclusiveness," or monopolies on knowledge, to the maintenance of professional power (Friedson 1970, Larson 1979). Professions appear in this literature as competitive, aiming to exercise control over one another, over abstract knowledges and tasks, over the cooperation of laypeople and clients, and over supply and demand for their services (Friedson 1970, Abbott 1988, Eyal 2013). Professions also appear in both STS and

sociological literature as powerful cultural actors: they may structurally maintain their dominance through state-sanctioned limits on competitors, but the foundation of that social authority is the power they maintain to condition the choices available (Jasanoff 2004:2-3) and shape laypeoples' understandings of their own experiences and needs (Starr 1982).

Contemporary homebirth midwives are engaged in a different kind of expert and professional work from the ones these literatures examine: the institutionalization of a challenge to professional knowledge and work that self-consciously attempts to do expertise differently. Where Brian Wynne, for instance, demonstrated sheep farmers' readings of the advice of scientific experts through their own local knowledge of farming conditions in the wake of the Chernobyl nuclear disaster, those farmers did not attempt to replace nuclear experts' public guidance with their own. Ruha Benjamin's argument that Black sickle-cell patients declining stem cell transplants mobilized confidence in knowledges *other* than experimental method did not include a concurrent attempt to create legal parameters around those knowledges. Homebirth midwives, however, *institutionalize* their challenges to the cognitive exclusiveness, legal control, and cultural authority of a powerful profession like obstetrics. In this respect, they match many classical sociological understandings of professions as emerging when occupational groups court institutional legitimacy. Yet they do not seek to concentrate a comparable kind of professional power to that weilded by those a sociological approach to the professions might identify as their "competitors": obstetricians, or even family physicians or Certified Nurse Midwives. Contemporary homebirth midwives, I wish to suggest, are a different kind of professional, one we might usefully name as *counterprofessionals*.

They seek to institutionalize a particular kind of expert knowledge and work, but that expert knowledge and work is based on a significant critique of expertise and the professions as they are most commonly known.

The term "counterprofession," as I wish to define it, makes two references. First, the suffix "profession" highlights that such an occupational group seeks to advance a set of definitions of problems and solutions at the level of cultural common-sense, control its own work, and to institutionalize its claims. In the case of contemporary professional homebirth midwives, this point is illustrated by practitioners' insistence that what they do is *not* the lay midwifery of back-to-the-land activists or small, highly specific communities. Skilled and knowedgeable though they insist those midwives were, as one midwifery student put it in differentiating professional midwives with those serving Plain families, "CPMs ought to be differentiated from traditional midwives who are working in line with practices of a religious community that's not evidence based—or evidence informed, even. [Religious communities] have a right to a midwife who agrees with them…[but] we want to be a professionalized option for people who want to have out of hospital births." The prefix "counter," meanwhile, highlights that a counter professional occupational group emerges and institutionalizes its work in response to claims that an existing profession is approaching something wrong—both understanding a problem wrong and using the wrong tools to solve it. If another group of practitioners can make a claim to be experts at another approach to that problem, a counterprofession can be born.

Second, the term "counterprofession" highlights an oppositional stance taken against typical understandings of professional power. In this regard, the term is reminiscent of "counterpower," or a particular quality of power that seeks not to

compromise with or instantiate itself in existing authority structures that are understood to be repressive, but rather to "preserve the power and autonomy of individuals" through the exercise of another kind of social-movement power (Williams 2017: 55-6, 150-1). In echoing counterpower, or the "capacity of social actors to challenge the power embedded in the institutions of society for the purpose of claiming representation of their own values and interests" (Castells 2015:5), the term points to the social movement ties held by many occupational groups I think we might usefully understand as counterprofessions. It also emphasizes that counterprofessions often seek to return power in the scene of practice to laypeople, or to intervene in the construction of lay-expert hierarchies of knowledge and practice. The prefix "counter" then also recalls Michelle Murphy's use of the term "counter-conduct" (Murphy 2012: 2, 29, 49) to describe the commitments that, when entangled with techno science, produced the feminist health projects of the late 20th century.

Certainly the use of the term "counterprofession" hazards[38] reifying a position of subordination for a field of knowledge and work whose advocates might hope its practitioners might be able to practice independently and its approaches could one day become more mainstream than alternative. Turning to the concepts of counterpower and counter-conduct, however, helps clarify what is *counter* about a counterprofession: its approach to expert or professional power, and to action taken to reify that power. A counterprofession need not, to my mind, necessarily have or retain an adversarial or oppositional relationship to any particular more established or mainstream profession.

In both of these respects, midwifery practiced in home settings has certainly not

[38] Many thanks to Gary Downey for his sensitive and challenging questions on this point.

always been a counterprofession. The midwifery preceding the development of obstetrics, for instance, did not develop in response to a critique of another existing profession. Neither did the professional midwifery of immigrant midwives in the United States in the early twentieth century. Contemporary families, too, do not always see themselves as social movement actors: not every client seeks out a homebirth midwife out of a desire to be countercultural, or to avoid or challenge obstetric knowledge or practice. Some simply like the idea of having a baby at home, or live rurally and expect that a community midwife might provide more convenient care than a far-away hospital. Yet, as this chapter has described, the contemporary homebirth midwifery community has institutionally defined itself with a model of care that was directly written on the basis of social movement "strateg[ies] of counter-conduct" (Murphy 2012: 49-50) and social scientific critiques of the medicalization of birth, the consolidation of medical authority, and the availability of other approaches in the work of existing midwives. Those social scientific critiques drew on the practical work of activists and the intellectual contributions of social movements who were their feminist contemporaries.

A counterprofession emerges on the basis of claims that existing professions both know their objects wrong and offer the wrong kinds of solutions. It makes a claim to expertise at a different way to *know*, and a different way to intervene, in that problem or phenomenon, and distinctively, it aims to organize power differently in both that knowledge and that work. Counterprofessions, then, pose normative, epistemic, and practical challenges to existing professions. In this way, they differ from other insurgent groups: rather than developing "when jurisdictions become vacant," they develop when claims are made that jurisdictions have been wrongly defined (Abbott 1988:3). They

must make bids for cultural authority in order to publicly credential that critique of an existing jurisdiction: in order for families to understand pregnancy and birth as concerns requiring decision-making, emotional, and social support, rather than medical expertise, homebirth midwives claim not just an alternative set of facts, but a different normative epistemology, and they work to credential those approaches to how knowledge should be made, recognized and used.

The work social science has done in constituting the contemporary counterprofession of homebirth midwifery is, then, the work of authorizing on a couple of levels: first, in that the contemporary counterprofession of homebirth midwifery builds a basis of legitimacy for its clinical approach with social scientific and critical knowledge, and second, that the writers who made that knowledge in the last decades of the 20th century named or authored the description of how we should recognize and understand the field of work that we see today. This means that the discipline of which this dissertation is a part shapes the questions I have asked by *playing a key role in producing the phenomenon at hand*.

Conclusion: Hypothesizing Counterprofessions

Informed choice, as I have argued in this chapter, is more than a set of steps taken with the aim of making sure clients do not feel harmed or disempowered in their pregnancies and births. It is also a key feature of what I have called the normative epistemic environment homebirth midwives and other consequential actors in the field seek to establish for their work. By normative epistemology, I mean to highlight that the field of homebirth midwifery proceeds from a set of commitments about how knowledge

ought to be produced and deployed. Informed choice, I have argued, serves as a programmatic solution to the question of how to manage multiple knowledges, how to interact with not-knowing and constrain non-knowledge, how to elevate situated knowledges, and how to incorporate a critical eye to the conditions of knowledge's production into the evaluation and use of that knowledge. The abstract knowledge that characterizes the professional jurisdiction of contemporary professional or credentialed homebirth midwifery, as I have shown, appears as distinctively social-scientific and distinctive in its approach to what makes for a good and ethical way to use knowledge in clinical care.

I have also argued that homebirth midwives' work to establish a domain of work guided by this normative epistemology is one case of two more general phenomena: first, that of normative epistemologies as underlying preconditions for any of the stages of professionalization identified by previous analysts. In other words, I have argued that before a profession can make a claim to cultural authority or control any set of knowledge or tasks, the field must settle on a set of organizing principles for how knowledge ought to be recognized, produced, and deployed. Second, I have argued that when an occupational group makes a claim to a new kind of professional domain that seeks to know the same object or concern differently from another professional approach, use different tools to approach that object or concern, and distribute power differently in the process, we might usefully conceive of that occupational group as a *counterprofession*.

Do other challenges to professional power and expert knowledge organize themselves as counterprofessions? Analysis of additional cases would certainly be

necessary in order to answer this question. If, however, the growth of counterprofessions is in fact a more widespread phenomenon, future analyses might fruitfully consider a number of hypotheses. First: that social science and social scientific thinking often play a role like this in the development of counterprofessions. Counterprofessions emerge on the basis of fundamentally social-scientific questions: what kind of knowledge is valued, and whose knowledge, in the way we address this life moment or problem? How do our current approaches to this phenomenon succeed or fail in reorganizing distributions of resources or power? Where does our common sense about this object—how to understand its formation, what solutions are appropriate--come from? That work may be done by social movement actors and leaders, or by practicing social scientists, but it requires making strange the familiar professions that weild epistemic, cultural, and institutional power. Second, counterprofessions are faced in practice with the challenges and pitfalls of the theories on which they construct themselves. If, for instance, constraint is a challenge of constructivism, it becomes a material challenge for practitioners who base their practice approaches on critiques of status-quo care formed in deep conversation with constructivist thought. Third, that counterprofessions are particularly good places for analysts to see the intersections of normative and epistemic work required to make an insurgent professional claim of any kind. Settling on a normative epistemology, in other words, is always a necessary step in the making of new claims to a professional jurisdiction. Because counterprofessions organize themselves on the basis of an active critique of both knowledge and practice, however, they tend to make their normative epistemologies particularly explicit, and thus particularly easy for analysts to identify.

The fourth and final hypothesis I wish to offer is that counterprofessions always face some degree of internal conflict over the question of whether and how to mainstream. As one Indiebirth blog post titled "Doctors suck but so does your midwife" lamented, "Midwives aren't listening to women anymore. Midwifery care feels just as cold and clinical as OB care, just with a rocking chair and some nice music in the background. The rules and regulations are more important than the mother's wishes." Are institutional integration or collaboration with other professionals, even those whose approaches to expert and professional power are radically different, advances for a counterprofession? Or do the practical compromises often involved in building those relationships constitute betrayals of the counterprofessional essence? While a counterprofession need not necessarily remain marginal, counterprofessions may universally be faced with the question of how to relate to mainstream professions—and the legal and other institutional structures that surround them. The next chapter will take up this question, examining the ways home birth midwives position themselves in the legal and other rule-systems that surround their work.

Chapter Four

Managing the Law: Informed Choice and Regulation

Introduction

The question of direct-entry midwifery's legality has preoccupied scholars and commentators for decades. In this chapter, I argue that law, like science, does not succeed in "making order, and guarding against disorder" (Jasanoff 2007: 761) for homebirth midwifery. After reviewing existing sociological literature about the heterogeneity of homebirth midwifery law and regulation, which I argue is yet more multiple than previous authors have described, I identify two major ways midwives understand and position themselves relative to this prolific field of law and regulation, or two "stories about law". In one, I argue, midwives appropriate law's power for midwifery by making or changing law. In the other, they evade law's power by breaking or dodging law. I describe the ways these two strategies reflect a larger conversation in the midwifery community about whether to seek or to reject protection in the law, and argue that these two strategies reflect two major "stories about law" that together form a core legal paradox. Navigating these two "stories about law," I argue, midwives find themselves caught on the horns of a key dilemma about law's relationship to choice: while law can enable or enshrine the right to individual choice, it also serves to limit individual choice. Knowledge of the law, I find, thus appears as a core element of the knowledge necessary for midwifery practice. Using that knowledge of law to manage the two sides this dilemma becomes a crucial part of the epistemic choreography involved in the day-to-day work of midwifery, as well as the work of protecting the profession of

midwifery and the practice of informed choice.

Midwives are faced with another challenge in addition to this paradox and the enormous inconsistency of legal and regulatory treatment of non-nurse midwifery. This additional challenge is a mismatch between home birth midwifery's core ethical and epistemic commitments and the legal infrastructures that surround their practices. Relating to the law as counterprofessionals, I argue, midwives must become active managers of law, turning to legal normative pluralism in order to uphold commitments to informed choice, physiologic birth, and the midwifery model of care. I suggest that such encounters are general conditions for counterprofessions, which must operate in the context of legal infrastructures not built for their normative epistemologies or their practices. As counterprofessionals interact with those legal systems, the law's seeming seamlessness is fractured, and its plurality, contingency, and constructedness is revealed. These encounters relativize the law, preventing assumption that law can act as a consistent or trustworthy arbiter of truth or guide to right action and demanding that actors become active managers of the law. Finally, I consider the role of rules held by private entities such as hospitals and insurance companies in conditioning the environment in which homebirth midwives practice and clients receive care.

Is Non-Nurse Midwifery Legal?

The distinctively heterogeneous legal landscape occupied by the profession of non-nurse midwifery has long preoccupied sociologists (see, for instance, De Vries 1996: xxvii, Davis-Floyd and Johnson eds. 2006, Reiger and Morton 2012, Pope and Fisch 2013, Craven 2010), with analysts contending that law exerts as shaping a force on the

profession of midwifery as medicine (De Vries 1996: xxv). In addition to being enormously varied, these laws are also rapidly changing, particularly due to the coordinated efforts of statewide midwifery organizations and affiliates of national organizations such as the National Association of Certified Professional Midwives and campaigns such as the Big Push For Midwives to pass bills decriminalizing midwifery and establishing procedures for CPM licensure. Many of these bills have passed as recently as 2019 (in Hawaii). These changes come to a regulatory environment for direct-entry midwives in the United States that entirely on a state-by-state basis.[39] Analysts have often depicted the landscape formed by state's positions on the matter as a spectrum from regulation to formal stricture of practice. In 1996, Raymond De Vries classified states' legal treatment of midwives into three categories: in the first category were states forbidding anyone besides physicians from providing prenatal or postpartum care or assisting at births. In the second, states lacked clear legal definitions of midwifery. "Because the provision of assistance at birth is not defined as the practice of medicine," De Vries wrote, "midwives have what some have called 'legality by default'." The third, he wrote, was the most common regulatory arrangement: permission for midwives to practice granted alongside prohibitions on access to some clients, some technologies, and some clinical techniques (De Vries 1996: 16). As of May 2019, this is the arrangement in 33 states: midwifery practice for CPMs is legally recognized by statute, regulated by the state, and a pathway to licensure or certification has been legally defined on the basis of some combination of credentials, schooling, examination, and/or "grandmother"

[39] Nurse midwives are also regulated at the state level. While their scope of practice and ability to practice independent of physician oversight varies by state, nurse-midwives, unlike certified professional midwives, are licensed by all 50 states.

provisions for elder midwives whose training and practice preceded the development of contemporary CPM regulation. In some of these states, licensure is voluntary, and/or includes provisions for the practices of traditional or uncredentialed midwives. In others—particularly those whose licensure bills were written after the creation of US-MERA[40] in accordance with its guidelines—the requirements for licensure exceed the maintenance of the CPM, often requiring attendance at a MEAC-accredited midwifery school and/or completion of a "bridge" certificate for apprentice- or PEP-trained CPMs. In three of these states,[41] licensure bills have passed and been signed into law, but have not yet been fully implemented: regulations have yet to be finalized and/or licenses have yet to be granted.

Two decades after the publication of De Vries' *Regulating Midwifery*, the regulatory environment for homebirth midwives remains similarly split between states that criminalize midwifery, those that regulate its practice, and those in which no clear statute exists. Pope and Fisch, for instance, described three similar categories of state approaches to the legal treatment of direct-entry midwives in 2013: regulation of midwives' practices and assignment of licenses, criminally outlawing the practice of homebirth midwifery, and lack of clear or certain legislation on the matter (Pope and Fisch 2013: 295). Echoing Christa Craven and De Vries, who note that "court cases have taken on a regulatory function" (Craven 2010: 55, De Vries 1996: 175) in states without

[40] The US Midwifery Education, Regulation, and Association (US MERA) coalition is made up of representatives from comprised of representatives of national midwifery associations, credentialing organizations, and education accreditation agencies. Its members include representatives from nurse-midwifery specific organizations and non-nurse midwifery-specific organizations. US-MERA's primary function has been the creation of standardized legislative language approved by all organizations to be used in the introduction of licensure bills, ensuring that such bills will be supported by all member organizations at the time of introduction.

[41] Including Michigan, Maine, and Hawaii

clear regulation, Pope and Fisch added a fourth category of permission of direct entry or non-nurse midwives' practices without licensure. They noted that in these states, while no statute permits the practice of non-nurse midwifery, direct-entry midwives have obtained court decisions, attorney general opinions, or statutes specifying that direct-entry differs from the practice of nursing or medicine such that prosecution for practicing medicine or nursing without a license do not constitute viable charges (Pope and Fisch 2013: 297). The North American Registry of Midwives (see fig. 1) similarly distinguishes between states with inactive licensure laws on the books and no current regulation, states in which no statute legally defines the category of non-nurse midwifery, and states in which the issue is addressed only through variable judicial interpretation.

DIRECT ENTRY MIDWIFERY STATE-BY-STATE LEGAL STATUS

STATE	REGULATED	UNREGULATED				CPM	MEDICAID REIMBURSEMENT
	Licensure (L) Certification (C) Registration (R) Statute (S)	Judicial Interpretation Varies	Not legally defined, but not prohibited	Statute, but Licensure Unavailable	Statute, Judicial Interpretation, or Stricture of Practice		
AL	L					*CPM*	
AK	L					*CPM*	X
AR	L					*CPM*	
AZ	L					*CPM*	X
CA	L					*E*	X
CO	R					*CPM*	
CT			X				
DC					X		
DE	L					*CPM*	
FL	L					*E*	X
GA				X			
HI	L					*CPM*	
IA		X					
ID	L					*CPM*	X
IL					X		
IN	L					*CPM*	
KS		X					
KY	L					*CPM*	
LA	L					*CPM*	
MA		X					
MD	L					*CPM*	
ME	L					*CPM*	
MI	L					*CPM*	
MN	L					*CPM*	X
MO	S					*CPM*	
MS		X					
MT	L					*E*	
NC					X		
NE			X				
NH	C					*CPM*	X
NJ	L					*CPM*	
NM	L					*CPM*	X
NV		X					
NY	C					*	
ND		X					
OH			X				
OK		X					
OR	L					*CPM*	X
PA		X					
RI	C					*CPM*	
SC	L					*CPM*	X
SD	L					*CPM*	
TN	C					*CPM*	
TX	L					*CPM*	
UT	Voluntary-L					*CPM*	
VA	L					*CPM*	X
VT	L					*CPM*	X
WA	L					*CPM*	X
WI	L					*CPM*	X
WV			X				
WY	L					*CPM*	

Licensure/Certification
Inference/unregulated
Illegal

5/15/2019

E - State uses NARM Exam as part of licensure process

CPM - Reciprocity of CPM credential or CPM plus state specific requirements accepted for licensure, certification, documentation or registration.

***** - Certified Midwives (CMs) are direct-entry midwives certified by the American Midwifery Certification Board (AMCB).

For more information on direct-entry midwifery, visit NARM's web site: http://www.narm.org or MANA's web site: http://www.mana.org

*** ***Information for this chart was provided by the Midwives Alliance of North America (MANA), and the North American Registry of Midwives (NARM).***

Fig. 1

In addition to characterizing states with respect to whether or not non-nurse midwives are prohibited or allowed, in some way, to practice, analysts of midwifery and law have also divided licensed states further into those in which licensure laws enable midwives to self-govern and those in which licensure laws establish physicians and their representatives as regulatory supervisors of midwives. For De Vries, for instance, some states have what Friedman (1965) referred to as "hostile" licensure laws, or laws in which "an occupation group is placed under outside control" and specifically under medical control. A small number of others have what De Vries and Friedman call "friendly" licensure in which "the licensing process is controlled by individuals drawn from the occupation group being regulated (De Vries 1996: 29, 83). De Vries argues that the case of midwifery unsettles the common-sense notion that licensure strengthens professions, contending that this is so only in cases of friendly licensure such as that enjoyed by physicians (De Vries 1996: 30, 86). "Friendliness" or "hostility" of licensure thus becomes a second axis of differentiation, alongside legality or illegality of practice, by which homebirth midwifery practice is classified sociologically.

Friendly and Hostile Licensure in Action

This "binary within a binary" framework focuses attention on two elements of the legal circumstances of homebirth midwives: first, with regard to licensure, whether investigations and disciplinary proceedings of midwives following misconduct, adverse outcomes or scope-of-practice concerns will be administrative or criminal; and second, in the case of licensed states, whether those overseeing rule-making and investigation will

be midwives or non-midwives, generally physicians. The importance of these distinctions is undeniable. For one thing, they function as actors' categories: debates over licensure in states that are currently unregulated are frequently heated, and usually, when I ask about how midwives experience law and regulation in the place where they practice, they begin with telling me whether the state or states in which they practice is one in which CPM practice is licensed, "alegal," or criminalized. "I've had raids," one midwife in an unlicensed state told me, pointing to the waiting room with its racks of pamphlets about dental health and its rows clipboards holding sign-up sheets for birth education classes, "men with guns, and a homicide detective." This midwife, like others in states without the routine investigative processes stipulated by licensure law and regulation, received a cease-and-desist letter and a charge of practicing medicine without a license—a charge carrying a significant fine and possible jail time in her state. A midwife in a licensed state who was the target of a state investigation following an intrapartum fetal demise, meanwhile, told me she was also ordered to stop practicing for the duration of the investigation. She was eventually found not to have been at fault in any way, and though her investigation was lengthy, unpredictable, and difficult, never faced criminal charges or possible jail time, and armed law enforcement never entered her workplace.

Midwifery council meetings that I attended, similarly, unfolded enormously differently in states in which these councils had rulemaking authority and states in which they were merely advisors. One New Hampshire Midwifery Council meeting, for instance, started as the last clients were finishing up a prenatal visit in the next room of the birth center. Three midwives, a "consumer representative", a staff attorney from the

state Office of Professional Licensure and Certification, and a local pediatrician settled themselves down in one of the birth rooms. “Someone can sit on the birth stool or the birth ball if we’re out of chairs,” joked Tamara, one of the midwife representative, as she set up a plate of cheese and crackers, three-ring binder, and stack of meeting agendas. “So I think I’ll move to call this meeting to order.” “I guess I’ll second that,” someone added, and everyone laughed, the formality of the use of Robert’s Rules at odds with the intentionally homey atmosphere of the birth center. Once the meeting was underway, though, the members of the council got down to business quickly. The council, which has both rule making and investigative authority, was in the process of adding to the training requirements for licensed midwives in the state. Everyone agreed that the lack of a pharmacology course requirement was a big problem for a state in which midwives regularly administered anti-hemorrhagic drugs and intravenous antibiotics. One of the midwives turned to the pediatrician representative. “Don’t listen to what I’m about to say,” she said, “but I give miso[prostol], and I know how to give miso because I’ve seen someone do it. But that’s no good! And we’re allowed to administer antibiotics with a prescription from a physician, but nothing insures that everyone actually knows *how* to do that.” “Which is pretty ridiculous,” another midwife broke in. Everyone agreed that if a requirement was to be added, then a course would have to be made available to support midwives fulfilling that requirement. The whole point was, after all, to give midwives more resources, not to erect barriers to licensure or practice. Another midwife representative took the floor to make a presentation reviewing options for how to offer a course: currently available college-level pharmacology courses offered at local schools, midwifery educators who could create a course specific to the state’s formulary, existing

continuing education courses for practicing midwives. The OPLC lawyer weighed in about which section of the regulations could accommodate this new requirement with a simple vote of the Council, and which sections could not be altered without an amendment to the law through the state legislature. No one wanted to introduce an amendment. That process would make the whole licensure law, and the midwifery council arrangement itself, vulnerable to change. Eventually, the group settled on a plan. The chair summarized: "Let's stick it in as a CEU [continuing education unit], keep it as a two-hour requirement, and wait until we're ready to open the law. We can do that—we got misoprostol by slipping it into a 'such as'!"

I stepped outside during the closed session portion of the meeting, during which reportable events during care are discussed and any investigations are conducted. When I asked about investigations, two of the midwives on the council told me they weren't aimed at punishment at all. "The mostly common outcome," one told me, "is that we'd recommend a particular CEU, or recommend you have another midwife with you while you do something for a while." The goal, she explained, was to make sure midwives had what they needed to bring their practices into compliance with regulations, and to make sure those regulations reflected as much as possible the midwifery community's consensus about what constitutes good care.

I rarely met midwives who had experienced state investigation in northern New England, where the two states in which licensure was active were judged relatively friendly by most midwives. In a state with "hostile" licensure, however, talking to midwives who had experienced investigation was judged by almost everyone to be a crucial part of understanding what it was like to practice in the area. "You should really

talk to Tina," everyone told me, "but I don't know if she'll be willing to." It took weeks to get in touch. I called and left several messages, texted, and sent an email. I was starting to worry that I looked like a stalker when Daniella, the midwife I was shadowing, told me I had to use someone's name. "She's not going to talk to you unless she knows she can trust you," she told me. "She probably thinks that you're really an undercover investigator from the medical board and you're just pretending to be a researcher. That's what I'd think, if I was her." Tina's practice was suspended for the moment. She had had her turn with the nightmare most midwives told me they knew they'd experience at some point in their practices: the death of an infant in her care, this time in a stillbirth after a sudden uterine rupture. All her colleagues agreed that there were no particulars of her care that led them to believe she was at fault in the baby's death, and indeed an investigation by the Medical Examiners Board responsible for licensing CPMs in Louisiana would later clear her of any responsibility and restore her license in full. But while they conducted that investigation, the board had given Tina a choice between voluntarily suspending her practice or having her license suspended. For the time being, Tina was unable to conduct prenatal or postpartum visits for any other clients, and should those clients go into labor and, without access to Tina's care, seek care at a nearby hospital, she was unable to attend their births at all in the role of doula or support person. Tina was working as a per diem medical assistant for the meantime, doing pap smears, losing tens of thousands of dollars in income refunded to clients whose care she could not provide, and feeling terrible that her clients were without their midwife and taking over her clients' care was straining the time of her already-busy colleagues.

When we met at last, Tina told me that though she knew she hadn't done anything

wrong, she was worried that the Board would find some way to exploit the gaps in Louisiana's regulations to find her out of compliance and strip her of her license. "For instance, the eye ointment," she told me. "It says we're that we're required to administer eye ointment within a certain amount of hours. Pretty much 100% of my clients will not do eye ointment. And that's true for all the midwives in the state. But it doesn't specify informed choice, and being able to decline things." She herself had served as an expert witness during the investigation of a midwife who lost her license when a client declined a glucose tolerance test. The investigation had initially concerned the midwife's handling of a shoulder dystocia. Though the board cleared the midwife of any wrongdoing with regard to the shoulder dystocia, a decision with which Tina had agreed in her expert testimony, the midwife lost her license because the board did not find a signed informed choice document declining glucose tolerance testing to be an acceptable reason not to test the client. "They spun it," Tina told me. That's what she'd learned happened to a lot of people who went before the board: "They assume they're going for one particular reason, the board reviews their cases, and then the board calls them on something else completely different." Moreover, she told me, the board didn't really seem to know what home birth midwifery practice actually entailed. "The lady who is handling my case called me and asked for the printout of fetal heart tones for the birth I was at. I was like, 'we don't bring electronic fetal monitors to home births!' And that was news to her!"

Lack of familiarity with homebirth practice was what had started this nightmare for Tina's practice in the first place. When Tina had first noticed the problem with the baby's heart tones during labor, she called ahead to the hospital and told the head nurse and EMTs she suspected an umbilical cord issue or placental abruption. "I'm losing this

baby's heartbeat," she told them, "and we need to get the ER [emergency room] and OR [operating room] ready right now. When we arrive, make sure that's ready." But when they arrived, there was no obstetrician or anesthesiologist present, and it took a full hour from the time they arrived for the client to finally receive the cesarean she needed. "We're very, very lucky that we didn't lose her, too," Tina told me. The baby died, and the mother ended up in the intensive care unit. The bereavement counselor assigned to the case wasn't familiar with licensed midwives, simply didn't believe the other hospital staff who told her that Tina had acted within the scope of her license, and reported Tina to the licensing board. Tina was simultaneously upset that her client had received such delayed care and appalled at what felt like a double standard. Her lawyer, who specialized in representing hospitals and physicians before the state medical board, had initially tried to calm her down. "You know people lose babies in the OR, on the operating table," he'd told her. "These things happen, and it's a shame it happened to you, but when you go to so many births, eventually you're going to see something crazy and wild like this." But he gradually began to notice that Tina was being treated differently from his other clients. Eventually, Tina asked one of the board's staff members whether physicians have to report intrapartum fetal deaths for investigation, too. "Actually," she told Tina, "no, they don't have to report fetal death at all. We don't hear anything about it unless there is some kind of medical lawsuit." What happens then, Tina asked? "Well, we let them know that we're reviewing their case, but they don't have to stop practicing," the staff member told her. She couldn't explain why Tina had to stop practicing when an OB would not. She couldn't explain why Tina's practice was the one suspended when her actions had been standard of care, and the hospital was the one

that was unprepared for the emergency transport about which she'd warned them. Many Louisiana midwives agreed with Tina that the Medical Examiners Board actively interferes with the provision of care governed by informed choice; investigates licensed midwives significantly more aggressively than it does obstetricians hospital staff, or other care providers, even when their actions had a larger hand than a midwife's in a bad outcome; and doesn't appear to know much about the standard of care in homebirth.

Midwives in Louisiana were not alone in feeling subject to opaque investigative processes that seemed designed to cast midwives as guilty of wrongdoing by holding them to the standard of the medical, not the midwifery model of care. Several months later, I drove to the regularly scheduled meeting of the California Midwifery Advisory Council in Sacramento. I picked up half-inch thick copy of the meeting agenda on the way into the hearing room where two licensed midwives, one consumer representative, and a physician were slowly assembling behind their nameplates at a long desk. Two staff people from the medical board buzzed about, setting up webcasting equipment. Midwives in the 25-person audience passed around a copy of *Real Food for Gestational Diabetes* and chatted until a medical board staff member called the meeting to order. Lacking a quorum, she said, the council would not vote that day and would skip several elements of the agenda. Public comments were taken first, and one licensed midwife commented on some confusion about the dates of annual data reporting before the chair of the council—another licensed midwife—reported back on her visit to the full medical board, where she and on her proposals for future agenda items. "I'm interested in figuring out the most effective use of our time on the MAC," she said. "Dealing with LMAR (the Licensed Midwife Annual Report) is coming to a close, and CALM (the

California Association of Licensed Midwives) will be seeking legislation to create a midwifery board. What is the most effective use of the time we have left?" The question was a genuinely difficult one to answer for a chair who, as she later told me, had "no real power." "The MAC is totally impotent," she told me. "We can't even set our own agendas without the medical board approving it." And when she went to the board's meeting for the first time as chair of one of its advisory councils, a representative cut her off while speaking. "It just felt like it signaled, 'you are *not* my colleague,'" she said, "'and I don't have to take you seriously at all.'"

The lights dimmed for two powerpoint presentations. The first, by the chief of licensing, explained a new interface for submitting annual reports. The second, by the executive director of the medical board, described the enforcement process by which the board's staff receives and investigates complaints against licensed providers. The questions midwives asked after the presentation illustrated just how opaque they found the investigation process, and just how profoundly they felt that it was out of the profession's control: at what point would a case be reviewed by a physician, as opposed to a midwife? Would probation monitors have midwifery training? Does a midwife know if a complaint is made, or only if it proceeds to investigation? Do medical board staff ever operate undercover during an investigation? Why wasn't the board following up with midwives who had applied to serve as Midwifery Experts during investigations? What could midwives do if they had problems with the way the medical board had conducted an investigation? "In all my years I've been coming to midwifery council meetings and even serving on the council," one midwife said, "I didn't know half of this." I knew from my conversations with midwives in the state and my experience in

prenatal and postpartum visits that midwives in the state had real concerns with scope of practice and investigations: many felt that investigations were often opened in inappropriate circumstances because the board just treated midwives with suspicion, and that these investigations, even when settled with decisions that midwives were not responsible for adverse outcomes, incurred enormous and ultimately punitive costs to midwives. Many were frustrated that they could not refer their clients directly to specialists for concerns like urinary tract infections that they were allowed to diagnose, requiring unnecessary additional appointments for their already-busy clients with physicians who often told clients one more time that their homebirth plans were a bad or irresponsible idea. But unlike in New Hampshire, the appointed leaders of the professional community were powerless to regulate these issues—at least while legislation to create a Midwifery Board with rule-making and investigative authority waited in the wings.

Additional Variation in Homebirth Midwifery Regulation: Policy, Practice, and Informed Choice

While these distinctions are clearly important, non-nurse midwifery regulation is yet more multiple than is captured by that "binary-within-a-binary" framework. Variety in the content of both midwifery-specific statutes and regulations, as well as the rules and practices of other state agencies, characterizes the landscape of midwifery regulation as much as the structure of licensure arrangements. Furthermore, the rules and practices of those other agencies can restrict practice even in situations of friendly licensure. One significant additional source of variation is in the question of whether the specifics of

scope of practice, peer review, transport protocol, ability to assess clinical risk independently, and more are protected or stipulated by law—and thus more difficult to change or update—or addressed in rules and regulations. As the Council noted, New Hampshire's midwifery licensure law,[42] for instance, includes the specific formulary for drugs and medications a certified midwife may obtain, possess, and administer, while the specifics of medication formularies are stipulated by regulation and thus possible to change without amending statute in many other states. Vermont's law[43] specifies a timeframe for peer review following events such as a death, significant morbidity, transfer to hospital, or out-of-scope action; California's law[44] includes required protocols for transfer of care to a hospital, which in New England are determined by a regional perinatal care quality improvement network, and stipulates some significant elements of scope of practice, such as a prohibition on licensed midwives attending breech births without additional physician authorization. Louisiana's law[45] requires that all clients be evaluated and deemed low-risk by a physician in order to pursue home birth midwifery care. As the Council in New Hampshire noted, the placement of these provisions in statute rather than in regulation makes it far more difficult for even midwifery councils in states with "friendly" licensure to keep state guidelines up to date with research and standard of practice in the local community of midwives, as amendment becomes subject to legislative and popular opinion.

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[42] See New Hampshire Revised Statutes Title XXX Occupations and Professions: Chapter 326:D Midwifery

[43] See Vermont Statutes Title 26 Professions and Occupations: Chapter 85 Midwives

[44] See California Code of Regulations Chapter 4: Licensed Midwives, and relevant summaries by the California Association of Licensed Midwives ("Summary: AB1308—Amended Licensed Midwifery Practice Act")

[45] see Louisiana Revised Statues Title 37 Chapter 46: Midwife

In addition to variation in whether and how midwifery is regulated, variation in the content of licensure laws, variation in the oversight and rule making structures established by statute, and variation in the scope of which matters are addressed in statute and which in rules and regulations, the content of home birth midwifery regulations also varies from state to state. For instance, medication formularies in many state regulations—including those of Vermont, California, and Louisiana—allow midwives to independently obtain and use anti-hemorrhagics, Rhogam, Vitamin K, and other medications, while in other states, including Texas, difficult-to-obtain standing orders with physicians are required or carrying and administering medications is prohibited.[46] Midwives who practice in the border region of western Louisiana and east Texas tell me they thus treat the similar hemorrhages differently depending on where they are. Likewise, some states' rules and regulations include specific definitions of the conditions under which midwives may work with clients seeking vaginal birth after cesarean. In New Hampshire, for instance, regulations stipulate that a NHCM may accept a VBAC client only if that client has had just one previous cesarean section and no other uterine surgeries. The midwife must then confirm that that incision in that previous cesarean was a transverse incision in the lower uterine segment, rather than a vertical or "classical" cesarean incision; that the client's due date is at least 18 months after the previous cesarean section; that ultrasound demonstrates that the client's placenta is not in a low-lying position; and that the birth will take place within twenty minutes of a hospital with obstetrical and anesthesia services on 24-hour call.[47]

While many midwives felt these particular regulations matched entirely or closely

[46] For instance, Virginia's licensure laws prohibit carrying or administering medication.
[47] See Chapter Mid 500, Scope of Practice

with the limits they would wish to set for their own practices, this was not the case with all such regulations. Indeed, many midwives told me that it is regulations, more than the provisions of statute, that most frequently interfere with the provision of informed choice in care. 2017 changes to Arkansas regulations, for instance, required vaginal exams at the beginning of pregnancy and at 36 weeks gestation, and prohibited licensed midwives from continuing care should clients decline either exam. In a departure from the pattern of relative quiet surrounding administrative disciplinary hearings identified by De Vries,[48] several newspapers followed the story of a midwife disciplined by the Board of Health for refusing to drop a client who had declined the vaginal exam (see Davis 2019, Associated Press 2019, Tsai 2019). These regulations are directly at odds with the standard of practice in home birth midwifery by dint of both commitments to physiologic birth and informed choice. Vaginal exams are rare in CPMs' prenatal care: I would estimate that I saw fewer than 10 performed at all. They are understood to constitute an intervention in and of themselves, increasing infection risks for both parent and infant by virtue of the bacteria introduced into the vagina, and indeed many homebirth midwives' practice protocols formally list avoiding vaginal exams as an element of their approach to limiting risk of Group B Strep infection. Performing routine vaginal examinations, as

[48] De Vries described a fairly predictable pattern of investigation: physicians report midwives' practices when they believe "something improper" has been done, particularly when they seek to deflect responsibility from their own practices. These reports lead to arrests and prosecutions of midwives, which draw attention from supporters and the media, and courts then tend to be relatively hesitant to harshly penalize midwives (De Vries 1996: 121, 175). Indeed, De Vries contends, such prosecutions often attract more support than similar disciplinary proceedings initiated by physician reports in licensed states, and absent public attention and the ability to argue that conviction would restrict the freedom to choose midwifery care for parents, administrative agencies can actually be less lenient than courts (De Vries 1996: 136). This observation has led some, including De Vries, to contend that midwifery practice is functionally less harshly policed in so-called "alegal" states than in many regulated states.

discussed in previous chapters, was also described by many midwives as unnecessarily re-traumatizing for clients who had had had the common experience of non-consensual procedures during vaginal exams in past obstetrical care. Finally, the fact that the Arkansas rule did not allow for clients to decline was directly at odds with the principle of informed choice. When vaginal exams are performed in homebirth midwifery care, it is usually because a client has specifically requested one for a particular reason. One client requested a vaginal exam to determine the extent of and attempt to break up cervical scar tissue from a prior procedure that she was concerned could impede her cervix opening during labor, for instance. Another, whose husband was about to go out of town for work when she was 38 weeks pregnant, asked for an exam. The midwife explained that the exam could increase the risk of infection, but said that since the client was GBS negative, she was comfortable with it, and reminded the client that an sam wouldn't necessarily predict anything about how soon she would go into labor. The midwife and client chatted through the exam. "Your cervix is soft, that's really good," the midwife reported, "about 60% effaced, and one centimeter. He can go!" When vaginal exams are performed in accordance with commitments to physiologic birth and informed choice, they are instigated by a client's sense that the peace of mind afforded by information they could provide is worth the risks, including the risks of infection..

Telling a client that they had to choose between undergoing an exam they did not want—and taking on attendant risks they were hoping to avoid—in order to continue to receive care was anathema for every midwife I spoke with. Indeed, when I told this story to one midwifery student in another state—one whose regulations required nothing similar—as we took a walk one day, she whipped her head around, shocked. She hadn't

heard about the Arkansas story. "That's requiring a midwife to assault someone," she said. Another late-stage student told me she planned to practice in a different state from the one in which she was training because of a similar vaginal exam requirement without option to decline and continue care. Regulations like these, or like the regulation requiring eye ointment with no option to decline that Tina described, conflict with standard of practice for homebirth midwives at least as commonly as statute—either because they conflict with physiologic birth as midwives understand it, or because they interfere with the provision of informed choice, or both.

Furthermore, the policies and practices of other state agencies can restrict practice even in situations of "friendly" licensure. I attended another public meeting of the New Hampshire state midwifery council several months after the initial meeting about pharmacology requirements. Meg, one of the CPMs on the board, pulled out a letter that all the state's independent, CPM-led birth centers had recently received. These letters had been issued by the Department of Health and Human Services, she said, because though midwives were certified through the Midwifery Board housed in the Office of Professional Licensure and Certification, birth centers were governed under DHHS's division of residential care and health facilities. A new staff member had been assigned to birth center recertification this year, and she had decided that birth centers had been misclassified in the past and would now need to meet the requirements for collecting stations. This, Meg explained, was going to be a big problem for CPMs and birth centers for both philosophical and practical reasons. Practically, the buildings, many of which had ben constructed as freestanding houses or retail spaces, did not have the required six-foot counters or reclining chairs of collecting stations. No independent birth center could

afford the renovations required to add these elements. But even if they could, changes like these would also alter the experience of receiving care in a birth center for clients. Independent birth centers in New Hampshire essentially look like exceptionally tidy private. Their purpose is visible mostly in their unusually spacious bathtubs, atypical concentration of yoga balls, and labor slings suspended from ceilings. Clinical equipment is generally kept out of sight in bureaus, changing tables, or hallway cabinets, and rooms are furnished with not with standardized institutional chairs and stools but with unique furniture and decorations: a velvet couch, a king-sized bed with a patchwork quilt, a brocade loveseat, framed photographs of parents and babies, decorative lamps, angel-shaped window decals, windchimes. Chairs and sofas are upholstered with fabric, not the plastic material hospitals use for ease of cleaning. Many clients, as Meg reminded the council, sit on a couch next to their midwife with a pillow under their elbow to have their blood drawn. Those clients who have had traumatic experiences with hospitals or obstetric care but cannot have their prenatal care or birth at home often say they rely on the homelike environment of the birth center with its absence of institutional furnishings for care they feel is less likely to be triggering. Given the often-repeated aphorism that "the 'first intervention' is the transition from home to hospital," or from the home to institutional space, many clients and midwives feel this lack of visible signals of clinical space helps all clients to relax prenatally and in labor and facilitates smoother births and safer outcomes. And so even if cost had not been a factor, many were uninterested in making independent birth centers look more like hospitals. But neither were they comfortable with the idea of ceasing to offer the choice of blood-draws during prenatals at birth centers, since that would force those clients to make additional

appointments to have their blood drawn in another institutional setting such as a private lab where they'd likely have to pay an additional fee. Another midwife on the council raised an issue of compliance with the midwifery certification requirements: if midwives who mostly saw their clients at birth centers stopped drawing blood themselves, these midwives would be out of compliance with the certification regulations, which require midwives to keep their skills in venipuncture current. Here again, even with this state's "friendly" licensure laws—and the regulations that make it one of the few in which CPMs can independently operate birth centers—[49]a key element of the care midwives aimed to provide was subject to regulation by another state agency, one whose staff was not uniquely committed to or even terribly familiar with CPMs' model of care.

One of the circumstances in which this collision with other state regulations was the most fraught during my fieldwork concerned drug use. Northern New England is currently experiencing a particularly dire opioid overdose crisis, and many midwives told me that hospitals near them had begun routinely running tox screens on all patients in labor and delivery wards. At some hospitals, midwives told me the pattern they observed was that babies' diapers were tested without parental consent and Child Protective Services was sometimes called if patients declined that tox screen. Meanwhile, VCHIP (Vermont Children's Health Improvement Plan), the statewide pediatric quality improvement program housed at the University of Vermont, began a program asking homebirth midwives to report suspected drug use by parents. Homebirth midwives found themselves caught in the middle because of these policies: they wanted to maintain their

[49] Certified professional midwives and licensed midwives participated in care in just 20% of births in the last major survey of birth centers, providing care independently of nurse midwives in just 14% of births (see Stapleton, Osborne and Illuzzi 2013).

good relationships with hospitals and with statewide healthcare quality improvement networks, which had served their interests powerfully at times, such as in the creation of regional homebirth transport guidelines, and gave them access to important resources. Acting collaboratively with hospital staff during transports and following VCHIP rules was an important part of maintaining those relationships. But for most, following these kinds of rules was completely at odds with the kind of consent and informed choice processes they were committed to using, and the inability to protect clients from nonconsensual tox screens—and possible CPS action—was deeply uncomfortable. Many midwives told me that while they felt current drug use (or, for that matter, smoking more than a certain number of cigarettes per day with no plans to stop) typically indicated that a pregnancy was higher-risk than would be appropriate for home birth care, they were opposed to nonconsensual testing and to punitive responses to parental substance use like calling Child Protective Services.

Finally, the *practices* of relevant state agencies—over and above their stated policies—consequentially condition practice for midwives. Daniella agreed that Tina's experience of a license suspension after an adverse outcome *before* an investigation could conclude that a midwife was responsible in any way for that outcome seemed to be the general practice of the medical board in Louisiana. "[Your license] will get suspended if you lose a baby," she told me, "even if you didn't do anything wrong. It'll always be suspended. Which just sucks—before they ever do an investigation!" This practice, she explained, was particularly consequential for post-dates clients. "Here, at 41 weeks, you kind of have to transfer care, even though legally it's 42 [weeks]. But you have to consult

at 41+3[50]. An OB has to see you *by* 41+3." In order to accommodate obstetricians' schedules and make entirely sure those visits occurred by 41 weeks and three days, Daniella explained, she found that she had to refer her clients by 41 weeks. Then there was the matter of what happened in these visits. "The problem is that here, it's hard to find an OB who's not going to be like, 'I recommend induction.' They recommend that, and you say, well, there's no medical indication for that, which you can totally do." The scenario Daniella was explaining was a familiar one from my fieldwork in Northern New England, where midwives were similarly required to refer clients for a BPP and consultation with an OB by 42 weeks. The difference was in what happened next. Daniella told me that if parents exercised their continuing right to informed choice and chose a CPM-attended homebirth in the first three days after 41 weeks and if something then went wrong, such as a neonatal death or even a significant resuscitation or hospitalization for the baby, the midwife's license would be suspended. "When they go to the board, the board is going to say *well, Dr. So-and-So advised induction, and this baby would be alive [if you had induced]…*it's an unspoken rule," she said, "that you're going to get your license suspended. Even if the rules say 41+3. It doesn't matter. You're getting your license suspended." Because of that, Daniella said, she practices more interventively in Lousiana than she does across the state line in Texas. "Here in Louisiana, I often strip membranes at 40 weeks," she said, "Super early. I have no other option. At 41 weeks, you're going to go to the hospital. So which of these is the lesser evil, right? Stripping membranes is the lesser evil…and would you have had your baby anyway? Probably. But we don't have time to wait." What sociolegal scholars identify as the "gap" between the law "on the

[50] Clinical abbreviation for 41 weeks and 3 days gestation

books" and the law "in practice" (Gould 2012) thus conditioned clinical decisions for midwives in Louisiana—and available care for parents.

One day, I began to have the sense that a significant portion of the midwives I had spoken with and been the target of a formal state investigation, I took advantage of a break between prenatal visits to make an informal count in my notebook. I was right: of the 47 homebirth midwives I had interviewed at the time, I found 7 had experienced some kind of formal investigation by a state agency or prosecution. That was nearly 15% of my admittedly non-representative sample, though I had not intentionally sought out midwives who have experienced prosecution or investigation. Stories of these investigations and prosecutions are told often. They are also frequently—though not always—narrated as stories of entrapment. Melissa, a midwife in Pennsylvania, an unlicensed state, told me she received phone calls and demands to turn over her charts from a Board of Health investigator in her state because of a phone call she took from a woman with cerebral palsy who was not pregnant but was interested in having a homebirth in the future. Melissa had deliberately not said yes or no. She'd told the woman that her birth might or might not be within a homebirth midwife's scope of practice, but that much would depend on her particular symptoms, the recommendations of the clinicians who help her routinely manage her cerebral palsy, and her particular pregnancy. She'd suggested the woman get in touch if she was pregnant in the future to discuss the question of whether homebirth would be an option. When she got the call from the Board of Health, she found herself wondering if the woman had been an undercover investigator—and whether she'd misrepresented Melissa's answers as a definite yes to the Board. This sense that there might be representatives of regulatory

boards engaging in entrapment was ubiquitous in Louisiana, too, where I learned soon after my arrival that midwives had been phoning around to one another to check up on me and whether I was an investigator before agreeing to talk with me or allow me to attend their events. Daniella said she'd vouched for me, saying, "she's cool, she gets it" (and, as a flattering bonus, she told me she'd described me as "not even awkward"!).

Many midwives fear that in the case of investigation or prosecution, their hands-off, less interventive care, which they believe is frequently actually safer than obstetric care, will be portrayed as sloppy or negligent. They fear that their approach to informed choice, with its premium on client decision making and its avoidance of "pulling the dead baby card," will be portrayed as naïve or indifferent. They fear, in other words, that the ubiquity of obstetrical common sense will make it impossible for decision makers to see that they did their jobs well—and that their jobs are different from the jobs of obstetricians. And so they often articulate their fear as one of being punished for acting like midwives. It's no surprise, then, that midwives often appear in the stories of investigation and prosecution that circulate publically in the community as embattled, oppressed by Boards of Health or Medicine and physicians who want to control or even eliminate them. I was often asked if know "what they did to" a particular midwife, or told "how they got" another. In many areas there is a sense that authorities are looking for a reason—any reason—to investigate or prosecute a midwife, and that once one is found, the charges will be trumped-up. The narrative of punitive laws as instruments of a medical community seeking a monopoly on birth and an end to midwifery is one of continuity, emphasizing the similarities between 20th century anti-midwifery campaigns and what is often described as present-day targeting of homebirth midwives. Certainly

the central insight of De Vries' germinal study, then, is correct: perhaps the most consequential thing a midwifery law can do is establish the question of whether midwives themselves hold rule-making and investigatory powers or whether they are regulated by physicians. However, as is demonstrated by the case of New Hampshire, where midwives do hold a majority on the midwifery council even as they collaborate with physicians and consumers, even midwives in conditions of "friendly" licensure are subject to the broader regulations of health and human services. The homebirth midwifery community's central approaches to birth and perinatal care *and* the practice of informed choice are often incompatible with these regulations, as well as with the practices that attend them.

At the end of my time in Northern New England, I sat down with George Till, division chief of OB/GYN at the University of Vermont Medical Center and Democratic representative to the Vermont Legislature. He told me that amending the law licensing midwives in Vermont to further limit scope of practice was one of his legislative priorities for the next session. "Frankly, I'm going back next year—I mean if I get re-elected!—and we're going to try to take away this concept of a vaginal birth after a C-section," he said. He quoted a 2017 American College of Obstetricians and Gynecologists opinion (see ACOG 2017) calling previous cesarean an "absolute contraindication to home birth." The report, he said, seemed validated by his experience as a hospital laborist who sometimes took referrals from local homebirth midwives. "I can tell you that last month we had a lady who would've died had she had delivered at home, just because of the way things unfolded," he said. "But the home birth midwife, appropriately, had gotten a consultation because she had high blood pressure before she went into labor, and she had

to be induced. And so she was in the hospital getting induced when her uterus ruptured. And honestly she came close to dying anyway, but absolutely would've at home…It's not a good idea. Even in the setting of being here with the operating room just feet away, anesthesiologists are here in-house, usually on the floor, surgeon here in-house, usually on the floor. Of the 12 last ruptures I've looked at…delivering somewhere else, even in a hospital setting somewhere else, those kids would be permanently injured." Even in Vermont, a state in which midwives were licensed by a midwifery-specific board not overseen by the board of medicine, possible limits to a major element of midwives' scope of practice were on the horizon. Those changes, notably, were premised on medical knowledge—both the knowledge of institutional recommendations produced by ACOG and the clinical-experiential knowledge of a physician in a tertiary care center—about VBAC, not on midwifery knowledge about VBAC. For midwives who are suspicious that licensure will be beneficial for the professional community or for parents, changes like these and like enforcement of New Hampshire independent birth centers' collecting stations designation seem like proof that licensure is no protection from escalating limits to practice that could well leave the practice of midwifery *to the midwifery community's own clinical and epistemic standard* functionally illegal. The escalating prohibitions they fear call to mind the limits on abortion care imposed by targeted regulations of abortion providers, or TRAP laws, which impose requirements for staffing, facilities construction, and clinic and provider credentialing that are both more stringent than those medically necessary for patient safety and designed by anti-abortion advocates to be too onerous for most clinics to meet such that the availability of abortion care is restricted (Mercier et al 2016: 2, Mercier et al 2015, Medoff and Dennis 2011). Much as TRAP regulations have

been decisively associated with declines in the number of clinics offering abortion care (Jones and Jerman 2017), some midwives fear that representatives of obstetrics hostile to the notion that homebirth is safe will find ways to limit the availability of homebirth midwifery care by making practice functionally impossible without enacting outright bans.

The question of homebirth midwifery's legality is thus not fully captured by that "binary within a binary" analytic. Indeed, answering the question of *whether homebirth midwifery is legal* requires asking whether the midwifery community's current standard of practice—including the clinical choices that reflect commitment to physiologic birth and to informed choice in practice—is compatible with both midwifery specific law and regulation on the books and in practice, as well as with other state agencies' laws and practices. Can midwives generally attend births up to the local midwifery community's standard of practice concerning low-risk gestational age without fear of legal reprisal? Can clients reliably choose what elements of care they do and do not want without threatening a midwife's ability to continue practicing? Can midwives offer the full scope of typical home birth midwifery care—including options such as home blood draws, multiple options for glucose tolerance screening, and more—without being out of compliance with the regulations of any state agency, midwifery-focused or not? Answering questions such as these is at least as important as answering the question of whether statute or judicial interpretation protects the status of midwifery in any given state. The process of fully answering these questions reveals just how prolific, heterogeneous, and many-headed the field of law and regulation governing homebirth midwifery really is.

Responding to Regulatory Unevenness

How do midwives understand their work and position themselves in relation to this profusion of varied law, regulation, and official rules? I found that the strategies midwives used broadly fell into two categories. Sometimes, midwives aimed to appropriate law's power to safeguard the practice of midwifery, informed choice, and physiologic birth approaches by self-consciously following existing laws for the benefit of the profession or by actively participating in making or revising laws and regulations. At other times, midwives tried to evade law's power to restrict practice or care by dodging or violating laws and regulations.

Following and Making Laws and Regulations

Within minutes of meeting Cheryl, a former New Hampshire midwife who retired after health concerns stopped her from doing on-call work, she recalled to me what had made her resume her then-paused midwifery training upon moving to the state:

> When I got up here I opened up- well, first I had looked up the New Hampshire Law, and fell in love with the first paragraph! I was like, "That is so cool!" I don't remember the exact wording, but it basically was that "...because we believe in the freedom of all people, here in New Hampshire it can be a woman's place [to choose where to give birth]." You'll have to find it, and just that first paragraph is amazing.

Cheryl refers here to the opening of the New Hampshire's Revised Statutes Section 326-D:1 Midwifery.:

> *The general court finds that the practice of midwifery has been a part of the culture and tradition of New Hampshire since colonial days and that it is in the public interest to remove impediments to the practice of midwifery. For personal and economic reasons some New Hampshire citizens will have home births. It is the intent of the general court to preserve the rights of women to deliver children at home, to remove obstacles to safe out-of-hospital deliveries, and to assure quality care. The general court further finds that childbirth is a culmination of pregnancy and is a natural process rather than an illness. The general court acknowledges that the services of a certified midwife are a reasonable alternative for healthy pregnant women.*

For many midwives, it was affirming to hear their commitments to clients' rights to make choices about the conditions of their birth, endorsement of their care as a "reasonable" option for healthy pregnant parents, and a demedicalized understanding of birth reflected in statute. The story of the midwifery law's enactment was also a familiar one to most practicing midwives, told both in gatherings of midwives and in print. Indeed, when I asked one midwife to tell me about the laws in New Hampshire, she brought me a copy of Carol Leonard's memoir *Lady's Hands, Lion's Heart*. Amongst the tale of her own discovery of midwifery, a gut-wrenching love story and the chronicles of many births, Leonard describes the process by which the law was conceived and enacted. She celebrates the 1999 version and its creation of the New Hampshire Midwifery council, "a completely autonomous regulatory board and state agency governing midwifery practice." "It was the first independent Board of Midwifery in the United States," she writes (Leonard 2008:352).

The book came up in conversation during the potluck lunch break at the March meeting of the New Hampshire Midwives Association. The familiar story of a pivotal hearing during the process of passing the original licensure law law (see Leonard 2008:164) was re-told: the American College of Gynecologists, who opposed the bill put together by midwives and authored by a sympathetic legislator, had convinced a local physician to testify that homebirth was dangerous and all babies born at home were brain damaged. But then a representative from the midwives' campaign, knowing that New Hampshire was a rural state where birth had never fully transitioned to hospital settings, stood up to testify and asked the legislators in the room to raise their hands if they were born at home, asking, "Are you brain-damaged?" The physician was discredited, and the midwives' bill was saved. Everyone at the NHMA meeting was delighted to learn this last detail, which hadn't been included in the memoir, from one of the midwives present. Re-telling creation stories like these bolstered a sense of ownership of the legislation, which was often referred to as "our law," and brought it relationally close to practicing midwives—some of whom hadn't even been born at the time it was enacted. But they also reinforced both the truth-status of midwives' claims that homebirth is safe—look at this roomful of born-at-home legislators who are just fine!—and a sense that law's power could be appropriated to support midwifery, enable self-governance of midwives, and bolster individual rights in general, not just sanction midwifery or hamper individual freedoms.

For those midwives in unlicensed states who are excited about making laws, licensure and regulation offers protection for the practice of non-nurse midwifery—and thus protection for care choices that are important to some parents and unavailable in

mainstream, hospital-based care. One homebirth midwife in Pennsylvania whose training had taken place in a state with licensure and a large population of CPMs practicing in relatively straightforward collaboration with other healthcare providers described the transition to practice in an unlicensed state as enormously anxiety provoking. "In just the first, year of practice, I developed hypertension. Navigating this level of liability is new for me," Sandy told me, "I didn't train for [the possibility] that I could go to jail or lose everything. Can I buy a house, or is that too risky for me? Should I not own property? If I have more resources, are those just things I'm going to lose if I'm sued? I could be charged with insurance fraud for billing insurance, practicing medicine without a license, manslaughter. " Sandy described midwifery as "feeling extreme" after moving to Pennsylvania, "[even though] I'm a pretty conventional homebirth midwife." Other pro-licensure midwives in Pennsylvania Massachusetts described a similar sense that practice without the protection of law was stressful. Many told me that they were concerned about the possibility that parents disappointed with a CPM's care could use the midwife's unlicensed status as a way to escalate a grievance to the level of prosecution. They knew that disagreements with clients would happen at times, they said, and that in that event that those disagreements turned ugly enough that a client sought redress through the state, they preferred the idea of losing their license following a client-initiated investigation to facing prosecution for practicing medicine without a license and possible incarceration.

Sandy was a leader in efforts by some Pennsylvania midwives to pass a licensure law both because of a similar desire to experience the protections from prosecution and litigation that such a law would afford for midwives. But like other pro-licensure midwives, Sandy's hope was that a licensure law would protect both midwives' right to

practice without fear of prosecution and parents' right to access care. because licensure provided the only pathway by which access to midwifery care could be safeguarded for low-income parents. Without licensure, advocates reasoned, it would be impossible to pass legislation requiring Medicaid to reimburse for CPMs' care. "It's outrageous that we're doing this for just half the clients [we could be]," Teresa, a Massachusetts licensure activist, told me, explaining that she felt that even the low sliding scales and long payment plans some anti-licensure activists argued made their care accessible to low-income families did not adequately protect poor parents' right to homebirth care. Sandy felt similarly that the ability of homebirth midwives to reach clients without the money to privately pay for care—particularly parents of color—hinged on eventual Medicaid reimbursement legislation, telling me, "if I want to be able to impact racial health outcomes, I have to be able to bill Medicaid."

In states with active licensure and regulation, some midwives found that regulation became a resource they could use. "If we have a question…if we're at a birth, and somebody's water has been broken for a long time," Jackie, a midwife and regulatory council member told me, "we can go to the rules, and say 'Okay, what do we have to do?" When midwives had made their own rules, those rules specifically became resources in navigating the tensions that sometimes arose between their understandings of their professional responsibilities and the desires clients presented them with. Some midwives told me they sometimes felt relieved when they were able to cite law or regulations as reasons they could not fulfill client requests with which they were not themselves comfortable. One client of Alex's, for instance, asked her whether she could decline the routine presence of an assistant at her birth. She felt comfortable with having

just one midwife present, and since money was tight in her family, she wanted to save the $500 assistant fee. Alex agreed that the cost was a bummer. But she reminded the client that the state's rules and regulations required her to have an assistant present and offered to ask the assistant on call to drop her fee to $400. When we talked it over later, she told me that being able to cite the rules and regulations simplified the conversation *and* backed up her own opinion, which was that, particularly for a client with this history of bleeding, she wanted an assistant there in case both mother and baby needed attention. "I'd feel much more comfortable with two pairs of hands there for that purpose," she told me. "I need to be clear that I'm there as a clinician, not as labor company—and that means *I* need particular things, like backup." Many midwives told me they appreciated that conflict with clients could be avoided in these situations by saying that the law would not allow the midwife to attend a birth or provide prenatal care without measures such as backup, regular auscultation, or transferring care after waters had been broken with no signs of labor for 72 hours. As Hannah put it, "I don't decide what blood pressure is too high." For her, it was a relief to depersonalize the limits of her practice by deferring to a law whose content she trusted—a relief, as she said,"for that to be a line that comes from outside."

Sylvie, who was experiencing a rapid increase in the number of prospective clients contacting her seeking radically non-interventive care, shared with me an email inquiry she had recently received from someone seeking a "completely hands-off" midwife. "It's my personal believe that western medicine (even though it has had magnificent benefits to our civilization) has truly removed our animal intuition and seeded distrust within women when it comes to this process, " the email read. "We are

deeply lost down this labyrinth of doubt, but I believe that healing this ancestral wound and reclaiming our power begins with the mothers...slowly unwinding this narrative, for themselves and their babies. Knowing that our bodies know how to birth and our babies know how to be born, it's that simple and we don't need someone or a hospital to tell us how. I feel a deep calling to honor that during this journey." She listed several things she wanted from a midwife: minimal prenatal visits until the last two weeks before her due date, a provider present to "hold space" and "act as a calming energy rather than a hands on practitioner (unless medical intervention is absolutely necessary since our lives are on the line," administer a Rhogam shot, and "offer a few postpartum visits for support." Sylvie was taken aback by the email and declined to meet with the woman. Melissa, another midwife who frequently received such requests told me she finally began explaining to clients that she was not willing to limit prenatal visits to the very end of pregnancy because doing so undercut her ability to assess whether or not clients' pregnancies and births were indeed remaining low-risk and thus good candidates for homebirth. Without seeing you at 20 weeks, she would explain, I can't establish the baseline for things like blood pressure. I can't know whether your normal-range blood pressures in your due window are high *for you* without seeing the long pattern of your blood pressure throughout your pregnancy. "I need to be able to tell the difference between your blood pressure hanging out high and spiking," she would say. "I need to see how you're measuring over time, so I can track growth and see if it does something funny relative to how it has been. I need to see the 20 week baseline for your hemoglobin so I can make sure I see it drop at 28 weeks as it should when your blood volume expands, and then I need to see that it increases again at 36 weeks. I need to feel

confident that you don't just have a 'good' hemoglobin number, but that it's 'good' relative to the rest of what I've seen." Melissa and Sylvie found themselves explaining to clients who wanted to decline major elements of standard prenatal care, *if I am "completely hands-off," I cannot assess risk in the individualized way that is the hallmark of homebirth midwifery care and I cannot fully inform you or myself about how healthy or risky your pregnancy is.* In other words, they explained, *I cannot be a midwife if I skip these steps.* When rules and regulations reflected midwives' understandings of their own professional responsibilities, they could be a resource to cite in protecting not only a midwife's individual practice, but also the occupational mandate of the profession. As one midwifery council member in New Hampshire told me, both the work of making and revising law and regulation and the work of clinical decision-making about how to manage regulations required thinking about both the client's needs and the profession's needs. "The ultimate goal," she told me, "is the safety of the mom and safety of the babies, *and* the safety of midwifery as a whole."

Dodging and Breaking Laws and Regulations

Just a few minutes after she told me the story of "falling in love" with New Hampshire's midwifery law, Cheryl and I were discussing the VBAC regulations in Vermont. Cheryl told me she felt the state's required informed choice document was "a list of questions written in a fear-based way:"

> *The questions are terrible. Like, 'do you realize you're taking your baby's life in your hands?' In the beginning, you know, I'm a licensed midwife, and I dutifully made these copies out. Then one woman actually said, 'are you kidding me?*

I've got to sign that I've read this? I can't believe you handed this to me. This isn't like you.' So I just was like, I've got to re-read that and really think about what do I stand for. This is my practice. Yes, there's laws, and yes, I'm licensed, but I've never been the kind of person that has stood behind something that I didn't actually believe in, and I don't believe in this. And so I've never had a C-section myself, but I learned at [the birth center where I trained] that sometimes a woman has to get through psychological scars [from her previous cesarean], and you know what? It's illegal in Vermont to let a VBAC mother push for more than two hours, but I've seen a VBAC mom that's had to push for seven with her first VBAC, and five hours maybe with her second. And the reason being, she made it to ten centimeters and was told her baby was stuck, and so she would get very quickly and easily to those ten centimeters and then we would have to work through it.

Many midwives disliked the Vermont VBAC rules not only because required them to deliver information to their clients in a way they expressly avoided in their practices, but also because its status as official truth meant that other institutions, including hospitals with which they hoped to make transfer plans, looked upon home VBAC as risky and parents who chose that option as reckless. Many felt that following the protocols outlined in the law did their clients more harm than good, exposing clients to providers who would "pull the dead baby card" even if their midwives were carefully avoiding doing so. Indeed, one client in Alex's practice during the period of time I was in her practice ended up altering her plans for where to give birth on the basis of her experience of following the VBAC rules. Here's my fieldnote about what happened:

Kelly had a consult with an OB at Cheshire in the beginning of her third trimester. VT licensure laws require this for a VBAC if it is possible, and given that it truly is possible here, Alex understands that to be a requirement. They went over the guidelines for VBAC [established by the regional perinatal quality improvement network] Kelly had done a ton of research and knew what questions to ask—she asked for lots of follow up information, additional studies, specifics for particular populations. Cheshire is a homebirth-friendly hospital and they have an official consultation relationship with midwives, including Alex. Brattleboro, on the other hand, does not, and of the obstetricians there, at least two are pretty opposed to homebirth. Because she lives near both hospitals, Kelly also went and met with the nursing coordinator there and asked lots of questions about what her options would be if she did have to transfer her care to there during the birth and felt satisfied with her answers. Alex and Kelly faxed over Kelly's chart and birth plan to Brattleboro to make sure a transfer of care could go well there. But then Kelly got a phone call from the Brattleboro risk management coordinator asking her to come in for a meeting with two obstetricians—likely the two most opposed to homebirth, Alex thought. She talked it over with Alex and decided she felt fully informed and didn't need to have this meeting. Then several days later Kelly got a certified mail package containing a letter telling her she was putting her baby's life in danger by having her baby at home, and also including a study that Alex said she already knew was flawed because it doesn't differentiate between planned and unplanned homebirths. The letter was upsetting--Alex said by the time she got to Kelly's house for the next prenatal visit Kelly had recycled the

whole thing and wanted to move on. She also decided to have the birth at her husband's parents' house, which was somewhat closer to Cheshire than hers, so that she could go there instead of Brattleboro in the event of a non-emergency transport.

When laws and regulations require midwives to "pull the dead baby card" or require them to expose their clients to other providers who do so, they feel coercive and choice-limiting even if they do not ban particular practices. For this reason, even midwives who practice with licensure in those states where it is available—and are generally pro-licensure—sometimes find themselves breaking the rules (and thus the law, which requires that they practice within the limits of their regulations) when those rules interfere with the core values of their practices. Cheryl, for instance, quit giving out the VBAC informed consent document in Vermont. "Even though I was licensed," she said, "I really feel like- and I hate to even say this, but I'm gonna say it- I broke the law every day. I broke that licensure every day, and not in the name of being a criminal, or a bad person, but in the name of trusting and believing in the human body to birth."

Other midwives found routes around the rules they disagreed with, often using other rules and laws to as resources in their strategizing about how to legally protect themselves and their clients. In Louisiana, for instance, waterbirth is prohibited but the use of a tub to make labor more comfortable is allowed. But Daniella found that if someone had reached the point that their baby was crowning while in a labor pool, they were very unlikely to want to get out of the water at that moment. They felt that was completely reasonable and that the policy interfered with clients' choices about where to give birth, and for no good reason—they believed that waterbirth, done right, was safe.

"What am I going to do, haul you out of the tub? Nope," Daniella told me, "I know enough to know that's assault!" She knew as much, she said, from her work with another midwife in the state who served as an advocate for a domestic violence organization and who had helped Daniella support a client who was leaving an abusive relationship. Instead, Daniella would simply tell the client at the appropriate time that they were required to tell them to get out of the tub, and that as always, the client had the right to refuse. Then she'd write in the chart that the client had refused to get out of the tub, and carry on with the waterbirth. Charting is a frequent site of such creative rule-dodging. Melissa, a Pennsylvania midwife, told me she has stopped charting medication use because if her charts were to be reviewed in an investigation by the State Board of Medicine, she'd be "busted." Because the midwives in this unlicensed state were protected from charges of practicing medicine without a license only by judicial opinion defining the practice of midwifery as different from the practice of medicine, "anytime a midwife does anything 'medical'," she said, like starting an IV or giving Pitocin, it makes her vulnerable. Melissa didn't like omitting medication use in her charts. But, she said, she felt forced to if she was going to protect her practice.

Another strategy midwives often used to dodge restrictive laws and regulations was a turn to gray areas of regulation. When Meg, the New Hampshire Midwifery Council member who was managing communication with the Department of Health and Human Services about the requirement that independent brith centers meet collecting stations standards, presented at the Council meeting, she also updated the members on the solutions she'd brainstormed. Meg told us all she'd phoned the new DHHS staffer and asked her, "could I draw a client's blood in the parking lot? Go next door to a massage

therapist's office and do it there? Draw it in the office part of the birth center, which isn't a birthing room?" The staffer hadn't said yes to any of these strategies for getting around the rule, Meg said, but she hadn't said no either! Similarly, in states in which midwives' scope of practice was restricted to "the childbearing year" and prohibited well-body visits, many offered routine Pap smears to clients by charting the exam as a "preconception" screening.

In still other cases, midwives and clients rely on their knowledge of the laws in neighboring states in order to find ways to do things legally they couldn't do in their home states. Lea, another client of Alex's, arrived at one prenatal asking to do her GBS swab earlier than was typical in Alex's practice because she wanted to be prepared for home delivery even if she went into labor before the date at which regulation allowed Alex to attend her birth at home in New Hampshire, where she lived. "I've thought about river-jumping if I go into labor before 37 weeks," she told us. She'd talked to a friend across the river in Vermont, where the regulations allowed homebirth midwives to attend deliveries at 36 weeks gestation, who had volunteered to let Lea use her house for the labor and birth if she went into labor between 36 and 37 weeks. Another of Daniella's clients similarly planned to have her birth across the state line in Texas, where midwives could attend VBACs, rather than at her home in Louisiana, where they are not allowed to. Daniella required that she have all of her appointments in Texas too. That way, she reasoned, she could honestly say this client had received all of her care in a state in which the care she was providing was legal. We drove across the state line to go to her prenatal visits in her uncle's house, where her uncle showed off the meat he was curing from a wild boar he'd shot and her mom told family in-jokes and ribbed him quietly from the

kitchen table during Daniella's review of the client's diet diary in the living room. All was unfolding as usual—but we were forty miles from the client's actual home, and planning for this homebirth was turning out to require enlisting not only the typical participation of nuclear family members but the help of more distant relatives.

Proximity to a state in which midwifery is neither licensed nor criminalized can add even more care options for clients in regulated states where some practice areas are limited for homebirth midwives—and thus knowledge of the gray areas or openings in law or regulation in *another* state combined with a strong network of colleagues there can also serve as a resource for getting around the limitations imposed one's home state's policy. As the Massachusetts Midwives Association meeting broke for lunch this May, Cory, who was sitting next to me on the living room throw pillows we'd grabbed to provide a little cushioning from the cold stone of the hosting midwife's patio, turned to Sara, a midwife who practices in Massachusetts. Cory lives in Vermont and holds licenses in both New Hampshire and Vermont, and while she and her midwifery partner attend births in Massachusetts, they practice according to their Vermont and New Hampshire licenses—which do not allow homebirth midwives to attend known breech deliveries—when they do. Sara asked Cory how the version had gone, using the shorthand name for an external cephalic version procedure used to turn a baby in breech position. Cory said it had been successful and that it took less than a minute for the baby to turn. She thanked Sara for her help and Sara mentioned that it's actually her midwifery partner who has more experience with breech. Neither of them looked at me during this conversation—despite the fact that Cory and I had been whispering through the previous two agenda items—and when Sara turned back and started to talk to me, she

changed the subject. It seemed clear to me that Cory and her midwifery partner had contacted Sara and her midwifery partner to see whether they would be willing to take over the care of this client should her baby remain in the breech position. I'd heard that there were unlicensed Massachusetts midwives who were willing to take clients from neighboring licensed states who had the twin or breech pregnancies that licensed midwives were prohibited from attending, but it was the first time I had seen that kind of handoff of care to a midwife in another state discussed openly. This is certainly not the procedure intended by regulators for handling a persistently breech pregnancy. But as far as I can tell, no law expressly prohibits this strategy. The client is free to terminate care at any time and seek another provider, and the midwife is not prohibited from telling the client that a provider exists in a bordering state who might be wiling to take on care.

Seeking and Rejecting Protection: Two Stories About Law

There is open conflict in the midwifery community over the understandings of law that underlie these two strategies. Alongside all the CPMs who hope to pass new laws or amend existing laws and regulations with the aim of protecting the practice of homebirth midwifery, a significant community of anti-licensure midwives tell a very different "story about law" (Ewick and Silbey 1998:28). Anti-licensure midwives often referred to an understanding of law as providing protection as "hiding behind the law," and rejected the idea that laws were protective and that midwives needed protection from clients. For these midwives, any situation in which a client might take legal action already constituted a failure of relationship, trust, and informed choice. Indeed, many saw licensure laws as self-fulfilling prophecies: because informed choice is constrained by

regulation, the logic goes, trust, relationship, and the robustness of clients' understandings of the stakes of their own choices are degraded, and clients are more likely to blame providers when things go wrong. Quinn, one such midwife, told me, "I view the law as a contract that really ties my hands—because I am bound to it before I am to my clients." Without the ability to be responsive to clients above all else, anti-licensure midwives feel that the central features of the informed choice paradigm are lost. For these midwives, there is no such thing as a benevolent authority or good set of provisions in midwifery regulation, and there is certainly no "falling in love with the law"--midwifery law in general is anathema.

Midwives are, in other words, caught between two forms of legal consciousness, or two key ideas about "the nature, function and operation of law" (Trubek 1984). In the first, law is an instrument of democratic self-governance that can enshrine the right to midwifery care, open pathways to resource allocation for midwives and parents, and enlist the power of the state in validating midwifery knowledge and protecting midwifery practices. Law is—or can be—a source of security for homebirth midwifery in this view. In the second, law imposes artificial and often harmful limits on choice. It enshrines obstetrical common sense, adding normative force to the epistemic dominance that obstetrical medicine has attained in the United States, and serves as an instrument of punishment for midwives and clients for daring to break with that common sense. The problem with law in this second story—and with rule-systems in general--is that it they are both epistemically and normatively standardizing. Even if laws can adapt to accommodate the demedicalized understanding of physiologic birth that is one of the foundations of contemporary midwifery care, they purport to say what is true, what is

right, and what the best course of action is, and they create rule-breakers by virtue of having created rules. Crucially, they make rule-breakers of those who would pursue the kind of radical individuality and relativism that is core to the informed choice perspective. To "hide behind law," in this view, thus constitutes an abandonment of true informed choice. This tension extends to non-law rules, too. Standardized policies in midwifery practice—such as the use of predictable practice protocols, help homebirth midwifery appear predictably and legibly to other healthcare providers, facilitating trust and cooperation. Yet they also collide with a vision of radically individual informed choice and individual risk assessment. There is enough standardization, some argue, in the world of maternity care reform marked by evidence-based clinical guidelines and universal of care protocols (Reiger and Morton 2012).

Many midwives walk the tightrope of this paradox with respect to their own practice protocols by phrasing scope of practice boundaries as a personal limit on the basis of the provider's individual risk tolerance and not a "wrong" choice or rule violation. Many feel it undergirds their practices of informed choice and is one way they avoid coercion in the care they provide. The project of defining one's practice limits is a core part of becoming a midwife. The work of setting the many specifics—at what gestational ages a midwife will attend a birth, what the midwife will treat as a contraindication for homebirth or a prenatal or postpartum condition requiring consultation or referral to a physician, what conditions will normally demand intrapartum transport--is a formal requirement, as writing individual practice protocols is part of the process of obtaining the CPM credential from the North American Registry of Midwives. That work is also sometimes undertaken collectively, as is the case in Massachusetts,

where the Massachusetts Midwives Association has collaboratively written practice protocols that all members agree to respect.

But it is also something midwifery educators describe as a constant and relatively intangible internal thought process that new midwives must learn to do throughout their practices. This is in part true because many midwives describe their willingness to take risks as dependent on the particularities of the relationship with a client. One midwife who practices in a state in which attending breech birth is outside her scope of practice, for instance, told me she encountered a rare surprise breech. The labor was progressing fine and the baby was crowning, and she felt the woman could safely have the baby at home—and that birth was imminent. The midwife knew that in order to comply with the regulations, she needed to demonstrably initiate a transfer of care. She decided to offer the client two options: she could phone a nearby hospital and say they had a surprise breech and were coming in, or she could phone EMS and let them take their time to arrive. She was almost certain that if she chose that second option, the woman would have time to have her baby at home. The midwife emphasized that she only offers this kind of limit-pushing care to "the right client," meaning a client she "trusts" to "take responsibility." This is a common way to describe what a client must do in order for a midwife to be comfortable participating in a birth or pregnancy that is more risky or pushes the limits of her licensure or self-defined scope of practice. It took me a long time to understand that it frequently refers quite simply to the midwife's sense that the client will not blame her or attempt to hold her criminally responsible should the pregnancy or birth unfold unexpectedly or with complications that could have been avoided had the midwife not been willing to participate in the riskier approach to care the client wanted.

This constant, relational negotiation of the boundaries of any given midwife's practice means that there are as many gray areas to the policies midwives set for themselves as there are to the regulations and laws under which some practice. As the director of one midwifery school told me, it is precisely because the work of defining practice limits is ongoing that she thinks that the most important factor for selecting applicants is the ability to be reflective about one's own risk tolerance.

Phrasing scope of practice as being about the limits of a midwife's personal comfort feels better to midwives than making judgements about what is or is not "safe" or rules for what clients "may" or "may not" do. But functionally, the boundaries homebirth midwives set on their practices also do limit the choices available to homebirth clients—and some homebirthing parents feel these limits echo those they experienced in medical perinatal care. The moderator of the Facebook group attached to the organization Indiebirth, which describes itself as providing "out of the box" information about midwifery, pregnancy and birth, posted a request last year for parents to share such stories to be used in developing a workshop. "RISKED OUT," the invitation read, "how many of you have been 'risked out' of certain types of care, have been labeled 'high-risk,' or otherwise categorized out of the pregnancy/birth experience you were wanting?" Comments poured in from parents, some of whom had had such experiences when receiving care from hospital-based medical providers, but some of whom were "risked out" of homebirth care and felt isolated and disempowered by the experience. Some had gone on to have freebirths or births with traditional midwives, and told those stories in the thread and others that followed. These stories echoed the terms in which the initial escape to homebirth midwifery from hospital-based obstetric care is often narrated:

experts tried to make my decisions for me and tell me what was best, but they didn't know what was right for me, so I took the power back and got out.

This is one of the binds that contemporary homebirth midwifery encounters as it formalizes and negotiates its relationship with the mainstream medical system: both creating and hewing to existing standardized policy helps homebirth midwifery to appear predictably and legibly to other healthcare providers and to regulators, facilitating trust and cooperation. But such policies collide with the vision of radical individual informed choice and individual risk assessment to which homebirth midwives are committed. They curtail individual choice—practicing with an eye to those rules does so even when there is no interaction with other providers or healthcare settings, and even as homebirth midwives strive to provide care guided by the choices of their clients.

The problem, of course, is that both the power to protect rights or choice and the power to punish those who make some choices are features of law. In the disagreement between those who would seek protection in the law and those who dismiss "hiding behind the law," midwives have identified a central paradox about how to think about what law is: law enables freedom of choice, but law limits choice. The landscape of this conversation in the midwifery community suggests that in places and times where the presence of law is uneven & people experience both its ability to protect and facilitate choice *and* its ability to limit choice, common-sense definitions of law are challenged to accommodate that multiplicity and its paradoxical nature. Both the "hard, bureaucratic," punitive face of law and its "rights-protecting concerns" become inescapable (Sarat 1990: 344). "Stories about law," in other words, expand: they come to incorporate both the varying forms law can take (statute, regulation, practices of governing bodies, rules of

adjacent agencies) and the paradoxical nature of law's relationship to choice.

Managing the Paradox

How do midwives approach this paradox? Given that expanded understanding of law, midwives must relate to law in *all* of those different ways. They must, in other words, become active participants in managing the law and its multiplicity, such that as was the case for Cheryl, the very same people often both break law and describe themselves as "falling in love" with law, or dodge law or regulation in clinical practice while they work for regulatory and legislative change. What these expressions of legal consciousness share is a "knowledge-is-power" approach to solving this paradox. Using knowledge of the protections, weaknesses, gray areas, and lacunae of law, regulation, and the policies of public agencies and private entities to defend client's choices and navigate between these two faces of law thus forms another key element of the epistemic choreography midwives must perform if their practices are to be guided by a commitment to informed choice. This argument departs from that of many scholars of midwifery who have suggested midwives must become advocates in public debates surrounding midwifery and perinatal care (Davis-Floyd and Johnson 2006). Accountability to an informed-choice occupational mandate often demands knowledge of not only how to make or seek protection in law, but also knowledge of how to evade and help clients evade law and other rule-systems. Grace, an elder midwife in California, told me she thinks all midwives need to be legal experts. Sometimes, as is true for Cory, Grace and those midwives who were part of the effort to pass New Hampshire's licensure bills, that knowledge is gained through their experience advocating to pass those laws. For others,

that knowledge—of both their own regulatory context and the laws of other states—comes from experiences of prosecution. Laurie, a CPM who was prosecuted for practicing midwifery without a license when she preceded her supervising midwife to a birth as a student, learned a great deal about the laws of her state through that experience of prosecution. But she also undertook a study of all the midwifery laws in other states, examining the degree to which regulatory and investigative authority rested with midwives or with other professionals in each. She ultimately decided to move across the country—with her two children--to New Hampshire, whose autonomous midwifery council structure she found to be the most secure environment for midwifery practice. With enough knowledge and the right networks, then, border regions become zones of opportunity for both clients and midwives. Collecting and weilding knowledge of the law, including knowledge of statute or regulation and of regulatory agencies' institutional practices (Ewick and Silbey 1998: 360), thus becomes a crucial part of the epistemic choreography involved in protecting the profession of homebirth midwifery and its central commitments to informed choice and demedicalized birth—whether that protection is sought *from* law or *in* law.

In addition to using other laws to resist objectionable midwifery regulation, as Daniella did in enabling her clients to have waterbirths and or enabling her clients to have VBAC births across a state line, and in addition to using knowledge of law's gray areas to enable practice, midwives use law against law in other ways as well. In unlicensed states, many midwives organize their practice protocols and limits on scope of practice to mimic the provisions of licensure laws in place in other states. The midwife I shadowed in Pennsylvania, for instance, shared with me the thirteen-page informed disclosure

document she had compiled with close attention to a MANA resource. "I practice 'Cover Your Ass documentation'," she told me, charting in compliance with MANA guidelines—despite the fact that the State Board of Medicine would not recognize those guidelines. Another Pennsylvania midwife described practicing to the standards of the licensed state where she had trained. Likewise, a CPM who practices in a border region between one state with licensure and one without told me she participates in peer review processes in both the state where she holds a license and the one in which licensure is unavailable. These practitioners imitate professional standards that have come to have enshrined in law elsewhere, following the procedures that they imagine law would require were they to have a regulatory body with whom to interact (see Mnookin and Kornhauser 1979). In the absence of state capacity dedicated to the protection of midwifery and homebirthing families, these legally marginal practitioners mobilize the language and practices of legality to "appropriate part of the power of law" (Ewick and Silbey 1998: 28) and establish procedures created in the image of the state (Garland 2005, Comaroff and Comaroff 2008). Crucially these strategies do not always work: midwives who practice to these standards in unlicensed states can be, and sometimes are, arrested for and charged with practicing medicine without a license (see Pager 2019).

In a turn to a form of legal pluralism (Merry 1988:870), others turn to alternative normative frameworks to manage the legal inconsistency, fragmentation, and contradiction (Merry 2013:2) they encounter in midwifery regulation. Informed choice itself is, of course, often the most prominent such normative system. One midwife felt comfortable attending the birth of a client who who truly did not want to go to the hospital if the baby was not able to breathe with just the resuscitation tools available at

home. Midwife and client were preparing an extensive informed choice document together, one that certainly was not routine or even specifically recognized by the state's regulations, but one that the midwife felt was enabling a process of true informed decision-making for the client. "She's really taking responsibility," the midwife told me, for the possible outcomes of that choice—including the plan to let the baby die should the circumstance arise.

Others attempt to use private rule-systems to throw off the public rules that constitute law and regulation in more radical ways. One of the solutions that some have turned to is the "private membership association" or "private contract association." While advocates insist these two structures are somewhat different, they share a goal of creating a private space in which individual decision-making need not be governed by any public entity—including those would directly limit the practice of midwifery, such as regulatory authorities, and those whose jurisdiction includes but is not specific to midwives, such as Departments of Health and Human Services. Advocates of private membership agreements argue that though the relationship of patient to provider is a public one, care can be provided in a different kind of relationship that preserves individual autonomy. One midwife who operates her practice as a PMA describes it this way:

> *"Properly set up, what occurs inside a Private Membership Association by and among members is private; generally not subject to any public law, regulation, or agency rule. A PMA is similar to a private family in that what is stated or done inside the family home by, to and among family members is not generally subject to any governmental scrutiny, censorship or control…."*

Advocates of PCAS and PMAs believe operating their practices under the auspices of such associations entitles them to act in ways that would otherwise not be allowed by both midwifery-specific legislation and regulation and by broader healthcare related policies such as HIPAA—in other words, if you set up a PMA, you can attend breech births, you can practice as a non-nurse regardless of certification or your state's relevant laws, share non-HIPAA compliant information on your website, so long as you only do so with members of your association who have "knowingly and voluntarily chosen to become members," as another collective providing homebirth services puts it. Explanations of why this is legal often reference the constitution:

> *PMA functions by the members asserting and standing upon their constitutionally secured rights to freedom of association, speech, the press, to be free from unwarranted searches and seizures, to their individual right to privacy; which are all in effect when people knowingly and voluntarily choose to become members of a PMA. A PMA is created by and exists upon the exact same authority and power that people asserted in The Declaration of Independence of the thirteen united States of America; The Articles of Confederation; The Constitution for the United States of America; The Bill of Rights and in the Laws made in pursuance thereof.*

I had suspected for a long time that PMAs and PCAs were closely connected to the part of the homebirth community that overlaps with sovereign citizenship and other radically anti-state groups. This sense was confirmed when the Indiebirth organization, which operates as a PCA, held a webinar about "practicing midwifery in the private." The invitation promised a "potentially life-altering" webinar whose goal was "to open your

eyes about the true nature of the world system and to show you a path to work with women unencumbered by the corporate statutes (most people are trained to refer to them as laws) created to coopt your life force for the gain of others." Quinn, a homebirth midwife I had spent time with at a state midwifery organization meeting, along with an interview participant who is a friend of hers and a local doula, had made plans to watch the webinar together, as they were both interested in the possibility of setting up their practices this way. A family emergency prevented me from joining them, but I watched the webinar later. The process of registration for the webinar was extensive. I had to join the Indiebirth Private Contract Association, paying a $30 "donation" and agreeing to their terms of membership and the terms of membership of Green River, the larger Private Contract Association of which Indiebirth is an "extension." This required confirming that I had read the Green River Society's mission statement and something called a "Declaration and Affadavit" of its "Overseer; a "Declaration of Intention" of the PanTerra D'Oro Global Society, the "private Society" of which the Green River Society creators are members; several disclaimers, acceptances of personal responsibility, and non-disclosure agreements; and finally, a 31-page document signed with the "absolute autographs" and red thumbprints of the "Living Men and Women" making up the "Board of Trustees of PanTerra D'Oro" that outlined the creation of a "court of the Ekklesia." It was clear to me that I had stepped into a world of extralegal fantasy, and the content of the webinar—which advocated severing ties with state institutions in the manner of sovereign citizens, and used a great deal of the movement's signature language, including terms like "world-system" and "Living Men and Women"—bore this sense out.

What was the appeal of such an approach to practicing homebirth midwives?

Quinn and I talked about it over tea afterwards. She was frustrated with the webinar's emphasis on what she called the "lifestyle" it had promoted and its lack of specific focus on midwifery, and she said she was particularly frustrated that the presenter had ultimately admitted that arrest is still possible for a midwife operating a practice with a PCA or PMA. But she also said she'd been drawn to the possibility of private contract associations as a structure to use in protecting the radical particularism in care that guides her practice approach, providing a shield between her practice and the law or any rule system that presumes to come before parents' wishes. Quinn is the midwife who described the law as "a contract that ties my hands because I am bound to it before I am to my clients."

Private Contract Associations and Private Membership Associations, even given their shaky legal standing[51] and association with sovereign citizens, resemble other elements of the midwifery community's "stories about law" or stories about rules. They are a variation of the dictum "you're not allowed to not allow me," common among those who advocate against coercion, condescension, and disempowerment in hospital birth (see Fig. 2):

[51] Arrest and prosecution is, in fact, possible for midwives using private membership associations. An uncredentialed Nebraska midwife whose practice was arranged as a Private Membership Association was arrested following the intrapartum death of a baby in her care in 2019 and charged with negligent child abuse resulting in the death of a baby, a homicide charge carrying up to 20 years imprisonment (see Vigdor 2019).

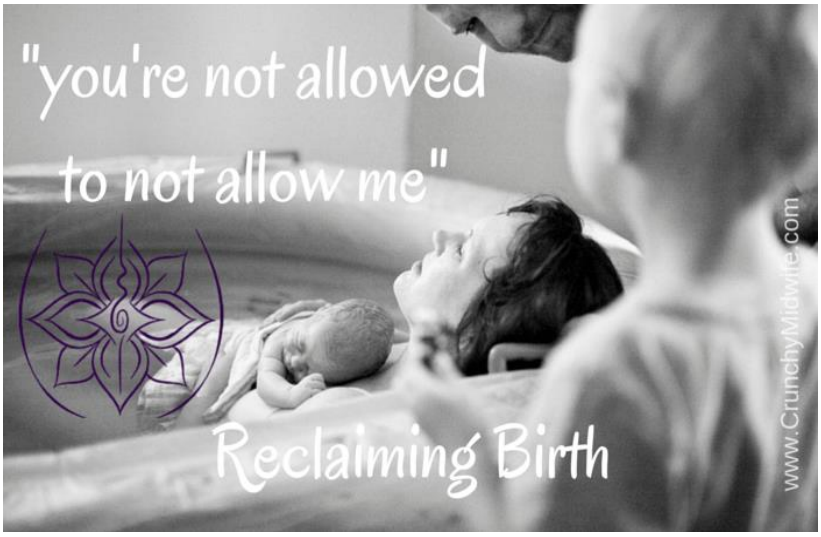



Fig. 2

The risk of this strategy, of course, is that it lacks any of the institutional backing that the rule systems it responds to possess, and while it may enable negative liberty (Berlin 1958), it cannot require that resources be dedicated to care. A Private Membership Association is not like a law in that it does not enshrine a right to particular care options, and it certainly cannot guarantee funding or other resources to make those care options

available. It does not provide any legally viable protections for those providing that care--even if its proponents argue that it *ought* to. Of course, none of this is surprising: in its purest form, the PCA/PMA strategy is a creation of people who do not accept the legitimacy of state power! But even in its more diffuse form, the strategy of making individual rules that collective rules don't apply *aspires* to a secure landscape of non-coercive care but cannot, finally, guarantee that care.

Non-law Rule Systems

Finally, while law, regulation, and the policies and practices of state entities are enormously powerful determinants of the opportunities for and constraints on practice guided by informed choice, the rules and policies of private entities are enormously consequential as well. Though the conversation among scholars of midwifery and midwives themselves about the relationship of midwifery to other forms of healthcare has tended to focus centrally on the ways that a legacy of often racially-motivated criminalization has restrict or interfered with practice and punished midwives, the conditions of practice for contemporary home birth midwives in the US—and the conditions of care for their clients—are currently crucially shaped by the decisions of non-elected officials and private actors, neither of whom are directly accountable to voters, including midwives and clients. For instance, the period of my fieldwork in New Hampshire was a moment of change in the medical malpractice insurance policies many midwives carried. Medical malpractice was required for all midwives accepting Medicaid. Though carrying these policies—along with the extremely low rate of reimbursement provided by Medicaid—meant that accepting clients who planned to pay

using Medicaid translated to significant practice costs to midwives, many felt strongly that they had a responsibility to accept these costs in order to increase access to out-of-hospital midwifery care for low-income families in the area. Out-of-hospital birth centers can be operated by licensed midwives in New Hampshire, and many midwives in private practice maintained privileges at local birth centers. This enabled them to offer the birth center as a setting to clients and also enabled them to carry medical malpractice insurance through those birth centers' group policies[52] at a significant savings: Alex, the midwife I shadowed in New England, paid $3500 annually for coverage in the group policy of the local birth center, while she and other local midwives had been quoted rates of $5-6000 for solo practice policies. As we prepared for prenatal and postpartum visits at the birth center one day, the office manager came by to update Alex with some news about the policy. Starting at the beginning of that month, she said, a $1000 fee would be assessed by the insurance company for each VBAC. Alex was shocked and concerned. One of the appointments that day was with a family who was seeking VBAC care and was in the midst of a major move, one of the circumstances that often led families to seek birth

[52] New Hampshire midwives are also able to carry medical malpractice insurance because of state underwriting. New Hampshire established a fund (usually referred to as the JUA, actually called the New Hampshire Medical Malpractice Joint Underwriting Association Plan) in the 1970s for healthcare providers who needed medical malpractice insurance who could not afford it in the open market—including independent family practice doctors, of whom there were many in such a rural area, along with optometrists, acupuncturists, chiropractors, and more. Midwives and others were insured this way until several years ago, when, because policies had become more affordable, the JUA could no longer sustainably afford the providers who were in the pool. New Hampshire midwives lacked a good alternative, but the JUA had genuinely become financially inviable. What they were able to do is get language into the legislation that wound down the JUA that allocated part of the JUA surplus for a hardship fund. Now, anyone who *had* a JUA policy takes their JUA policy amount, multiplies it by 120%, pays that amount, and the hardship fund pays the difference between that and their current quote. The current hardship fund solution has two major unknowns for midwives in the future: 1) how anyone will be able to open a birth center, because it is a requirement to have had a JUA policy to get hardship fund money, and 2) what will happen when that hardship fund runs out—it is only about $2 million, which goes quickly in premiums.

center care despite the attendant facility fee. "With the birth center fee and that VBAC fee, that nearly doubles the cost of their birth," Alex explained. Alex wasn't sure the family would be able to afford it, and she knew many others wouldn't able to either. And there was no way that Alex could afford to absorb an additional $1,000 fee per VBAC herself—not when she was already stretching herself financially to provide sliding-scale care and accept Medicaid reimbursements of just $1400 for all prenatal, intrapartum, and postpartum care. It was beginning to seem that out-of-hospital VBAC might become a luxury in the area. And given the difficulty many clients had in finding a physician who would attend a hospital VBAC, the possibility that all VBAC might become a luxury seemed near at hand. This represented a real change in a region in which most homebirth parents were not wealthy, highly educated city-dwellers but instead included many farmers, cooks, and construction workers who lived rurally and relied on Medicaid for health insurance. Alex and many other midwives in the area worried that this policy change by a private company would effectively make out-of-hospital VBAC care inaccessible for all but the wealthiest parents despite a friendly legislative and regulatory environment.

In states were no licensure laws had been passed, even the promise of possible "friendly" licensure seemed to some like inadequate protection for access to midwifery services given the ability of private insurers to preemptively enact policies that might exclude coverage for home birth care. One evening in April, I attended the regular meeting of a regional midwifery study group in Massachusetts. The group usually picks a topic and reads a number of recent studies on the subject before having a discussion of the articles over snacks. Tonight, Nadine, the midwife who was hosting, pointed me to

her kitchen island when I got there. Right next to the bowls of fruit and rotisserie chickens was a stack of photocopied announcements from Blue Cross Blue Shield. Nadine picked one up and read it to me. "Blue Cross Blue Shield reimburses medically necessary services provided by participating certified nurse midwives," the payment policy opened. "Blue Cross does not contract with certified professional midwives (CPM) or any midwives who are not registered nurses." Nadine pointed to a provision halfway down the page. "Blue cross does not reimburse home births except for an emergency or unplanned delivery that occurs at home prior to being admitted to a hospital or for maternity services furnished outside of Massachusetts." Several of the midwives attending the study group that day had been involved in organizing against a bill that would have licensed midwives. The proof, they said, was right there on the page: licensure wouldn't increase access to homebirth midwifery care because it wouldn't compel insurers to cover any care that happened at home and it wouldn't cover care provided by CPMs, licensed or not. Indeed, the policy seemed designed to preempt any attempts to get homebirth care reimbursed under future licensure laws or through the formation of the kinds of group home birth practices staffed by both CNMs and CPMs that are common in some other states. "Blue Cross is a leader in the industry," one midwife said, and others agreed that they expected this new policy would set the tone for other insurance in the state. Another added that the policy represented a big change from a few years ago, when people were getting good out-of-network reimbursements from Blue Cross. "And they also won't reimburse for any maternal care obtained out of state, which means clients who can only get reimbursement by hiring a licensed midwife can't even hire a NHCM [New Hampshire Certified Midwife] or VTLM [Vermont Licensed

Midwife] anymore," another midwife added. Many of the midwives who supported licensure in Massachusetts did so because they felt it was a first step towards securing insurance reimbursement for homebirth services and therefore making homebirth care available to clients who could not afford expensive private-pay care and did not have the very high-end PPO plans through which some clients had been able to secure reimbursement for their care. But now, some felt that even the friendliest licensure law would be powerless before the policy of a private insurer like this. The pro-licensure midwives argued that a second statute could be passed compelling reimbursement once licensure law had passed, but others were skeptical that statute could compel an insurer to alter an existing policy that provided for midwifery care of another kind. Which would be more powerful? Law, or the policy of a private entity?

The policies and practices of local hospitals are also consequential non-law rule systems, and gathering information about them in order to discuss clients' and midwives' plans for how to interact with them is a surprisingly significant part of clinical care in out-of-hospital midwifery. In one prenatal appointment I attended with Daniella in Louisiana, she was scheduled to have a routine conversation with her client Bridget about plans for possible transport during or immediately after labor. This kind of transport planning is both required by the state and is typical for homebirth midwives even in many states in regulation does not require it. The conversation was pretty grim. The closest hospital, Daniella said, is East Cal,[53] she said, and "if you're dying I'll take you there. If you're dying in an hour, I'll take you somewhere else." Bridget, her husband, and Daniella all laughed. Bridget turned to fill me in. "They call it East Kill," she said. Then

[53] Abbreviation and anonymization of hospital name

they talked about an actually preferred hospital. They agreed that a particular physician with whom they both have had good experiences at the major city hospital would be a good option. But, Daniella reminded Bridget, "if we go [there], there's no guarantee you'll get her. You could refuse other OBs. It doesn't mean if we go to [the city hospital] you won't be treated ok. But you will not be treated nice." It's certainly the case that some of these concerns have to do with quality of care or general rudeness of hospital staff towards homebirth parents and midwives. In Louisiana, these concerns also have to do with the sense that homebirth families will be treated with downright cruelty. Multiple midwives told me about hospitals in the state at which all homebirth patients who come in for intrapartum transfers are told they need classical or vertical-incision cesarean sections. Because classical cesareans are usually reserved for extreme emergencies and preterm birth, the use of this procedure in non-emergency situations was understood by midwives to be a way to punish parents who "dared" attempt a homebirth with a classical cesarean's higher rate of complications, more significant blood loss, and foreclosure of future vaginal birth. No one presumed that this pattern of treatment represented a formal rule, but it certainly seemed to be the general policy at that hospital, and keeping track of which providers and which hospitals were likely to recommend it constituted a significant piece of homebirth midwives' jobs. Hospitals also have different formal policies about matters such as whether a particular OB with whom a parent has already consulted will be called in the event of a transport or whether whichever OB is on call will be phoned, or whether the midwife can accompany the client into the operating room in the event of a cesarean—tracking these policies, likewise, is essential to the work of providing clients with the information to make informed choices about their care in the

event of transport.

And because most homebirthing parents do plan to go to a hospital under some circumstances, these informal and formal policies and protocols become factors in parents' decision-making despite their hopes to avoid a birth conditioned by them—and regardless of the laws governing homebirth midwifery. In the case of Group B strep, for instance, Alex told her clients that while her practice offered the option of screening or not screening. However, she also told them that in the event of a transfer of care before or during labor to the hospital setting, hospital staff would treat a record of no screening the same way as they would treat a record of a positive screen, and would give antibiotics. The only way to be certain that no antibiotics would be given was to screen and receive a positive result.

A kind of reverse process, however, was also possible: private entities could generate more room to move for midwives. Midwives in New England often emphasized to me that their practices were consequentially conditioned by their inclusion in a regional perinatal care network, the Northern New England Perinatal Quality Improvement Network, that had both devoted time to study, relationship building, and protocol development and admitted the homebirth midwifery organizations of all three states in its catchment area as members. The first homebirth midwifery organization had been invited to join the network almost a decade before my fieldwork began. Many midwives told me the first stages of the relationships between midwives and obstetricians had been challenging, and when I interviewed area obstetricians, they agreed. At the beginning, one told me, "there was very much a sense of, 'we don't even want to acknowledge that [homebirth] is happening because we're concerned about vicarious liability, we're not

gonna sign off on any documents that say we are their backup.'" Many obstetricians, he said, felt that building more collaborative relationships with homebirth midwives was the right thing to do. But they felt caught between those commitments and the policies of their hospitals. Hosted by a hospital-based nurse midwife, they began to meet for potluck dinners with area licensed midwives. Midwives and obstetricians were cautious in those initial meetings,. "I think the cultural divide can't be underestimated," one midwife who had participated said. "On both sides we had really large misconceptions about what the scope of practice was, what we could do, maybe why one group does things a certain way." For instance, she said, physicians often weren't sure why midwives were contacting them, even when midwives were doing so because they were required to by law. "We would call with these things that are not clinical, high stakes issues, but per our rules, we need to consult…'So my patient broke her water and she's not in labor.' The physician would go, 'Well, what do you want? Well, duh, get her into labor….You know?'… But we have to make that call and consult. That's on the list."

Once they had trusting relationships, they began to draft policies and build infrastructures. The physicians told the midwives, as the obstetrician put it, "here's how we would appreciate you communicating with us if you have a client who you'd like for us to either see for an outpatient consult who needs lab work, who needs an ultrasound, or who needs an intrapartum transport, to clarify that and make that a consistent process." The obstetricians and hospital-based nurse-midwives then began to brief their nursing staff and emergency department about what to expect from licensed midwives. Using the QA structure of the hospital as an institutional setting, they developed a routine of transport conferences including homebirth midwives, community hospital providers,

maternal-fetal medicine specialists, and NICU physicians from a nearby tertiary care center. By a decade later, homebirth midwives could participate in continuing medical education through the network, participate in best practice statement development through the network, have their cases reviewed by the network's confidential board. When midwives transported to hospitals, or met with providers to discuss transports, they brought with them NNEPQIN guidance documents. NNEPQIN gave midwives more predictable, more collaborative relationships with hospital-based providers, but it also, one midwife told me, gave them more legal room to maneuver. "The practice changes much more quickly than the legislative parameters under which we function," she told me. But NNEPQIN made it possible, she said, "to say, 'Hey, I know it says this in the rules. I'm gonna do it this other way because it's best practice…' being part of the quality collaborative gave us a leg to stand on to say, 'Well, I broke the rules, but I met the regional standard.'" In New England, then, the laws functioned well for midwives in part *because* of the work of providers to build care infrastructures to support them.

Conclusion

Law cannot appear seamless when actors constantly encounter its multiplicity. Furthermore, its hegemony is shaken when law consistently cannot fully accommodate an ethical & epistemic practice to which actors are committed. This relationship to law relativizes the law and makes it impossible to assume that a good practice will mean always following the law. Law and regulation cannot appear as a given, a consistent or trustworthy arbiter of truth, guide to right action, or unitary force: they cannot sustain a status as Sheila Jasanoff puts it, a "prime custodian of the…'ought' of human experience"

(Jasanoff 2007: 767). Much as the authority of obstetric medical scientific knowledge is shaken in the homebirth midwifery context, encounters between law or regulation and the practice of informed choice prevent law from smoothly functioning as an "instrument of authority-making" (Jasanoff 2007: 762). Law cannot appear as something to be unquestioningly obeyed, or as something to which human action is *subject,* but instead as *the object* of human action—it must be actively managed. The knowledge of the law necessary to accomplish that management becomes a core element of the knowledge necessary for midwifery practice, and the work of managing the law becomes part of the work of midwifery.

Sociologists have long noted that law is a key site of contention for insurgent occupational groups. While analysts of the professions have usually described professionalizing groups as courting the support of legal institutions in order to lend state power their professional dominance (see Freidson 1970: xvii, 72, 185), the case of homebirth midwifery demonstrates something different. Professions must also establish the way they will relate to the law, and the answer to that question will depend on the compatibility of their normative epistemology with the legal system as it stands. For counterprofessions aiming less for dominance than for power-sharing in both knowledge and practice, law may consistently appear as an institution to be managed, rather than courted.

Escape through homebirth from the policies of private entities like hospitals that might interfere with the fullest expression of informed choice, in other words, is incomplete—in part because of the very integration that advocates argue makes homebirth midwifery practice safest. Integrating homebirth midwives into regional

perinatal care systems and increasing their collaboration with medical perinatal care providers is strongly associated with better outcomes for both birthing parents and infants (see Vedam et al 2018). Yet the same measures that facilitate this coordination of care also bring homebirth midwives and parents into more contact with the private rule-systems of hospitals, health insurance providers, and liability insurers. If the law is not set up to safeguard informed choice in perinatal care, these rule-systems are even less so. Furthermore, they are not subject to the "story about law" that understands law to be an instrument and object of democratic process. The arrangement of legal formations can thus enhance or limit the power of private entities in particular to curtail or encourage the practice of informed choice, but in a national healthcare system in which all care is treated as a saleable good, their power to protect informed choice is far from total[54]. As scholars have repeatedly emphasized in the case of abortion, "irrespective of their presence in law, rights do little to ensure that people with said rights…can practically exercise them" (Luna 2009, Luna 2010). It takes more—more resources, more institutional infrastructures and relational work such as those involved in collaborative regional perinatal care networks—to make informed choice possible in practice. Sociologists of midwifery, long preoccupied with the role of law and regulation, must now turn significantly more attention to the rules, policies, and infrastructures of the private insurers and hospitals who collaborate with midwives, and the ways they condition midwifery practice and practical access to care in homebirth.

[54] For more on the role of insurance providers in determining clinical perinatal care, see Morris 2016.

Chapter Five

"Cooperation Without Consensus": Political Knowledges

Introduction

One of the most common ways analysts and practitioners describe homebirth midwifery is in terms of the political "strange bedfellows" that make up the community of practice. Indeed, the kinds of sustained, close relationships across political difference that homebirth midwives commonly have are increasingly uncommon in the contemporary United States. A great deal of political hope has also been invested in these kinds of relationships: they are often imagined to be the key to addressing both political deadlock and political extremism. How can claims on homebirth midwifery care be made from such radically different political positions? How can the same critiques of medical expertise, authority, and practice—and the same set of profferred solutions—appeal to libertarians, progressives, evangelical Republicans, queer and lesbian feminists, fundamentalist Christians, middle-of-the-road Democrats, and anarchists? What enables intimate, collaborative relationships in this politically heterogeneous field? Does this site provide some kind of roadmap to healing polarization? This chapter brings to bear theoretical tools from science and technology studies, a domain which analysts routinely contend with epistemic and praxis pluralities and heterogeneities, to examine political multiplicity. I will argue that closer attention to what happens in this politically heterogeneous scene reveals that the bedfellows are not so strange. Furthermore, their coexistence should probably give us more pause than hope, because it depends on bracketing critical political concerns.

The answer to what lets these politically heterogeneous actors work together so closely is threefold. First, creating and sustaining an alternative system of care—and the infrastructure required to support it—requires close collaboration. The content of that collaboration is often extremely mundane and bureaucratic. It is not terribly connected to the conflicts that characterize the field, but is instead about matters about which there is great agreement. These collaborations, while they may produce an experience of intimate or collaborative relationship that is relatively rare at the moment, do not bring polarized actors together in political dialogue. Instead, the focus is on what analysts of boundary objects call standardized methods, which do not depend on what they call 'standardizing theory.' In this respect, close relationships of this kind should be no surprise to analysts.

Second, homebirth midwives share enormous and extremely significant common ground on the moral, epistemic, and ontological matters to which the informed choice and midwifery model of care concepts refer. They agree that in the majority of cases babies are born best with minimal intervention, sharing a vision of a body that is not interfered with as the site of safety. Morally, they agree that individual choice and maternal sovereignty are important, that incursions on those things are bad, and that reproductive life should not be the scene of bodily harm, abuse, or manipulation. Epistemically, they agree on the value of multiple knowledges, and that autonomy in healthcare includes the ability to personally evaluate information and make individual assessments of facticity. While these are mostly not political claims, many homebirth midwives do share a broad political sense that birth can function as a kind of rehearsal for social life, and that what unfolds in the scene of birth can set in motion dynamics with powerful possible effects on the social world. Most agree that homebirth midwifery is a

site of potential empowerment to address any number of kinds of social harm: that it is a good place to turn in addressing medical racism in mainstream perinatal care, or the site in which clients who have experienced medical or intimate partner abuse can reclaim their sense of their own power and agency. Birth can, many agree, provide a kind of social blueprint. While it is, in obstetric settings, often a blueprint for domination, it can also be a scene in which relations are set right. There is no contradiction under a broad maternalist umbrella about these questions. And this set of consensus points is not at all superficial—indeed, in the context of widespread obstetric neglect and harm in medicalized perinatal care, this consensus is a countercultural boundary object around which enough deep shared commitment, lively conversation and rich, high-stakes collaboration can occur to enable significant, deeply-felt relationships. While it is the "weakly structured," network-level version of a boundary object that unites disparate actors, there is nothing weak about the affective attachments midwives and clients feel to this understanding of birth or midwifery care. Indeed, midwives often say that what enables their relationships across political distance is the experience of feeling embattled together against the same other, in service of the same vision.

Third, this consensus is sustained by bracketing anything that exceeds or challenges it. In practice, this means bracketing most political claims about birth: the elements of this consensus are not about states. They skirt the issue of difference, and they are profoundly individual, imagining amelioration occurring one individual birth or course of care at a time. The interpretive flexibility of the boundary object, in other words, is enabled by avoiding engagement with the more specific, more political ways that midwives locally understand their work to have political meaning. The urgency and

immediacy of many of the issues about which midwives agree provide a readily available logic for avoiding areas of bitter *disagreement*: abortion, sexuality, gender, race and coloniality, and how to think about state power. Crucially, actors do not sort themselves neatly into two groups, right and left, who oppose each other on all of these issues. Instead, the conservatisms and radicalisms of the site are themselves plural. Second-wave feminists *and* conservative religious women are committed to the idea that gender is biological and that sexual difference provides the material for social and individual good both in midwifery and more broadly. Actors with many different political identifications believe in an idea of a "common good" that might supercede individual concerns and that is served by state action in the realm of health and risk management. These disparate actors imagine that state and federal governments, as manifestations of popular will, can be turned to popular ends such as coordinating communication among private actors for quality improvements for midwifery, protecting the public from malfeasance, establishing and enforcing standards and best practices through licensure, or appropriating and directing resources to healthcare ends. Likewise, other actors from the right and the left describe states mostly as vehicles of repression of individual will that improperly trade off purported collective benefits for individual harm, and argue for less state elaboration or action in the realm of perinatal care and for birth to be more private. The material strategies associated with this position—notably, opposing licensure—are also often agreed upon by midwives from both the right and the left. When these issues of disagreement are openly engaged, the resulting bitter conflicts often sever relationships.

In this chapter, I will describe midwives' collaborations to sustain new standardized

methods for demedicalized perinatal care. I will illustrate the weakly structured, network-level boundary object of homebirth midwifery are and the attachments to consensus and collaboration around that object of many midwives. I will then describe the breakdowns in collaboration that occur once the brackets on contentious political matters—abortion, sexuality, gender, race and coloniality, and the notion of state power—are removed. I will advance a number of arguments throughout the chapter: first, that analysts must complicate our understanding of what it means to be strange bedfellows. It is entirely possible to find enormous moral and epistemic and ontological common ground with your ostensible political opponents, and this should be neither surprising or especially hopeful. Furthermore, I will argue even when actors with radically different political commitments agree, that agreement should sometimes give us pause. Embrace of critiques of state involvement in adjudicating knowledge claims and regulating bodily practices by *both* rights-and-choice-oriented feminisms that prize individual autonomy *and* libertarians, for instance, reveal some disquieting affinities between these actors' ideas of what states should be and do. I will also argue that making political claims about birth and homebirth midwifery requires breaking the brackets around contentious political matters. As I show, most midwives in daily practice are unlikely to do so, as the costs of breaking those brackets is high, as the ability to collaborate frequently falls apart. Analysts and advocates, however, can do so, and I will contend that the ease with which anti-interventionist approaches to birth and articulations of the right to refusal in healthcare translate to arguments for privacy and small government mean that they must directly engage with questions of resource distribution and state power if they are to articulate a vision of a right to good care.

"Freaking Polar Opposites": Difference and Heterogeneity in Midwifery and Political Life

Lesbians and Amish women, radical feminists and Mormon libertarians, back-to-the-land hippies and back-to-the-land evangelicals: the "strange coalitions" that characterize the community of practice surrounding contemporary alternatives to standard hospital-based obstetrical care are often cited in unexpected pairs (Katz Rothman 1982:86, Craven 2010, Klassen 2001b:778, Klassen 2001a: 31). Variously described as feminists and maternalists, progressives and conservatives, or hippies and traditionalists, these disparate actors have been described as "divided over other issues but united by their efforts to challenge the legal, medical, and insurance systems that structure birth in North America" (Klassen 2001b: 803) through the advancement of a midwifery model of perinatal care. These "strange coalitions" are nothing new to the homebirth community: indeed, historians of the resurgence of contemporary homebirth in 1960s and 1970s United States note the similarly varied cultural settings in which it took hold, including both back-to-the-land and feminist countercultural contexts (Borst 1995:158, Katz Rothman 2007:9, Morgen 2002, Kline 2015, Murphy 2012, Kline 2019). These communities shared, according to historians, comfort with the frank presentation of information about anatomy (Kline 2015: 539); an interest in reversing the process by which childbirth and pregnancy had come to be defined as medical events requiring obstetric management (see Katz Rothman 1982, 1996); an end to highly interventive protocols such as routine use of sedatives and scopolamine, restraints, extensive episiotomy and forceps, that characterized midcentury hospital birth; and a desire to reclaim birth-related work and

knowledge from the field of professional obstetrics (Morgen 2002), even as their political visions differed radically in other ways.

Unsurprisingly, this variation was indeed borne out in my fieldwork. I shadowed midwives who described themselves as leftists and conservatives. Likewise, I interviewed midwives and parents with widely divergent political affiliations. One described herself as a constitutionalist who tends to vote more to the right than to the left. "I like to tell people I am a God-fearing, Bible-believing, Christ-loving, truck-driver-swearing Christian," she told me. Another described herself to me as politically progressive, ending her interview with an invitation to a demonstration against police violence she was organizing with a local racial-justice organization. Many practitioners also vocally identified with this "divided but united" notion of alternative birth spaces. One midwife I interviewed described her clientele of "lefty professors and conservative Christians." Another told me her practice is about 60% conservative, 40% liberal. She said most of her clients are "either really hippie or super conservative," a description of the homebirth community in the area that one of her clients, an Evangelical pastor's wife, would confirm the next day when she described area homebirth families and participants on a local natural birth Facebook page as "either super Jesus people...or super opposite people!"[55] Many indicated that what they identified with was not simply coexistence: they emphasized that these disparate actors did not simply brush shoulders at midwifery conferences or as clients in a clinic waiting room, but often formed lasting, intimate

[55] This association of Evangelical Christianity with conservatism, while certainly a complicated relationship, is both a frequent actor's category and born out enough in macropolitical trends (such as the 81% of white Evangelicals who voted for the Republican candidate in the 2016 presidential election) that I have continued to use it here (Smith and Martínez 2016).

relationships and worked closely together in midwifery practice. Jennie, an apprentice to a homebirth midwife in whose offices I was observing clinic days, described shared midwifery training experience as an overriding commonality. Describing herself as a "Conservative Catholic" who holds "about the rightest-wing views ever," Jennie recounted to me a recent conversation with her mother about meeting one of the other student trainees at the clinic. "We were freaking polar opposites," she told me. She related to her mother that the other midwifery student was "extremist left- wing," disagreed with her conservative beliefs about sexuality, and "hat[ed] religion". "How can you have friends like that?" her mother asked. "You have nothing in common with them." "But we do," Jennie said, "we have the biggest thing in common."

In the contemporary United States, critics and analysts of political culture frequently lament the rise of Jennie's mother's attitude towards close relationships of this kind between individuals with radically different political commitments. Debates about political pluralism and conflict in open societies have long been bread-and-butter questions for political sociologists. How do polities or publics manage difference and sameness? Are too much difference, or the absence of some core of shared commitments, hazards for democracy? Since the 1990s, these conversations have been dogged by the concern that polarization and relational alienation on the basis of ideology might threaten democratic discussion and collaboration. The terms of the debate identified in 1999 by Robert Wuthnow as a "discourse of discontent" presage more recent preoccupations with polarization. "There is," wrote Wuthnow, "a clear sense that democracy itself may be in jeopardy" (Wuthnow 1999: 19), with many commentators linking social diversity to major declines in civic engagement and participation in politics and government, (Putnam

1995, 2000) “general sociability” (Fukuyama 1995:308), and even the ability to talk with others with differing views of the world. Wuthnow quoted Jean Elshtain: “It is no longer possible for us to speak to one another,” read her 1995 Democracy on Trial, sounding not dissimilar from popular laments after the 2016 presidential election. “We, quite literally, inhabit our own little islands of bristling difference where we comport with those just like ourselves” (Elshtain 1995:xi). As Wuthnow and others (Alexander and Smelser 1999) pointed out, these claims to the disappearance of common ground were themselves shared by critics at opposing ends of the political spectrum.

While race and ethnicity as categories of difference figured prominently in the “discourse of discontent” and conservative formulations frequently departed from laments over the “fragmentation and undermining of cultural homogeneity” (Alexander and Smelser 1995:3), concern with the insurmountability of ideological difference also troubled critics.These concerns appeared in pundits’ arguments that the United States was in a “culture war” over “moral” issues such as abortion, sex education, women’s participation in paid work, and more (Evans 2003). They also appeared in critics’ diagnoses of partisan division: a “‘red’and ‘blue’ electoral map of America”, marking “an electorate bitterly divided by cultural patterns and life styles as well as by partisan division” (Boyte 2005: 1-2). Many social scientific responses aimed to test this notion: in a germinal article published in 1996, for instance, Di Maggio et al used data from the General Social Survey and National Election Survey to test a number of the key issues associated with the vaunted “culture war,” finding little evidence of polarization except in the cases of opinion differences between Republican and Democratic party identifiers and in attitudes towards abortion (DiMaggio et al 1996: 690). Seven years later, one author

repeated the analysis on updated data, finding that polarization had increased between Democrats and Republicans, and more issues—including sex education and school prayer—now evinced that polarization (Evans 2003: 86). Other major studies conducted in the first decade of the 21st century found similar trends, with attitudes increasingly correlating with party identification (Baldassari and Gelman 2008, Baldassari and Bearman 2007). By 2012, Pew research called this divide "overwhelming," reporting that the average partisan gap had doubled in previous quarter century, with most increases occurring during the George W. Bush and Obama presidencies (Pew 2012). Divisions between Republicans and Democrats continued to grow in the ensuing five years: Pew reported in 2017 that they had "reached record levels during Barack Obama's presidency" and swelled further during the first year of Donald Trump's presidency (Pew 2017).

Why this "partisan sorting"? One theory went that polarization among individuals followed polarization in political parties. "Individuals themselves," Baldassari and Gelman noted, "have not moved…they now perceive parties as being more radical, and they split accordingly" (Baldassari and Gelman 2008: 411, Fiorina et al 2005). Emphasizing that United States voting has become more partisan, with fewer voters splitting their tickets and more consistency in partisan representation by district, more recent analyses have contended that simply following more "ideologically coherent" party leaders and candidates cannot account for increases in partisan voting behavior (see Prior 2013:105-7). Instead, these analyses have demonstrated an association between media, specifically cable television, and partisan voting (Prior 2007, 2013). Others suggested that polarization was hastened by partisan animus. These authors identified not only increased gaps in the content of political opinion but also increases in partisan

antipathy, with some authors claiming that partisan animus had replaced race as "the deepest divide in American society" (Iyengar and Westwood 2015). Pew data suggested a similar close relationship between polarized political opinions and politically homogenous social worlds: not only did Republicans and Democrats disagree more than white and Black respondents, college graduate and non-college graduate respondents, religious and non-religious respondents, or even older and younger respondents, they also neither liked one another nor had particularly close social relationships. Most Republicans (55%) and Democrats (65%) reported having just a few or none of their friends were affiliated with the opposing party (Pew 2017).

In the wake of the 2016 presidential election, partisan relational sorting began to be treated by designers and journalists as a problem with a solution, hazarding that if problems of ideological extremism stem from lack of relationship with one's political others (Sunstein 2006, Iyengar and Westwood 2015), the answer must be to create those relationships. United States voters simply didn't know anyone who voted for the "other side" well enough to actually talk with them. Online platforms like mest.io proliferated, designed to engineer conversations between Trump and Clinton voters. "Talk with someone you disagree with," they urged. By 2019, major news outlets were reporting the growth of organizations like the National Institute for Civil Discourse, Helena, Better Angels, Democracy Café, Living Room Conversations, and the National Conversation Project aiming to bring people with varying and opposing political commitments into conversations with one another (see NPR, "Can We Come Together?", New York Times, "These 526 Voters Represent All of America. And They Spent a Weekend Together."). Such conversations would, advocates and political scientists hoped, re-humanize political

adversaries, facilitate listening and understanding, and promote bipartisanship.

These commentators and advocates once again echoed commentators of earlier decades, who had warned of the hazards of a political culture that "only mobilizes the righteous on one side against the enemy on the other" (Boyte 2005:79-80). Commentators in the 1990s, too, had urged their audiences to seek commonalities, listen to the other side, and make intentional relationships with individuals of "diverse ideological backgrounds" (Boyte 2005:38). The laments themselves, they suggested, might have something of a performative force, "weakening…the intellectual middle ground" (Alexander and Smelser 1999: 7) on which they contended the democratic work of deliberation and collaborative problem-solving might unfold. Pointing to the "everyday politics" of broad-based civic organizations (Boyte 2005) and the rise of innovative coalitions, partnerships, and alliances (Wuthnow 1999, Alexander and Smelser 1999), many suggested that these common values and relationships across ideological difference were in fact more extant than the "protagonists of discontent" might assume.

Meanwhile, to participants in social movement coalitions and the scholars who study them, the contention that the work of politics across difference is more common than uncommon comes as no surprise. Coalition is typically defined by social movement scholars as a process of interaction between groups or organizations who define themselves as different but allied, and through which these disparate organizations work toward a shared goal (Cole and Luna 2010, Whittier 2018). Coalitions collaborate for long periods of time or on discrete campaigns, and analyses of their patterns have noted that they frequently arise in response to necessity (Reagon 1983), including shared threats (Van Dyke and McCammon 2010). Difference is a defining quality of coalition—

coalition work, as Bernice Johnson Reagon famously put it, "is not work done in your home" (Reagon 1983:359)—and it also appears as a persistent challenge. Coalitions, many have noted, are difficult to sustain in the absence of ideological compatibility or shared collective identity (Roth 2010, Whittier 2018, Kleidman and Rochon 1997, McCammon and Campbell 2002, Staggenborg 1986). These difficulties both often arise and are often analyzed in the context of the development of "agreed-upon framing of issues" to be dealt with in the coalition (Gilmore 2008:xvi). The effectiveness of frames as diagnoses of social problems or as formulations of solutions (Luna 2010, Snow et al 1986), scholars agree, depends on their credibility with decision-makers and with the general public, but also on their compatibility with discourses already surrounding a particular issue (Ferree 2003, McCammon, Muse, and Newman 2007, Whittier 2018). As many have noted, frames are frequent sites of conflict (Luna 2010:557), as coalition partners bring differing identifications, ideologies, and discourses to the work of generating them.

Managing difference in coalition, then, appears as a key political challenge in social movement scholarship, too. Analyses of feminist, women's, and reproductive health movements have frequently highlighted the difficulties of contending with difference in an organizing context that takes shared experience as a key point of departure. The failures of the notion of "sisterhood" or the ideal of a "women's movement" for all women to account for racial oppression's mutually constitutive relationship with gender oppression have been repeatedly documented (Luna 2010, Luna 2016, Crenshaw 1994, Poster 1995, Scott 1998). Even the "ethos" of "organizing one's own" has itself been identified as a barrier to coalition building (Roth 2004:106).

Difference is not always or even often power-neutral in coalitions, as these literatures highlight, and work of decoding tacit knowledge, identifying blind spots, and building organizational structures to prevent the entrenchment of power imbalances is itself frequently unevenly distributed (Cole and Luna 2010: 94, Luna 2010). On this basis, then, many feminists have suggested that difference in political life is best addressed not through a search for more common ground, but through close attention to what Iris Marion Young has called "the specific situations of differentiated social groups" (Young 1997:383).

In the context of longstanding and recent anxieties about rising partisan animus, the tightening of political homogeneity in social life, and the challenges of relating across political difference, the homebirth midwifery is a rich site. It is, in many ways, an example of just the kind of group many commentators contend are key to democracy, and that many post-2016 advocates have aimed to create: politically heterogeneous, yet characterized by close collaboration and long-standing relationships. These relationships are neither formal coalitions between organizations nor elements of an ideologically homogenous political community. If relationships of this kind are rare in the contemporary US, what enables their ubiquity among homebirth midwives?

"The Biggest Thing In Common"

What are the mechanics of collaboration without consensus? The science and technology studies literature examining the function of "boundary objects" offers one theoretical framework for conceiving of this kind of social interaction. Science and technology studies frequently encounters both epistemic and praxis pluralities, and thus

as developed robust ways of approaching these sorts of heterogeneities (see, for instance, Law 1987, Mol and Law 2002). Turning to the boundary object literature raises important questions that complement those posed by the political sociology literatures on coalition and political difference in everyday life: what kinds of objects enable collaboration across significant difference? What kind of action unfolds around those objects? And what are the costs or tradeoffs of collaboration without consensus? The close, collaborative relationships between actors with extremely different politics are enabled by convergence on demedicalized midwifery care as an extremely consequential object held held in common. The ideals of homebirth midwifery care—and the practices in which those ideals become material—function, in other words, as what Star and Griesmer call "boundary objects," or shared objects that enable close collaboration between highly varied actors.

The term was initially coined to explain Leigh Star's observation that collaboration in conditions of heterogeneity is a given in the day-to-day work of science (Star 1989: 250). Scientists, she wrote, routinely "cooperate without having good models of each other's work, successfully work together while employing different units of analysis, methods of aggregating data, and different abstractions of data, [and] cooperate while having different goals, time horizons, and audiences to satisfy" (Star 1989: 251). How do they do this? Drawing on research in Berkeley's Museum of Vertebrate Zoology, Star found that the professional biologists who developed the museum's collection of natural specimens enrolled help from amateur conservationists and collectors, philanthropists, backwoods trappers, and university administrators. These actors did not agree or even share a definition of their work: they held enormously different visions of

the project of collecting natural specimens in which they were all engaged, and they understood the identities of the animals that became the research specimens themselves quite differently (Star and Griesemer 1989:179). Their collaboration was enabled, Star observed, by their shared use of particular objects: both the specimens themselves and the documentation used by researchers to make information compatible. Star and Griesemer called these "boundary objects," defined in their now-often-quoted terms as objects "plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites" (Star and Griesemer 1989: 188, 176). These objects might be as tangible as bodies of animals and maps, but they need not be—they could be theories, or other objects "people…act toward and with" (Star 2010: 603). Star and Griesemer described constant negotiation among allies over an object that remains necessarily indeterminate at the level of the network of collaborating actors, yet "strongly structured" in the local context. Boundary objects, they argued, act as "anchors or bridges, however temporary", facilitating the possibility of "developing and maintaining coherence across intersecting worlds" (Star and Griesemer 1989:194, 173-7).

It is perhaps easiest to see the boundary object of homebirth midwifery care at work in organizational settings. I found that meetings of groups and organizations frequently included significant time devoted to midwives generation of material strategies to enact the abstract ideals of contemporary homebirth midwifery's clinical approach. A midwifery study group meeting I attended, for example, ended with distribution of bags of IV solution by a midwife who was able to buy them from the local hospital where she worked part-time. Having these IV bags available enabled homebirth midwives in this

unlicensed state to offer clients the option of home antibiotic treatment for Group B Strep during labor. At one meeting of a state midwives' association, participants traded advice about how to work with both area and national chain lab companies to offer fetal Rh typing from maternal blood to clients without full genetic screening. The central tenet of the Midwives' Model that care should be individualized—along with the contention that testing itself can introduce risky anxiety, even if those tests ultimately reveal typical results (see Katz Rothman 2014, Hallgrimsdottir and Benner 2014)—leads many midwives to separate frequently-bundled tests such as these. This means midwives must take on significant bureaucratic work in order to allow clients to learn just the information they want—fetal Rh type—without investigating the possibility of, for instance, spina bifida or Down's Syndrome. The midwives in attendance, who ran the full gamut from relatively conservative to self-identified leftists, got down to the work of compiling a list of laboratories together. They noted which ones were currently giving accounts to CPMs and which were not, who offered a package test and who would run an Rh type alone, which labs were more and less expensive to use, until an answer emerged that all were comfortable using in their practices: when a client wants an Rh type and no other tests, you call LabCorp and request the test from the Sequenom brand.

A few minutes later, Quinn, a relatively conservative newly-credentialed midwife, raised the possibility of using baby aspirin for prevention of pre-eclampsia. She had recently come across an article suggesting it and was appalled that she'd never heard of this simple, low-risk, over-the-counter method for minimizing the need for future possible technological intervention in a serious complication of pregnancy and birth. She groaned, "Why wasn't this part of my didactic training? Looking at the studies, it just

looks like a no-brainer. I would do it now for *anyone* with a history of hypertensive disorders." Two other midwives— both self-identified liberals—were particularly excited by the idea. Hannah had just had a client with preeclampsia, which she'd discovered when the client's blood pressure was high at the three-day postpartum visit that is standard among homebirth midwives but not among hospital providers. She thanked Quinn profusely for the suggestion. The incident had made her aware of her desire for more resources about low-risk ways to prevent pre-eclampsia, and everyone was spooked about the likelihood that Hannah's client's preeclampsia would have gone unnoticed had she had typical hospital-based obstetrical care. Jackie, who works part time at Equality Healthcare,[56] said she'd ask the OB/GYN interns there what their training had included on the subject. Quinn was eager to hear what she'd learn, and Jackie promised to keep her updated.

Providing care guided by a commitment to informed choice and to physiologic birth depends on collaborative work like this. If clients are to be offered choice in screening, testing or treatment that exceeds that typically offered in medical perinatal care environments, then midwives must generate a correspondingly wider range of options—including measures such as home Group B strep treatment or individual genetic tests that are otherwise unavailable—among which clients can actually choose. Approaching conditions such as preeclampsia with the aim of proactively working to keep clients in a "normal range" by selecting early, simple, interventions with minimal side effects, rather than planning to use more invasive treatments later, requires identifying and generating

[56] Founded in the 1970s, this clinic provides routine gynecological care, hormone therapies for trans patients, abortion, contraception, STI and HIV testing and treatment, and counseling. Name is anonymized.

research bases for new clinical approaches. Because the infrastructures of medical equipment sales and laboratory testing are built for routines from which homebirth midwives self-consciously depart, midwives must collaborate directly with their colleagues in order to sustain the systems that make these options and clinical approaches available, particularly given their marginal status relative to the mainstream health care system.

Alternative care infrastructures for informed-choice-driven, physiologic-birth-oriented perinatal care constitute what Star and Griesemer call *standardized methods*. Methods standardization, they argue, allows disparate actors to "find a common ground" not in concessions to another's opposing theoretical apparatus, but in "clear, precise manual tasks." Importantly for my purposes, this highlights that boundary objects are not compromises between positions. As Star and Griesemer put it, "standardizing methods is different from standardizing theory." Boundary objects do not stake out middle ground with some of what each social world believes or resolve disagreements between social worlds. A trapper does not become more like a university administrator through collaboration over the installation of an animal specimen in a museum any more than a constitutionalist becomes more like a socialist while spending long hours labor-sitting[57] or developing low-risk protocols for preventing preeclampsia together. As Star and Griesemer write, "potential differences in beliefs…or higher order questions tend to be displaced by a focus on 'how,' not 'why'" (Star and Griesemer 2015 [1989]: 188-9).

[57] Homebirth midwives often used this term to describe the long hours or days spent at the home of a client in labor. Labor-sitting is time-consuming work and often involves a great deal of time spent with a second midwife, student, or client's family, and it involves much more "hanging out" than the more focused work of supporting pushing or delivery, or than of providing the examinations and possible treatments for tearing or hemorrhage required immediately postpartum.

This focus on "how" means that while these collaborations can be high-stakes—midwives depend on them to carry out their practices—and involved enough to generate warm, caring, curious, and mutually appreciative relationships, their content is often extremely bureaucratic and not terribly connected to the political distance between collaborators. It should thus come as no surprise to analysts that this collaboration both frequently occurs and does not result in political dialogue.

These collaborations also, of course, focus mostly on matters about which there is great internal agreement in the field, skirting its internal conflicts. "The biggest thing" held in common by homebirth midwives is thus not just a significant task or set of tasks, but also a set of commitments. Cory and Daniela, for instance, are a former preceptor[58] and apprentice. Cory moved away soon after the completion of Daniela's apprenticeship with her, and though they now live hours apart, they talk by phone regularly and remain close. They also describe their commitments to midwifery in similar terms. Daniela, who worked for years as a labor and delivery nurse, told me that she came to midwifery care because she "couldn't stand seeing women abused." She and Cory both said once they knew there was an alternative to the neglectful, coercive care by obstetricians in hospitals they had experienced—Cory as a parent, and Daniela as a nurse—they knew they wanted to provide it. Cory also told me the story of her first birth. She was given intravenous Pitocin and cervical Cytotec to augment her contractions; intravenous medication for the pain caused by the Pitocin, to which she had an anaphylactic reaction; and then an epidural to which her husband consented for her while she was unconscious from the treatment of her allergic reaction. When her baby was taken to the nursery, she

[58] Preceptors are practicing midwives who supervise the education of student apprentice midwives.

said, “I called a million times and they didn’t bring her back to me for hours.” Cory was furious about the experience but tried to move on and focus on parenting her child. But when she got pregnant again, she felt she couldn’t go through the same thing. “I was like no, I cannot have this baby,” she said. “Not because I don’t want another baby. I loved having a baby. But I cannot give birth again.”

While I was shadowing Daniela’s practice, Julie, who was several weeks pregnant, brought her husband and two-year-old to an interview with Daniela to consider hiring her. The couple was divided on the question of homebirth. Julie’s husband, laughing gently at himself, asked a volley of questions while his toddler drove a small plastic truck back and forth over his polished cowboy boot: “Why *isn’t* it safer to have continuous electronic fetal monitoring like they do in the hospital?” Daniela scoffed. “If you think for one minute they sit up in that nurse’s station and watch the monitor…they don’t! They don’t even pay attention!” “Which is a sin,” Julie broke in. “It is a sin,” Daniela replied firmly. She explained the intermittent monitoring procedures most homebirth midwives use, describing listening with a specialized stethoscope called a fetuscope or portable Doppler ultrasound machine at regular intervals, during contractions, more frequently during pushing. “You actually get more information that way,” she said.

Julie went on to tell Daniela the story of the hemorrhage she’d experienced after her first labor. “Me and my doctor had talked,” she said, “And I said *no* medication. I held up my hand when I saw the nurse coming in with the needle but she said I needed it.” Daniela shook her head. She doesn’t see a lot of hemorrhages, she said, “because I take such good care of my clients! In the hospital, they don’t care if your hemoglobin is low. They have an operating room! They can give you a hysterectomy! I’ve had

physicians tell me, '9.2, that's not bad.' I want my girls to be at an 11 [g/dL].[59] I've had clients tell me their obstetrician checked their iron once. I check three times!" She described the detailed diet diaries she has her clients fill out at various points in pregnancy, the long conversations about which of their family's favorite dishes would taste good with a handful of spinach added, the iron supplements her clients all take. By preventing anemia through individualized nutritional coaching and education, she said, she prevents hemorrhage.

Cory and Daniela have both dedicated their lives to homebirth midwifery care. They describe why they care about that model of care—and what experiences they believe it can help clients avoid—in remarkably similar terms, terms that offer a shared critique of the practices of contemporary medical institutions. Both insist that providing homebirth midwifery care is an expression of their deeply-held ideological commitments. Yet those personal political commitments, meanwhile, are utterly divergent. Daniela describes herself as "super-conservative" and fits a canonical image of a contemporary American conservative: she is a member of a large Evangelical Baptist church; she doesn't believe in gay marriage; she does believe in corporal punishment; she believes all people have the same opportunities in the United States regardless of race and thinks it preposterous to blame racial inequality on resource distribution. Cory, on the other hand, calls herself a socialist feminist. She is not religious, and during her first pregnancy, she says, she was a gender studies major who listened prominent 1990s alternative singer-songwriter Ani DiFranco. For both Cory and Daniela, providing care that proceeds from an ontological view of the body as powerful and mostly safest when minimally

[59] Hemoglobin is generally measured in grams per deciliter, and reference ranges for pregnancy vary by trimester but never drop below 9.5 g/dL.

interfered-with, helps clients remain low-risk with extremely attentive monitoring and intensive support and coaching, minimizes interventions and the possibility of iatrogenic conditions, and prioritizes informed choice and connection between parent and child is an expression of their most deeply-held commitments. Daniela later told me that providing midwifery care was not just an easier job than working as a labor and delivery nurse and seeing women abused and neglected in her care—it was a calling from God. "The tenets of the Midwifery Model of Care apply to *everything*," Cory told me when she finished the story of how she'd found midwives to attend her second birth. The experience had left her clear: "This is what my feminism looks like," she said, "It's being a midwife."

Stories of incursions on maternal sovereignty, bodily harm, and neglect in medical perinatal care provide a common backdrop to homebirth midwifery gatherings. As midwives assembled for a midwifery study group[60], they traded these stories—gleaned from transports and from the doula work many do in this area to supplement homebirth practice—over snacks: a woman held down on her back by four people while she said she wanted to change positions; a woman whose cervix tore in so many places that it looked "like a starfish" and almost needed surgical repair in the operating room after an obstetrician held her cervical lip back and encouraged her to push as hard as she could instead of waiting for her to be fully dilated; a resident who jerked a baby's head back and forth before the shoulders were born so hard that an obstetrician intervened to prevent the baby from being injured but who tore the woman's perineum badly in the process; an obstetrician who never told his patient he didn't have privileges at the hospital where she planned to deliver, leaving her to discover she had no care provider

[60] This particular group was convened by a CNM in private home practice and attended by CPMs, apprentice midwives training for homebirth practice, and one CNM student.

when she arrived at the hospital in labor; a woman whose postpartum hemorrhage—including an eight-inch clot—went untreated in a postpartum unit while she waited for staff to be phoned because postpartum nurses in that hospital were not trained in treating hemorrhage; an obstetrician who roughly tore a woman's vagina with a finger instead of cutting an episiotomy. That reproductive life should not be a scene of these kinds of bodily injuries, or of the abuse, neglect, and manipulation that an ever-growing body of both studies and legal cases have shown characterize perinatal care in many cases, is a moral stand easily agreed upon by care providers from the right and the left.

"Every one of these babies' emergence into this world opens up a universe and tips this planet on its axis," narrated one midwife in the video invitation to her one woman show based on her homebirth practice. Indeed many midwives describe describe the scene of birth and perinatal care as a time in which relations of power can shift profoundly. Midwives commonly told me that they saw clients who had experienced obstetric abuse during previous pregnancies or intimate partner abuse grow less fearful and more clear in their choices over the course of their care experiences in homebirth midwifery, and many told me they then saw those clients parenting more confidently as they worked with them from pregnancy to pregnancy. Others said that clients, especially low-income clients, who had experienced enormous disrespect from care providers in the past seemed to benefit the most from homebirth midwifery care. And many felt certain that these shifts would "scale up" to social change writ large. "My personal philosophy is that birth is the only issue that connects us all, because all of us are born," Nova, a queer midwife whose practice includes many queer families and families of color, told me. "And I think that the experiences that people get being born in a hospital, being

separated, all of the higher rates of intervention, drugs, and everything, treatment, instills deep trauma in mothers or birthing people, and these new babies. And addressing that, and having more holistic, and actually kind and compassionate and revolutionary experience of birth would lay the foundation for healing all of the other systems of oppression in the world."

This sense that taking a different approach to birth is a kind of political action in and of itself has predominated among advocates for natural birth for decades. "Had the quiet strength and indomitable purpose of the natural forces of reproduction been heard in the councils of statesmen the world over," wrote Grantly Dick-Read in the introduction to his 1942 *Childbirth Without Fear*, "war amongst the nations would have been stifled by stern emotional reactions which direct the human mind to fundamental truth and a greater understanding of the omnipotent but unseen forces of the universe." For Dick-Read, whose germinal work was written in England during the Second World War, the "natural forces of reproduction" were to be understood in direct opposition to the "dangerous and painful experience" that childbirth had become, and the retrieval of these "forces" was of paramount political importance. "From time to time," he wrote, pestilence and war sweep through nations, robbing them of much that is best in their stock. If we are to survive as a people, and as an empire, we must constantly be alert to improve our stock. The structure of society can only be erected upon foundations of biological facts." That motherhood is "perfected" in reproduction was, he argued, one of those facts; that society needs motherhood for not only the maintenance of populations but also the maintenance of tenderness necessary to avoid a descent into overwhelming militarism was another. "There are," he assured his readers, "methods of escorting women through pregnancy and

parturition which will give these results" (Dick-Read 2006[1942]: xiii-xvi). Contemporary midwives may diagnose different concerns as most pressing and might use the language of attachment more, as Nova does here, but the notion that the "methods" of birth might have enormous political and social consequence persists. "The capitalism that we live in..depends on us feeling isolated and hurried. That's what birth has been. Let's hurry this along. Let's make it as little of an emotional and spiritual experience as possible. Let's separate moms and babies." Making birth go differently, Nova explained to me, can give people an experience of something different, something countercultural, something "so much deeper and more profound than anything else in our society": "As far as attachment theory goes, I think that our our culture and society is so ... it functions around isolation, as far as we drink lots of caffeine, and watch a lot of TV, and go to work, and sit in our cars by ourselves. And there's just this culture of that. And I think that having a connected birth process with skin to skin, and immediate breastfeeding, and calm hormones, and nobody trying to rush and do this, and do this. I think that that puts a very serious wrench into the hamster wheel of our capitalist society."

Taken together with the commitments to informed choice, multiple knowledges, and a belief that autonomy in healthcare depends upon the ability to personally evaluate information and make individual assessments of risk, facticity, and relevance of information, these points form a kind of updated contemporary maternalist consensus. Preparing for birth, and the scene of birth itself, are not illness states, but rather states of extraordinary capability, and as such they are not times in which autonomy should be compromised. That autonomy includes epistemic autonomy. Safety in birth is facilitated by attending closely to the body's needs and meeting them in order to support that

capability. Acting differently in birth can set in motion major shifts to relations of power that might transform the world. This contemporary maternalist consensus constitutes what Star and Griesemer call the "network-level" version of the boundary object of midwifery care, "weakly structured" and flexible enough to accommodate many more specific interpretations at the local level (Star and Griesemer 1989:194, 173-7). There is nothing weak, however, about the attachments midwives sustain to this consensus. Against the backdrop of widespread perinatal harm, it is clearly countercultural, and its ontological, epistemic, and moral points provide enough material—and enough urgent, sometimes life-or-death material—to sustain relationships without consensus on other matters, including political matters.

A decade after the boundary object's arrival on the STS stage, Star looked back on the concept. Boundary objects, she wrote, had been oversimplified to the point of treatment as "almost synonymous with interpretive flexibility" (Star 2010: 602). The work of what Star called "tacking back and forth" between these vague and specific identities of the object, she argued, had often been ignored in papers using the concept (Star 2010: 605). In the homebirth midwifery context, tacking back and forth leans heavily on another aspect of the boundary object concept raised in retrospect by a foundational analyst: bracketing. Griesemer's 2015 contention that a boundary object must "have 'brackets' in place" drew attention to standardization of methods (Griesemer 2015: 207). Methods standardization highlights what the brackets around a boundary object keep *in* for the purposes of collaboration. But in the case of homebirth midwifery those brackets must also keep something *out:* overt engagement with political disagreement.

Avoiding overt engagement with political disagreement in interactions with clients might seem intuitive: healthcare providers do not generally have long conversations about politics or social life with their patients. The holism of homebirth midwifery care, however, means that it is instead typical for prenatal and postpartum visits to include extensive talk about a much broader range of issues: discussions are actively invited of family dynamics, dreams, faith, work and financial challenges, intimate relationship conflict, and other subjects that might otherwise be treated as personal, left unaddressed in a clinical relationship, and avoided in relationships in which conflict is avoided. Yet despite the fact that the Midwives' Model of Care defines perinatal wellness in social terms, and midwives' visits with their clients often include talk about topics that might well be the subject of intense politicized disagreement, that talk occurred only in the context of shared ideology. When midwife and client were collaborating in care across political distance, open engagement of their disagreements was bracketed.

Heather, for instance, told me about a client whose family she had helped since the very beginning of her practice. Over the years she'd built a strong relationship with them: she loves them, she told me simply, and they love her. When the client and her husband came for one prenatal visit, Heather was appalled by the husband's comments about a "satanic homosexual agenda." Upon hearing the story, Heather's husband was equally appalled that she hadn't argued or challenged him. "You can't just sit there and listen to that crap," he said. Heather wasn't happy or comfortable with the situation but continued to feel she'd made the right choice when we discussed it later. When you're the client, she said, "it's your hour." And she didn't want to make the client feel uncomfortable by arguing with her family member. Heather decided that supporting the client and her

family, and creating for them the atmosphere of care and ease for which homebirth midwives aim, required deciding *not* to act on her otherwise crucial and closely-held commitments to addressing homophobic speech.

As a midwife, a commitment to supporting the social well-being of a client can mean supporting that client to thrive in a social world that is not your own, even in a social world whose core beliefs are anathema to you. Daniela described this to me one day during a long car ride from a home prenatal visit with Briana, a client whose townhouse was relatively far away from her own home: "As a Christian," she told me, "I don't agree with gay marriage. And if I had a gay couple it wouldn't affect their prenatal care. I would still give them very good prenatal care. And I could do that because that doesn't matter. It's your belief, I'm probably not going to change your belief, and that's okay![61]" It is worth noting that while it might be entirely unsurprising for a healthcare provider to avoid discussing political matters with a client, homebirth midwives' relationships with clients are often significantly more capacious than other healthcare providers' relationships with their patients. Midwives and clients often continue to see one another socially after formal care closes, sometimes becoming close friends: it was not uncommon for Alex's final visits with clients to include invitations to meet for play dates or attend family birthday parties. They often engage in political work together—both about midwifery, such as lobbying for bills about midwifery licensure, and more broadly, such as participating together in a parent-and-kid contingent of a racial justice

[61] Daniela did later tell me that she offers to pray for clients. "I have had some women start out atheist or agnostic and turn Christian," she told me. "If they're having a long labor…I'm like do you want me to pray for you? And I've never had someone say no. Because in that moment you need something. You need hope." A home social world whose theology demands proselytizing is one way the agreement to disagree can wear thin!

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During prenatal visits in which client and midwife *share* a social world, those brackets on contentious talk are much looser. The same conservative Christian faith that she expects would be a source of difference with a gay couple structures a very specific, local understanding of homebirth midwifery care that Daniela routinely draws on when she and her clients share a social world. Briana was one such client. She spent the later part of her visit discussing conflict she was having with her mother. Briana's sister had had five cesareans, and her mother, spooked by her sister's obstetrician's assessments, was concerned that the homebirth wouldn't be safe. Daniela and Briana talked for a while about this frustrating dynamic in Briana's family, and eventually they settled on a strategy of calling upon the convictions that structure that local version of midwifery. Briana described the approach this way: "I'll just keep talking our faith, that she believes also—we go to the same church!" She tried out a way she might open a response to her mother next time the conflict arose: "Mom, if you truly believe these things that you have taught me my whole life…" Support for this conservative client in her family context involved helping her to turn to the institutions of Evangelical Christianity, recall, and rearticulate her family's belief in a human body created by God to work perfectly without reliance on the routine interventions of hospital protocols to create safety.

The day-to-day work of midwifery care thus requires "tacking back and forth" (Star 2010:605) between what Griesemer later called this "custom-fit" version of the object in the local practice of one "participating world" (Griesemer 2015: 207) and a more general version of the object that is loosely structured enough to be held in common across difference: being pro-midwife, pro-natural birth, and invested in prenatal care. When

Daniela describes her approach to working with a hypothetical gay client, she knows she would lack the more specific local definition of the midwifery model of care she shares with Briana, and "tacks back" to a more general one: "very good prenatal care." Using a boundary object to collaborate without consensus can thus require bracketing the very disagreements that are core to collaborators' local understandings of the object. Agreeing to disagree can mean agreeing not to talk about the disagreement—and agreeing not to talk about how the content of the disagreement might affect client care.

The weakly-structured version of homebirth midwifery care did at times reveal itself to be *too* weak to accommodate client needs. These revelations, however, often came with some ambivalence, as like Daniela, many midwives felt strongly that there was some particular good in serving clients across great social distance. "During my apprenticeship," Nova told me, "I worked with a…very conservative, very Republican, Christian, not into queer people, kind of population. And my preceptor was a not out bisexual woman, as far as her clients went, and was just very clear before I started working with her, for some clients, this is just the case…I definitely had the experience that we were able to develop very close and intimate relationships, because I was present, and holding space, and taking care of them during this deeply intimate and vulnerable time. It was a great lesson for me, as a radical queer young person that that's possible." Nova covered a tattoo during this apprenticeship in order to avoid signaling that social distance to clients. But after the apprenticeship was over, she declined an offer to join her former preceptor's practice, despite their excellent relationship. "I wanted to work with people who felt like they could be my friends," she explained, "that we had more of a shared rapport. Because one of the reasons that I love being a midwife is getting to have

that shared relationship and that intimate moment with people, and developing that over time. And I think that it's a two-way street. So, I made the decision to be really out on my website, and just very clear that my target audience is queer families. I love working with heterosexual people as well, but…I think there are definitely situations that queer people or poly people will feel safer and more comfortable with somebody who just either has been through that, or has a couple friends [who have]." She and others sometimes told me—though it often took my asking several times—about situations in which they felt clear that providing good prenatal care would not have been possible had they been bracketing some kind of social distance: "I recently had a sex worker client who looked far and wide for a midwife who felt comfortable with her working during her pregnancy, and that lifestyle. And that was very important to her. And she definitely couldn't have been with somebody who thought that her profession was…negative in whatever way."

Over the past several years, the premium on providing care across difference has receded as a conversation about what is often called "culturally matched" care has grown in homebirth midwifery circles. From MANA presentations to midwifery schools to statewide midwives' organizations, a thesis has been advanced that care is best when provider and client share a social world or experience of the world much as Nova describes here. The conversation often echos Black midwives' and families' calls for midwives to work to reduce Black maternal mortality by materially supporting the education of more Black midwives to attend Black families. At one meeting of the California Association of Licensed Midwives that I attended, for instance, preparations were underway for a meeting of the organization's Birth Disparities and Equity Team. This team was formed after the organization compared the percentages of midwives of

color and people of color in the state, finding them drastically disproportionate. Student midwives and midwives of color reported that the white midwives in the state were, in many cases, no more prepared to offer care to Black clients than the hospitals in which Black families already experienced dangerous perinatal care: "During my apprenticeship," one reported, "I was asked questions such as; how can you tell if a black baby needs resuscitation or comments like I have never repaired a black vaginal before are the tissues tough like their skin?!" The organization decided to prioritize increasing the number of midwives of color practicing in the state in order to make availability of "culturally matched" midwifery care for more families families of color, and a group of midwives of color drafted a letter about what would have helped them as they were starting out, settling on support for passing the NARM credentialing exam. The program they created, "Strong Midwives Strong Families," undertook an initiative called Jumpstart: An Insiders' Guide for the NARM. The program was developed in partnership with Courtney Everson, a social scientist on the faculty of the Midwives' College of Utah, and would culminate in a study retreat for midwifery students of color to prepare for the exam. Everson helped out, a team member told me, by tracking down citations about why culturally matched midwifery care matters and convincing MCU to make an in-kind donation of their test bank of practice questions and exams. Their materials made their case clear: "Racism in health care means that black mothers and their babies are 3 to 4 times more likely to experience serious complications, even when income, education, and access to health insurance are taken into account…Midwives—especially those who look like the communities they serve—can help." MANA Stats researchers, meanwhile, announced at the 2018 conference that they wanted to to begin comparing outcomes

between births in which providers who do and do not share a racial identity with their clients, but needed to increase the population of midwives of color in order to have a large enough sample size to do so.

If collaborating without consensus in homebirth midwifery has required bracketing disagreement, that has certainly included disagreement over the realities of dispossession and violence that attend Black life, migrant life, queer and trans life. The conversation about culturally matched midwifery care has begun to challenge those brackets. In the next section of this chapter, I will describe what happens when conflict becomes open.

Open Conflict

What happens when disagreements are openly engaged? Over the course of my fieldwork, I saw open conflict over the same issues many midwives told me they avoided discussing with colleagues and clients: abortion, sexuality, gender, race and colonially, and the notion of state power at all. These conflicts frequently flared around midwifery organizations and events more than around day-to-day practice relationships, though as I will discuss, their reach did sometimes ultimately extend to that level. They also frequently occurred in Facebook groups and other social media spaces, and frequently came to a head around online petitions. This section of the chapter will describe three open conflicts: one ongoing conflict among midwives in the Massachusetts Midwives' Alliance over licensure and the role of states in midwifery; one surrounding a 2019 announcement of a Midwifery Today conference location, in which gender and sexuality were particularly prominent issues of conflict; and one surrounding the MANA conference in 2018, in which abortion and what might constitute an adequate

organizational approach to racism and coloniality were particularly hotly contested. While I attended meetings of many of the organizations surrounding these conflicts and interviewed members and attendees in many cases, I was not deeply embedded in any of these organizations. My aim in including these descriptions is to orient the reader to what the landscape of conflict over an approximately two-year period in the homebirth midwifery community looked like.

Massachusetts Midwives Association

My fieldwork in northern New England happened to coincide with a moment of high conflict within the community of Massachusetts homebirth midwives over whether or not to attempt to get pass legislation creating licensure for CPMs. At the annual meeting of the Massachusetts Midwives' Association, Kathleen, one of the organization's officers and the meeting's facilitator, held up her stack of agendas. "This is my folder for today," she said, pointing out the index cards on which she had written a series of reminders for the group in bright colors. Kathleen read them out loud to the twenty homebirth midwives and student midwives: "Kindness is everything. We all want what is best. No midwife attends a birth to harm. Speak kindly from your heart. Where is there agreement and connection?"

Agreement and connection had been scarce over the past year. A bill drafted by the organization's former legislative committee, which would have licensed CPMs for the first time in the state's history, had proven enormously divisive. Two of the participants in the meeting had helped to draft the bill; Kathleen had founded an organization of midwives to lobby in opposition. There were extremely hurt feelings about the tone of the

conversations that had transpired, which midwives on both sides of the conflict told me had been traumatizing and which many described as having included personal attacks, bullying, and character assassination. The content of the disagreement was likewise complex and concerned many different issues. But one central point concerned the question of whether regulation would enhance or threaten autonomy for clients. Kathleen, like many other direct-entry midwives who are ambivalent about or opposed to licensure, objected to state interference: "Women get the best possible care when they are with the person that they want to be with, and when you've provided the information, education, knowledge, opportunities of the person that's serving them," she told me. "I refuse to let the state be the [one] who adjudicates my relationship with my clients." She'd been told by a member of a regulatory board in another state, "listen, we have laws—like 'you can't have a VBAC[62] if you're more than thirty minutes from a hospital, and it can't be after two [cesareans], and you have to have an ultrasound'—for the safe practice of midwifery," but she wasn't buying it. "I was like, how do you get to decide what's safe? How do you get to decide what each person's individual risk comfort is?" For Kathleen, the restrictions to scope of practice and the requirements that commonly attend licensure threatened two pillars of the model of the care she thought they were all aiming to provide: informed choice and the individualized nature of homebirth midwifery care.

But for Teresa, Lila, and other midwives who had advocated for licensure, the regulation was just one step in eventually gaining access to Medicaid reimbursement that they believed would increase access to care for low-income clients. "It's outrageous, it's *outrageous* that we're only doing this for half of the clients," Theresa told me. She

[62] Vaginal Birth After Cesarean

acknowledged that Kathleen and others had pointed out that additional legislation would be necessary to secure Medicaid reimbursement: "[Getting coverage by MassHealth] will be its own 30 year process. To get it comprehensively is its own struggle." But she was adamant that "we need to start that struggle." Lila, similarly, told me that "in terms of diversity and increasing access," she has "a real problem with the status quo about of who gets to 'have a homebirth." Her comments echoed those of another activist for licensure: "I want to give this individualized care, and I still will be able to, mostly. But I am willing to give things up in exchange for this model of care getting beyond 1 or 2% of people." Theresa was frustrated with midwives who claimed that the existing measures midwives took to make their services available to poor and low-income clients, such as creating sliding scales or long payment plans. She'd heard, she said, other midwives arguing that these existing systems allowed clients to pay as little as $50 per month towards their midwifery care balances. "Okay," she said, "but how about a study I read in the *[New York] Times* about a year ago that said 60% of people would't be able to find $2,000?…For those of us who would take births for $1,700, we know we're not also making [clients] starve to pay for their home birth." For pro-licensure activists, remaining unregulated was a decision to continue to ask many clients to choose between paying out-of-pocket for healthcare or paying for other basic necessities, and to entirely restrict access to out of hospital midwifery—and thereby to the benefits the model could afford—for many other potential clients. Pointing up the institutional constraints conditioning choice, they argued against Kathleen's understanding of licensure as threatening autonomy in birth.

Theresa and other pro-licensure midwives also hoped that regulation would

increase accountability in midwifery practice. "I would love it if we could regulate ourselves, but I think it's proven that we can't," she told me. "We still have midwives who I know we all think are practicing in ways that are harmful. One or two. Not many. But…we have no teeth for when there are losses and poor practice." Theresa was in favor of what she and other licensure activists called a "tiered system" for accountability following a finding of a midwife's poor practice, with rescinding a license as a final step. She was frustrated with anti-licensure activists' focus on the inclusion of prison time in the current version of the bill, pointing out that the regulations governing other other healthcare providers, such as acupuncturists, included possible prison time. Kathleen was indeed particularly upset about that provision. "They're punishing midwives," she said. It was one more way that she saw punitive state action increasing around birth in ways that scared her and that she felt she never could have anticipated. "DCF doesn't get called in Massachusetts," she told me. "We're totally progressive. And last year, I transferred a client and she declined vitamin K and then signed MMA to go home. And three cops and three social workers in an ambulance showed up at her house and took her baby out of her arms and put her baby in the ambulance and took it to the hospital. And they said that they got a call from the hospital saying that there was an imminent risk of harm because she had declined the vitamin K injection. And her and her baby's blood type are different. They don't know any different. They're not medical providers. That's total bullshit by the way. And I thought... all the things that I couldn't think could possibly happen, like Donald Trump being president, and that DCF would—that a hospital, that someone would be so retaliatory that they would take a newborn baby out of her mother's arms." For Kathleen, pulling someone's license seemed like no more robust an

accountability measure than pulling someone's MMA membership because of a violation of MMA practice guidelines, which was the organization's current accountability mechanism. Licensure would simply make those consequences more punitive for midwives.

"The rallying cry of the opposition is *stop*," Theresa said. "Stop what? Birth choice? Women's choice? 'Stop legislating women's bodies' sounds very hippie and liberal, but at the same time…this is a consumer protection law!" "I don't think licensing makes midwives' practice safer," Kathleen told me. "It just gives another avenue of control to a state entity over a group of people…it's a false sense of security." These are not partisan disagreements—support for midwifery licensure did not fall along partisan lines in either the Massachusetts legislature or among midwives in the state, or in other states. Indeed, one midwifery student in another state told me her work for homebirth midwifery licensure was the first time that she, as a conservative, had ever worked with the National Organization for Women. All four of these midwives describe themselves as progressive—the arguments had been over essentially political questions about whether choice is an individual or institutional artifact, what role states ought to play in the regulation fo healthcare, and whether state power might best be understood as a possible *tool* for increasing liberty or *impediment* to that liberty. This enormously heterogeneous group of midwives, had, over the previous year, stopped being able to reliably collaborate. The MMA's meetings had become contentious enough that multiple members had withdrawn their membership entirely. They no longer participated in group continuing education or in the group's peer review process.[63] Some had gone so far as to

[63] Peer review, at which midwives present cases, discuss outcomes, brainstorm possible ways to approach similar cases differently in the future, and support one another about difficult

refuse to attend births with midwives[64] on the opposing side.

Midwifery Today 2019 Announcement

In August of 2019, Facebook posts began popping up on a midwifery study group I follow. Other midwives I know began reposting them, too. Ray Rachlin, a Philadelphia midwife, had started a Change.org petition. "I am a proud Philly midwife and the President of the Pennsylvania Association of Certified Professional Midwives, yet I am not able to attend *Midwifery Today*'s 2020 conference in my own state of PA because Midwifery Today chose a conference venue with an explicit policy banning LGBTQ people and speakers," the header read. "This is outrageous and unacceptable! Join me in demanding *Midwifery Today* change the [venue] of the Midwifery Today 2020 conference to a location that welcomes LGBTQ midwives to attend and speak AND diversify the speakers at the conference to hear from more midwives of color and midwives who are LGBTQ identified!"

Midwifery Today is a midwifery magazine that was first printed in 1987. It is a key institution associated with the twentieth century resurgence of midwifery and homebirth, printing clinical reports, essays about issues such as attachment that inform many contemporary midwives' practice approaches, and midwives' personal narratives. Topics

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moments in care, is required for those who hold the CPM credential and required in particular cases (such as intrapartum deaths or transfers of care) in some states where licensure is mandatory for practicing homebirth midwives. State midwifery organizations commonly hold peer reviews as part of their regular meetings. I observed four peer review sessions (one ad-hoc meeting and three peer reviews following state midwifery organizations' meetings) during my research.

64 It is common practice (and under some circumstances a legal requirement) to attend births with two fully trained and/or credentialed midwives. For this reason, midwives who practice independently frequently attend births together, collaborating as a care team for days on end. Though no institution compels any given midwife to say yes when asked, refusing to go to a birth with someone is relatively atypical. "It's like a small family," Kathleen said, "We all have to back each other up because no one wants someone going to births alone."

are wide-ranging: a recent issue included articles on how the lithotomy position became standard, the idea of choice during birth, variations in pushing times, the Virgin Mary's midwives, suggestions for breech attendants, and the use of salt in treating umbilical granulomas. Since 1992, the organization has also held conferences both in the United States and overseas.

The petition itself opened with screenshots from Facebook conversations in the conference page, which had recently announced a new venue in Lancaster for the spring 2020 conference. A Pennsylvania-based midwife, reading the program and venue information posted, had asked the organizers why there were so few speakers of color listed and whether there were any "LGBTQIA++" speakers. "Sharing birth culture is the theme, correct? Yet it looks like mostly white, heterosexual culture? If you are looking for speakers outside of those you have had at your conferences dozens of times I'm sure we can make some suggestions?" Others added comments suggesting possible queer, trans, and nonbinary speakers until a reply from Jan Tritten, editor of the magazine and leader of the conference: "Sorry all but in this venue we can't. Though it is a secular conference our venue is in a Christian retreat center with guidelines that are opposed to this." One midwife responded, "Gotcha. Then we can't be there. Sigh…" Tritten cited cost concerns in the location choice: "Sorry. Perhaps another time. This is a very unusual venue for us but so reasonable in price and they give us so much."

The venue's policy guideline was quoted in the petition language. "All guest groups shall honor Biblical standards of conduct. This includes, but is not limited to refraining from the use of illegal drugs, alcohol, firearms, explosives, profanity, secular music and videos, immodest clothing, and refraining from practicing or condoning sexual

activity outside of the relationship of marriage between a man and a woman." "Because Midwifery Today chose this location with this discriminatory policy," the petition went on, "LGBTQ speakers are not allowed to participate in the conference." Signatories were urged to cancel their subscriptions to the publication until a venue change and programming change adding "more speakers from communities of color and the LGBTQ community" could be made, and to sign on to demands to move the venue.

The conversation on the Facebook midwifery study group clearly became heated. Many were angry and disappointed, but unsurprised that the organization had failed to prioritize issues of gender, sexuality, and racism in its programming. Some felt that they would be able to attend without anyone in the venue knowing that they were themselves queer, but that to do so would be to leave behind midwives of color and queer midwives who would not be able to pass in this way. Others argued that the exclusionary policy of the venue was not "real" Christianity. When one poster suggested that *topics* might be disallowed but queer and trans *attendees* might not be banned, a series of midwives responded that their objections were about daily practice, not about ideology. Such an arrangement, one replied, "means that we can't talk about our jobs, the lives and realities of some or our clients, not to mention the lives & realities of many midwives and students who would have liked to attend…you cannot have a midwifery conference to talk about culture in midwifery without IBPOC & LGBTQIA+ midwives present and talking about their culture, which, gasp, includes pregnancy out of wedlock, sex & marriage between people of all genders, and abortion." Another chimed in to make it more specific: "you may not discuss well care or safe sex for anyone unmarried or LGBTQ, cannot discuss LGBTQ issues within midwifery and how [to] care for sexual

issues regarding LGBTQ people, no well and birth care for trans people, cannot discuss IUI unless it is a married straight couple…I could go on." A third added that those were, in fact, the very topics that they would seek out in conference workshops.

Others sought to protect *Midwifery Today*. "Why does it always come down to this??? I'm tired of my sisters being attacked," one poster wrote. "Everyone is offended because all differences are not represented all the time?? These women (yes women!) work hard to present an educational offering and this is what they get? Who would be encouraged to continue in their work?" Some were taken aback and angry with this response. "When minorities protest those in power their protests are labeled 'angry' 'out of proportion' 'inappropriate attacks,'" one wrote. "There is no way to…stage a protest against the status quo that will not disturb the status quo." Others agreed, adding that they felt "afraid to speak" or like they were "walking on eggshells" to avoid being "attacked". Eventually, admins in the page referred to the study group's own Community Guidelines and Justice Policy, which stipulate that the group is "specifically and purposefully welcoming to indigenous people, disabled people, people of color and trans/queer folks," and to which all participants are asked to agree upon joining the group. The admins muted the detractors while asking them to decide whether they would respect those guidelines or leave.

Meanwhile, other parts of the conversation turned to broader questions about the place of organizations like *Midwifery Today* with roots in the 1970s and 80s homebirth and midwifery resurgence. Several commenters who had authored articles for the publication reported noticing that *Midwifery Today* had removed their uses of the term "birthing people," added so as to be inclusive of clients such as trans and nonbinary

parents who do not identify as women, replacing them with "woman" or "women". Others offered reminders that "exclusionary opinions" towards queer and trans people were nothing new in midwifery, referring to another letter from 2014 in which signatories urged MANA to use the word "women" instead of the gender-neutral language the organization had begun to adopt. One administrator of the page shared a short synthesis of the MANA conference events and *Midwifery Today*'s actions. "MANA: engages in specific systemic oppression; promises to support up-and-coming POC leadership, and then refuses to make way fo rush, brings a white dude onto their board instead. Midwifery Today: hold my doppler…and give me a donation to support my bigotry." A bitter contest over the correct narrative about MANA board membership transitions over the previous year ensued, with the page administrator[65] describing leadership transitions as orchestrated by existing, predominantly white leadership even as commitments were made and broken to create space for leaders of color. A MANA board member responded asserting that the "terrible scenes" at the Maine conference the year before had been caused by people who had been recommended for leadership by those organizing a pipeline for midwives of color, adding that those people were not "ready for national leadership" and that MANA had needed to "return to our focus…to that of being a midwifery association," adding that MANA had "gone off track from our mission as an organization" and accusing some of attempting to destroy MANA[66].

In the midst of this conflict, *Midwifery Today* issued a statement cancelling the conference and calling the notion that "members of the LGBTQ community are not welcome at our April 2020 conference" false and misinformation. One commenter made

[65] Delmar Bauta
[66] Colleen Moira Donovan-Batson

another succinct summary of the conflict. "Us: Be inclusive! Come on y'all! MT: No, and now no one gets to have anything, hmph *flounces out*[67]." The comment highlighted the stakes of the incident for many midwives, who pointed out that their activism on the issue had not been solely symbolic. For many in a field in which solo or two-person practice is common, traveling to conferences to complete CEUs and learn new clinical skills can be difficult given the challenge of finding practice coverage while away, and each conference becomes a precious opportunity. Finding that one of the those few opportunities had decided to work with a venue with this kind of policy was personally hurtful to be sure, but it also deprived midwives in the Mid-Atlantic region of the opportunity to learn more about clinical care for queer and trans clients—with negative care quality implications for those families.

MANA 2018

Vicki Hedley, president of the Midwives' Alliance of North America, opened her welcome to the 2018 conference with thanks to organizers, local midwives, the organization's board, and the families and midwives providing coverage to all the organizers and attendees. Standing between a vibrant textile wall-hanging, baskets of chrysanthemums, and a large projector screen, she announced her intention to honor elders and ancestors, indigenous peoples of the area in southern Maine, and invited participants to connect "eye to eye, word to word, and hand to hand, if you are so inclined." She guided the group in a deep breath and described the past year of organizational work. There was laughter in the room as she displayed a meme on the

[67] Kristyn M Gerchalk

projector screen showing a “before” and “after” image of a white woman who appeared to have aged decades between the two photographs. “What is the status quo?”, she asked rhetorically, listing a cesarean rate of over 32%, overuse of technology in perinatal care, “no postpartum care,” reduced satisfaction for families, horrific mother and child outcomes, and institutionalized racism, and offering the midwives’ model of care, “when implemented equitably,” as a solution. Hedley reviewed a series of statements MANA had released during the “year of reproductive health” the organization had undertaken “because we can no longer be silent on contentious issues”: two reproductive health statements adopting the Beijing Conference on Women definition of reproductive health and the SisterSong definition of reproductive justice, recognizing that “contemporary midwifery in the US has grown out of the knowledge of enslaved African midwives and healers from Indigenous and immigrant communities” and calling for an end to obstetric violence, obstetric neglect, “violence used as an agent of control against female bodied and female identified people”, and “the use of Child Protective Services as a means to enforce medical compliance and cultural norms, and as a weapon against LGBTQIA2S+ families and people of color”, a statement in support of universal healthcare, and a health policy statement on passport denials to US citizens born at home near the US-Mexico border. On many elements of care, Hedley said, attendees could agree, but “the white elephant in the room” was abortion. “Who here remembers when MANA actively decided not to speak about abortion,” she asked? It was, she said, considered to be divisive and contentious, controversial, and polarizing, and there was a critical need to unify around issues of autonomy in birth and credentialing. “We were enmeshed in a melting pot mentality,” she said. “It helped with movement building. It served us for a

while. But who was 'we'? Who was left out as a result of that desire for unity?" The unintended consequences of that approach, she said, were serious: white midwives "unintentially" appropriating culture in an attempt to bring midwifery back; entire groups of people and reproductive issues left out.

Hedley repeatedly invited the audience to take "big breaths" and to imagine the midwifery community as a "patchwork quilt," after Jesse Jackson's 1988 speech, rather than as a "melting pot." She told the assembled midwives that the conference program had changed. Following the organization's newly clarified use of a Beijing Conference reproductive health definition that includes choice about when, if, and how to reproduce and access to family planning methods, an abortion provider had been invited to speak at the conference. Some speakers, members, and board members, Hedley said, had not been comfortable with that. I was later informed by other midwives that Mercy in Action, a prominent midwifery organization with Christian leadership that provides MEAC-accredited schooling, ongoing continuing education, and more, had been one of the organizations in question. "Trust was broken," Hedley said, "the board divided, and relationships—relationships, the most important part—were affected." Quoting organizational consultant Margaret Wheatley, she told the audience that the world changes "through networks of relationships," not one person at a time. "We don't convince large numbers of people to change," she said, instead urging the audience to consider "practices, courage, and commitment" in relationships. Hedley finished her speech with an announcement that a contra dance scheduled for Saturday night had been cancelled and replaced with a DJ. She was sorry, she said that the change could feel sad or uncomfortable for some, but the organization had been made aware that it might be

triggering to indigenous people and people of color, and had decided to make the change. She reminded the audience to seek common ground in "autonomy, respect for personal dignity, and the belief that birth is sacred and people having babies are doing sacred work."

Jus Crea Giammarino, a naturopathic doctor who is a member of the Penobscot Nation, gave a plenary session immediately afterwards about traditional birth and health care for Wabenaki Indigenous women in Maine. Giammarino walked the audience through the history of Indian Island, her reservation, and the people and lands in the area: the 1724 massacre at Norridgewock, a 1755 proclamation of a bounty on Penobscot scalps, the development of residential boarding schools and their violences, the theft of lands from Penobscot peoples and attendant loss of access to traditional food and medicines, the restrictions on the teaching of botanical medicine following the 1910 Flexner report. "Colonized medicine is not holistic," she told the audience, reminding them that birthing is ceremonial and indigenous religious practice was outlawed in the area until 1978. "Part of our sovereignty and freedom of religion is to have birthing as part of our ceremonies."

Giammarino once again cited findings[68] that culturally sensitive medicine improves outcomes in pregnancy. "But we've been here for 14,000 years," she said. She described a gathering of Cree, Dakota and Lakota, Penobscot, and Ojibwe women reclaiming birth traditions, as well as Penobscot Nation programs providing breastfeeding, birth, and postpartum support. Reminding the audience of the findings of the Maine Wabenaki Truth and Reconciliation Committee, she choked up: in a context in which indigenous

[68] Various publications and position statements have affirmed this position: see, for instance, WHO 2015; Coast et al 2016.

children have been five times more likely to be removed from their families, often for reasons of poverty such as lack go access to running water or electricity, placed in foster care, fear of the state coming to take your children played a role in how women have chosen to birth and parent. “If your mother or grandmother went to boarding school, she’ll tell you that you can’t breastfeed, and this is intergenerational trauma,” Giammarino said, apologizing for beginning to break down. “Why shouldn’t you?” one audience member called back. “Bring it on!” The plenary closed with a discussion of food sovereignty and rebuilding clan structures in the context of theft of ocean lands and environmental degradation endangering roots such as black and blue cohosh used in birthing.

When the open forum for MANA members convened that afternoon, though, the overwhelming sentiment in the room was that a plenary and a set of organizational statements did not sufficiently address the issues of indigenous sovereignty in birth, reproductive justice, and safe care for Black families that Giammarino’s talk had highlighted. “I would like to see the board be like the United Nations,” one person offered. Another told the board that the reproductive justice framework MANA was attempting to adopt seemed notably absent from many of the breakout sessions, even if there were prominent speakers representing this approach. Allowing people without a framework for racial justice to present, one person told the board, felt like being invited to something triggering. “Are we going to come back? Stay in our rooms tomorrow? What is being done to solve this situation?” Rhonda Lee Grantham, an indigenous midwife and member of the program committee, spoke about the process of reading abstracts and submissions to the conference and scoring them with an attempt to create a

conference space that would elevate people of color. “We had intense, great, powerful discussions,” she said, “and sometimes the person who walks in the room and is in this position of power as a speaker is not going to be safe for the people in that room.” The organization, she said, had still not done enough. “It’s not enough to not invite a speaker back. It’s not enough to be like, ‘oops.’ A lot of the incidents that have been violating or hard have been from other conference attendees—how do we create safety net when [things don’t] work the way we intended?” Other concerns—including about conference locations and dates, programming and organizational leadership for students, and publicity and budget arose—but racism and coloniality were ever-present in the comments. By the end of the session, it was clear that the legitimacy of the organization’s leadership was at stake. “I hear the word diversity that keeps getting thrown around,” one commenter said. “Diversity includes being antiracist. Tripping over [your] words makes us feel like we don’t belong here or like we’re not human. You have to do the homework, the reading, the training before you say you want to lead this organization.” Other commenters highlighted conference organizers’ inability to accommodate disabled attendees’ participation—“I can’t even get to the mic,” one noted—and the pervasive use of gendered terms like “woman” to refer to a group of attendees that included many trans and nonbinary people.

The conflict, I later learned, continued on successive days of the conference. I had to leave the conference early, but after seeing a flurry of relevant Facebook posts in the week afterwards, I got in touch with others I knew who had been there. A student I knew from a statewide midwives’ organization in the area filled me in on her experience. One major moment, she said, occurred during two concurrent dinners: one honoring Judy

Norsigian, key figure behind the Boston Women's Health Collective of *Our Bodies, Ourselves* fame, and another for midwives of color in another room. The dinner honoring Norsigian was predominantly attended by white conference participants, though some indigenous people were in the room, too. Entertainment for the evening was provided by a Inana, three-person band of white women playing drums and singing in what the student identified as Yoruba or another West African language, and their performance was introduced by one band member talking about the role of drumming in greeting babies at birth. "It was *weird*," the student told me, relating the way the introduction claimed the band had received the musical tradition from a teacher and was part of a tradition that was thousands of years old without any specificity about whose tradition that might be. Vicki Hedley, the MANA president, eventually got up and interrupted the performance. Grabbing the mic, the student said, she apologized to indigenous attendees and attendees of color who had been harmed by the performance, saying, "yes, these are traditional drums, but they are not our drums—they are not white women's drums." She apologized, began to cry, and apologized for her "white tears."

Silence followed, according to the student. "The people who were uncomfortable about the band playing clapped, so I clapped," she said. "Then Rhonda Lee got up and was just furious, and was like, 'I saw some of you dancing to this music—this is the kind of cultural appropriation we talk about…the women of color [whose drums these are] are in the next room over. '" Grantham was, the student said, spot on, but as she looked around, she saw bewilderment on many faces, especially, she said, the faces of those at Norsigian's table. White attendees' bewilderment continued the next day—and escalated to open hostility at times—when plenary speaker Chanel Portia-Albert, founder of a

Black-community-focused doula training program, asked participants to have small group discussions about the way they saw themselves and thought their clients saw them. "Our table did a piss-poor job," the student told me. Another midwife said that other white participants at her table complained, calling the exercise a waste of time. The organization, the student told me, seemed to have been confronted at this conference by the failure of their efforts to adequately center families and birthworkers of color.

By the end of the conference, others told me, the conflict over abortion seemed to have fallen by the wayside. An organization and professional community already divided on the issue of abortion was now facing its divisions over racism, colonialism, and white supremacy. A list by a member of the Black Midwives' Alliance[69] of "things that happened at the Midwives' Alliance conference" circulated on Facebook in the days afterwards, listing these events and a white midwife who "assaulted (pushed) a Black midwifery student after the student tried to call her in on her racism," along with some concessions from the organization such as agreements to support leaders of color in MANA and a midwives of color gathering following the conference. "My only purpose to be there," the post read, "is to take care of my people and grab as many resources as possible to build our own institutions where we don't have to deal with this bullshit."

It was clear that Hedley's repeated requests for attendees to remember that the organization was "going from the melting pot to the patchwork quilt," including in a statement following up on her interruption of the drumming group's performance, were not felt by attendees of color to be adequate responses to their experiences at the conference, which, according to the student I spoke with, Portia-Alberts called "a tornado

[69] Ja Ola Amani, 10/15/2018

of racism." As families and providers have begun to speak more publicly about the connections between provider racism and neglect or abuse in perinatal care, the bodily effects of "weathering" or the increased burdens of both systemic dispossession and daily interactions with both institutional and interpersonal racism, and the killing perinatal outcomes faced by Black families and other families of color, the way that bracketing contentious issues in service of collaboration in conditions of disagreement concedes Black safety to white comfort has become increasingly part of the public conversation.

Strange Bedfellows in Conflict

Each of these conflicts represents one flashpoint of a larger conflict in the home birth midwifery community at large. And as these and other moments of these conflicts show, midwives do not neatly sort themselves into conservative and liberal with regard to any of these individual issues: rights and lefts are multiple and messy in these conflicts. Second-wave feminists and evangelical women bristle at the request to imagine and refer to their clients as anything other than women. Self-described libertarians and self-described leftists or anarchists agree about abortion access *and* their suspicions of the idea that more state oversight of midwifery might produce more, rather than less, choice for clients, and that individual concessions might be worthwhile tradeoffs if they yield opportunities that can be made available to more people. These are the strange bedfellows about whom we should care the most. Like the coalitions of feminists and conservatives that have surrounded sex trafficking activism (Whittier 2018), they coalesce around fundamentally conservative ideas—essentialism, individual-level understandings of choice and rights (Simonds 2007:196).

Yet regardless of whether political disagreement is partisan or even nominally right-left, one constant appears: collaboration without consensus increasingly breaks down as the immediacy of praxis is lost. Professional organizations, conferences, and study groups—Facebook or in-person—are sites where midwives gather without actually providing care, and conversations venture quickly into the realm of the ideological without a tether to the materiality of practice. Midwives meet one another in "seamful spaces" (Vertesi 2014), where multiple infrastructures admit varying degrees of practice: relatively little in a Facebook group; relatively more in a professional organization's discussion of protocols for baby aspirin use in preeclampsia prevention. Indeed, one strategy midwives often use in conflict is to attenuate their justifications in settings where practice is *not* occurring to accounts of the demands of practice in other settings: in asserting that, for instance, they need knowledge of trans health in order to provide safe care to the clients they actually see. If the boundary object of the Midwifery Model of Care holds this community of practice together, then, it does so only insofar as the community is actually practicing together. In other words, this finding suggests that boundary objects become more difficult to hold together the more abstract they are.

Conclusion

Conceiving of the Midwives' Model of Care ™ as a boundary object has implications for the study of homebirth and alternative birth, for the study of political heterogeneity, and for theorizing boundary objects. The Midwives' Model of Care or Midwifery Model of Care extends what we might usefully think of as a boundary object to suggest that a set of normative commitments—and a set of practices enacting those

commitments—might function to sustain collaboration without consensus. Yet the very abstraction of those normative commitments appears to be a hazard for the utility of the boundary object. The capacity of that model to maintain interpretive flexibility raises uncomfortable questions about the idea that it is an anti-patriarchal model of care. The model's adaptability to various local environments—including extremely conservative ones—suggests that there might be nothing inherently feminist in the idea that pregnancy, labor, and birth need not be a medical event or an experience of injury or abuse and no necessary radicalism to the idea one ought to be able to make one's own choices in pregnancy, labor and birth. The Midwives' Model of Care™ is, in other words, not in and of itself a necessarily political or feminist stance or orientation.

There is also no guarantee that care offered under some interpretations of the Midwives' Model of Care ™ will prevent "the incidence of birth injury [or] trauma" related to those concerns that are bracketed in service of cooperation. This is an argument midwives and analysts have been making for a long time (Goode 2014). Some have argued for a different, more specific object than the Midwives Model of Care ™, such as Asasiya Muhammad's People's Midwife Model of Care ™. Muhammad's model,[70] by design, has much less interpretive flexibility. It leaves no room for the idea that adequate care can be provided to Black clients, whose experiences of pregnancy, labor, and birth are often the most dangerous (Villarosa 2018) without accounting for resource distribution or the psychic costs of life in white supremacy:

[70] The People's Midwife Model of Care: https://innercirclemidwifery.com/

THE PEOPLE'S MIDWIFE MODEL OF CARE™

The People's Midwife Model of Care emerged from a need to have a culturally responsive means to address the maternal infant health crisis in Black America. We hold that the mainstream midwifery models do not adequately address the unique concerns of women of African descent. We honor the history of our own ancestral midwives and in their spirit offer a new paradigm that addresses the contemporary concerns of our families. We value the spiritual, physical, mental, emotional, and economic empowerment of women, recognizing that they are central to her ability to make truly informed choices. We commit ourselves to the social role of midwives as intermediaries between every woman and family's access to the community resources that are vital to long-term holistic health and wellness.



Fig. 1

Activists working with the terminology of birth justice have consistently made a similar point. The Southern Birth Justice Network holds that midwifery care without access to a full range of pregnancy- related healthcare—including abortion, miscarriage, prenatal, birth, and postpartum care—is insufficient, arguing that "Birth Justice includes the right to choose whether or not to carry a pregnancy, to choose when, where how, and with whom to birth, including access to traditional and indigenous healers, such as midwives and other birthworkers, and the right to breastfeeding support".[71] There is no such thing as adequate pregnancy and birth care for "people of color, immigrant peoples, and LGQBT communities" so long as politically charged issues are bracketed, they argue, in part because the dangers faced by families in pregnancy and childbirth are themselves a product of attacks on community members, cosmologies, and caregivers (Amani 2016).

Crucially, homebirth midwives in this study did not make apolitical communities, nor did they avoid all contentious talk about matters of public concern. They were not, as were the members of voluntary associations who people Nina Eliasoph's *Avoiding Politics*, engaged in the production of general apathy—indeed, the challenge to medical

[71] "Birth Justice Framework": https://southernbirthjustice.org/birth-justice-framework

perinatal care mounted by the midwifery model is just the kind of public-spirited, highly sociological talk that Eliasoph's actors avoided (Eliasoph 1998:14, 16). Similarly, they did not express general sentiments of cynicism or disbelief in the possibilities of collective action like those expressed by the young Russians interviewed by Anna Zhelnina. Homebirth midwives certainly "cared about politics" (Zhelnina 2019). The work of building alternative perinatal care systems is, in many ways, a distinctive example of what Harry Boyte has called "everyday politics": "ordinary people of different views and interests working together to define and to solve problems" (Boyte 2005:xi-xii). But in those areas of public or political concern where midwives disagreed, hashing out disagreement—and, indeed, taking political action on matters about which disagreement was pitched—was incompatible with the smooth continuation of day-to-day collaboration. The costs of breaking the brackets around contentious political matters is high in day-to-day practice: in a small profession, backup, call coverage, and peer reviewing relationships are high-stakes, and midwives truly rely on them to be able to practice. It is, in other words, the very intimacy and mutual reliance of those relationships across difference that makes them unlikely sites for the kind of bipartisan hashing-out that many hope might occur.

This finding complicates those of political scientist Diana Mutz, who contends that political activism is best supported by politically homogenous social networks, rather than by the social networks populated by "the other side" (Mutz 2006). In this case, the use of a shared model of care as a boundary object enabled collaboration in a politically heterogeneous social network, but only so long as ideological sameness was highlighted and differing ideological commitments were bracketed. This finding also speaks to

literatures suggesting that engaging with conflict among disparate actors may be key to the generation of political meaning (Auyero, Hernandez, and Stitt 2017). Scholars of coalition have pointed up the crucial nature of balancing a focus on shared commitments and direct engagement with conflicting views (Cole and Luna 2010: 95). When claims to neutrality are substituted for direct engagement with difference, many have argued, the result is the "reproduc[tion of] patterns of privilege and oppression" (Young 1990:167). These findings reinforce calls for similar active negotiation of commonality and difference (Luna 2016) in political formations that are not inter-organization coalitions. In the absence of this active negotiation, bridging ideological divides using boundary objects has distinct political downsides. Collaborative relationships and coalitions hazard precariousness and the depoliticization of shared concerns when they are bound by a weakly structured, network-level object whose use demands the allocation of attention to sameness and bracketing of difference and political disagreement.

Furthermore, the centrality of a maternalist consensus to the network level version of that object does not demand that practitioners talk about what makes birth social (Ginsburg and Rapp 1991), rather than the way the social world might be made in birth. It does not demand attention to resource inequities or repression that do not take *midwives* or *natural-birth families* as the oppressed group. Anti-interventionist approaches to birth, relativist epistemologies, and articulations of a right to *refusal* in healthcare translate more readily to arguments for privacy and small government than to arguments for state capacity or resource redistribution. Analysts *and* practitioners will need to generate alternative forms of framing if homebirth midwifery is to be the site from which to articulate a different set of social conditions for birth, or something like a

right to good care.

In 1989, Star and Griesemer identified their central analytical question thus: “How do heterogeneity and cooperation coexist, and with what consequences for managing information?” In this chapter, I have asked a corollary question: “How do heterogeneity and cooperation coexist, and with what consequences for managing politics?” I find that the use of a key boundary object—the Midwives’ Model of Care ™—enables close collaboration in this politically heterogeneous community so long as the boundary object remains bracketed against open engagement with political disagreement. Once those brackets are removed, the interpretive flexibility of the boundary object is exceeded. The boundary object, in other words, must maintain its status as apolitical *at the network level* in order to enable cooperation.

Conclusion

What does professionalization look like in an age of epistemic multiplicity and local expertise? Professionalizing is a stabilizing and standardizing project. Yet the core commitments of informed choice presume that good care requires radically individual approaches, assuming that the right course of action and indeed the right way to evaluate information is particular to each person and each family. The codification and standardization professionalization demands are thus difficult to reconcile with rising public interest in—and professional commitment to—radical epistemic multiplicity and individual choice. In this dissertation, I have argued that homebirth midwifery has attempted to thread that needle by claiming a different kind of expert knowledge. Rather than constructing themselves as experts in determining what the right answers are to the questions associated with perinatal care, homebirth midwives have constructed themselves as experts of in the practice of informed choice, experts of epistemic multiplicity and experts at shepherding highly local forms of expertise. I have argued that we might usefully understand homebirth midwives as what I have called *counterprofessionals* who seek to institutionalize a particular kind of expert knowledge and work, based on a significant critique of expertise and the professions as they are most commonly known. Protecting their counterprofessional approach, I have contended, has required that homebirth midwives claim knowledge and skill of how to make and manage policy and regulation in order to safeguard epistemic multiplicity and local expertise.

But in addition to epistemic questions, professionalization raises questions about the status of homebirth midwifery as work. Many younger midwives told me they came

to homebirth midwifery not as a calling for which they were willing to make radical personal sacrifices, but as a kind of job in healthcare—a job in which they felt they could enact their values, but a job nonetheless. For many, it felt wrong to be expected to risk arrest daily, routinely miss important family events, and accept low and unpredictable pay while bearing the enormous, life-and-death responsibilities of their jobs. As a mounting conversation about burnout and a crisis of sustainability in the field powerfully demonstrates, the job of contemporary homebirth midwifery often feels impossible. Indeed, of the four midwives I shadowed, two were actively considering suspending their practices during the time I shadowed them, and two have stopped practicing—even if temporarily—within the last year alone. While I certainly met homebirth midwives with thirty year careers, I also commonly met midwives who had "retired" from home birth midwifery in their thirties and forties after a decade of practice. And when the Midwives Alliance of North America surveyed their membership in 2019, they found that midwives reported sustainability as the greatest challenge facing the field—alongside obstetrical violence, health disparities, and access to midwives working in their full scope.[72]

Homebirth midwifery proceeds from an understanding of safety in birth as dependent on having one's needs met fairly broadly: one's bodily needs, yes, but also one's emotional and social needs. This approach hinges on an understanding of the body as inseparable from its social world—an understand that, of course, owes a great deal to social scientific arguments. Yet the work of establishing that safety is often approached

[72] It will also then come as no surprise that my interlocutors sometimes asked if I'd read Jenny Brown's 2019 *Birth Strike*, Sophie Lewis's 2019 *Full Surrogacy Now,* or "postwork" texts such as Kathi Weeks' *The Problem with Work.* Even as I concluded work on this dissertation, one midwife emailed me to share a doctoral thesis from New Zealand about burnout in midwifery (Young 2011).

in the field as something that an individual midwife can do: as I saw repeatedly, individual midwives help parents apply for FMLA parental leave, or find themselves offering on-the-spot family and couples counseling in the postpartum period. Striving to facilitate parents' emotional and social safety in birth makes for an undoable job when midwives find themselves filling in for profound public disinvestment in care of all kinds, including disinvestment from rural healthcare. Even with an extremely high level of commitment and moral investment, the pressures of political systems are too much: midwives, alone, cannot become or replace a social safety net.

The paradox, of course, is that in this community bound by their desire for birth not to be interfered with, midwives' jobs would be easier and more possible to do if the state were *more* involved in birth—if there were to be an *expansion* of public resources devoted to caregiving. What would make the work of protecting noninterventive birth at the individual level possible, in other words, is intervention at the state level. Midwives insist to their clients that physiologic birth is supported by high-quality nutrition, an absence of overwhelming stress, ample time for exercise and movement. Yet in a political moment characterized by stagnation in real wages and vicious conservative attacks on safety net programs, most parents in the United States can count on virtually none of these supports to healthy pregnancy. Without a political vision that actually engages with material redistribution of some kind, homebirth midwifery as a field perpetuates an undoable job that will always remain undoable. In order to persist, in other words, the field will need to take on the very political questions it has bracketed.

Maternalist and natalist turns in politics are essentially always regressive. Of course, a keen interest in flourishing in reproductive life and caring work need not be

maternalist or natalist, but it must then engage directly with questions of resource distribution, alongside political questions of what a state should do and who has access to the benefits of the state. That requires breaking the maternalist consensus that has thus far held the disparate parts homebirth world together. It requires seeing birth as produced by the social world, instead of the social world as produced by what happens in birth. Birth can also be the site of rehearsals of different ways of living, different ways of understanding need, or different relations of care, but a different birth cannot produce a different world without any changes to the social surroundings of that birth. It is undeniable that it would constitute a major social shift for all parents and birthing people to be treated with dignity, in a manner that respects both their agency and autonomy and the caring work of parenting, in pregnancy and birth. Such a picture is certainly profoundly at odds with the way most healthcare is delivered and particularly with the way that obstetrics has been constructed to render women and birthing people passive. But the idea, central to that maternalist consensus, that this shift can be the origin of a social movement is impossible. Such a change can happen if the social context in which that care is happening changes quite radically. Midwives will keep leaving midwifery, and that utopian vision will remain unrealized, unless the field engages with the political questions with which it has hesitated to engage—questions many see as secondary to the maintenance of the largest possible tent, or would prefer to delegate to individual organizations. Perhaps the biggest question facing the field right now is over whether to engage those political questions—and in the process, choose to risk, rather than bracket, community conflict and even fracture.

Will homebirth midwifery communities engage with the question of a right to

care? Anti-interventionist approaches to birth share disquieting affinities with a libertarian politics fueled mostly by a focus on negative liberty. An approach to healthcare in which the emphasis is on getting out of the way—particularly for practitioners who have mostly experienced state resources as punitive and restrictive—makes itself enormously available to an argument that states should play no role at all in healthcare. But a safe, joyful, undisturbed birth, as valuable as it is, does not necessarily result in any other institution valuing anyone's dignity or investing in their caring work without additional political work. Anti-interventionist approaches, in other words, can speak powerfully to claims for autonomy. But without framing perinatal care as a resource problem, they do not meaningfully credential a right to care. They speak to only one of the two faces of law I have argued midwives encounter: the face that limits individual choice, but not the face that enables it. They provide little to work with for the parent whose child needs emergency room care six weeks after an uncomplicated and beautiful undisturbed birth. While it was certainly not universal, perhaps the most distressing kind of talk I encountered in the world of contemporary homebirth was the re-narration of enormous deprivation as a political good. The most common example of this happened when parents who could not afford midwifery care and did not have health insurance described their pregnancies and births without perinatal care as empowering unassisted births, moments in which they saw their own autonomy and strength and realized they did not need assistance. For many midwives, these characterizations of a lack of access to care as a lack of need for care made them profoundly uncomfortable with unassisted birth. Some approaches to midwifery practice, instead, are explicit about the institutional architecture they need in order to do noninterventionist practice. Perhaps

the opposite of this kind of talk is the argument—around which a strong consensus is building (see Vedam et al 2018) that safe homebirth midwifery practice is directly tied to integration with regional medical care. Many midwives, too, personally articulate their sense that the safety of their practices is dependent on Medicaid and the fact that their clients can receive other medical care when they need it or on consulting relationships and regional perinatal care networks.

Scholars of law and midwifery have given a great deal of attention to the question of whether midwifery is regulated and scope of practice curtailed—but that is not the most consequential regulatory environmental factor in contemporary homebirth midwifery practice. The missing factor, instead, is whether resources are made available for healthcare: for midwifery care, but also for the other basic healthcare that enables parents to have uncomplicated pregnancies, for coordination of care, and for training. Licensure and regulation are not the only question. They matter—and they matter particularly to the extent that they are understood as one small piece of a much larger project of using state capacity to direct resources to perinatal care, and care of all kinds.

If contemporary homebirth midwifery is one major location in which to see the long afterlife of a 20th century feminism attuned to coercion and the centrality of knowledge to power, it is then also a place in which to observe the ways that that feminism that deemphasized resource inequities and contentious politics in favor of maternalisms, albeit radical ones at times. The radical epistemic individualism of informed choice is, then, just one face of the radical individualism of the concept. And though commentators lamenting the rise of a "post-truth" era or the "death of expertise" might argue otherwise, it is perhaps not the most consequential one. It is no accident that

an artifact of a feminist critique of professional authority and epistemic violence—indeed, a key way that second-wave feminism found a praxis—that has come to be defined so individually would prove so compatible with right-wing and libertarian beliefs. Libertarianism is, of course, fueled by to an understanding of itself as opposed to coercion. Yet it is the exercise of power that enables the kind of resource redistribution that would make either midwifery or mothering materially doable. It should come as no surprise, then, that it is over this issue that the maternalist consensus that has held the midwifery world together is now splintering.

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