11

RENEGADE MIDWIVES: ASSETS OR LIABILITIES?

Robbie Davis-Floyd and Christine Barbara Johnson

Scratch any midwife, and you'll find a renegade.

—**Richard Jennings, CNM**

RENEGADE MIDWIVES' STORIES

A homebirth midwife in Massachusetts receives a knock on the door in the middle of the afternoon. She opens it to find a woman she has never met before in early labor and in tears. She had planned to give birth in a birth center run by nurse-midwives, but was refused at the last minute because she was two days past the forty-two-week deadline the nurse-midwives by state regulation were obliged to comply with. They had officially transferred her to the hospital, but instead she drove to the home of this particular midwife because she was known as a *renegade* who would sometimes ignore protocols in the interests of serving

the woman. The homebirth midwife conducted an exam, concluded that the baby and mother were fine, and proceeded to assist the mother to give birth in the midwife's home, with an excellent outcome.

A nurse-midwife in California attended homebirths in her community for many years; in so doing, she was practicing outside the protocols of nurse-midwifery in the state because she had no physician backup. She was honored and revered by the women she served, and by many California midwives who saw her as a courageous, skilled, and compassionate midwifery pioneer. One day she had a mother with an obstetric emergency and transported her to the hospital appropriately. Both mother and baby were fine, and the birth turned out well. But the hospital and the state prosecuted the nurse-midwife for illegally attending births at home; she was not supported by the local or national nurse-midwifery associations, some of whose members had long considered her a renegade. She was forced to stop practicing. A few years later she died both of cancer and of grief. Her name was June Whitson.

A young nurse-midwife in Washington state opened a highly successful homebirth practice. One day she made an appropriate transport for an emergency; the baby died in the hospital. She experienced immediate ostracism from the hospital-based nurse-midwives, but was supported during the trial by the homebirth midwives. Her license was revoked; nevertheless, she continues to practice.

A highly experienced direct-entry midwife in southern California, who had been in practice for twenty years and had trained many of the younger homebirth midwives in her community, was attending over ten homebirths a month, a huge stress factor in itself. When the births happened back to back, she was going without sleep for days at a time, and she was taking on cases that even the midwives she had trained as apprentices felt were "way too far out of protocol." (At the time, all of the DEMs in California were illegal, but they had formed a state association and created their own set of protocols and their own peer-review process.) Several peer reviews of this particular midwife's practice resulted in censure, but she paid no heed. Then she was approached by a woman with two previous cesareans who asked

her to attend a VBAC at home. The midwife went to the library and did some research, and warned the couple that there was approximately a three percent risk that the woman's uterus would rupture. The couple declared their willingness to accept this risk. In early labor the woman's uterus did rupture. The midwife transported her immediately, but the baby died. On this and several other counts, the midwife was prosecuted by the state. None of the midwives in her community would testify on her behalf. Even though they loved her and many of them had been trained by her, they were angry that she had not heeded their warnings, which they had repeated over four or more years. She was convicted and spent four years in prison. The letters she sent from prison to her supporters and friends were published in newsletters and widely distributed. They revealed her enormous courage, strength of will, compassion for other prisoners, and her openness to learning and growing as much as she could from the often devastating things she experienced during her imprisonment (from extreme verbal abuse to leg chains). Finally she was released, returned home to her family and friends, and as far as we know has not gone back to attending births.

A couple in one state, deeply committed to homebirth, received their prenatal care from a direct-entry midwife. Toward the end of the pregnancy, she diagnosed the position of the baby as footling breech. This condition is perceived as dangerous, but breeches often change their status from footling to complete to frank at the end, as well as during, the delivery. The client insisted that she did not want a cesarean and did not want to go to the hospital. A straightforward breech (bottom first) only occurs in about three percent of all births, and is medically considered a risk condition. In states where they are licensed and regulated, homebirth midwives are usually prohibited from attending any kind of breech birth. In this particular state, homebirth direct-entry midwives are illegal anyway, and so their practice is entirely unregulated and autonomous. This midwife felt that she had the skills to handle a breech birth, so she agreed to go ahead and attend the birth at home. She successfully delivered the baby's feet, but there was a significant delay between the emergence of the feet and the emergence of the baby's head. The baby did not breathe upon birth. The midwife attempted resuscitation, which failed. The baby died. The couple remained supportive of the midwife, but she was put on trial by the state.

> At the time she attended this birth, she was already on probation because the state had discovered that she was attending home-births illegally. Her attendance at this birth constituted a tremendous risk for her, for the parents, for the baby, and for the efforts of the direct-entry midwives toward legalization. The birth was videotaped, and the tape was widely circulated to midwives for legal purposes.

Some months later, Robbie attended a meeting of highly experienced midwives involved in the national midwifery movement. This case came up for discussion. Some of these midwives had seen the videotape and had concluded that the midwife was guilty of irresponsible practice: (1) she should not have taken on the birth in the first place, given the risks of footling breech and her own already probationary status; (2) she waited too long between the delivery of the feet and the head, when she could and should have intervened to make the birth happen faster; (3) they believed her neonatal resuscitation skills were not up to par, as her efforts as recorded on the videotape seemed to them to be inadequate and inappropriate. There was general agreement at the meeting that her care had been substandard, and that she had not only been responsible for the baby's death, but also had enormously impeded the legalization efforts of the midwives in her state. But the discussion did not focus on the issue of footling breech in itself.

So, ever the anthropologist, Robbie asked these experienced midwives how many of them had attended footling breech births at home. About half of the hands in the room went up. Then she asked, "Have any of you experienced a bad outcome as a result?" No one had. Her next question was, "How many of you would do it again?" and the same midwives who had raised their hands in the first place did so again. For them, the issue was not attendance at a footling breech per se, but the *particular instances of this particular birth*: a challenging delivery position, known about in advance, and attended anyway by a midwife already on probation in a state currently in the midst of legislative procedures involving midwifery in general. ("Too many tensions and risks all in one basket," one midwife noted.)

A bit shocked that footling breech, considered an immediate indicator for a cesarean in the hospital, was not per se the issue for this group of experienced midwives, Robbie was forced once again to realize how much these midwives' philosophy, practice, and experience differed from American norms, how deeply reliant and confident they were in their hands-on skills, and how willing some of them were to take what

any obstetrician, most nurse-midwives, and about half of all homebirth midwives, would consider a totally unacceptable risk. Further questioning revealed that the midwives who had raised their hands both times had attended, over twenty or thirty years of practice, dozens and sometimes over 100 breech births, footling and otherwise, and considered themselves the preservers and guardians of this skill, which they pointed out, the vast majority of American obstetricians do not have because they are taught simply to do a cesarean for any type of breech.

STORIES FROM WOMEN CHOOSING TO GIVE BIRTH WITH RENEGADE MIDWIVES

Mary's first birth by cesarean section had taken place years before, but she still lived with the deep psychological scarring that she sustained as a result of this experience. In fact, for close to a year after the birth she was deeply depressed and unable to function, a recluse in her house. Before this birth she had been vibrant, active, and professionally and personally successful. Eventually, she began to sense that she had mostly put this tough birth experience behind her, and was feeling more and more like her old self. Then Mary discovered that she was pregnant again. She did not feel ready to handle a hospital birth, as she was still in the final stages of completing her recovery from the first one. A number of midwives she approached declined to attend her, due to her VBAC status. Finally, she located a renegade midwife in her state who agreed to attend her. This homebirth was deeply healing and nurturing for her; afterward she felt that all the scars from the first birth had healed. She emerged from this second birth with an enthusiasm and strength that she "had never experienced before."

Celene was pregnant and planning to give birth at home when she and her midwife determined that she was carrying twins, which made her ineligible for a homebirth because her midwife was unwilling to jeopardize her professional standing in the community by risking a bad outcome in what most would consider a risky birth. Celene was beside herself; she was terrified of hospitals and believed that if she were to be forced into this option she would have a very difficult birth and an even more difficult time recovering. She called midwife after midwife, but they all said the same thing: "It's not worth the risk."

Celene was desperate to find someone who would attend her at home; finally, some midwives referred her to a midwife willing to fly in to attend her. Ultimately, two midwives came. The birth of the first twin went smoothly, but the second one was stuck and the midwives urged hospital transport. They transported, with one midwife from the team remaining behind and another accompanying Celene to the hospital to ensure that she was supported. The second baby was delivered by cesarean section and emerged healthy and well. The hospital staff was aghast and gave Celene many severe looks and lectures, but Celene herself was ecstatic that she was able to labor and have the first baby at home. She was sorry about the hospital birth, but was grateful that she had her midwife there to support her through it. She feels very empowered and is most grateful that this alternative was available to her, certain that had she been forced to start out in the hospital she would have been discounted and disempowered in ways that would have been difficult to recover from, and would have adversely affected her parenting.

A woman whose first homebirth ended in cesarean section was so emotionally traumatized by this birth that no midwife in her state would agree to attend her second birth at home. The mother was a highly respected professional with a demanding career, a commitment to social activism, and an enthusiastic attitude for life, but the scars from her first birth ran deep. This emotional baggage, coupled with a VBAC at home, seemed just too risky for the midwives in her state. Some were willing to assist at the birth, but refused to be the primary midwife in charge. Rather than leave the woman stranded, these midwives suggested a midwife from out of state who would fly in and attend her at home. The woman elected this option and the result was a healthy baby born at home. This birth was deeply healing, and in the aftermath she noted that her parenting improved immensely as well as her overall emotional well-being. She stresses that if she had been forced to enter the hospital, she is not sure what shape she would be in today.

A mother in Connecticut was diagnosed with severe schizophrenia and depression. She believed that part of the cause lay in the highly medicalized hospital birth she had endured a few years earlier. She was pregnant again and desired a homebirth,

not only for the experience but also because she believed it would help her to heal. No homebirth midwife in her state would take her on because they all considered her "crazy" and therefore high risk. Finally she found a doula in another state who was willing to fly to her city to assist her, and the doula found a midwife who was also willing to fly in from another state. She successfully gave birth at home to twins, and her psychological health improved enormously. She became a birth activist, organizing various conferences and meetings in her community, and advocating for midwives to expand their definitions of *normal.*

After Robbie completed a talk on humanistic childbirth at a university in Michigan, she was approached by a student/mother with tears her eyes, who spoke of the trauma of the cesarean birth of her first baby. Pregnant with her second child, this woman deeply desired a homebirth, but had been told that no homebirth midwife in Michigan would attend a VBAC at home. Certain this was not the case, Robbie made a few calls to various homebirth midwives, and was assured that some of them would attend home VBACs. She gave their phone numbers to the mother, who went away radiant with the hope that her dreams of an empowering birth might yet be achieved. Robbie was close to tears herself: her certainty had been reaffirmed that these professional Michigan midwives, although prohibited by protocols to attend VBACs at home, would not deny the option to this mother who so deeply desired it and had nowhere else to turn.

NORMALIZING UNIQUENESS: HOW FAR SHOULD IT GO?

> Licensure is not something that should be forced on recalcitrant midwives by a paternalistic government. It is something that should be created by midwives; it is the next step in self-actualization.
>
> **—Ida Darragh, North American Registry of Midwives Newsletter, 2004**

All midwives can be considered renegades to some extent. Just to be a midwife, any kind of midwife in the United States, is to constitute a radical critique of the dominant obstetrical system in which physicians attend ninety percent of all births. But there is a special category of *renegade midwives*, illustrated in the preceding stories, which we wish to

specifically address in this chapter because they are very important to American midwifery in both positive and negative ways.

The term *renegade midwife* is used by midwives themselves. Sometimes they use it pejoratively, as a criticism of the midwife who practices, in the majority peer opinion, too far outside the protocols of her peer group or state regulations. Some midwives apply the term to themselves, using it to acknowledge the fact that they often practice outside of protocols, and to emphasize that their doing so constitutes a very conscious critique of those protocols.

The midwife who calls herself a renegade believes that other midwives adhere too strictly to protocols and standards of care and do not go far enough to serve the birthing woman. She believes that a woman's desire to give birth naturally, even in conditions that others would regard as adverse to homebirth, should be primary and that the midwife should serve the client and not the regulatory system. Thus, renegades are often highly skilled and experienced midwives who feel confident in their abilities to handle such conditions as VBACs, breeches, and sometimes even twins at home. Unless there are signs of fetal distress or insufficient amniotic fluid, they are often willing to let a woman go two or three weeks past her due date and still attend her at home (most protocols state that women should be induced after forty-two weeks). They will take on women whom other midwives might screen out because of gestational diabetes (which many midwives think is a medical myth), or, as the preceding stories illustrate, because of odd psychological characteristics or even complications as extreme as footling breech. These midwives believe they are placing the desires of the client first, and that doing so is appropriate. When there is a condition that they truly believe they cannot handle, even renegade midwives refer the woman to a physician in advance or transport her if the condition develops during labor. What makes them "renegades" is usually not ignorance, arrogance, or lack of training, but rather the fact that they will take on women whom most other midwives would reject. Thus they constitute both a liability to other midwives, and an asset.

The asset has to do with the services renegade midwives provide. Licensed professional midwives who are not renegade, who do practice within agreed-upon peer protocols or within established state regulations, often feel conflicted when confronted with a woman who deeply desires an out-of-hospital birth but should, according to protocols, be screened out in advance or transported if certain conditions develop during labor. As we have seen in earlier chapters, homebirth midwifery itself began as a renegade social movement in which midwives and mothers together agreed to flout obstetrical norms and to jointly take

responsibility for conducting births in radically alternative ways. Many homebirth midwives are still loyal to the flavor and force of this movement, and feel a strong pull to place the interests of the client first, as "lay" midwives (in the beginning) tended almost always to do. But those were the days (the early 1970s) when lay midwives had little experience with birth complications and risk management. Because homebirths attended by midwives turn out fine for the vast majority of the women who plan them, it took years for some of the early homebirth midwifery pioneers to encounter enough complications and dangers to begin to take more seriously their responsibility to acknowledge and deal with risk. When they did begin to get together to discuss and establish protocols, it was usually in individual regions or states where they were illegal anyway, so any protocols they set were ones they themselves agreed on. Herein lies the liability: in spite of the fact that babies die in the hospital too, because homebirth is so culturally marginal, all it takes is one death at home that would most likely have been prevented in the hospital, or one "botched transport," to undo years of goodwill.

As the battle for legality and licensure in various states got underway, the homebirth midwifery movement in some states became deeply divided over the issue of the renegade midwife. On one side were the professionalizing midwives who were willing to accept regulations (such as prohibition from attending VBACs, breeches, and twins) in return for legality and the benefits of not having to live in terror of arrest or prosecution and of opportunities to serve many more women. On the other side were midwives who refused to accept any restrictions on their practice and preferred to remain illegal or alegal, completely outside the system, because as long as they were not regulated they were fully autonomous and able to practice in any way they pleased. In Pennsylvania and a few other states, such midwives refer to themselves as "plain midwives." This rhetoric constitutes a deep critique of labels such as "direct-entry midwife" or "nurse-midwife," which these plain midwives perceive as restrictive. For the sake of clarity, in this chapter we will use the term *plain midwife* to refer to midwives who reject legalization, licensure, and the usually resultant restrictions on practice.

In *The Rhetoric of Midwifery: Gender, Knowledge, and Power* (2000), Mary Lay thoroughly described this divide as it occurred in Minnesota, where the professionalizing midwives developed a rhetorical strategy that stressed accountability, protocols, and regulation, and the plain midwives stuck to their insistence on keeping the woman central and not being restricted in any way. This rhetorical strategy on the part of

the professionalizing midwives impressed state legislators; at the same time, it clarified and magnified the gap between the professionals and the "plains."

Some plain midwives are so because of religious reasons. There are hundreds of Christian midwives practicing in various states completely outside the law and the health-care system; their belief system revolves around the concept that "God is the real midwife," that God's will should and will prevail, and that any complications that develop during birth can be resolved through prayer and openness to the Holy Spirit. Christine has interviewed a number of these midwives who are deeply committed and can recount story after story about the practical results of relying on divine intervention at birth. One recounted her own birth story—she had an unassisted birth with her husband because she could not find anyone willing to attend her. This was in the 1970s when the homebirth movement was in its nascent stages. During her ninth month she sensed that something "felt funny," but she did not know what it was and this filled her with fear. At this time she was not yet a full-fledged midwife. She stayed in prayer almost constantly for three days. During labor, she could feel that "something was in the way"; again she was not sure what it was and she continued her prayer vigil. (See Klassen 2001 for a cogent analysis of the various types of spirituality that influence the choices of homebirthers and the midwives who serve them.)

Eventually a healthy baby girl emerged. The mother's subsequent midwifery experience showed her that what she experienced was placenta previa. Many professionalizing midwives do believe in God and do pray during birth, but tend to take the more pragmatic approach that "God helps those who help themselves." Thus they transport to the hospital when they believe they do not possess the necessary knowledge and skills to handle complications at home. Such professionalizing homebirth midwives are the ones who have worked hard to create CPM certification and to lobby for legalization and licensure of the CPM (achieving it in twenty-one states to date; see chapter 1). Their nurse-midwifery counterparts worked hard in earlier decades to achieve the same thing for the CNM.

It would be easy to say that the plain midwives are the renegades while the professionally oriented midwives, most of whom are CNMs or LMs or CPMs, are not, but reality is not that simple. As we noted previously, renegade midwives are often highly skilled and experienced. Many of them practice outside of protocols because they believe that they can handle the complications the protocols would instruct them to avoid. They observe that such protocols are often set by regulatory

boards or state legislators who understand little about the knowledge base of homebirth midwives. And they know from statistics and from long experience that their services are the only means by which women with complications defined obstetrically as "high risk" can avoid a cesarean. (Most obstetricians will automatically do a cesarean for breeches or twins, and often for VBACs; many younger OBs have no experience with vaginal delivery in such situations.) Many such midwives achieve CNM or CPM certification and state licensure. In the process, they fight for regulations that will allow them the broadest possible scope of practice. But if they lose the regulatory battle and are forced to accept narrow protocols, they deal with this failure by occasionally flouting the state regulations they resisted in the first place. In this way, they distinguish themselves from midwives who stick carefully to such regulations. Such midwives place a higher priority on protecting the profession of midwifery in their state than on putting the desires of the client first. They believe that protecting midwifery is essential to maintaining out-of-hospital birth as an option, at least for women who do meet protocols, and that endangering it by taking obvious risks is irresponsible. They are often angry and resentful of renegade midwives who threaten the status of professional homebirth midwifery. But these same professionally oriented midwives are often grateful for the existence of the renegades (who are often also licensed or certified), because when a professionally oriented midwife is confronted with a potential client whom she has to screen out, she does not have to let the woman down utterly by telling her that her only option is the hospital birth she dreads. Instead, she can refer the mother to the renegade midwife who lives down the road or perhaps many miles away, who is more likely to go out on a limb to honor the mother's wishes.

At the 2001 MANA conference in Albuquerque, New Mexico, Robbie was asked to moderate a panel entitled "When Clients' Wishes Conflict with Midwifery Protocols." The room was packed—obviously this was an issue of great import to MANA members because, as we mentioned above, it places the social movement of midwifery in direct conflict with the professionalization process (see chapter 10), leaving many midwives in a quandary that they are often unable to philosophically resolve. If they refuse care in high-risk cases, they are letting the woman down. If they grant care, they are endangering the profession they have worked so hard to build. Quite a dilemma!

On the panel was a mother who had two previous cesareans and wanted a home VBAC, her husband (who had fully supported her choices), the midwife she had originally approached but who had

refused to take her case because it was out of protocol, and an obstetrician who is very supportive of homebirth. The woman described how devastated she was when the professional midwife refused to take her on for a homebirth, and how relieved she was when that same midwife provided her with the option of going to an illegal, unlicensed (and therefore unregulated) midwife who lived over 100 miles away in an adjacent state. The woman and her husband went to talk with that renegade midwife, who agreed to take them on. The result was a "fantastic" birth experience for the couple, who had such faith in their choice that they gave birth in a remote desert location.

The professional midwife who had originally refused homebirth care keenly felt her responsibility to her profession, and did not regret making this her priority. At the same time, she was thrilled that the renegade midwife had been able to provide the birth experience the woman had so deeply desired. (The alternative would have been giving birth completely unassisted. Some women do choose this option [Moran 1981; Shanley 1994], but because this book is focused on midwives, we do not fully address such choices here.) Again paradoxically, the gratitude of the professional midwife to the renegade midwife was accompanied by the fear that the renegade would eventually have bad outcomes that would then endanger the status of midwives everywhere.

The obstetrician on the panel at first spoke about the importance of risk management and of appropriate referral. She noted with regret that this would mean that women like the mother on the panel might not be able to have the birth experience they longed for, but felt that this was the price that had to be paid for assuring safety in birth. She was challenged by several homebirth midwives in the audience, and toward the end of the discussion did a complete about-face. In essence, she acknowledged her fears, noted that they were inappropriate and that they reflected her socialization as an obstetrician, and apologized to all the midwives present for forgetting that "trusting birth and a woman's ability to give birth is the most important ingredient in a successful birth outcome."

Near the end of the scheduled time for this session, Robbie noticed that the audience was about to be left with an irreconcilable conceptual split between sticking to protocols for the sake of the profession, and flouting them for the sake of the woman. Seeking to provide the midwives on the panel and in the audience with another way of thinking about this opposition, Robbie attempted to provide a deeper, less oppositional approach. She reminded the audience of her study of midwives' use of intuition during prenatal care and birth (Davis-Floyd and Davis 1997), noting that midwives themselves had told her that

one of their greatest skills is listening to the inner voice that can inform them which woman is truly at risk and which woman can actually achieve the homebirth she wants. She spoke of the importance of individualization, as opposed to standardization, of care, reminding them that whereas obstetricians are taught to standardize (Davis-Floyd 1987, 2004; Davis-Floyd and St. John 1998), midwives ideally are taught to individualize—to "normalize uniqueness" (Davis-Floyd and Davis 1997).

As an anthropologist who had studied midwives for over a decade, Robbie was able to speak a truth that every midwife in the audience recognized. Almost all homebirth midwives, and many nurse-midwives, will respond to the individual beliefs, desires, and circumstances of an individual woman in individual ways. The standards and protocols of midwifery care and of evidence-based medicine are there in front of them. But for midwives, standards are only "standard" (in other words, representative and expressive of the hegemonic obstetrical system), and research that compares two groups within a hospital can be irrelevant and often actually misleading and detrimental to homebirth practice.

For example, the famous *Friedman's curve*, which has for many years set the standard for how long women should be allowed to labor, was based not on normal, natural childbirths but on women drugged on scopolamine and whose labors were often augmented with pitocin. In spite of this extreme deficiency, obstetricians still utilize Freidman's curve to justify radical interventions to speed up labor (from pitocin to episiotomy to forceps to cesarean section). Midwives' experiences of homebirths teach them that Friedman's curve is not a reliable standard but rather a detriment to successful homebirth outcomes, because labors with no medical intervention can vary in time from a few hours to a few days without danger to mother or baby. Thus every midwife who practices outside the hospital has good reasons to ignore, even to scorn, obstetrical standards that many midwives who practice in the hospital are obliged to heed. In some cases, their scorn results from the inadequacy or misuse of medical "evidence." In other cases, such as VBACs, breeches, and twins, homebirth midwives acknowledge that the evidence does indicate increased risk, but they also note that the risks are small, and that hospital birth entails its own set of risks, which include unnecessary cesareans and iatrogenic damage to mother and/or child.

Thus, homebirth midwives who look carefully at the data come to understand that negative outcomes can occur as much or more from inappropriate obstetrical interventions as from deficiencies of nature.

Thus when confronted with specific women with specific complications, their only viable option becomes individualization of care. Sometimes a homebirth midwife's intuition tells her that *in this particular case, this particular woman* needs, and can achieve, natural birth even if her condition does not meet protocols, and consequently the midwife will accept the risk of attending the woman at home. Conversely, when everything seems normal and totally within protocol, that same homebirth midwife may transport simply because she intuits that something is wrong (for potent examples see Roncalli 1997). In other words, midwifery care tends to be individualized, not standardized, and some of that individualization comes from the deep reliance many midwives come to develop on their inner knowing and that of their clients.

As Robbie spoke, every midwife in the audience nodded her head; some were sobbing. What we noted at the beginning of this chapter was displayed in that moment—the spirit of the renegade lives in every midwife, whether she acts on it or not. And in fact, every midwife either of us has ever interviewed (over 400 practicing midwives of all types) admits or is overtly proud of the fact that she will sometimes practice out of protocols in any setting in order to protect a woman from unnecessary intervention.

It is important to note that hospital midwives too have a whole myriad of strategies for subverting the system: they fudge charts to keep the laboring woman off of Friedman's curve and thus give her more time, let her family members slip in food and drink although the hospital prohibits it, avoid the monitor when they can, break amniotic sacs covertly (and/or stretch the cervix) with their fingers to speed labor when the threat of pitocin looms, and sometimes even lock the door to the labor room to give the couple the privacy they need to make love and thus strengthen labor through nipple and clitoral stimulation (which naturally increases oxytocin levels) instead of through a pitocin drip. As the quote from Richard Jennings (director of the Bellevue Birthing Center and the midwifery practice in Bellevue Hospital, New York City) with which we began this chapter was intended to express, many hospital-based midwives are closet renegades; they just do subtly what homebirth midwives do much more overtly.

The great myth about themselves that nurse-midwives have created is that they only attend low-risk, normal births—an area in which they are the experts. In truth, from the beginning of their entry into hospitals in the mid-1950s, nurse-midwives have been attending the births of poor, inner-city, malnourished, and therefore high-risk women—and they have been doing an excellent job, as all their studies show (see

Rooks 1997 for summaries). But their attendance of these high-risk women is in contrast to the public image of themselves they have sought to create, an image they hope makes them appear to be less of a threat to physicians and safe practitioners for normal women. Their frequent attendance of poor, relatively high-risk women, in tandem with the many subversive strategies they develop in the hospital, reinforces our point that CNMs are often closet renegades, flouting the system while appearing to comply with it, and expanding the choices for their clients while appearing to normatively conform to medical protocols and state regulations.

We acknowledge that Robbie's take on homebirth renegade midwives is necessarily influenced by her 1984 experience of a home VBAC at forty-three weeks with a three-day labor and a ten-pound baby. This birth would not have been allowed to take place naturally in any hospital in the United States. In her written birth stories (Davis-Floyd, n.d.), Robbie notes that the pain was stunning but the accomplishment was far more so. Her deep intuition that her choice was right and that the baby was safe all the way through seemed to Robbie and to her midwives to be far more meaningful than "risk factors." Robbie's experience of pushing through the pain to give birth with her own psychological strength and physical power was utterly life transforming. Had she not been able to find two renegade midwives in Austin, Texas, in 1984, who were willing to attend her VBAC at home even though their state regulations made that illegal, she could not have experienced the empowerment of that birth, but would have had to relive the devastating disempowerment of her previous cesarean.

Is the price of the risk worth the value of the reward? Robbie is, in effect, in the same dilemma as the midwives she studies. She supports and has actively aided the professionalization of lay midwifery and the development and implementation of national certification for direct-entry midwives and national recognition for direct-entry schools, which perforce has entailed some degree of standardization of skills and care. At the same time, she is also keenly aware (through her own experience and her interviews with over 100 women about their birth experiences) of the importance of normalizing uniqueness though with individualized, intuitive care—the kind of care that in some cases can only fully be offered by those midwives who proudly claim the term "renegade."

Renegade midwives acknowledge that their existence and praxis threaten the tenuous toehold in the technocracy that their professional compatriots, and often they themselves, are working so hard to establish. They are also aware that their existence and praxis help to keep the

spirit of the homebirth midwifery movement alive and the full range of options open to American women. Here again the differences between plain and professional midwives come into play. Plain midwives have made it clear that they prefer to practice completely outside the law; they desire neither national certification nor state licensure. Thus plain midwives who are renegades can at least be rhetorically excluded (Lay 2000) by the professionally oriented CNMs, CPMs, and LMs, who have both worked for the creation of, and have themselves obtained, national certification and/or state licensure. But when one of these professional midwives practices as a renegade, she cannot be rhetorically excluded or differentiated from licensed or certified midwives who do (usually) stick to protocols (or at least try to appear to) in the interests of protecting their profession. Thus the overtly renegade professional midwife constitutes the greater liability. And yet the fact that she has achieved licensure or certification as a CNM, CPM, LM, or CM at least demonstrates that she has obtained the requisite knowledge, skills, and experience to practice safely and presumably to trust her own judgment, and thus is perhaps more qualified to be a renegade than the plain midwife who has not been formally tested.

Many midwives have noted that "the CPMs remind the CNMs about the dangers of overmedicalizing, and renegades remind both groups of the same danger." One very experienced CPM reaffirmed this perception: "I'm glad there are people out there pushing the envelope—if they didn't, people like us would be on the edge. I don't want to put mothers and babies in danger to be on the edge." Another longtime midwife who had been somewhat of a renegade in her early years, responded, "I don't want to go out on a limb anymore. My heart can only handle so much stress. You end up on the edge often enough without knowingly, premeditatedly going there."

Our awareness of the existence of various renegade CPMs in the United States is the reason why we waited with baited breath for the outcomes of the CPM2000 statistical study. When the data finally did become available, our fears were allayed. To recap from chapter 3, eighty-eight out of every 100 women who planned a homebirth with a CPM did give birth at home successfully and safely. CPMs transported twelve out of every 100 women to the hospital during labor, and only 3.6 percent of the time was it considered urgent. The cesarean rate for CPM clients was 3.7 percent, and the perinatal mortality rate was two in 1,000 (1.7 in 1,000 if breeches are not included)—equivalent to what it is for CNMs attending out-of-hospital births and for physicians attending low-risk women in hospitals (in other words, exactly what it should be given optimal care) (Johnson and Daviss 2005).

We are certain that the data submitted by 350 CPMs for this study included data from a number of known "renegades." And we are grateful that their willingness to practice outside of regulations and protocols does not statistically generate negative data, but rather reinforces the point that CPMs attending homebirths have outcomes as good as, and often better than, other kinds of birth practitioners. But the results of this study are not yet widely known; thus *one* bad outcome from a CPM-attended birth still has the detrimental effect of reinforcing cultural stereotypes and making midwives of all types appear incompetent to the general public. Such stereotypes constitute part of the reason why these midwives, after decades of practice, still attend less than one percent of American births. Combating such stereotypes through an emphasis on professionalization and professionalism has been a dominant ethos of nurse-midwifery from its inception; such an emphasis only became important to the former lay midwives in the 1990s. Now they too wish to change the cultural image of midwifery, but at what price? This is a question many nurse-midwives also pose to themselves.

And so we repeat at the end of this section the thought with which we began this chapter: all midwives are, to some extent, renegades. Yet there is a *spectrum of renegadeness,* and those at the further end of it threaten the cultural acceptance of professional midwifery. Every midwife must decide for herself to what extent and under what circumstances she will adhere to regulations and protocols, and to what extent and under which circumstances she will flout those protocols in what she believes are the best interests not of her profession, but of her individual client. And every midwife must also keep in mind that protecting the profession is also ultimately in the best interests of mothers and babies, because it is the existence of midwifery that keeps the options of safe, non-interventive, and nurturant birth open to all who choose midwifery care.

THE ROLE OF THE STRANGER

> The stranger does not share the local assumption and so becomes essentially the one who has to place in question nearly everything that seems to be unquestionable to members of the approached group.
>
> **—Zymunt Baumann**

Renegade midwives are to professional midwives what midwifery is to biomedicine—a challenger to everything that appears evident and beyond question. This is the role the "stranger" has played from time

immemorial. Without exception, all societies produce strangers, and most subgroups in society produce their own unique set of strangers. Knowledge systems are self-evident as long as no one from a contesting ideology is around to ask questions "about their grounds and reasons, point out the discrepancies, lay bare their arbitrariness. This is why the arrival of the stranger has the impact of an earthquake. The stranger shatters the rock on which the security of daily life rests" (Baumann 1997:9). Such outsiders make life uncomfortable. Encounters with the stranger stir things up and produce uncertainty, anxiety, and questions about boundaries. One of the most exasperating things about this state of affairs is the difficulty in creating definitive guidelines for action when "the stranger exhales uncertainty where certainty and clarity should have ruled" (Bauman 1997:18). The stranger impedes the professionalization effort at every turn by stimulating this uncertainty. In so doing the very ground of professionalization—building methodical and secure knowledge systems—is undercut.

In confrontations with the stranger, one of two options is usually chosen: assimilation or banishment. In the case of the renegade, no matter how many are assimilated, there will always be more who refuse and resist this assimilation. Is banishment a viable alternative? With banishment the lines of communication are broken and there is precious little chance to develop shared meanings leading to constructive dialogue and transformation (as we point out in chapter 12, on home-to-hospital transport).

There is a third alternative—a middle way between these two extremes that involves recognizing the key point that "social actors can and do play a crucial role in creating new combinations of compliance and commitment, power and autonomy, control and trust" (Reed 2001:13). This third and most radical alternative is remaining in dialogue and keeping the channels of communication open. Nothing meaningful can be accomplished if trust is not established. Midwives have the opportunity to chart new territory in today's world, not only with respect to their systems of knowledge, but also with respect to innovating new typologies for collegial conduct. They have the chance to pioneer groundbreaking forms for staying in discourse despite ferocious disagreements with one another. This effort will take a tremendous commitment of time and energy, but what is the alternative? Keeping these lines of communication open can only add to the rich heritage and contemporary viability of midwifery.

Judith Rooks (1998) discusses three possible models for future relationships between nurse-midwives and direct-entry midwives. We can extend her analysis to include the relations between protocol-oriented

and renegade midwives. The first path involves co-option, which is akin to assimilation; the second path is remaining isolated from one another with minimal contact—a path where hostility and competition prevail. The third alternative calls for a convergence of views in which the best of both are combined into a unified whole. While renegade midwives and protocol-oriented midwives will continue to reside in separate domains, a great deal more convergence between the two models can be accomplished. This convergence can only add to the vitality of the midwifery knowledge system.

The renegade's very existence can contribute to clarifying the boundaries and parameters of the midwifery knowledge system. As mentioned earlier, homebirth midwifery itself arose as a renegade movement that captured society's attention with regard to the need for reforms in biomedical birth practices. At her best, the renegade can serve as check and balance that professional homebirth midwives do not stray too far from the heart of their commitment to women.

During one of Christine's conversations with a CNM, the nurse-midwife explained that she remained in continuous contact with a renegade midwife to keep her from straying too far from her midwifery origins. Plain and renegade midwives can sharpen the edges of midwifery social change by imploring careful consideration of the compromises that are made in the bid for social legitimacy. In addition, renegade midwives serve as keepers of alternative knowledge, which thereby remains available to both protocol-oriented midwives and their clients to provide alternatives that formal regulations deem unacceptable. Given enough evidence over time, VBAC, breech, and twin births may become acknowledged as variants of "normal," and thereby become viable candidates for both homebirth and vaginal births in the hospital.

The potential for radical change in institutional views about midwifery with respect to issues such as breech birth became evident in a California court case in which a renegade licensed midwife was sued by the medical board for vaginally delivering a breech birth at home. The court brief noted that "the medical 'standard of care' for breech birth is to do a cesarean section in most cases," however, the court also emphasized that "the medical model's applicability to midwifery is inappropriate and summarily dismissed" (Department of Consumer Affairs, State of California 1999:3,11). The tribunal hearing the case allotted the midwifery model the same level of authority as the medical model:

> Midwives employ a midwifery model of practice distinct from the medical model of practice. . . . Unlike physicians, physician's

> assistants, physician assistant midwives, registered nurses, or certified nurse-midwives who practice within the context of a medical model, licensed midwives practice within the context of a midwifery model. Complainant contends that the medical model should function to define the scope of a midwife's practice. This issue arises because the ACT provides that a licensed midwife is authorized by his or her license, "under the supervision of a licensed physician and surgeon to attend cases of normal childbirth.... "Normal" within the context of the medical model specifically excludes, inter alia, breech presentation because of the risk for complications. *Within the context of the midwifery model, breech presentation is merely a variant of normal childbirth.* (Department of Consumer Affairs, State of California 1999:11,14)

This case is noteworthy and instructive in that it dramatically illustrates how important renegade midwifery can be for mainstreaming midwifery practices often sacrificed in the name of state sanction.

At her worst, the renegade midwife can go too far with resultant bad outcomes either at home or in a hospital transport. These incidents do considerable damage by spoiling the reputation of midwifery and requiring years to reestablish the legitimacy of midwifery in a given community. In a tit-for-tat way, protocol-oriented midwives can provide a check and balance for renegade midwives by reminding them of the larger context in which they practice. Much as the renegade would prefer the luxury of only considering the needs of the individual woman she is attending, the renegade acts in a larger context and is responsible for this whether or not she chooses to acknowledge it. Ongoing dialogue with professionally oriented midwifery groups will give the renegade midwife a stronger sense of orientation.

Battles between professionally oriented and renegade midwives over the proper domain of midwifery invoke larger philosophical issues of choice and responsibility. "The acceptance of responsibility does not come easy—not just because it ushers in the torments of choice (which always entails forfeiting something as well as gaining something else), but also because it heralds the perpetual anxiety of being—who knows?—in the wrong. . . . The snag is, though, that foolproof recipes are to freedom, to responsibility, and to responsible freedom what water is to fire" (Bauman 1997:202–203). Creativity comes through the courage to engage the tension of opposites until a new synthesis can be fashioned.

LIVING INTO THE ANSWERS

> Trust is not something out there but rather a social process that is constructed for and by people and a matter of the choices and actions of individuated subjects.
>
> —**Christine Garsten (2001)**

In ending this chapter we propose that each midwife ask of herself the following question: What is my responsibility to the "other" midwife? What is the best way to address this issue from a position of higher consciousness rather than a position of lower consciousness? The answers to these questions cannot be intellectually crafted or analytically developed, but rather must be lived into. How each midwife decides to answer these questions involves nothing less than the quality and integrity of the legacy contemporary midwives bequeath to the future.

ACKNOWLEDGMENTS

Our thanks to Betty Anne Daviss for her careful reading of, and corrections to, this chapter, and to Barbara Katz Rothman and Raymond DeVries for their helpful comments.

REFERENCES

Baumann, Zymunt. 1997. *Postmodernity and Its Discontents.* New York: New York University Press.

Boston University Corporate Education Center. 2003. *Management Development Programs.* Boston, MA: Trustees of Boston University.

Davis-Floyd, Robbie. Nd. "Knowing: A Story of Two Births." Unpublished manuscript.

———. 1987. "Obstetric Training as a Rite of Passage." *Medical Anthropology Quarterly* 1(3):288-318.

———. 2004. *Birth as an American Rite of Passage,* 2nd edition. Berkeley: University of California Press.

Davis-Floyd, Robbie and Elizabeth Davis. 1997. "Intuition as Authoritative Knowledge in Midwifery and Home Birth." In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives,* pp. 315-349. Berkeley: University of California Press.

Davis-Floyd, Robbie and Gloria St. John. 1998. *From Doctor to Healer: The Transformative Journey.* New Brunswick, NJ: Rutgers University Press.

Department of Consumer Affairs, State of California. August 16–20, 1999. *In the Matter of the Accusation Against Alison Osborn, Case No. 1M-98-83794.*

Durkheim Emile. 1933, *The Division of Labor in Society.* New York: The Free Press.

Garston, Christine. 2001. "Trust, Control and Post-bureaucracy." *Organizational Studies.* March.

Johnson, Kenneth C. and Betty Anne Daviss. 2005. "Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America." *British Medical Journal* 330(7505): 1416, June. www.bmj.com.

Klassen, Pamela. 2001. *Blessed Events: Religion and Home Birth in America.* Princeton: Princeton University Press.

Lay, Mary M. 2000. *The Rhetoric of Midwifery: Gender, Knowledge, and Power.* New Brunswick, NJ: Rutgers University Press.

Moran, Marilyn A. 1981. *Birth and the Dialogue of Love.* Leawood, KS: New Nativity Press.

Reed Michael I. 2001. "Organization, Trust and Control: A Realist Analysis." *Organizational Studies.* March.

Roncalli, Lucia. 1997. "Standing by Process: A Midwife's Notes on Storytelling, Passage, and Intuition." In *Intuition: The Inside Story,* eds Robbie Davis-Floyd and P. Sven Arvidson, pp. 177–200. New York: Routledge.

Rooks, Judith. 1997. *Midwifery and Childbirth in America.* Philadelphia: Temple University Press.

Rooks, Judith. 1998. "Unity in Midwifery?: Realities and Alternatives." *Journal of Nurse-Midwifery* 43 (5): 315–319.

Shanley, Laura Kaplan. 1994. *Unassisted Childbirth.* Westport, CT: Bergin and Garvey.

12

HOME TO HOSPITAL TRANSPORT: FRACTURED ARTICULATIONS OR MAGICAL MANDORLAS?[1]

Christine Barbara Johnson and Robbie Davis-Floyd

> The Mandorla signifies the place . . . where miracles arise. It is beyond our ordinary way of seeing . . . where two irreconcilable opposites are overlapped into a sublime whole.
>
> —**Robert A. Johnson,** ***Owning Your Own Shadow***

DISPARATE KNOWLEDGE SYSTEMS AND MAGICAL MADORLAS

Ideologies and institutions are not smoothly functioning monoliths. Rather, they form amalgams of internally contested and inconsistent ideas. In complex societies, for each cultural ideology, parallel knowledge systems exist. Throughout history a selected few gain cultural ascendancy while numerous others are marginalized and disappear or survive on the cultural fringe. The cultural ascendancy of a particular knowledge system must not be mistaken for truth, but rather seen as an outcrop of social power. As Bauman (1997:13) notes:

> The dispute about the veracity or falsity of certain beliefs is always simultaneously the contest about the right of some to speak with authority which some others should obey [and] about the establishment or reassertion of the relations of superiority and inferiority, of domination and submission, between holders of beliefs.

The biomedical model and the midwifery model characterize two parallel, often conflicting, and sometimes overlapping knowledge systems (Giddens 1991; Jordan 1993). The biomedical model is culturally ascendant while the midwifery model is culturally marginalized and devalued. Both systems of knowledge encapsulate vital truths about birth, which all too often remain fragmented from one another, especially in states where midwifery is illegal or unlicensed.

In this chapter we explore what happens when the ascendant knowledge system (biomedicine) and the devalued one (midwifery) are forced to confront one another on today's postmodern terrain. The postmodern technocracy offers an unprecedented opportunity for deconstructing and reconstructing knowledge systems. Postmodernism dismantles and disembeds traditional institutions by popularizing the principles of relativity and radical doubt. In this venue, "all knowledge takes the form of hypotheses: claims which may very well be true, but which are in principle always open to revision and may have at some point to be abandoned" (Giddens 1991:4). These postmodern developments have particular importance for the health-care arena. Alternative health-care models that directly challenge the biomedical model have gained widespread public support. This public acceptance, coupled with the modern emphasis on consumer needs, puts enormous pressure on the biomedical environment to innovate new health-care systems that combine standard and alternative care (Best and Kellner 1997). In the United States, midwifery transport to the hospital exemplifies a place where conflicting ideologies, hegemonic and alternative, are forced to encounter one another during a crisis to resolve a problem. These compulsory interactions have the potential to heal the split or further solidify the division.

In "Home Birth Emergencies in the US and Mexico: The Trouble with Transport," Robbie Davis-Floyd (2003) presented and compared transport stories told by American homebirth midwives and Mexican traditional midwives. She noted that:

> biomedicine and home-birth midwifery exist in separate cultural domains and are based on distinctively different knowledge systems.

> When a midwife transports a client to the hospital, she brings specific prior knowledge that can be vital to the mother's successful treatment by the hospital system. But the culture of biomedicine in general tends not to understand or recognize as valid the knowledge of midwifery. The tensions and dysfunctions that often result are displayed in midwives' transport stories, which I identify as a narrative genre and analyze to show how reproduction can go unnecessarily awry when domains of knowledge conflict and existing power structures ensure that only one kind of knowledge counts. (Davis-Floyd 2003:1912)

Robbie's article analyzes "*dis-articulations* that occur when there is no correspondence of information or action between the midwife and the hospital staff," and "*fractured articulations* of biomedical and midwifery knowledge systems that result from partial and incomplete correspondences," contrasting these two kinds of disjuncture with the "*smooth articulation* of systems that results when mutual accommodation characterizes the interactions between midwife and medical personnel" (Davis-Floyd 2003:1912). Her focus in that article was primarily on the fractures in care that result when the midwife's knowledge and recommendations are discounted in the hospital. Such fractured articulations between the medical and midwifery systems can and do result in the unnecessary death of mother or child. Robbie's article recounts numerous examples of such fractures, in which the midwife's knowledge about the mother's history, prior labor status, and present needs is ignored by medical staff, and the midwife, in spite of giving good care and transporting appropriately, may be threatened with a lawsuit for a "botched" homebirth—certainly a detriment to her willingness to transport in the future and a cementing of further alienation between the medical and midwifery worlds.[2]

In this chapter, we will extend Robbie's work through a primarily positive focus on what Robbie termed "smooth articulations" between the medical and homebirth midwifery systems. From the outset of the medical-midwifery encounter, the power differential becomes evident as the midwife is usually forced to cross the threshold into the biomedical world and act within its institutional and ideological parameters. Despite this power divide, genuine reconciliation between these separate worlds and their reconstruction into a unified whole does occur on many occasions, which we seek to exemplify here in the interests of presenting a more positive set of possibilities for mother, child,

midwife, and hospital staff, and a further pathway to the mainstreaming of midwifery care.

We will use the mandorla as a conceptual ideal type to investigate the nuances of these more positive transport sagas. The *mandorla* is an ancient symbol for the place where opposites can meet and honor one another, and in this reconciliation forge a new reality that is greater than the sum of its parts. "A mandorla is the almond-shaped segment that is made when two circles partly overlap" (Johnson 1991:98). Inside the overlap, separate domains are united and merged into innovative structures, within which effective solutions can emerge. This perspective can offer us a conceptual prototype for transcending the bounds of ordinary consciousness by overlapping opposites and integrating them into a transcendent whole in which everyone's interests and concerns are appropriately addressed. This chapter takes an in-depth look at what conditions facilitate a transport mandorla in states where midwifery is either illegal or allowed to exist, but remains unsanctioned by a legislative mandate. In these cases, the individual actors must transcend the limits of their knowledge systems without benefit of structural guidelines. Studying such smooth articulations between systems provides an opportunity to view how, when, and under what circumstances mutual accommodation by opposing parties become the predominant theme. These mandorla encounters embody what Grossberg (1992:57) calls the recasting of separate spheres into "active structures . . . that cut across domains and planes."

THE NATURE OF A CRISIS

Dialogues among homebirth midwives and physicians are uncommon, especially in states where homebirth midwives remain unlicensed. Most often, these practitioners inhabit separate worlds that only intersect when a homebirth goes awry and a transport is the necessary

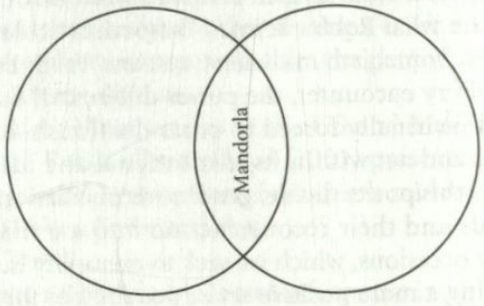

Fig. 12.1 The Mandorla.

result. Most home-to-hospital transports are preventive, but some take place during genuine crises. Such crises can create important opportunities. The Chinese depict a crisis as an "opportunity riding on dangerous wings." (The Chinese pictograph for *crisis* incorporates both the character for *danger* and the character for *opportunity.*) A homebirth transport is a threshold moment in which the seeds for the new are present but not yet manifest. Vulnerability and its potential for lowering of defenses can make crises a fertile ground for creating new ways of understanding and forging innovative structures. In meeting the "other" during such intense and vulnerable encounters, alliances that might never otherwise be made can be forged. The inertia that typically supports alienation from one another can be transformed into creative amalgamation.

Analyzing the crisis scenario has another advantage. Institutional behavior constantly reaffirms itself through regularized patterns, rituals, and routines that take on the appearance of being "evident." These regularized encounters promote a trust founded on predictability. The predictable nature of the environment masks the dynamic and active process of maintaining trust. A crisis breaks the routine and exposes the often forgotten fragility of social processes, and in so doing allows the unmasking of the social processes that undergird daily reality and the degrees of freedom that exist for reconfiguration. "In circumstances of uncertainty and multiple choice, the notions of trust and risk have particular application" (Giddens 1991:4). By exploring the interplay of risk and trust, constellations that promote social integration or disintegration can be clarified.

Hospital transports capture the interactive and dynamic processes through which meaning structures are generated and regenerated by the actors themselves. By analyzing these events, we can observe how the meaning of a particular transport situation is actively constructed—created and recreated through shared interaction, whether or not the actors are conscious of this process. While it is true that institutions generate unspoken rules that tend to regularize encounters between biomedical and "outside" practitioners, their interaction during a crisis can nevertheless generate a sense of freedom from these rules in the interests of serving the mother and child. What emerges from the mandorla transport narratives presented in this chapter are the ways in which everyday life interactions carry within them not only the possibility of conformity to stereotypes, but also the possibility of transformation of those stereotypes into systems of mutual understanding and trust. These narratives reveal the potential for *flow*, in which involved individuals participate through acting, reflecting,

adjusting their opinions to input from others, and negotiating in order to achieve a shared meaning of the situation (Wallace and Wolf 1995).

All midwives who practice out of the hospital must occasionally transport. In the United States, homebirth midwives have a transport rate of twelve percent (Johnson and Daviss 2005). In other words, eighty-eight percent of their clients give birth safely at home, while twelve percent are transported to the hospital during or after labor for various reasons (see chapter 3). In only 3.6 percent of intended homebirths does the midwife consider the transfer urgent. The transport stories we have culled from our interview data and selected to recount cluster inside that three to twelve percent. We ask our readers to keep in mind that the circumstances they recount are rare and not representative of the vast majority of births. These experiences are often encoded in narrative because they are so unusual, and because of their heavy emotional charge. Stories give meaning and coherence to experience. Midwives who transport under frightening circumstances often need to find that coherence and to evaluate through narrative, with the benefit of hindsight, their own actions and those of the mother and the biomedical personnel.

As we describe in the Introduction to this volume, both of us have conducted extensive interviews with midwives and their clients. During the course of this research, which involved hours of formal interviewing and even more hours of "hanging out" with midwives and mothers, we both heard many transport stories. Over time, these transport stories began to emerge for both of us as a narrative genre that richly encapsulates the continuum of possibilities that result when a subaltern system encounters a dominant system.

We chose the particular stories we present here primarily because they represent and typify the integrated mandorla type of transport we seek to highlight in this chapter, illuminating the ground upon which opposite systems find their reconciliation. The stories thus embody both the collision of worlds and the merging of worlds, portraying integrated mandorla transports as positive models of smooth articulation between the medical and midwifery knowledge systems. (All names used here are pseudonyms.)

MANDORLA TRANSPORT STORIES

The stories Robbie presented in her article on transport were all told by midwives. Here we present primarily stories told by mothers who elected to give birth at home with a midwife, so that we can see how an integrated mandorla transport looks and feels from the birthing

woman's point of view. We also include one midwife's story because we want to highlight the significance of the mandorla transport for the midwife and her relationships with the technomedical system. Because we have no way of ascertaining the truth or untruth of these stories, for the purposes of this chapter we take them at face value and unpack them for what they reveal about midwives' and women's perceptions of, and meanings they attribute to, events as they unfold. We seek to elucidate the social processes through which adherents of a dominant knowledge system sometimes dismiss what adherents of a marginalized system have to say, and other times honor and include them.

Mothers' Stories

> Gradually, the two disparate circles begin to overlap and the mandorla grows.
>
> —**Robert A. Johnson, *Owning Your Own Shadow* (1991:106)**

The following stories illustrate the wide variety of transport problems that can culminate in a creative amalgamation of the biomedical and midwifery models. These narratives unmask the process through which boundary renegotiation occurs. The first story shows how even a neonatal death can provide fertile ground for forging connections. The next account is from a woman interviewed both before and after her first birth, and demonstrates how a transport ending in a cesarean can strengthen the connection between opposites. The final story in this section is also from a woman who was interviewed both before and after her second birth. This woman became the first in her family to give birth without a cesarean. Were it not for the emerging respect and appreciation of the "other" that took place in the hospital after transport, this woman would have been the next in a long line to give birth by cesarean. This particular story is illustrative of how a transport that begins with strained communication can end with a mutual respect that enlarges the worldview of all those involved.

Kate's Story: The Long Journey Kate Sims, a white female in her early forties who straddles the fence between lower-middle and middle-class, has a BA in social science and owns her own small business. She has been married for over ten years and has given birth three times. Her first child was born in a hospital by cesarean in 1991. Her second child was born at home in 1995, was transported to the hospital in critical condition, and died shortly after the transport. Her third baby was born at home in 1996, healthy and well, without hospital involvement of any kind.

Kate's first birth, which took place in a large teaching hospital, left her devastated. At the time she was unaware of the difference between the midwifery and the biomedical model of birth. Against her better judgment, Kate agreed to have her labor induced. As her contractions became increasingly intense, she was left alone for most of her labor. Even when she felt that the biomedical suggestions she received were in error, Kate had no point of reference from which to evaluate them. Lacking access to alternative information, Kate felt that the least risky option was to capitulate, but she left this birth experience convinced that a trusted support person would have transformed its nature and that the outcome would have been radically different. We recount the following narrative of her first birth to demonstrate the extent of her aversion to the hospital at the time of her second birth transport, and to show that despite Kate's negative predisposition and the critical nature of her second birth, the subsequent transport encounter paved the way for new understandings and an embracing of the cultural other.

As Kate's labor intensified, the force of the pitocin-induced contraction "frightened me and no one reassured me that I was okay. And that would have made a huge difference to me." Eventually, Kate asked for an epidural, and soon after:

> I was numb from my breasts to my toes. . . . And I remember my blood pressure dropping right after I got the epidural—it was eighty over something. I felt woozy, breathless, and I was passing in and out of consciousness. It was very clear that the hospital staff was worried and someone came in and gave me an injection to stimulate things. I began to stabilize and they turned out the light. I remember waking up after about an hour and looking around and feeling that "this is no way to have a baby. Now I can't even tell that I am in labor. This is the most momentous day of my life and I am not even able to participate in the experience. I have all these machines that are keeping an eye on me so no personal contact is necessary." I just remember feeling so disappointed and so let down. After a while they started to prep for a cesarean section and it hit me that I was about to have major abdominal surgery. The only surgery I had ever had in my life was a tonsillectomy when I was a child. I was just beside myself and I totally forgot I was having a baby and I started shaking. They put an oxygen mask on me and I just remember being so claustrophobic and terrified. Eventually I noticed the physician standing there holding a baby and I thought, "Why is

> he telling me to look?" I was so disoriented. This birth was an awful experience and not something I would wish on anyone.

After this devastating experience, Kate launched an extensive investigation into her birthing options. Eventually she decided to give birth at home with a direct-entry midwife. Three years later she became pregnant. During this pregnancy Kate immersed herself in building solid and trusting relationships with her caregivers. In addition to her one-hour prenatal care visits, she elected to take an independent childbirth course with another direct-entry midwife she met during her research endeavors. This childbirth class was instrumental in leading Kate through the tragedy of her second birth:

> In one of our childbirth classes, we explored our worst-case scenario. During this class, my husband and I felt that we really needed to become settled in taking responsibility for a homebirth even with the possibility of a poor outcome. Not that we were being cavalier about our baby's health. We had already completed a copious amount of research and became convinced that homebirth was a safe option. So in this childbirth class my husband and I wrote out our worst nightmare to bring it down to size and make it manageable. Both my husband and I had a very similar worst case: the baby might be severely compromised and wind up on a lot of machines with a medical limbo status with always more that could be medically done with unknown consequences. This process was very powerful for us. It had a huge impact on how we addressed all our fears about a worst-case scenario birth outcome. So when it actually happened I was never afraid. I was frustrated, angry, excited, elated, joyful, and sad, but I was never afraid.

This narrative makes it clear that Kate now felt empowered to trust herself and the midwifery model of care with respect to what kinds of risks were acceptable to her and what kinds were untenable.

Kate was well prepared for her second birth by the time she went into labor. She had a complete trust in the midwifery model of birth and was ready to fully embrace any risks involved. On the other hand, she distrusted the biomedical approach to birth and perceived it to be fraught with a greater set of risks. This unwavering faith in the midwifery model helped to promote an integrated transport.

As her labor began, Kate felt a multitude of emotions: happy, excited, comfortable, and relaxed, knowing she was well prepared and

attended to by midwives she trusted. These feelings were augmented by the awareness that she didn't have to go anywhere because she would give birth in her own haven—her home. She called a few family members and friends to join her as her labor began. As the contractions became more intense, the midwives arrived. Kate commented:

> I got what I asked for. I was not detached from my experience—I was very present and connected. The result was a real family experience with a couple of friends there as well. This time I had all the support that was lacking in the first birth. I got into this labor rhythm and I remember feeling very connected in particular with my friend. It was so important to me just to know that she was there. Suddenly I let out a roar and felt this uncontrollable urge to push. My baby came out really fast, she just pushed out and I only had a tiny little tear because the midwives did perineal support, massage, and stretching.

Kate's second birth unfolded exactly as she had dreamed it would. The birth began and ended at home with the support of family, friends, and supportive and competent caregivers she trusted completely. As a result of this birth, Kate gained a new appreciation of her own strength. Her extensive research had been well worth it, culminating in a joyful, empowering birth experience. But Kate had little time to assimilate and savor this moment.

> After about ten minutes we noticed that his ribs were starting to retract. At this point I began thinking, "This is starting to look like the worst-case scenario." The midwives called the hospital and they told us to bring the baby in. We had been in the hospital for a while when finally the neonatologist came out to meet with us. The neonatologist and all the staff were very gracious and included my midwife in all the professional conversations.

Here we see that the inclusion of the midwife in the lines of communication laid the foundation for the reconciliation of opposites.

> As we all met (my husband, myself, our midwife and the neonatologist), our midwife Maria [said to the neonatologist] "I need to ask you, is there anything that I or any of the other midwives did or did not do that contributed to this baby's problems?" I must say that is the greatest act of personal courage I have ever witnessed in my life. The doctor responded immediately, saying

"Absolutely not. This baby was in such great condition when it came in! We were expecting to get a disaster when we heard that it was a homebirth transport. Instead, this baby was in terrific condition given what is wrong." After an initial exam the doctor noted that our baby had severe lung and heart problems, and she suspected a fatal genetic disorder and that there wasn't anything that could really be done. The neonatologist talked about how strong he looked and what a great job we had done with the prenatal health and that most babies with this condition don't grow to be this big and strong. The temp was normal, the baby was pink—"This baby is doing really, really well."

As illustrated in Kate's words, in the mandorla transport, two opposites meet, and in the encounter see for the first time who the "other" really is, devoid of stereotypes. In the process, these opposites renegotiate the boundaries of their own worldviews. The meaning of homebirth was profoundly redefined by the biomedical team as the physician herself openly acknowledged the validity of homebirth midwifery care. At the same time, Kate and her midwife changed their definition of the hospital as hostile territory as it became increasingly obvious that they were being met with honor and respect. Kate's narrative documents how the trust between the biomedical team and the midwifery team was a cumulative process with each interaction building and reconstructing the nature of trust between these separate cultural spheres. From the onset, both the midwife and the neonatologist were able to accommodate one another and thereby establish a mutually beneficial line of communication. Each communication solidified and built upon the previous communication, as if each side were feeling the other out and only too happy to respond in kind when met with respect. The hospital team initiated the contact in a respectful and honoring manner. The midwife in turn responded by exposing herself to a potentially scathing critique from the biomedical system. The neonatologist followed this response by emphasizing the high quality of midwifery care that she observed, while stressing that her own evaluation of midwifery was being reconstructed to accommodate this new evidence. If one or both parties had insisted on devaluing the proverbial "other," this transport could easily have resulted in a further entrenchment of the alienation each had previously felt. Instead, through this transport such a strong connection was made that homebirth transports by this midwife became welcomed at this hospital, and the midwife became more willing to transport earlier in the labor rather than later because of this receptive environment.

The nature of the infant's condition was a major contributing factor promoting the trust and the reverence that each party exhibited toward the other. The baby was genetically fatally ill and there was nothing anyone could do medically to alter this fact. Rather than blaming the midwife and the couple, the neonatologist kept her mind open to recognizing the midwife's quality of care. And the midwives kept their minds open to learning from the neonatologist. This psychological openness on the part of both parties is essential to the emergence of a mandorla transport: we have both recorded stories of similar genetic problems becoming evident at homebirths, yet in these other stories when the midwife transported, she was not received with openness but with blame. Kate said:

> The neonatologist told us that "this transport has really altered mine and my staff's view of what homebirth midwifery is and the level of care that is provided. We were all incredibly impressed." Since then our midwife Maria has had to transport several times and has brought them to this doctor because this team developed a respect for homebirth midwifery as a result of this transport. The result has been a friendly transport environment.
>
> After the geneticists looked at him they were very sure that he had a genetic disorder that was fatal 100 percent of the time. We said, "Okay, now it is time to take out the tubes so we can be with our baby without all the tubes and wires." We were in the neonatal care unit at that point, but once we made the decision to unhook everything, they moved us to what they call a family room so we could have privacy. Our midwife stayed with us the whole time. The hospital staff was very supportive and they brought in a camera and took numerous photographs. Thank God! I would not have thought of doing that and I am so grateful to have them. The whole experience was really peaceful and powerful and the nurses came in very quietly and one kneeled down next to me and just put her hand on the baby's foot. They were so caring and supportive.

At this point in the encounter Kate and her midwife have actively reconstructed their concepts about hospital care to incorporate the idea of the hospital as an environment where their needs could be met in a supportive and respectful manner. As trust and respect became the framework for the communication between parties, each side became increasingly accommodating to the other. Each side engaged in countless versions of "perhaps this, perhaps that, maybe it follows that, I

wonder if . . ."(Johnson 1991:106), which broke the bounds of ordinary consciousness to heal the split and recombine biomedicine and midwifery into parts of an innovatively emerging whole.

> I remember the neonatologist saying to us after this experience how moved the hospital staff was by the way we had just embraced the baby's passing and how we were able to be with her through everything. The neonate told us that this outcome is not something people want to think about so they are usually just totally unprepared to deal with it. She went on to say, "The fact that the two of you could just look at each other and know that you needed to take the tubes out and just be with your baby is so powerful." My husband and I had already come face to face with this worst-case scenario in our childbirth class and knew that we wanted the human connection and did not want to use the technology to avoid it.

Here we see the growing respect by the hospital staff for Kate's choices. Kate is not blaming medicine for the death of her baby, but rather understanding the limits of medical technology and welcoming the emotional support. Recognition of the limits of medical technology, and the accepting presence by both the biomedical team and the midwifery team at an impending death, created an opportunity for communicating through shared symbols that allowed an overlap in worlds. There were no angry accusations on either side, and each party was stretched to new depths by this encounter with the other.

Kate, her family, the midwife, and the nursing staff attended the baby until she died in Kate's arms. She was more grateful than ever that she had so diligently prepared for this birth, including facing her worst-case scenario much prior to it actually happening. After the baby's death, Kate and her family had an added burden that most bereaved parents do not face: the need to assure her community that the baby's death had nothing to do with being born at home. Consequently, they held a neighborhood memorial service for their infant about one week after the birth/death. The midwife, her apprentices, and a few of the hospital staff attended, including the neonatologist, who spoke about how unusually healthy the baby was given the genetic condition, and how there was nothing anyone could have done, emphasizing that the death was "definitely not the result of a homebirth." Her words turned this newly created transcendent whole (integrating biomedicine and homebirth midwifery) into a public announcement. Kate's transport is an extraordinary example of how stereotypes can be demolished and a

new integration of formerly conflicting ideologies can then become possible. The "other" is embraced as companion. One year later Kate gave birth again at home with the same midwifery prenatal care team. This birth was ideal from start to finish, and on this occasion Kate "felt like the sun came out again and a cycle had been completed."

This transport story illustrates how even a fatal outcome, if evaluated objectively by the dominant knowledge system and met openly by the midwifery model, can lead to expanding the boundaries of both the dominant and the alternative ideological systems.

Rose's Story: The Best-Laid Plans We recount the following birth story for two major reasons: (1) to include both a before and after birth sequence to avoid using only retrospective accounts of situations; and (2) to illustrate the wide-ranging effects that accumulate over time when opposites are united into a transcendent whole. Christine interviewed Rose both before and after her first birth.

Rose was a white, upper-middle-class woman in her late thirties and pregnant for the first time. While she never felt an intense biological drive to give birth, she decided to get pregnant because she sensed that her opportunity to have a family would soon disappear if she did not act. At the time of her birth, she had been married for almost a decade and felt very securely grounded both economically and emotionally. Her husband had a successful business as a consultant and she was the president of a thriving corporation. Rose was a participant in an eight-week childbirth course that Christine attended as a research participant observer. Consequently, Christine was able to witness Rose's struggle to define the set of risks she was willing to accept and the concomitant levels of trust she accorded to the biomedical and midwifery models of birth. Rose initially planned to give birth in the hospital, but eventually opted for a homebirth in 2000.

Prior to her pregnancy, Rose was familiar with homebirth and midwifery. While she was attracted to the idea of homebirth, she was initially not ready to make that choice because she perceived it as too risky. On the other hand, she also knew that hospital birth entails another set of risks. Unable to fully trust either model, Rose decided to straddle the fence between models in order to reduce her set of risks. She engaged the services of both an obstetrician and a direct-entry midwife for prenatal care. Her initial plan was to use the midwife as labor support in the hospital, but also to provide for the possibility that if she changed her mind, she would have already established a relationship with a midwife. This arrangement had the additional advantage of enabling Rose to evaluate closely the level of trust she was willing to invest in each

caregiver and a more extensive knowledge about the risks endemic to each situation. Rose's story exemplifies the advantages of holding the tension between opposites until a greater and more unified reality can be formed.

As her pregnancy progressed, Rose became increasingly knowledgeable about the many aspects of pregnancy and birth. About eight weeks before Rose was due to give birth, she was able to choose where her allegiance would lie. She discovered that having her questions answered in a way that suited her needs was an essential ingredient for trust building and risk reduction. Rose experienced the obstetrician as increasingly defensive and began to wonder just what kind of a birth she would have with this woman when communication was already so strained. The obstetrician exhibited minimal willingness to incorporate midwifery tools and techniques that Rose desired. If the obstetrician had been more flexible, Rose would have felt secure in the boundary-spanning behavior she was attempting to generate between the biomedical and midwifery worlds, and probably would have opted for a hospital birth. Simultaneously, Rose was feeling more and more comfortable with the care and expertise of the midwife, who was not only willing to answer her questions, but also embraced the value of the biomedical model. Rose opted for the model that was more inclusive rather than less, as this choice reduced her efforts to stretch between worlds. In addition, Rose and her husband had been doing a lot of research into the safety of hospital and homebirth and had come to the conclusion that homebirth was a well-considered and safe alternative. Before the birth, Rose said:

> We started out with an obstetrician because we were not sure that homebirth was for us. At the same time, we had been seeing [this midwife who was to be our labor support] from the beginning and really got to know her and developed a lot of trust and confidence in her. She had already done over 800 homebirths. And we feel that she has a really great approach to transport; if there is an issue she has no problem bringing us into the hospital and that is what we need in a midwife. I also know that I want to be fully present for my birth. My choice of homebirth is interesting because several years ago a few of my family members had homebirths and I thought they were crazy. I thought, "They are really taking a risk." I had no facts on which I based this judgment. And now based on our own very thorough research it really is clear that the decision to give birth at home is a safe one. This has been a major concern of mine all along.

> At this point, after checking all the options and exhaustively doing all the research, we can't imagine not being at home.

So Rose decided to stay home to have her baby—a decision made with relative ease given that she already had developed a strong and trusting relationship with the midwife. If Rose had not chosen the unique path of utilizing the services of both models from the outset, she would have had a more difficult time exiting the hospital structure because she would not have fully understood the alternatives. Building trust takes time, and the eighth month of pregnancy is a difficult time to begin a new relationship with prenatal care provider. As Rose recounts below, an unexpected hospital visit during her pregnancy became a primary factor nudging Rose toward a homebirth:

> I had tightness in my leg and I went to the hospital to check if it was a blood clot. I was anxious the moment I walked in the door. The whole culture was awful and I knew that I did not want to give birth in a culture like this. But I also want to make it clear that I am not at all anti-mainstream medicine. There are places for it and there are places not to use it and birth is one place not to use it if it is a healthy normal pregnancy. We want a safe, easy, and relaxing birth. We would also like a spiritual experience and this was the final piece that convinced us to do a homebirth.

Two months after her homebirth ended in a hospital transport and a cesarean section, Christine again spoke with Rose:

> As labor began we had all these candles in my bedroom and the lights were down. It was great. My husband was with me as well as another midwife. When the midwives said "it is time to push," I said "I don't feel like I have to"—I had no urge to push. I pushed for four hours but nothing was really happening. At this point we decided to transport for failure to progress. I was then at the hospital for another four hours without any real progress before we decided to go forward with the surgery.

During this time the midwives were welcomed as an integral part of Rose's caregiving team. This relationship between the hospital staff and the midwife had been built over varied and numerous previous transports by this midwife during which each side had gained an increasing respect for the other.

This background was one of the major factors contributing to Rose's midwife's willingness to transport earlier rather than later. While the presenting situation is substantially different from Kate's birth, the perceived level of risk is similar, in that through mutual agreement, the risk was judged to be minimal. Kate's healthy homebirth of a genetically unviable baby forged an opening between worlds. In contrast, Rose's trail toward an overlap in worlds had already been blazed by the time of she gave birth. Rose's midwife reported that her initial rapport with this hospital had been established previously, when she brought in a high-risk mother and the exemplary nature of her midwifery care was so obvious that the biomedical team substantially reconstructed their concepts of homebirth. The postmodern influence (see Introduction) in promoting this reconstruction became salient when someone from the hospital requested a meeting with this midwife shortly after the birth. In this meeting the hospital representative elucidated the postmodern theme of relativity by noting that expert knowledge is continually changing and that in today's world it is entirely possible that medical definitions of the situation can be supplanted by midwifery definitions. This openness to the smooth articulation of knowledge systems could only take place in a postmodern setting, where all knowledge is potentially open to question and continual revision.

Rose had an epidural and pitocin but still no progress was evident. After four hours in the hospital, it became obvious that that baby was stuck in a position that made delivery very difficult.

> At this point I just made a decision to have cesarean section. The midwife came into the surgery with the hospital staff. It was a really hard time for me. My husband and I were crying before the section because it was so disappointing. We had worked so hard and had really been committed to the homebirth.

Because the relationship had already been solidified, the hospital staff did not judge Rose for choosing to initially give birth at home. In fact they did just the opposite—they openly embraced her decision and supported her, even as she elected for the cesarean section. This care changed Rose's view of birth in the hospital. In this example, it is possible to see how trust continued to build and deepen on both sides over time:

> In the hospital we were just so surrounded by love—that is the best way for me to describe it. I felt so connected to the nursing

> staff, especially the one who came in and kissed me on the check and held my hand. We received so much support because people knew how disappointed we were not to have had a homebirth. Everyone knew that we started off with a homebirth and so there was just this outpouring for us. The head of obstetrics and gynecology came down to see me for a couple of days in a row. He was wonderful and he asked me why I chose a homebirth. He wanted to know. As for my decision to have a homebirth, I definitely feel that I got more of a spiritual intensity by starting out at home—there is no way I could have had that at the hospital. I have to say though that I was absolutely treated very well in the hospital.

While Rose's story does not have the drama of Kate's, her narrative depicts how attitudes can continue to be profoundly and subtly changed in the direction of increased wholeness and seamlessness over time. The transport provided an opportunity for Rose to see another, more compassionate side of hospital culture, and a chance for the chief of obstetrics to interact with a couple who chose homebirth and in the process soften stereotypes on both sides.

Jane's Story: Against All Odds The following integrated mandorla transport story was recounted by Jane, an upper-middle-class Hispanic female in her early thirties who had been married for four years at the time of the first interview. Both Jane and her husband have advanced degrees. Jane's first child was a planned hospital birth in 1997, and her second a planned homebirth in 1999. Christine interviewed Jane both before and after her second birth. Jane was so traumatized by her first hospital birth that she was certain she could not withstand another hospital encounter during labor. Nevertheless, her second birth required hospitalization. Jane's narrative unpacks the process through which a transport that begins as fractured can morph into integration. Jane's before-birth interview was inundated with references to her first birth to illustrate exactly what she hoped to avoid with the second birth, which began at home:

> I had a bad experience with my first birth—I didn't have an empowering idea about birth. I had a vision of what I wanted from my birth but no one around me was mirroring that vision back to me. I went to the doctor I chose because it was easy to get to him and close to my house. I didn't like the doctor but I thought, "He is competent—it doesn't really matter if I like him

> or not." The doctor told me, "People make such a big deal out of the birth—it is the baby that matters." I got the impression . . . that it was almost as if my contribution to the birth did not matter. In my family all the women had had cesarean sections. I wanted to be the first one in my family not to have a section. A lot of people around me, including my family, gave me a sense that this attitude was ridiculous. They told me that the baby is all that really matters, not the birthing experience itself.

Lines of shared communication between Jane and her physician were nonexistent, but because Jane was unaware of any other options, she felt constrained to operate within the bounds of the biomedical encounter. This lack of trust made it impossible for Jane adequately to assess her birthing risks and discern those she was willing to accept and those she was unwilling to engage. Without any symbols of shared meaning, Jane entered the hospital for her first birth feeling isolated and alone.

> My first experience in the hospital—I was always trying to protect myself emotionally while trying to relax and have my baby. My water broke and nothing happened for about twelve hours. The doctor came in and said, "We can put you on pitocin." I told him, "No, I want to wait and give it more time." I waited about a half-hour and then I started to cry. I told the doctor that I was scared. He promptly replied, "I know what your problem is—you need to let go of control." The nurse said, "Honey, you gave up control when you got pregnant." I felt so unsupported and unheard at that point that I just withdrew into myself.

In an ironic twist, Jane came to believe that the only way she could have any power at all in the hospital was to demand what she did not want, a cesarean section, before she was informed that she had to have one.

> Twelve hours later they started the pitocin and they told me that I had to be continually monitored. They put me on the non-portable fetal monitor because the portable one was broken. What this meant is that I only had a three-by-three area that I could walk in because I had to be plugged into the electronic fetal monitor. And it was awful—the little room to move about and I kept hearing the noise of the monitor. Finally I asked for

an epidural. After I got the epidural the doctor said that he was going to take a nap. At that point I said "No, don't take a nap, I want a c-section." Asking for a c-section was my way of taking control of the situation and getting some of my power back. They had told me before that I was a on a timetable and the baby had to be out within twenty-four hours. All I was thinking about was the clock and they had told me about the twenty-four-hour time limit because of the risk of infection after the water had broken. But I had no fever and no indication of a problem.

Jane had no reference point to dispute the necessity of a cesarean after a prescribed time period. Although Jane did not trust her caregivers, under the circumstances she felt forced to comply with the hospital definition of risk.

This whole terrible birth changed my life in a wonderful way. I was just not informed the first time I gave birth. The second time I got pregnant, I eventually found a direct-entry midwife. When I spoke with her on the phone for the first time I really liked the connection. As I learned more I thought, "I want a homebirth." I was so happy with my direct-entry midwife, I thought, "she is emotionally connected with me. . . . At this point in my life I cannot imagine giving birth with a stranger."

For my birth this time I have bought bouquets of flowers in every room and I am making soup that I love. I can smell it when people are on my side. I dislike the nursing mentality more and more. Everything is about shutting you down and managing you.

This time I am totally prepared. I have chosen a homebirth because I don't want to go back into the hospital . . . because I don't want to be physically guarded while I am trying to let go while giving birth. I am hoping to be really present and that my midwives will help me be present and I want it to be a life-changing spiritual event. I don't want it to be just something I have to get through.

Jane and Christine spoke again a few months after her second birth and subsequent hospital transport. As will be seen in her postbirth narrative, through an extended hospital transport stay Jane modified her view and eventually came to trust the biomedical team and develop a shared language and dialogue about the nature of risk.

> This time [second birth] my water broke early in the morning and by the afternoon I was feeling surges. And all the next day the same thing again—every hour I would have a few contractions and that would be it. My water had been broken for twenty-four hours. In addition to my direct-entry midwife, I also had asked another labor support person who knew about relaxation therapy to come. She just was really good at helping me focus and would say things like, "Let your birthing body take over." She put her hand on my belly and told me to breathe into her hand and breathe up the surge and then she would breathe with me and it was about taking really slow deep, deep breaths and slowly letting them out. I would let my birth team know a contraction was coming—"It is intense, help!" You can see it in the video when my direct-entry midwife kneels down and helps me and talks me through it and I really felt I needed connection during surges. That whole period from about 5 to 10 centimeters was so hard. I had been doing this for two days and I felt it was never was going to end.

This scene is radically different from the one described in her first birth. In this second birth, the trust and connection with her caregivers are solid.

> Eventually the midwives said, "We think the baby is turned the wrong way and we are going to try and turn her and it will hurt," and I said, "Whatever you have to do." They couldn't turn her and so they said, "Sorry honey, you are going to have to go to the hospital." I just started crying and wailing—I was so upset and I did not want to go to the hospital and I had no backup plan. Then I said, "Okay it is over—I give up." I was now sure that I would have a cesarean section.

At this stage, Jane perceived going into the hospital as entering enemy territory where all hope of connection and getting her needs met would be lost.

The transport began with strained relationships between the hospital staff and the midwifery team. When the hospital insisted on separating Jane from her trusted support team, Jane's fear escalated because she had no basis for trusting the care she would receive.

> We went to the hospital and I wanted my support team to be with me and with the initial evaluation they made me wait

> alone. For me the mind–body connection was so clear, but the relaxation exercises went out the window because I stopped being attentive to relaxing. I was just so tense and focused on all my fearful and scary thoughts and this cut off all the blood supply to my uterus and everything tensed up and I was a wreck. It was not so excruciating physically in the car, now that I think of it, it was more the emotional piece that was excruciating.

This particular hospital had been the recipient of many prior homebirth transports, in which lines of communication and nexuses for smooth articulation had been established. In fact, in response to the challenging economic climate, this hospital actively solicited homebirth transports. The reasons why the initial contact between the midwife and the hospital team was strained are unclear. Eventually, however, the midwife was allowed to share her information with the attending physician and the hospital staff. As a result of previous exposure to the midwifery model, the hospital staff exhibited a willingness to work more within the parameters of the midwifery model than the biomedical one by allowing Jane to continue her labor, despite the fact that she was considerably over the twenty-four-hour limit that the hospital allows for broken waters.

> And then the doctor came in and said, "We realize that you don't want to be here and we are going try and work with you, but let's be very clear. Your water has been broken for three days—this is a very serious situation and we are going to monitor you very closely and as long as there are not signs of infection we are going to work with you. But if we say that we have to prep for a cesarean section, we expect your cooperation."

This accommodation on the part of the hospital staff was tainted by the subsequent devaluing and discounting of the midwife's account of Jane's labor progress. The transfer of knowledge from midwife to hospital staff was partial and disjointed, with distrust mounting on both sides. Nevertheless, due to the prior positive experiences with other homebirth midwives at this hospital, the entire midwifery team was allowed to remain with Jane in her room.

The willingness of both teams to remain in contact and dialogue, disjointed though it had been, proved to be key in eventually paving the way for a smooth and mutually transforming mandorla transport.

> As my midwife relayed her information to this physician, she also told him that I had been to ten centimeters twice. [In the midwifery model, it is accepted knowledge that a cervix can dilate and then retract, usually as a result of emotional tension. The biomedical model does not recognize this possibility.] At this point he rolled his eyes to one of the other women there like my midwife was crazy. And I thought, "I am supposed to relax and trust this doctor when he doesn't believe my midwife," and that was hard. They gave me an epidural and pitocin.

Despite the rift in communication on both sides, there was enough rapport for Jane to make requests and have them heard and acted upon.

> I made them turn off the monitor because I did not want to hear it and they could have turned it off last time but I didn't know that. The doctor told me, "we are not going to check you a lot because of the risk of infection" and when he checked me I was at six centimeters and he looked at me and said, "You are at six," and he said it in such a way that was like, "Don't delude yourself—ten centimeters!" I didn't like him at the beginning but it got better later.

The biomedical expertise of the anesthesiologist and his eventual willingness to open the lines of communication began to alleviate Jane's fear and distrust of the hospital. Trust was established as the dialogue ensued:

> When the anesthesiologist came in we were talking about the possibility of a cesarean section. I told the anesthesiologist that I had to have a general before because there was a window in my back and I was terrified of it. He explained to me that, "There are many things we can do short of a general." He kept trying to brush me off and move on and I told him, "I need to know so I can move on." Finally he got engaged in the conversation and he explained to me what other things could be done to numb you short of a general. Then I started to feel a little better being here at this hospital—"At least these people know what they are doing, at least they have modern technology here." I was pissed—why didn't my other doctors know this?
>
> After spending all day in the hospital, my contractions were not getting closer together. They said, "You will have to think of

> what you want to do—we can keep upping the pitocin but there is a limit to how far we can go and at that point we will need something else"—obviously the something else was a c-section.

On the basis of prior experience with other homebirth clients who had transported into this hospital, the staff, wherever possible, was willing to honor the decision-making power of the woman who was giving birth. Almost all women electing to give birth at home become very knowledgeable about the process of birth and risks and benefits of each intervention. Hospital exposure to these homebirth clients created options for Jane that would not have been possible without this accumulated experience.

The attending physician had given Jane and her midwifery team time to confer with one another.

> After they left I said to my team, "Huddle up, huddle up," and they surrounded the bed—and said, "What are we going to do?" It was a major group decision for me—I needed to hear what they thought. My direct-entry midwife said, "Let's keep trying with the pitocin and see what happens." Her assistant said, "Well I am looking at this and thinking the baby is doing great and your uterus is tired and not performing the way it should, why wait until the baby is not doing great, now would be the time to stop and have a c-section—you are tired." And to me her assistant made more sense than pushing the limit. I was so focused but tired and I thought, "I don't want to wait until code red." And I said, "Okay, let's do it" [the c-section] and I started to cry again and I said to my midwifery team, "Help me have peace about this."

At this point, with everyone in agreement, Jane would have received a cesarean section if not for an emergency situation that occupied her obstetrician for a time.

> We called the doctor in and he said, "I hear you want a c-section but I can't do it right now. Why don't we just keep the pitocin going and we will see what happens. I have an emergency down the hall I have attend to now." I fell asleep at this point for the first time.

When the attending physician returned about one and one-half hours later and found Jane ready to give birth, he was happy to support

her in a vaginal birth. At this point he took the lead from Jane and honored her wishes without insisting that he direct the show.

> I slept until midnight when he came in and checked me. I was totally dilated and his face was just totally shocked, happy shocked, and he said, "Well you are ten and you can push now," and the whole room lit up. Suddenly everyone got up and got ready and got me positioned. My midwife said, "You can turn off the epidural if you want to, it might make you feel more and make your pushes more efficient." I agreed. Before doing this the physician asked, "Are you sure? A lot of women have a hard time when doing this." I said yes.

As the midwifery team and the hospital team interacted during the intimacy of the moment, they become more integrated. The physician facilitated their integration by making himself vulnerable and becoming interested in the outcome. He personalized his care, saying that he would treat Jane as his sister and give her the best care he could. In time, the midwives and Jane came to trust him to such an extent that they saw him as part of the birthing team. This created a space for Jane to respond in kind and share an intimate detail about birth:

> I told the physician that I wanted my husband and myself to be the first ones to touch the baby. He replied, "Okay, but that might be kind of hard for me—I get really excited when the baby comes out." At that point we all actually liked this doctor. He had made himself very human and he had been so patient.

It later became clear that the doctor's prior exposure to the midwifery model had been a major factor in his willingness to accommodate Jane's wishes and to do all he could to facilitate her vaginal birth.

After several hours of pushing with a great deal of unified support from her midwifery team and the physician, her baby was born vaginally. By this time the biomedical team and the midwifery team had bonded to the point of becoming a united, close-knit team with everyone enjoying the miracle of the moment.

> I told [here she calls her physician by his first name] I wanted the baby put on me immediately with the cord cut when the baby is on me. I don't want my baby taken away and I don't want her to be given a bath. I want her just to be with me and I asked him to do whatever he had to do to make this happen.

> He said "Okay." There she was and she was born and she was on my chest and we were all around her. Then [again she calls the physician by his first name] came in and said, "It has been five minutes, we have to cut the cord." I will never forget it—I just wanted to say no and then I said, "Fine." They cut the cord and kept her with me for a while and then they took her away.

The doctor was able to convey the effect that this birth had on him and some of the transformation he had undergone as a result.

> He came in the next day and he was really beaming and he said, "Wow, that was a really great experience. It was really good for me." I didn't quite know what he was referring to then, so I went back to see him a couple of weeks after the birth and talked to him about it. He said that it was really nice the way we cut the cord and that we waited a little bit. He had to really push it to do that because the hospital demands that it be done right away and that he was glad we waited. And he really liked that we cut the cord on top of me. Hospital protocol is to hold the baby down and cut it below the mother's body, which he said he thought was ridiculous and that he thought it should be done just the way it was done. The way we did it—he thought that that is the way birthing should happen. It felt really good.

Jane's story illustrates how individuals who inhabit separate conceptual worlds, when forced into an encounter, often begin the initial communication reluctantly and with resistance—with uneasy toleration rather than acceptance. But a generous amount of time spent together in a potentially critical situation can allow the possibility for establishing the rapport essential to a mutually satisfying and transforming, and eventually smooth, articulation of psyches and knowledge systems. Jane came away with a respect for biomedicine and trust in the care provided by the physician. The physician, in turn, allowed himself to be positively influenced by midwifery ideologies of birth, and initiated a reconstruction of his former concepts. Each made allowances to accommodate and adjust to the "other" along the way. In this case, extensive prior rapport with other homebirth midwives was the backdrop that facilitated the mandorla. Jane's transport illustrates how institutional protocols can be significantly and continually altered in individual situations as cultural opposites sustain continued contact with each other over time. We will return to the power of this theme in the conclusion of this chapter.

"A Home Birth in the Hospital" We close this section of midwifery homebirth client stories by briefly describing a transport that occurred a few months ago and was recounted to Christine. Both the midwife and the woman who gave birth shared their narratives. Christine conducted before and after birth interviews with the mother.

Prior to her birth, the one thing the woman most wanted was to stay at home. However, she was eventually transported for failure to progress. Upon arrival at the hospital, the midwife and laboring couple were greeted respectfully and warmly. The midwife showed the staff the woman's chart and answered any questions asked. The mother stated that she wanted an epidural, as she had been laboring throughout the night and was ready for some relief. She was given the epidural and pitocin. During her hospital stay, the mother noted that for the most part, they were treated respectfully and midwifery knowledge was honored to such an extent that when the time came for her to push, the doctor invited the midwife to massage the mother's perineum with oil. As she massaged, the midwife remarked to the parents that this was "a homebirth in the hospital." She said, "There we were, I was attending the birth, her husband was holding one leg and the nurse the other, as peaceful as can be, just as we had planned, only in a different location. We were grateful for the epidural and pitocin— it facilitated the success of this birth."

At the point of crowning, the hospital staff gathered around. The midwife recounted how she kept waiting for the doctor to say, "Okay, you can move aside now," but that didn't happen. Much to the contrary, as the baby was arriving, the attending chief resident stood back and asked the midwife if she needed anything else. The midwife asked for gauze and promptly a table with the necessary obstetrical equipment was brought over to her. The staff watched as the midwife received the baby and put him on his mother's chest. Soon after this, the hospital staff left to give the midwife, parents, and the baby time alone.

Both the mother and midwife enthusiastically expressed how positive this experience was for them. The mother emphasized that while she was previously very anti-transport, she has now changed her mind and realized that sometimes it is necessary. In retrospect she noted that the epidural and pitocin were welcome aides. In this transport we can witness the profound and extensive mandorla transformations that can occur from the bottom up to reconstruct the meaning of birth from both the biomedical and the midwifery perspectives.

A Midwife's Stories: Bridging Worlds

The following story comes from Carrie, a certified professional midwife (CPM) who has practiced in Georgia for almost twenty years, attending during that time over 850 births. Her practice is "unlawful" (meaning that it is punishable in the misdemeanor category in her state). Most of the homebirths she attends are for white middle-class couples. She does prenatal care out of her own home in an Atlanta suburb. She began her birth career in the late 1960s working as a volunteer in labor and delivery, and then took training as a biomedical assistant, working in labor and delivery and for a pediatrician for several years. Starting in 1977 she began attending the homebirths of friends; in the early 1980s she undertook an apprenticeship (1.5 years) with another homebirth midwife who later became her partner.

A mother pregnant with her second child, whose first birth had been very fast, started bleeding during mild early labor with contractions six to eight minutes apart. Carrie had sent her for an ultrasound at thirty-four weeks, which had been normal, so she knew she was not dealing with a placenta previa (the placenta does not move after thirty-four weeks). Carrie noted that "If the mother had not had the ultrasound, there is no way I could have checked her with that much bleeding at home." (In a case of true placenta previa, doing a cervical check can cause harm.) Carrie checked the baby's heart tones, which sounded good. Carrie was concerned by the dark red color of the blood, which indicated that it was not from a superficial cause. She called the hospital and talked to the nurse-midwife who works for Carrie's backup doctor, telling her it looked like some kind of placental abruption might be occurring. They drove the mother to the hospital, where the nurse welcomed them into the labor and delivery unit and put the mother on an electronic fetal monitor, hooked up an IV, and drew blood to type and screen in case she had to have a cesarean. The baby's heart tones remained steady and strong. The doctor came in about ten minutes after they arrived and said to Carrie and the nurse, "It looks like you have everything under control." Carrie expressed her concern about the color of the blood, but the doctor was not worried. He stayed for only about five minutes. After he left, the mother labored for another three hours. She spent time in the Jacuzzi, sat on the toilet, and then on the birth ball for a while; eventually she got in bed to try to rest. Carrie and the nurse-midwife turned all the lights off in the room. When pushing contractions kicked in, the mother pushed for about ten minutes, as Carrie recalls, and delivered on her hands and knees while the nurse-midwife caught the baby. The baby stayed with the mother. The placenta came fairly quickly after the birth; when Carrie and the CNM

examined it, they could see a five centimeter clot on it—an indication that the placenta had partially detached in that area and had been bleeding from that place for a while. (If a placenta detaches uniformly after the birth, there will not be many clots on it unless it has been sitting in the uterus for quite a while, but if there is a partial separation, there will be clotting or additional clotting at the site of the partial separation.) The mother and baby went home the next morning. After the birth, the doctor told Carrie that she probably could have stayed at home for this one. And Carrie told him, "You have to realize that it's important for me to transport sooner rather than later when I have the option." And he said "You are right—I don't always see it from your side."

In the hospital, a partial placental separation is not cause for major alarm because facilities for a cesarean are there at hand. But homebirth midwives like Carrie prefer to err on the side of caution—if you see too much bleeding to feel okay about it, you transport. A primary ingredient in Carrie's willingness to transport early rather than late was the trust she had established over time with this doctor and this particular hospital. This trust has evolved into a smooth articulation of knowledge systems in which risk assessments can be mutually understood. She said:

> Since the early years of my practice, over time we have built up a lot of really good rapport, so that we have a lot of unofficial backup [it can't be official as Carrie's practice is not legal or licensed in Georgia]. We now have a doctor who is providing backup for us in that during the pregnancy he will see the mothers if we need him to—if we need an ultrasound he'll do one in the office. He says he doesn't like homebirth, but also he doesn't like the fact that many doctors are refusing to see homebirth mothers. He says everybody deserves good medical care when necessary. And if something comes up in labor, we can call the nurse-midwives who are always in-house. They listen to what we have to say on the phone and have everything set up when we arrive—the operating room ready, the doctor already in-house. So it is a really good situation—there are no animosities or repercussions or "attitudes" toward homebirth mothers. The doctors aren't exactly thrilled—they have said to the CNMs, "I wish you'd quit being so nice to these midwives so they'll quit bringing women in." And the CNMs have answered, "Would you rather leave them at home?" And the hospital is wonderful! It has no newborn nursery—I would consider them mother-baby friendly.

> The babies are never taken away from the moms unless they are really in trouble and need to be in the NICU.

Carrie's experiences point out that different kinds of articulations can happen in the same location as the actors come to know and develop trust in each other over time.

In 1978 with the publication of *Birth in Four Cultures*, Brigitte Jordan issued a call for the replacement of top-down, culturally inappropriate obstetrical systems with models of mutual accommodation between biomedical and indigenous systems—a plea that is equally significant for all homebirth midwifery systems. The stories recounted above illustrate the positive results of this sort of mutual accommodation. These mandorla transports can reconstruct institutional knowledge and protocols from the bottom up. Nurse-midwives are especially well placed to achieve such relationships, as they inherently straddle and bridge (and occasionally fall into the fissures between) biomedicine and homebirth midwifery. Establishing close relationships with homebirth midwives who are not legal is simultaneously a transgressive and a boundary-spanning act.[3] The prior communication between Carrie, the nurse-midwives, and the supportive physician certainly facilitated the smooth articulation of systems illustrated in these stories. Carrie feels that the key to this sort of smooth articulation is mutual respect and a cooperative attitude on the part of all concerned. Carrie's long and safe practice in her community has earned her this kind of respect from the hospital practitioners who know her best. She notes that it can take years to build this kind of relationship, especially with physicians who start out mistrusting midwives. Once established, though, such relationships tend to last. Many homebirth midwives do presently enjoy mutually accommodating relationships with one or two supportive physicians, which they have worked hard to build over the years. But they note that such smooth articulations are jeopardized when the supportive physician moves away or retires and is replaced by a younger doctor "with an attitude," as Carrie puts it, and then the midwife has to start all over again on the process of building trust. Midwives cannot always count on the availability of the physicians who support them, and even those who have spent years building good reputations and good relations with certain physicians sometimes still have to deal with fractured articulations during transport.

But in Carrie's case, because of her long-term relationship with the nurse-midwives in her local hospital, the articulation between her knowledge system and that of the hospital and its practitioners is so smooth that she is more than willing to transport even for situations

that have nothing to do with risk, but rather with the mother's comfort alone, as the following short story shows:

A primapara (mother giving birth for the first time) had pulled a muscle in her back at the end of her pregnancy and was in a lot of pain as a result; she called Carrie to her home in the middle of the night. Carrie arrived to find the mother was in very early labor, at two centimeters dilation, but with close to unbearable pain from the back spasms. Carrie spent hours trying to relieve the pain in her back with showers and warm compresses and massage. She said:

> After a while we were running into brick walls as far as pain relief for the spasms, so we decided to go into the hospital where they have Jacuzzis in the labor rooms. By the time we got there, she was six centimeters. The nurse-midwives who received us told her she was doing great. The jets did good counterpressure on the back pain. They never started an IV and she had no pain medication. The baby's heart tones always sounded great. I was able to catch the baby as "the grandmother" on the chart—the nurse working with us had had her babies at home, and the nurse-midwife was very supportive and felt this mom really deserved the continuity. The baby was fine and the family went home twelve hours after the birth.

As these two stories illustrate, smooth articulation between knowledge systems proceeds through points of overlap, transition, and communication, which facilitate the seamless flow of information and linked, imbricated decision making in which the actions taken by one person or group build on the information supplied by another. The relationships between Carrie and the hospital-based CNMs encompass such points. This kind of bottom-up decision making within the top–down biomedical system requires a rejection of its tendency to discount or dismiss as irrelevant other ways of knowing. Such rejections can and do take place at the level of the individual even when the system as a whole remains dismissive. The process of forging connections between practices and effects across the midwifery/biomedical divide can produce not only safer transfers but also a merging of the best of midwifery and the best of biomedicine.

CONTEXTUALIZING THE MANDORLA TRANSPORT

What motivates or inspires a physician to reject the top–down system and give credence to homebirth midwifery knowledge? In our experience,

the ingredients key to an individual's rejection of biomedical hegemony in favor of mutual accommodation include: (1) exposure to midwifery care, (2) exposure to midwives, and (3) attention to the scientific evidence. We will briefly deal with each of these in turn.

Exposure to midwifery care. Some doctors train in hospitals where nurse-midwives practice and thus are able to observe first-hand the benefits of midwifery care. Physicians we have interviewed are often awed by the midwife-attended births they witness, which are often visually and aurally nothing like the births they have seen. Women attended by midwives in hospitals are more likely than women attended by physicians to give birth in upright positions, with lots of vocalization, without an episiotomy, and with a great deal of hands-on support. Nurturance and consideration tend to characterize the midwife's approach to the mother; shared decision making takes place in a context of mutual respect. Physicians who do not ordinarily witness this kind of birth can find the experience transformative, can become imbued with a desire to incorporate this kind of respectful, humanistic approach into their own practices, and will be more likely to work with nurse-midwives in the future from a partnership, rather than a hierarchical, perspective. Occasionally a brave physician will venture outside hospital bounds and observe a midwife-attended homebirth—an experience that tends to be emotionally evocative and ideologically transformative (see for example Wagner 1997).

More profoundly, it is important to note that clinicians judge other clinicians as individuals, not just as members of a class or category; individual judgments can overcome prejudices based on subcultural differences. Does a practitioner give good care, make good decisions, and communicate accurately? Individual practitioners make decisions on the basis of experience. All clinical practitioners constantly gather experience and information, and react differently to a comment, order, or action from someone they trust as opposed to someone whose judgment has been faulty in the past or whom they do not know. Midwives work best with the doctors they have come to trust as a result of experience, and vice versa. But most doctors have little or no experience working with homebirth midwives; the experience they do have may be skewed if it comes only during emergency transports. Lack of experience with working together creates problems that exacerbate and perpetuate lack of experience with working together (Judith Rooks, personal communication, 2002).

Exposure to midwives. We can say without overstatement that American homebirth midwives tend to have huge hearts, impressive personalities, a strong sense of commitment and dedication to serving women,

a secure sense of their own self- and professional worth, and a large fund of knowledge about parturition that seamlessly permeates their conversation. Simply spending time with them can turn a hospital practitioner from an opponent to a supporter. In U.S. communities where smooth articulation characterizes transport, home and hospital midwives, and sometimes physicians, occasionally participate in periodic potluck dinners where models of mutual accommodation begin to emerge over casseroles and drinks. Hospital midwives who develop respect for, and good relationships with, homebirth midwives often transmit this trust to the physicians with whom they work in a kind of spillover effect that paves the way for future smooth articulations during transport.

Attention to the scientific evidence. There is increasing emphasis these days on "evidence-based medicine" (Rooks 1999). As we have seen, midwifery tends to be more evidence based than obstetrics because midwives are generally less interventive than physicians (Frye 1995; Davis 1997; Gaskin 1990; Rooks 1997) and the scientific evidence (Rooks 1997:345–384; MacDorman and Singh 1998; Goer 1999; Enkin et al. 2000) shows that many common interventions do more damage than good. Any doctor who actually looks at the evidence, instead of relying solely on what he is taught by biomedical tradition, will take note of the benefits of midwifery care, will thus be less likely to assume a blanket superiority for obstetrics, and will be more open to learning in the moment, "going with the flow."

ARTICULATING TRANSPORT MANDORLAS

> Articulation is the production of identity on top of difference, of unities out of fragments, of structures across practices. Articulation links this practice to that effect, this text to that meaning, this meaning to that reality, this experience to those politics. . . . And these links are themselves articulated into larger structures.
>
> —**Lawrence Grossberg, *We Gotta Get out of This Place: Popular Construction and Postmodern Culture***

While trust is only possible when individuals continually form and reform institutional structures, it is equally true that it is difficult to keep trust sustainable among individuals without the contextual coordination enabled by social organizations. Action and structure are inextricably interlinked into different aspects of the same whole and cannot be disconnected from one another. The best guarantees of mandorla transports are legislative statutes that institute and clarify the

rules and resources available to midwives, and in so doing greatly reduce uncertainty and stabilize transport encounters.

Today in most developed countries, the homebirth rate hovers around one percent. That homebirth might be more widely chosen in the developed world if it were more readily available is indicated by the Netherlands experience, where the homebirth rate has never dropped below thirty percent (DeVries 2004); and by New Zealand and the Canadian province of Ontario, where in recent years it has risen significantly as the result of acknowledgement of the scientific evidence supporting homebirth and a strong alliance between midwives and consumers, which has generated active government support. These three regions stand as models of what Davis-Floyd calls *seamless articulation*—their midwives practice, and their health-care systems fully support, birth in all settings, creating ease of choice and continuity of care across what in most other countries can only be seen as the home/hospital divide (DeVries, van Teijlingen, Wrede, and Benoit 2001). In the United States, we find few examples of institutionalized seamlessness, but as we have shown in this chapter, *smooth articulation* that leads to an integrated individual birth experience can be manifested in the mandorla transport. The more such transports occur, the thicker will be the webs of articulation mandorla transports build between individuals across biomedical and midwifery knowledge systems and worlds. Until and unless institutional systems of seamless articulation can be created, the further mainstreaming of American midwives will depend on the continued weaving of these fragile, easily ruptured, but always reweavable webs.

ENDNOTES

1. Portions of this chapter are adapted from Davis-Floyd 2003.
2. Medical practitioners who only see problematic homebirths that are transported to the hospital tend to think that all homebirths are "botched." The rate of problems derives as a function of a numerator (number of cases with problems) and a denominator (total number of cases—the majority—that have good outcomes). If one only sees the numerator, it is impossible to realize that the rate of transports is actually very low compared to the number of successful homebirths (Johnson and Daviss 2005).
3. About 200 nurse-midwives attend homebirths in the United States. Ideally, their transport experiences should be smooth but often are not. While there is excellent data on the statistical *outcomes* of nurse-midwife-attended births in the U.S., including home to hospital transports (MacDorman and Singh 1998), we know of no research on American nurse-midwives' transport *experiences*. Further research should also include thorough quantitative and qualitative studies of the treatment of transported women and the specific outcomes.

REFERENCES

Baumann, Zymunt. 1997. *Postmodernity and Its Discontents.* New York: New York University Press.

Best, Steven, and Douglas Kellner. 1991. *Postmodern Theory: Critical Interrogations.* New York: The Guilford Press.

Davis, E. 1997/1983. *Heart and Hands: A Midwife's Guide to Pregnancy and Birth,* 3rd ed. Berkeley, CA: Celestial Arts.

Davis-Floyd, R. 1998a. "From Technobirth to Cyborg Babies: Reflections on the Emergent Discourse of a Holistic Anthropologist." In *Cyborg Babies: From Techno-Sex to Techno-Tots,* ed. R. Davis-Floyd and J. Dumit, 255–283. New York: Routledge.

———. 1998b. "The Ups, Downs, and Interlinkages of Nurse- and Direct-Entry Midwifery: Status, Practice, and Education." In *Getting an Education: Paths to Becoming a Midwife,* ed. J. Tritten J. and J. Southern, 4th ed., 67–118. Eugene, OR: Midwifery Today. Also available at http://www.midwiferytoday.com.

———. 2000. "Global Issues in Midwifery: Mutual Accommodation or Biomedical Hegemony?" *Midwifery Today,* March, 12–17, 68–69.

———. 2003. "Home Birth Emergencies in the US and Mexico: The Trouble with Transport." In "Reproduction Gone Awry," ed. Gwynne Jenkins and Marcis Inhorn. Special issue of *Social Science and Medicine.* 56(9): 1913-1931.

———. 2003. "Qualified Commodification: Consuming Midwifery Care." In *Consuming Motherhood,* ed. J. Taylor, D. Wozniack, and L. Layne.

DeVries, Raymond. 2004. *A Pleasing Birth: Midwives and Maternity Care in the Netherlands.* Philadelphia: Temple University Press.

DeVries, R., E. van Teijlingen, S. Wrede, and C. Benoit, eds. 2001. *Birth by Design: Pregnancy, Maternity Care and Midwifery in North America and Europe.* New York: Routledge.

Enkin, M., M. J. Kierse, J. Neilson, C. Crowther, L. Duley, E. Hodnett, and J. Hofmeyr. 2000. *A Guide to Effective Care in Pregnancy and Childbirth,* 3rd ed. New York: Oxford University Press.

Frye, A. 1995. *Holistic Midwifery: A Comprehensive Textbook for Midwives in Homebirth Practice, Volume I, Care During Pregnancy.* Portland, OR: Labyrs Press.

Garston, Christine. 2001. "Trust, Control and Post-bureaucracy." *Organizational Studies.* March.

Gaskin, Ina May. 1990. *Spiritual Midwifery, 3rd ed.* Summertown, TN: The Book Publishing Company.

Giddens, Anthony. 1991. *Modernity and Self-Identity.* Stanford, CA: Stanford University Press.

Goer, Henci. 1999. *The Thinking Woman's Guide to a Better Birth.* New York: Penguin Putnam/Perigree.

Grossberg, Lawrence. 1992. *We Gotta Get Outta This Place: Popular Conservatism and Postmodern Culture.* New York: Routledge.

Johnson, Christine Barbara. 1987. Normalizing Birth. PhD diss., Boston University.

———. 2000. "The Public Face of Midwifery in Massachusetts." Paper presented at the May American Anthropological Association, San Francisco, CA.

———. 2001. The Ethic of Care and the Ethic of Autonomy. Paper presented at the May Pacific Sociological Association, San Francisco, CA.

Johnson, Christine Barbara, and Priscilla Galvin. 2001. *Transforming the Health Care System with On-Line Technology.* United States National Library of Medicine Information Infrastructure Program, Contract N01-LM-6-3539.

Johnson, Kenneth C. and Betty Anne Daviss. 2005. "Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America." *British Medical Journal* 330(7505): 1416, June. www.bmj.com.

Johnson, Robert A. 1991. *Owning Your Own Shadow.* San Francisco: HarperSanFrancisco.

Jordan, Brigitte. 1993. [originally published in 1978] *Birth in Four Cultures*, revised and updated by Robbie Davis-Floyd. Prospect Heights, IL: Waveland Press.

MacDorman, M., and G. Singh. 1998. "Midwifery Care, Social and Biomedical Risk Factors, and Birth Outcomes in the USA." *Journal of Epidemiology and Community Health* 52:310–317.

Rooks, Judith P. 1997. *Midwifery and Childbirth in America.* Philadelphia, PA: Temple University Press.

———. 1999. "Evidence-Based Practice and Its Applications to Childbirth Care for Low-Risk Women." *Journal of Nurse- Midwifery* 44(4):355–369.

Ventura S. J., J. A. Martin, S. C. Curtin, R. Menacker, and B. E. Hamilton. 2001. Births: Final Data for 1999. *National Vital Statistics Reports* 49(1). Hyattsville, MD: National Center for Health Statistics.

Wagner, Marsden. 1997. "Confessions of a Dissident." In *Childbirth and Authoritative Knowledge: Cross-cultural Perspectives*, ed. R. Davis-Floyd and C. Sargent, 366–396. Berkeley, CA: University of California Press.

Wallace, R., and A. Wolf. 1995. *Contemporary Sociological Theory: Continuing the Classical Tradition*, 4th ed. Upper Saddle River, NJ: Prentice Hall.

Fig. 12.1 A birth that began at home in California with midwife Faith Gibson in attendance. Photographer: Jennifer Gates.

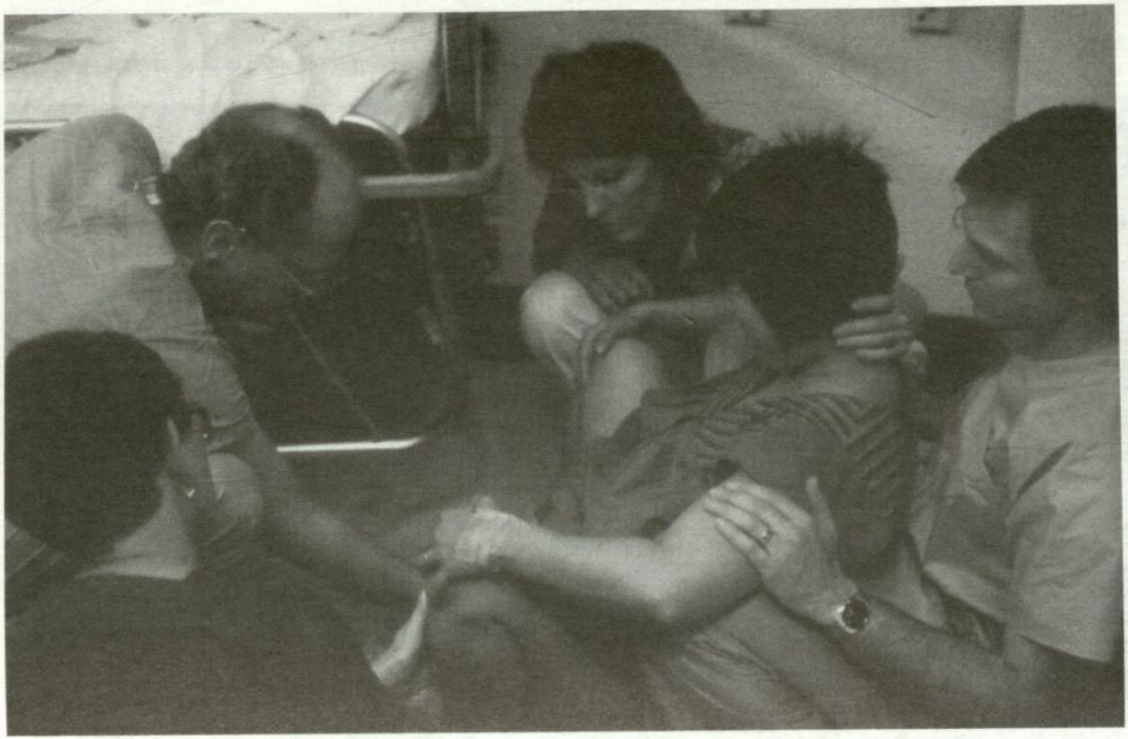

Fig. 12.2 A magical transport mandorla in which the homebirth midwife remains in supportive attendance and full cooperation with the hospital team. Photographer: Jennifer Gates.

13

WHY MIDWIVES MATTER: OVERCOMING BARRIERS TO CARETAKE THE POWER OF BIRTH

Christine Barbara Johnson and Robbie Davis-Floyd

The art and science of midwifery are characterized by these hallmarks:

1. Recognition of pregnancy, birth, and menopause as normal physiologic and developmental processes
2. Advocacy of non-intervention in the absence of complications
3. Incorporation of scientific evidence into clinical practice
4. Promotion of family-centered care
5. Empowerment of women as partners in health care
6. Facilitation of healthy family and interpersonal relationships
7. Promotion of continuity of care
8. Health promotion, disease prevention, and health education
9. Promotion of a public health care perspective
10. Care to vulnerable populations
11. Advocacy for informed choice, shared decision making, and the right to self-determination
12. Cultural competence
13. Familiarity with common complementary and alternative therapies
14. Skillful communication, guidance, and counseling