EXPERIENCES WITH HOSPITAL TRANSPORT FOR PLANNED HOME BIRTHS

by

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DISSERTATION ABSTRACT

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The midwifery model and the medical model constitute the two main bodies of knowledge and practice that characterize the way pregnancy and birth are viewed in the United States. The midwifery model emphasizes the normalcy of pregnancy and birth, while the medical model is characterized by a belief in the supremacy of technology over nature and in medical supervision and intervention during pregnancy and delivery. Although both models do espouse important information regarding pregnancy and birth and, at times, there is overlap in the practical application of the models, practitioners of the two models rarely interact with one another. The one situation where practitioners of these two models do come into contact is during home-to-hospital transports for planned home births.

Through in-depth interviews with direct-entry midwives, mothers, obstetricians, and nurses, this dissertation explores what happens when practitioners of the two models are forced to interact during home-to-hospital transports in order to provide care for women and their babies. Building on Davis-Floyd's and Johnson and Davis-Floyd's

work on home-to-hospital transport, interview data suggest that a series of professional and organizational level factors influence the interactions between obstetricians, direct-entry midwives, and nurses during transports. Findings indicate that care providers engage in emotion work as they navigate the disjuncture between home and hospital, managing their own feelings and the feelings of others during a home-to-hospital transport. Due to the lack of institutionalized protocols governing conduct during transports, practitioners of the two models of care are left to construct their own versions of protocols through micro-level interactions, which at particular times and among certain providers have the effect of transcending the boundaries that divide home and hospital. With the interaction that occurs during a home-to-hospital transport as the central focus, this dissertation provides insight into how the lack of integration between the more marginalized midwifery model and the dominant medical model of care in the U.S. affects care providers and laboring/birthing women during transport situations.

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To Raven, Savannah, and Alexander

TABLE OF CONTENTS

Chapter Page

I. INTRODUCTION 1

II. LITERATURE REVIEW 11
History of Midwifery in the United States 11
Physician Resistance to the Practice of Midwifery 13
Socio-Cultural Influences on the Practice of Midwifery: Race, Class, and Gender 15
Lack of Professional Organization by Midwives 17
Home Birth, Hospital Practices, and Consumer Social Movements 18
The Political and Professional Context of Midwifery 22
Certified Nurse Midwives (CNMs) 22
Direct-entry Midwives 24
Models of Care 27
The Professionalization of U.S. Medicine and the Rise of Obstetrics 28
The Technocratic, Humanistic, and Holistic Paradigms 31
Relations Between Direct-entry Midwives and Obstetricians 34
Hospital Transport 37
Medical Sociology 45

III. METHODOLOGY 49
Studying Home-to-Hospital Transport in Oregon 50
Study Samples and Data Sources 52
The Mothers 52
The Midwives 58
Nurses 66
Obstetricians 69
Confidentiality Concerns 73
Data Collection and Analysis 74
Researcher Positionality and Subjectivity 78

IV. TRANSPORT STORIES: LISTENING TO THE WOMEN 82
Introduction 82
The Process of Home-to-Hospital Transport 83
Types of Transports 84
Fractured Articulations and Disarticulations as Negative Experiences 89
Smooth Articulations and Mandorla-like Transports 105
Conclusion 118

V. THE ROLE OF PROFESSIONAL FACTORS IN INFLUENCING CARE PROVIDERS' VIEWS AND BEHAVIORS DURING TRANSPORT 120
Introduction 120

Obstetricians 121
Obstetricians’ Views on Birth 122
Obstetricians’ Views on Home Birth 127
Factors Influencing Obstetricians’ Views and Behaviors 132
Professional Level Influences 134
Medical School Education 134
Professional Culture and Socialization 144
Malpractice 155
Direct-entry Midwives 163
Professional Level Influences 163
Licensure 163
Conclusion 174

VI. THE INFLUENCE OF WORK OBLIGATIONS ON PROVIDERS’ VIEWS AND BEHAVIORS DURING TRANSPORT 177
Introduction 177
Obstetricians 179
Work/Organizational Level Factors 179
Colleagues 180
The Hospital 189
Variation in DEMs’ Training and Experience 190
Level of Counsel 195
Direct-entry Midwives 196
Work/Organizational Level Factors 196
Interfacing with the Medical Community 197
The Hospital 204
Nurses 207
Work/Organizational Level Factors 207
The Hospital 207
Discretionary Power 212
Conclusion 218

VII. THE EMOTION WORK OF TRANSPORT 220
Introduction 220
The Emotion Work of Obstetricians and Nurses 226
The Negative Emotions of Transport: Anxiety, Anger, and Frustration 226
Anxiety 226
Establishing Rapport 227
Liability 230
Not Providing Charts or Withholding Information 231
Resistance to Medical Recommendations 234
Enjoying the Challenge: Positive Work Feelings 236

Chapter Page

Managing Emotions 240
Empathizing with Women 240
Staffing Strategies 242
The Emotion Work of Midwives 243
The Negative Emotions of Transport: Anxiety, Frustration, and Powerlessness 244
Anxiety 244
Frustration and Powerlessness 247
Venting 251
Emotion Work and Impression Management 252
Managing Clients' Emotions 254
Prepping Clients 254
Conclusion 259

VIII. CONCLUSIONS-TRANSCENDING THE HOME HOSPITAL DIVIDE: HOSPITAL TRANSPORT AND THE POTENTIAL FOR COLLABORATIVE RELATIONS 261
Summary 261
Contributions to the Literature 274
Implications for Home-to-Hospital Transports 277
Marginalization and Power 279
Implications for U.S. Maternity Care 284

APPENDICES
A.SAMPLE TRANSPORT FORM AND CONSENT FORM USED BY DIRECT-ENTRY MIDWIVES 288
B. INTERVIEW PROTOCOLS 290

REFERENCES CITED 298

LIST OF TABLES

Table Page

3.1. Demographics of Women Who Transported 53

3.2. State-by-State Direct-entry Midwifery Legal Status and
Licensure/Certification 60

3.3. Demographic Variables of Direct-entry Midwives...66

3.4. Demographic Variables of Nurses 67

3.5. Demographic Variables of Obstetricians 70

5.1. Professional and Work/Organizational Factors by Provider 135

6.1. Qualities Associated with “Good Midwives” and “Bad Midwives”
As Identified by Obstetricians 192

CHAPTER I

INTRODUCTION

Currently in the United States, the majority of births take place in hospitals. Despite evidence-based science, which suggests that home birth is as safe if not safer than hospital birth for low-risk pregnancies (Johnson & Daviss, 2005; Schlenzka, 1999) coupled with "soft evidence" (Simonds & Rothman, 2007) that recognizes the emotional and spiritual empowerment that home birth can provide women, the U.S home birth rate lingers at only one percent (Johnson & Davis-Floyd, 2006). This is quite a dramatic shift from the beginning of the twentieth century when nearly all births were attended by a midwife and took place within a woman's home (Rooks, 1997; Donegan, 1984; Rothman, 1982; Wertz & Wertz, 1977).

Two main knowledge systems characterize birth in this country, the medical model and the midwifery model (Rothman 1982, 2007a, 2007b; Davis-Floyd 2003; Johnson & Davis-Floyd 2006). The biomedical model is defined by a belief in the supremacy of technology over nature and in medical supervision and intervention during pregnancy and delivery. Women and their bodies are constructed as defective and in need of the expertise and intervention extolled by medical practitioners and technology. In contrast, the midwifery model emphasizes birth as a natural, normal, albeit unpredictable process. The female body under this model is viewed as effective and capable of birth and birth is viewed as, not simply a physiological process, but one that

has the propensity to empower and transform the birthing woman. The medical model and the midwifery model tend to be theoretically isolated and exist as conflicting systems of knowledge. In the United States, the biomedical model of pregnancy and childbirth is dominant and tends to disregard and obscure the midwifery knowledge system, thus marginalizing and making alternatives to the hegemonic biomedical appear as invalid. Although any practitioner may subscribe to and practice according to the tenets of the midwifery model of care, in this dissertation I focus specifically on direct-entry midwives (DEMs) as practitioners of the midwifery model since DEMs practice exclusively in out-of-hospital settings.

There are two major classifications of midwives in the U.S.; certified nurse midwives (CNMs) and direct-entry midwives (DEMs). CNMs differ from DEMs in some important ways. First of all, CNMs are trained as nurses prior to becoming midwives. Most CNMs receive a Master's degree in midwifery and are trained in hospital-settings often working alongside obstetricians/gynecologists (OB/GYNs) and OB/GYN residents (Rooks, 1997; Davis-Floyd, 2006). In contrast, DEMs enter directly into the profession of midwifery without first becoming nurses. A variety of educational pathways characterizes the training of DEMs[1]. A second difference between the two major classifications of midwives is CNMs may practice legally in all fifty states. Many

[1] One of the central beliefs guiding the practice of direct-entry midwifery in the U.S. is that there are multiple routes to midwifery education.
See Midwives Alliance of North America (MANA) for a detailed discussion of the core competencies for basic midwifery practice (http://www.mana.org/manacore.html).
Also see the North American Registry of Midwives (NARM) for information on the educational requirements necessary for the Certified Professional Midwife (CPM) credential. NARM exists as the regulatory body for maintaining a process of evaluating multiple routes of midwifery education and provides the standardized examination leading to the CPM credential (http://www.narm.org/certification.htm)

CNMs enjoy hospital privileges, a small percentage attends home births[2], and some practice in hospitals and in hospital-affiliated birthing centers. Most CNMs have formal back-up relationships with OBs and easily interface with the obstetric community when their clients present with conditions or complications that necessitate medical expertise. For the most part, CNMs are well integrated into the medical community and are recognized as valid care providers by medical staff and the hospital institution. In comparison, DEMs are legally recognized in only twenty-six states. Despite the legal status and protection that some DEMs enjoy, DEMs do not have hospital privileges and most do not have formal physician back-up due to a combination of professional socialization and liability concerns. Interfacing with the medical community is more complicated for DEMs than for CNMs due to the way in which DEMs are marginalized from mainstream medicine, thus making inter-professional relationship building with the medical community more tenuous, and DEMs are not recognized as care providers within the context of the hospital institution. In this dissertation, I explore the way DEMs, as marginalized practitioners, interact with practitioners (OBs and Registered Nurses) of the dominant medical model.

The structure of U.S. health care positions DEMs and OBs as ideologically distinct and, as such, these two groups of practitioners rarely enter into dialogue with each other (Davis-Floyd, 2003; Johnson & Davis-Floyd, 2006). The one situation where practitioners of these two models are forced to come into contact is during home to

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[2] The proportion of CNMs who attend home births is around 5%.
According to Rooks (1997), CNMs inability to purchase sufficient liability insurance has had a deterring effect on CNMs attending home births.
See Rooks (1997) for a more detailed discussion of CNMs' scope of practice.
Also see Vedam et al. (2009) for a more detailed discussion of CNMs' attitudes towards and experiences with home birth.

hospital transports. The central question I investigate in this research is what happens when these two models interface? The definition of transport that will be used in this dissertation pertains to the event wherein an expectant mother had been receiving care from a direct-entry midwife and intended to have a home birth, but then, due to an unforeseen event or condition (prior to the onset of labor such as placental disorders) or after the onset of labor, is transported to the hospital. Therefore, the operating definition of transport will not only include transports that occur intrapartum (during labor and birth) or postpartum (within eight hours following birth), but will also include those women who were receiving prenatal care from a midwife up until the third trimester of pregnancy (28 weeks gestation) and planned a home birth but then sought out medical care feom an obstetrician due to a condition that required a different type of expertise than that held by a direct-entry midwife. Also, a situation is defined as a transport if a woman who gave birth at home or newborn that was born at home is transferred to the hospital during the post partum period. Therefore, the boundaries that encompass the working definition of transport for this dissertation begin at the onset of the third trimester of pregnancy (28 weeks) and extend to eight hours immediately following the birth or the post partum period.

In this dissertation, I examine the ways in which DEMs, who have no formal physician back-up or hospital privileges, interact with OBs and nurses during a situation when a mother who planned a home birth must now seek out medical care in a hospital facility in order to remedy a problem or complication that arises prior to the onset of labor, during labor, or the period immediately following birth. The interactions that occur between DEMs and medical staff during home to hospital transport range along a

continuum. At one end of the continuum, interactions have the capacity to reinforce the rift between DEMs and medical staff. The other end of the continuum consists of interactions that result in the establishment of collaborative relations between DEMs and medical staff blurring the divisions and ideological distinctions between the two models of care. I explore this continuum of possible interactions by analyzing mothers' transport stories and the experiences of transport as reported by DEMs, OBs, and nurses.

Currently, there is a limited amount of research that specifically examines the phenomenon of home-to-hospital transport for home births in the U.S. The U.S. maternity care system offers an interesting context for examining hospital transport for planned home births since direct-entry midwifery and home birth are not integrated into the broader medical system. It is this particular aspect of lack of integration of the two models that I explore in my examination of home-to-hospital transport. In comparison to other high-income nations[3], the U.S. health care system is unique in terms of its surmounting inequalities when it comes to accessing healthcare, the high degree of medicalization, and the significant influence of private insurance companies (DeVries, 2005; van Teijlingen et al, 2009; Wagner, 2006; Bone, 2009). Coupled with these important characteristics of the healthcare system, are ideological components, such as individualism and the ideology of neoliberalism that emphasize freedom from dependence on the state through the privatization of public services, including health care (Goode & Maskovsky, 2001). These ideologies strongly influence the way maternity care is structured in the U.S. (van Teijlingen et al, 2009).

[3] See Wagner (2006), de Jonge et al. (2009), Navarro & Young (2007), and van Teijlingen et al. (2009) for a discussion on the U.S. infant and maternal mortality rates in comparison to other high-income nations characterized by universal healthcare and where midwives are the primary care providers.
Currently, the U.S. ranks 32nd out of 33 for infant deaths and 41st in maternal deaths.

The scant literature which attempts to understand the phenomenon of transport tends to offer quantitative analyses of the frequency of transport among women who planned home births with a DEM, including the reasons that necessitated the transport (Johnson & Daviss, 2001, 2005). Although useful, these studies are not designed to elicit the nuances in transport experiences or capture the meanings that participants attribute to the experience. Some researchers have undertaken qualitative studies regarding home-to-hospital transport in the U.S. (Davis-Floyd, 2003; Johnson & Davis, 2006). These studies have focused on the transport experience from the midwives' or mothers' perspectives with relatively little attention given to the experience of transport from the vantage point of OBs or nurses. Davis-Floyd's (2003) examination of transport among direct-entry midwives in the U.S. and Mexico emphasizes the types of interactions that take place between DEMs and medical staff during a transport, exclusively from the DEMs' perspectives.

Davis-Floyd (2003) defines three types of articulations to illustrate how connections between the DEMs she interviewed and medical personnel were only partial or never actually made due to the dominance of biomedicine. Practitioners of biomedicine tend not to articulate with home birth midwives (DEMs), but, rather discredit and disregard its knowledge base in an attempt to maintain marginalization of midwifery. Davis-Floyd describes the encounters with medical personnel as narrated by DEMs as 1) *dis-articulations* which occur when "there is no correspondence of information or action between the midwife and the hospital staff"; 2) *fractured articulations* which describe incomplete and partial correspondence between the biomedical knowledge system and the midwifery knowledge system; and 3) *smooth*

articulations which are interactions between hospital personnel and midwives that are characterized by "mutual accommodation" wherein reconciliation between the two, often conflicting, knowledge systems occurs (2003: 3; Johnson & Davis 2006). In a later work, Johnson and Davis-Floyd (2006) examine the experience of transport primarily from the mothers' perspective, noting how the intersection of midwifery and medical models of care can occur in a way that appropriately addresses the interests and needs of those involved. The authors refer to these instances, characterized by collaboration between DEMs and OBs, as "mandorla transports."[4] Johnson and Davis-Floyd (2006) are particularly interested in what factors facilitate mandorla transports in those states where direct-entry midwifery is *illegal* or remains legislatively unsanctioned. It is their belief that in such contexts, "the individual actors must transcend the limits of their knowledge systems without benefit of structural guidelines" (472). Johnson and Davis-Floyd contend that the difficulty with transports and the precariousness of home-to-hospital transports in states where midwifery is illegal, or is not legislatively mandated, stem from the dearth of structural guidelines that govern the conduct of midwives and medical personnel during a transport. I return to the various types of transports as outlined by Davis-Floyd (2003) and Johnson and Davis-Floyd (2006) throughout this dissertation.

The legal status of direct-entry midwives in the U.S. varies by state, with twenty-six states offering regulatory protection for practicing DEMs (MANA, 2010). This dissertation explores transport in Oregon, a state whose laws surrounding midwifery are considered more progressive than other states (Boucher et al. 2009; MANA, 2010;

[4] According to Johnson and Davis-Floyd (2006), a transport mandorla occurs when practitioners of opposing knowledge systems engage in respectful dialogue and transcend their differences resulting in a merging of midwifery and medical models of care.

Cheyney, 2005). For instance, direct-entry midwifery and home birth are legal in Oregon and licensure is voluntary in the state meaning that an individual may self-identify as a DEM and legally practice. Midwives who pursue licensure must pass a national examination and meet additional state specific requirements. Both licensed and unlicensed DEMs in Oregon have protection under the law.

The interview data that I collected indicate that, even though Oregon has some of the most progressive laws surrounding midwifery and home birth in the country, the relations between DEMs and the medical community are not always characterized by "smooth articulations". My data reveal that even in a state where midwifery is legal and licensure is voluntary, structural guidelines surrounding conduct and practice for direct-entry midwives and medical personnel during a transport remain relatively absent for midwives, their clients, and medical staff when a transport takes place.

With the interaction that occurs during a home-to-hospital transport as the central focus, this study adds a new dimension to the analysis and understanding of transport by considering what factors influence how a care provider (DEM, OB, or nurse) views and behaves during transport situations. This study adds to existing literature on home-to-hospital transport through an analysis of mother's transport stories, including how mothers' transport experiences are impacted by the interaction among care providers of both models. I employ a theoretical framework (Hirschkorn & Bourgeault, 2008; Martin, 2005) to examine the way that structural forces influence a provider's response to and interaction during a transport. This approach allows for an understanding of the combined effect that individual provider attitudes and work-related obligations have on transport interactions.

Previous studies of transport have not given significant attention to the strategies that DEMs employ during a transport in order to ensure that their clients receive efficacious care in the hospital upon arrival (Davis-Floyd, 2003; Johnson & Davis-Floyd, 2006). This dissertation illustrates the ways that some DEMs play an active role in constructing the transport experience and strive to retain an element of power within the hospital so that they may continue providing care to their clients. Similarly, this dissertation reveals the way that some OBs utilize their discretionary power as medical professionals to collaborate with DEMs during transport situations. It must be noted that while some OBs were willing to collaborate with DEMs, others were not willing to expand their professional and work level obligations to support DEMs and their clients.

The experiences of care providers interviewed for this project demonstrate the ways that participating in a transport evokes strong emotions not only in birthing women, but also in those that provide their care. Analysis of interview data showed participants reported that emotion work (Hochschild, 1979, 1983) had both positive and negative effects and that the primary source of emotion work stemmed from the uncertainties that arise when the midwifery and medical models are forced to meet. I utilize the concept of emotion work/emotional labor to describe and explain the ways that transport necessitates the management of care providers' emotions and the emotions of mothers.

To summarize, in this dissertation, the phenomenon of hospital transport serves as the primary context for examining the interaction between DEMs and medical staff since it is uncommon in U.S. society for practitioners of the two models to interact in contexts outside of the transport moment. My data indicate that a consequence of the lack of integration between midwifery and medicine in the U.S. is a dearth of structural

guidelines governing and regulating conduct between DEMs and medical staff during transports. Therefore, I consider how smooth articulations and mandorla transports constitute relations that develop over time in micro level interactions with particular DEMs, OBs, and medical staff indicating that certain providers, at particular moments, are able to transcend the philosophical and ideological boundaries that divide home and hospital.

CHAPTER II

LITERATURE REVIEW

This study examines the interactions that take place among direct-entry midwives (DEMs), mothers, and medical staff during a home to hospital transport. Hospital transports for planned home births in the United States, occur in a climate that is characterized by a division between the midwifery and medical models of care. Due to this lack of integration between the two models of care, home to hospital transport may be fraught with tension in that when a home to hospital transport occurs, practitioners (DEMs) and consumers (mothers) of direct-entry midwifery and home birth are forced to interface and confront practitioners (obstetricians and nurses) of the medical model. It is the interaction which unfolds and takes place at the intersection of home and hospital that I seek to understand.

I operate from the assumption that when a lack of structural guidelines and institutional policies exist defining how practitioners of both models are expected to act, ambiguity exists for DEMs, mothers, and medical staff during a transport. In this chapter, I examine some of the relevant literature on midwifery, the professionalization of U.S. medicine, the models of care that characterize pregnancy and birth in the U.S., and home to hospital transport as a way to situate my research and analysis.

History of Midwifery in the United States

In this section, I outline the social history of midwifery and childbirth in the United States in order to provide an historical context for the current environment in which midwives practice. The history of midwifery in this country has implications for

the modern day practice of direct-entry midwifery in that many of the stereotypical images constructed by medical professionals and those in power that have plagued DEMs for generations still exist and are alive and well today. I include the history of midwifery in the U.S. as a way to understand the marginalization that the profession continues to experience in relation to the hegemonic position of biomedicine. Direct-entry midwifery's marginalized status has consequences for practitioners and consumers today including how DEMs and their clients are treated during a home to hospital transport. This dissertation considers the effect that longstanding stereotypes have on medical staff's perception of and treatment towards DEMs and their clients during a hospital transport.

Midwifery is the ancient practice of women assisting other women during pregnancy and childbirth. Midwives attended and assisted in the delivery of most babies in the United States until 1910 (Donegan, 1984; Leavitt, 1983; Sullivan & Wertz, 1988; Rooks, 1997). During the colonial period in the United States until close to the twentieth century childbirth was attended almost exclusively by women (Donegan, 1984; Leavitt, 1983; Rooks, 1997; Sullivan & Wertz, 1997; Wertz & Wertz, 1977). This was primarily due to the scant number of educated physicians settling in the colonies as most colonists were not members of the educated elite (Rooks, 1997). Within this particular context where a limited number of physicians practiced, midwives were actually quite valued (McCool & McCool, 1989). Most women gave birth at home with midwives, mothers, and friends present. The midwife's most important tasks were to lend emotional and spiritual support to the birthing woman and to assist her with household tasks as she entered into the mothering role. Colonial midwives were considered spiritual workers rather

than health care providers and worked under a system that did not provide consistent licensure nor were standardized training programs offered (Sullivan & Wertz, 1988; Rothman, 1982).

The knowledge and skills of individual midwives varied significantly. The majority of midwives acquired skills and training through apprenticing and observing more experienced midwives. Physicians rarely attended births unless midwives or families needed or requested their assistance. Davis-Floyd (2006) cites three factors that were responsible for the near eradication of midwifery in the U.S. healthcare system by the mid-twentieth century, "1) Physician resistance; 2) lack of professional organization by midwives, and 3) cultural influences on women's choices" (p. 32-33). I utilize her framework to discuss the history of midwifery in the United States.

Physician Resistance to the Practice of Midwifery

The emergence of obstetrics in the United States occurred in response to European medicine which at the time was considered superior to that found in the colonies (Sullivan & Wertz, 1988). These transformations were occurring within the context wherein rational thought permeated society and the "body as machine" metaphor came to dominate as males began to claim childbirth as their domain. In an attempt to compete with European medicine, America opened its first medical school in 1765. Those who attended the school were typically male and from upper class backgrounds. Upon attending school, students were exposed to more mechanistic views of medicine. Under this perspective the body takes on the Cartesian model of "body as machine" wherein there is a mind-body dualism. It was during this time that Dr. William Shippen Jr. offered the first formal instruction to midwives in the United States (Sullivan & Wertz, 1988; Rooks, 1997; Donegan, 1978). Most female midwives were not able to

access this training as many were constrained financially and were illiterate. Shippen and his students are among the ones who altered the way pregnancy and births were viewed in America. They are linked to ushering in a movement "to redefine childbirth as a pathological event requiring monitoring and intervention by medical men" (Sullivan &Wertz, 1988:3). Eventually, Shippen reserved his formal training for only men.

Beginning in the late nineteenth century, physicians who were adamant about taking control over maternity care in the U.S. initiated a campaign to eradicate the practice of midwifery. The medical takeover of pregnancy and childbirth was especially profound in the northeastern region of the U.S. where immigrant midwives attended the majority of births and, as such, they were viewed as posing the greatest threat to the physician monopoly on pregnancy and birth (Davis-Floyd, 2006). By 1935, only 12.5% of births in the U.S. were attended by midwives and 80% of all midwives were practicing and located in the rural south (Sullivan & Wertz, 1988; Rooks, 1997). The majority of upper and middle class women in the northern cities opted for male physicians during their pregnancies and births rather than midwives due to the way that male physicians became constructed as scientific professionals (Donegan, 1978; Sullivan & Wertz, 1988). Many women from middle and upper class backgrounds sought out the care of physicians not only in hopes of reducing the pain associated with birth, but also since ,the majority of physician's were male their gender and higher fees for services made them status symbols (Wertz, 1983; Leavitt, 1986). In contrast, midwives continued to provide care for those women who could not afford doctors' fees (Rooks, 1997). A common belief during this time, especially prominent in the south, was that midwives should be kept in practice even though their care was perceived as questionable and lacking scientific expertise so that poor whites and blacks and those in rural areas could receive services. Thus, it was acceptable for poor women,

especially women of color, to be under the care of a midwife, but such care was considered inappropriate for middle and upper class white women revealing the way that social class and race played a role in the transformation of maternity care in the U.S.

Ideological smear campaigns were employed by medical practitioners as a way to shake the public's perception of midwifery care and shift the public's view of pregnancy and birth as natural processes into dangerous complicated events that required trained medical experts. These campaigns involved the inaccurate portrayal of midwives invoking stereotypical images of midwives as illiterate, unskilled, dirty, uneducated, and irresponsible. Doctors, in an attempt to take control of birth, portrayed themselves as educated, clean, and responsible for safety in healthcare and contrasted their skills and medical philosophy of care with that of midwives (Davis-Floyd, 2006; Rooks, 1997; Rothman, 1982, 2007).

Socio-Cultural Influences on the Practice of Midwifery: Race, Class, and Gender

Gender biases during the nineteenth century contributed to the decline of midwifery. Women in general, including those who were practicing midwives, were socially constructed as inferior intellectually and this justified their exclusion from technical medical training and education. In addition, the construction of women and the practice of midwifery as overly emotional and thus lacking the rational perspective needed for attending birth was promulgated as a strategy to minimize consumer confidence in midwives' abilities. Thus, men were put in charge of women and their health during pregnancy and delivery including the authority to make medical decisions based on standardized medical training. Positioning men as authority figures in the birthplace had the combined effect of asserting the cultural domination of men along with the dominance of professional medicine in U.S. society (Starr, 1982; Wertz & Wertz, 1977; Wertz, 1982; Sullivan & Wertz, 1988; Rooks, 1997).

Another contributing factor to the near eradication of midwives in America had to do with the way in which many of the ethnic communities within which the midwives worked assimilated into the broader U.S. culture and adopted many of its values and practices, one of which was the emphasis and valuation of medical services for pregnant women. Therefore, midwives who had historically attended and provided services for poor, working class, immigrant, and African American women, were finding that by the mid-twentieth century, their services were no longer sought out or considered as valuable by the women in their communities who found new value and status in accessing medical practices and facilities that they had so long been excluded from (Fraser, 1998, 1995; Borst, 1998, 1989, 1995).

An examination of the history of childbirth and midwifery in the U.S. reveals how transformations in reproductive care involved not only the dominance of scientific medicine over midwifery, but also speaks of the way that race, class, and gender were, and still are, implicated in healthcare and in maternity care services. As previously mentioned, the initial takeover of pregnancy and birth was focused in the northern regions of the U.S, while public health officials in the south were determined to train female midwives since it would be difficult for primarily male physicians to provide care to all pregnant and birthing women. It was no accident that the southern U.S. was in large part ignored by physicians. The south in particular was a region where midwives provided services for working class, poor, immigrant, African American, and rural women. These women, who faced the structural barriers of race, class, and gender inequality, did not have access to the same resources that enabled middle class women to pay for physicians, and later obstetric-supervised, hospital-based births. Therefore, physicians intentionally sought out clientele who had the financial means to pay for their care.

Lack of Professional Organization by Midwives

Another explanation for the near demise of midwifery in the U.S. as compared to other industrialized nations is that unlike Europe, midwifery in the U.S. did not develop as a profession with formal education and licensure requirements (DeVries et al., 2001; Davis-Floyd, 2006). Midwives in America did not formulate professional organizations or develop educational standards stipulating the skill and knowledge requirements for practicing midwives. Attempts at establishing professional organizations and educational requirements were thwarted, in large part, during this time by language barriers among immigrant midwives and midwives' gender status in that women during the late nineteenth and early twentieth century were not typically given the opportunities to access venues that could elevate their political effectiveness when it came to advocating for the professionalization of the occupation (Davis-Floyd, 2006; Rooks, 1997).

The historical legacy of midwifery and efforts among DEMs to gain social legitimacy as care providers still carries over to today where the status of the practice of direct-entry midwifery remains ambiguous. When there is a lack of governmental regulation surrounding direct-entry midwifery education and licensing, it has the tendency to remain a marginalized profession and receive little visibility or legitimacy in comparison to the way that the obstetrics has professional level status and is a socially valued profession. In comparison, all states license obstetricians and certified nurse midwives (Boucher et al., 2009). Although the Midwives Alliance of North America (MANA) represents the professional organization for all practicing midwives in North America, currently only, twenty-six states provide licensure and/or certification for direct-entry midwives who primarily attend home births (MANA, 2010). I consider in this dissertation the effect that licensure and regulation has on the transport experience including the views that

medical staff form of DEMs and home birth. I argue that transport is an important context within which to view the ways in which interaction unfolds when practitioners of the more marginalized profession of midwifery are forced to confront practitioners of biomedicine. How does the marginalized status of DEM affect the views that medical staff holds towards home birth and midwifery? How does their status as marginalized practitioners affect the role that they play within the context or during a hospital transport? Does the marginalized status of DEMs vis-à-vis obstetricians within the hospital context affect the interaction between the two groups of practitioners and ultimately what effect does this interaction have on the mothers who sought out the care and services of DEMs?

Home Birth, Hospital Practices, and Consumer Social Movements

The medicalization of childbirth continued to increase during the first half of the twentieth century as midwives became replaced by physicians and birth was transferred from the home to hospital. In 1900, fewer than 5% of births took place in hospitals but by the middle of the twentieth century this figure grew to 88% (Devitt, 1977; Wertz & Wertz, 1977). The shift of birth from home to the hospital resulted in changes in the experience of childbirth. Within the hospital, women were confronted with a bureaucracy and no longer received individualized care that was characteristic of homebirth. Certain medical practices became standardized routines for labor and childbirth and included episiotomies, the lithotomy position, "Twilight Sleep" (a mix of morphine for pain relief and scopolamine which served as an amnesiac) The rountinization of childbirth was an attribute of hospital births and some women began to voice dissatisfaction with certain of these procedures such as being strapped to a delivery table, inductions, impersonal care, and isolation (Sullivan & Wertz, 1988). During the mid-1900's, women begin to question if all of the medical interventions during pregnancy and birth were really necessary and safe.

Women began to assert that they wanted to be "present" physically and emotionally without interventions during childbirth so that they could revel in the spirituality of the process (Sullivan &Wertz, 1988).

Based upon consumer resistance to overmedicalization of birth and the pressure of some women to find alternatives to obstetrical care various reforms took place. These reforms occurred within the context of other social structural changes such as the Civil Rights Movement, the Vietnam War, the Women's Movement, the holistic health movement, and the Women's Health Movement. New values and ideologies that threatened medical authority emerged from these movements (Rooks, 1997; Sullivan &Wertz, 1988). Feminists have radically critiqued medicalization and not only in the realm of pregnancy and childbirth. They have questioned and challenged how and why natural processes of menstruation, menopause, and aging become defined as dysfunctional and pathologized by the medical profession (Morgen, 2002; McCrea, 1983; Lorber, 1984). In some ways, women are socially controlled by medicalization. When certain female bodily functions are constructed as pathological, women may defer to male-dominated medical authority and their ability to assert their own views regarding care is constrained. Conrad (1992) found that medicalization impacts and affects some groups, such as women, more than others in society. The relationship between a woman and her doctor is often characterized by exploitation and inequality "an exaggeration of the power imbalance inherent in almost all male-female relationships in our society" (Boston Women's Health Collective 1984, p. 561-62; Morgen, 2002; Sullivan and Wertz, 1988). Feminists responded to these structural arrangements that impact everyday interaction in society through the creation of self-help feminist health centers

emphasizing education which involved “demystifying medical knowledge”, and re-centering the focus on prevention largely through self-education and self-care (Morgen, 2002; Sullivan & Wertz, 1988, p. 43).

The resurgence of home birth midwifery in the U.S. during the 1960’s and 1970’s emerged among primarily white, middle class, college educated women and this trend continues today (DeClercq et al., 2010, Boucher et al., 2009; Davis-Floyd, 2006; Rooks, 1997; Sullivan & Wertz, 1988.) Klassen (2001) contends that although the homebirth movement touts itself as being empowering and revolutionary it has been so for only a small group of mostly white women. Likewise, Cheyney (2005) asserts that “choice seems to be rooted in privilege and relative positions of power, and choice in care provider and place of birth is no exception” (p. 32). Michaelson (1988) correctly points to the fact that the movement towards more women-centered childbirth procedures was class and race specific. In particular, it tended to be white middle class women who were advocating for home births as the many books and articles published during the 1960’s and 1970’s that celebrated homebirth were directed towards audiences with a high standard of living. Therefore, Michaelson contends that natural childbirth in the United States has been more of a middle-class phenomenon and experience.

Heightened consumer criticism over the medical management of childbirth and the emergence of an alternative birth movement in the 1960’s and 1970’s coincided with the civil the women’s movement, the women’s health movement, and the civil rights movement. According to Davis-Floyd (2006) women who were planning births at home attended by a midwife during this era, came from a variety of cultural backgrounds, but their social class position tended to be middle class and as such, their class background

and the power that comes with occupying a middle or upper class position affords one the luxury to exercise choice:

> The home birth mother of the late 1960's and 1970's was as likely to be a childbirth educator or a conservative preacher's wife reacting against a negative hospital experience or a feminist seeking self-empowerment through birth or a hippie rejecting the hegemony of the medical establishment. Then, as now, she was likely to be middle class, which meant in part that she was used to exercising her right to choose (p. 39).

Fraser (1995) reminds us that "the model of birth as natural and elemental, with the unanesthetized, well-informed, woman choosing the site, conditions, and participants in the birthing experience, has emerged with the growth of a consumerist, choice-oriented social movement influenced in large part by middle-class (white) feminist theory and praxis" (55). Research like Fraser's (1995, 1998) and Nelson's (1986) cautions those of us studying childbirth in the U.S. and worldwide to avoid universalizing the "good" child birth experience. In other words, it is important not to apply white, middle-class ideals and desires surrounding childbirth to all women. Rather, it is important to keep in mind that child birth, like other social constructions, is experienced differently based upon one's social location.

Nelson (1986) conducted a study on middle class and working class women who chose to give birth in Vermont hospitals. Although her study examines the experience of hospital birth for women of varying social classes, its relevance to my study rests in the way that she illustrates how the expectations one has for the child birth experience are class contingent and culturally mediated. Among the women Nelson (1986) interviewed, "Middle class women wanted births in which they could actively participate while avoiding intervention; working class women wanted quick and easy births with as

much intervention as they perceived to be required to bring about this end" (p. 168). Therefore, social class plays a significant role in framing expectations and desires for the experience of birth. Women who chose to birth at home with a midwife are typically from middle class (or above) backgrounds and as such, their class position renders them more likely to assert their interests and desires when it comes to place of birth, birth attendant, and how they would like their birth to unfold. I argue that attending to the class background of the women who chose home birth is particularly important when examining the experience of hospital transport. For instance, are women who chose home birth more likely to resist and question medical interventions that have become part and parcel of the standard hospital-based birth in America? Studying transport allows for the development of an understanding of the ways that mostly middle class women negotiate and interact with medical personnel and/or their midwives during a home to hospital transport. I keep these ideas in mind throughout this dissertation noting that home births, and thus, home to hospital transports, are events primarily experienced by white, middle class women, and therefore, can tell us only about the birth experiences of a particular group of women.

The Political and Professional Context of Midwifery

Certified Nurse Midwives (CNMs)

In an attempt to combat many of the negative stereotypes associated with midwives during the early twentieth century, proponents of midwifery training came up with the idea of "nurse midwife" to serve as an alternative to more traditional midwives who did not receive formal education or training. According to Davis-Floyd (2006), "Their mechanism for the elevation of midwifery above this damning stereotype was the

union of midwifery with public health nursing" (p. 37). Nurse midwifery was first initiated in the U.S. in 1925, due to the efforts of Mary Breckenridge who studied midwifery and nursing and encouraged nurse-midwives to immigrate to the U.S. in order to demonstrate their competency and skills as practitioners. Breckenridge developed Frontier Nursing Services (FNS) in Kentucky where midwives rode horseback and provided maternity care services to nearby residents. FNS proved to be successful in reducing the high infant and maternal mortality rates that characterized the region prior to advent of midwifery services for women in the area (Rooks, 1997; Rothman, 1991, 1982; Wertz & Wertz, 1989, 1977).

The history of Certified Nurse Midwives differs from that of direct-entry midwives for several reasons. One reason is that nurse midwives were able to reject physicians' ideological assault on the practice of midwifery by becoming nurses and "serving populations (poor, black, inner city or rural) in dire need that physicians were not attending and did not wish to attend" (Davis-Floyd, 2006, p. 35). In addition, the nurse midwives, beginning with Mary Breckenridge, were able to illustrate that their services had a positive effect on infant and maternal mortality rates. The third way, in which the history of nurse midwives diverges from that of DEMs, is that from its inception, nurse midwifery enjoyed the availability of consultation and collaboration with physicians. In fact, Mary Breckenridge made the decision to appoint a physician to the position of medical director of FNS and this solidified the collaborative relations between CNMs and physicians that continues to exist today (Davis-Floyd, 2006). "Unlike nurse-midwifery, which arose from conscious efforts to develop a profession, lay midwifery was a grassroots movement." (Davis-Floyd, 2006, p. 40).

In comparison to DEMs, CNMs have historically been able to achieve greater success politically and professionally due to their medical-based training and close alignment with practicing physicians. The American College of Nurse Midwives (ACNM) was established in 1995 by a group of twenty CNMs (Rooks, 1997; Davis-Floyd, 2006). Since its inception, the ACNM has been successful in securing hospital privileges for CNMs, obtaining prescriptive authority for CNMs in various states, and defining and expanding CNMs scopes of practice. In the present day, CNMs are legally able to practice in all fifty U.S. states. There are over two hundred practicing CNMs in Oregon and those practicing in Oregon must complete a Master's degree certifying them to provide health care to women of all ages[5]. The scope of practice for CNMs in Oregon includes gynecological care, family planning, and maternity care services. In addition, CNMs possess prescriptive authority in Oregon.

Direct-entry Midwives

In 1982, a group of DEMs and CNMs joined together and formed the Midwives Alliance of North America (Rooks, 1997; Davis-Floyd, 2006). The practice of midwifery in Canada is unified with CNMs and DEMs practicing in both home and hospital settings. However, in the U.S. many DEMs resisted pursuing the education route of nurse midwifery that would enable them to have hospital privileges and perhaps elevate their professional status as practitioners among the medical community, because they did not believe that nursing should be a requirement to practice. In the minds of some DEMs, nurse midwifery represents the same medical management of pregnancy and birth as does the practice of obstetrics (Davis-Floyd, 1998; Davis-Floyd & Davis, 1997; Davis, 2001; DeVries et al., 2001). Therefore, part of the impetus behind the development of MANA was to establish a professional organization for all

[5] For more information on the education and regulation of practicing midwives in Oregon see http://oregonmidwives.org.

types of midwives and the recognition that there are multiple educational routes to the practice of midwifery. The Midwives Alliance of North America has been successful in achieving various political goals for practicing DEMs such as legalizing DEM in states where it was once prohibited, regulating the practice of DEM through increasing the availability of licensure and or certification in those places where DEM was unregulated, and securing insurance and Medicaid reimbursement in many states (Davis-Floyd, 2006).

The North American Registry of Midwives (NARM), the Midwives Education Accredidation Council (MEAC), and the Midwives Alliance of North America (MANA) joined together in 1986, to discuss the development of a national-level examination that would measure midwifery knowledge based on the MANA core competencies. During 1993-1995, five Certification Task Force (CFT) meetings were held and attended by CNMs and DEMs in an effort to formulate the certification process (Certified Professional Midwife) for DEMs. It was determined that the certification process would consist of two required components; education and certification. The education component involves documentation by a preceptor of clinical skills and a “Skills Assessment” administered by a trained “Qualified Educator.”[6] In terms of the certification component, an extensive written examination was developed and as of September 2006, 1,200 DEMs have received the CPM credential.

For many DEMs, the decision to pursue licensure and/or certification stems from the need to “commodify” their services in an effort to inform and thus attract more women to the care they provide (Davis-Floyd, 2006). The professionalization of DEM was also instigated by that reality many DEMs found themselves in, noting the inevitability that they would need to occasionally interface with practitioners of biomedicine. Hough (2006) found that among the

[6] To read more about the development of educational requirements for the CPM credential see www.narm.org/pdffiles/DevelopmentCPMProcess.pdf.

DEMs she interviewed and observed in Iowa who were in the process of pursuing licensure and legalization, in describing their identities they simultaneously upheld the spiritual elements of the midwifery model of care and expressed the importance of being recognized as credible practitioners. According to Hough (2006), "Recognizing the importance of demonstrating the safety and competence of midwifery care to their biomedical colleagues, they are also driven by their own passion for homebirth and by the desires of their clients for individualized and noninterventionist care at home" (p. 353). Davis Floyd et al. (2001) address the status of many contemporary DEMs, stating that the negotiation between tenets of the midwifery model and the medical model can be classified as "postmodern midwifery":

> The postmodern midwife knows the limitations and strengths of the biomedical system and of her own, and moves fluidly between them to serve the women she attends. She plays with the paradigms, working to ensure that her culture of midwifery is not subsumed by biomedicine. She is a shape-shifter, she knows how to subvert the medical system while appearing to comply with it, a bridge-builder, making alliances with biomedicine where possible, and a networker (p. 112).

This dissertation will build upon Davis-Floyd's conception of postmodern midwifery by considering the ways that DEMs interact with practitioners of biomedicine during a transport. I will address whether or not DEMs find it strategic to fluidly move between the two models of care during a transport in order to provide care to their clients. Likewise, I consider the impact that professionalization has on the treatment that DEMs and their clients receive during a transport. What strategies, if any, do DEMs employ in order to manage the impressions medical staff form of them and their clients? Does the professionalization of midwives and a willingness to incorporate elements of the medical model of care have an effect on mothers' transport experiences and the interaction between medical staff and DEMs? Foley and Faircloth (2003) touch upon the fluidity of modern midwives in their examination of the ways that CNMs and

DEMs employ medical discourse to legitimate their profession and this same discourse is used to contrast the woman-centered health care that they provide women. According to Foley and Faircloth (2003), the midwives they studied "blended" midwifery and medicine:

> Midwives must balance a world of medicine and a world of midwifery. At times they distance themselves from medicine, reifying the theoretical polarization of the two models. Yet, at other times, they draw on a discourse of medicine, medical culture or medical collaboration as a resource to legitmise their own work and occupational identities. They fluidly shift between the two as needed in the everyday pragmatics of midwifery (p. 182).

Models of Care

Rothman (1982) developed two models; the medical model and the midwifery model, in an effort to understand how childbirth is structured and experienced in U.S. society. She contends that it is important not to refer to these as paradigms since both obstetrics and midwifery are "applied, clinical practices" (Rothman, 2007, p. 6) and instead employs the concept "model of care". She defines model of care as "the underlying, sometimes unstated sets of assumptions practitioners make about the objects of their work" (p. 6). Rothman discusses two ideological underpinnings of the medical model: ideologies of technology and patriarchy. She argues that the medical model bases health and illness on the ideology of technology and patriarchy that stems from the work of Rene Descartes' mind body dualism wherein the body is viewed as a machine and the physician takes on the role of mechanic. Rothman (2007) suggests that patriarchy has sustained medicine as a male-dominated profession and even though more women are being trained as obstetricians, pregnancy and birth are still defined by medical men (p. 7). The medical model takes that male body as the norm, therefore, within the

context of the medical model the female body and physiological processes are defined as dysfunctional and in need of medical intervention.

The Professionalization of U.S. Medicine and the Rise of Obstetrics

As a way to understand the tenets of the medical model of care, it is useful to examine the professionalization of U.S. medicine since the profession of obstetrics rests upon many of the same scientific views of the human body and health that accompanied the transformation of U.S. medicine during the nineteenth century (Starr, 1982; Rothman, 1982, 2007; Davis-Floyd, 1987, 1992). I will explore the professional status of obstetricians in this dissertation examining if professional level obligations that accompany the fulfillment of OB/GYN's job duties haves an impact on their perception of, and their interaction with, DEMs during a home to hospital transport. I argue that the phenomenon of transport is well positioned to provide insight into the ways that practitioners' education, training, and socialization into their various professions affect or influence provider behaviors.

The dominant view of medicine in U.S. society is one that is rife with praise as medicine is heralded as groundbreaking science capable of improving human life. This represents the mainstream view of allopathic medicine in this country. The professionalization of medicine is often cited as the beginning of mainstream medicine's monopoly on health in the United States and as a time when new hierarchies of power and authority emerged (Starr, 1982). Paul Starr explores how medicine gained its dominance in U.S. society. He states that "The forces that transformed medicine into an authoritative profession involved both its internal development and broader changes in social and economic life" (p. 18). Starr points to ideological and cultural shifts arguing that as technological advances occurred in society and greater faith was put in

science, practitioners of science, including physicians, began to occupy a particularly powerful position.

During the nineteenth century nature became the focus as the source of illness rather than relying on magical or supernatural explanations. Navarro (1986) argues that the bourgeoisie used scientific medical knowledge to mask and mystify the deleterious effects of class inequality, "disease was not an outcome of specific power relations but rather a biological-individual phenomenon where the cause of disease was the immediately observable factor, the bacteria" (p. 160). Starr (1982) contends that the emergence of science when considering health shattered people's confidence in self-treatment and self-care of sickness. People came to lose faith in traditional health practitioners as physician authority went through a process of legitimation. Prevention and health became cast or constructed as something beyond the scope of the average individual's realm. Instead, it became infused with a sense of complexity and as something that only those with scientific training could accurately and adequately grasp. Scientific knowledge was embraced by medical physicians and their knowledge was used to convince the public that self or traditional forms of healing were ineffective and dangerous. It is within this context that pregnancy and childbirth came to be seen as complex requiring scientific knowledge and training that lay people, including midwives, did not possess. In 1910 the American Medical Association began a program of medical school accreditation to accompany licensure. This emphasis on standards gained the public's respect and support of physicians and facilitated the professional domination of healthcare in the United States. Part of this monopoly on American medicine involved the eradication of midwives.

The medical profession was solidified toward the end of the nineteenth century as practitioners became more cohesive in terms of their education, training, and practice and this

heightened cohesiveness bolstered their authority and power as professionals. Changes in ways of thinking and social life occurred during the end of the nineteenth century and such changes in consciousness opened up the space and acceptance of professional authority as dominant. Technological advances played a role in the acceptance of physicians and medicine as authoritative in society: "Bolstered by genuine advances in science and technology, the claims of the professionals to competent authority became more plausible, even when they were not yet objectively true; for science worked even greater changes on the imagination that it worked on the processes of disease" (Starr, 1982, p. 18). Physicians' status as authority figures became institutionalized through educational training at the end of the nineteenth century and this marks a transition away from *personal* authority that physicians once held. As physicians became trained through a standardized educational program and licensing their authority in American society became solidified: "The establishment of such a system reproduces authority from one generation to the next, and transmits it from the profession as a whole to all its individual members" (Starr, 1982, p. 19). No longer did physicians claim authority as individual practitioners, but now they constituted a community of professionals whose scientific training and licensure demonstrate their competence. In 1910, the American Medical Association began a program of medical school accreditation to accompany licensure. This emphasis on standards gained the public's respect and support of physicians and facilitated the professional domination of healthcare in the United States.

After the founding of the American Medical Association (AMA) in 1847 a special section on obstetrics was formed. Following this the American College of Obstetricians and Gynecologists emerged in 1888 (Leavitt, 1986; Rooks, 1997). In order to situate obstetrics as a valued profession, obstetrics had to debunk many of the practices undertaken by midwives and

reconstitute pregnancy and birth as conditions that necessitate medical attention and intervention. Even though the physiological processes of the body opening up for birth are painful, under the medical model, such pain became cast as something to avoid and manage with the assistance of medical staff rather than women relying on their own strength to transform pain into power. This still characterizes the medical model today and the medical model continues to dominate maternity care in the U.S. (Boucher et al., 2009; Rothman, 2007; Davis-Floyd, 1992; Wagner, 2006).

The Technocratic, Humanistic, and Holistic Paradigms

Davis-Floyd (2004, 2006) builds on, and expands Rothman's models of care. Davis-Floyd posits that there three paradigms of healthcare (technocratic, humanistic, and holistic) that significantly influence childbirth not only in the industrialized west but nowadays throughout the world. The technocratic model assumes that the body and mind are separate and views the human body as a machine in need of medical expertise and technological intervention. As in Rothman's medical model, the male body is viewed as the correctly functioning machine in technocratic health care. Technocratic physicians do not interact in a relational manner with their patients. Office visits are typically short for the woman under the care of a technocratic obstetrician and machines/technology often replace human contact and emotional support during labor and childbirth.

The humanistic model of health care seeks to reform the technocratic model by making it more humane. Davis-Floyd argues that since the humanistic model seeks to remedy some of the impersonalization and hierarchical character of the technocratic model and tends to be less subversive that the holistic model, "the humanistic paradigm has the most potential to open the technocratic system, from the inside, to the possibility

of widespread reform (2006, p. 6). Applying the humanistic model to childbirth allows for the recognition that the emotions of the laboring woman do indeed affect and influence the duration of labor. Under this model emotional support rather than technological intervention would be used deal with problems arising during childbirth. The humanistic physician treats the patient in a relational manner and there is an emphasis on connection between the patient, her family, and health care providers. Hodnet (2002) studied factors that impact women's childbirth experiences. She discovered that the attitudes and influences of a woman's caregivers during pregnancy and childbirth had more of an impact on maternal satisfaction than did pain relief and medical interventions. Such studies illustrate the significance of interactive and relational support between care providers and mothers.

In a recent work, Davis-Floyd et al. (2009) distinguish between *superficial humanism* and *deep humanism* cautioning us that characteristics of the humanistic paradigm have been and can be co-opted by the hegemonic technocratic model. For instance, superficial humanism involves making the birth environment more enjoyable and pleasant for the laboring woman. A woman may be treated kindly and kept comfortable by care providers but still is subject to unnecessary and invasive technologies such as electronic fetal monitoring and labor induction medications like pitocin. Deep humanism upholds and enacts techniques that acknowledge the emotional and physiological components of labor and birth. Facilitating deep humanism involves recognizing the way a woman's emotions affect and influence the labor process and encouraging the laboring woman to move about freely and in ways that the laboring woman feels are most effective.

Deviating significantly from the technocratic model stands the more marginalized holistic model. The holistic model emphasizes the importance of not only a mind-body connection but the spirit also must be incorporated into healing and care. Practitioners of the holistic model view the body as an energy field that interacts and is affected by other energy fields. Holistic physicians provide individualized care to their patients and in terms of labor and childbirth, the woman is encouraged to listen to her own body and move according to her needs and desires. This stands in contrast to the technocratic model that attempts to standardized labor by applying strict protocols to laboring women.

The biomedical model and the midwifery model rarely encounter one another but rather exist more as conflicting systems of knowledge. In the United States, the biomedical model of pregnancy and childbirth reigns dominant and tends to disregard and obscure the midwifery knowledge system, thus marginalizing and making alternatives to the hegemonic biomedical appear as invalid. Although both models do espouse and put into practice important knowledge regarding pregnancy and birth, the two knowledge systems rarely enter into dialogue with one another and therefore tend to remain ideologically isolated (Davis-Floyd, 2003; Johnson & Davis-Floyd, 2006).

In this dissertation, hospital transport is viewed as a situation where the midwifery model of care is forced to confront the medical model of are. As discussed in the introduction, transport has the potential to reveal the ways in which social institutions influence the relations between practitioners, including the way they view and behave towards home birth and DEMs. In this dissertation I seek to understand how the ideological isolation of the two models plays a role in the type of interaction that unfolds

between practitioners of the more marginalized midwifery model and the culturally ascendant medical model.

Relations between Direct-entry Midwives and Obstetricians

Currently in the United States, knowledge exchange across the medical and midwifery models continues to be limited. Practitioners tend to uphold and present childbirth options that are closely aligned with their own education, knowledge base, and experience (Davies et al., 1996; Lindgren et al., 2008; Cheyney, 2008; Reime et al., 2004; Vedam et al., 2009). Starr (1982) notes the privileged status that scientific knowledge has held since the middle of the twentieth century stating that at times the authority of medical professionals has been held in such high esteem that its authority "spills over its clinical boundaries into arenas of moral and political action for which medical judgment is only partially relevant" (p. 5). In so doing the medical profession has transformed its hegemonic position into "social privilege, economic power, and political influence" (Starr, 1982, p. 5). Due to the dominant position the medical model of pregnancy and birth occupies in U.S. society, a great deal of uncertainty exists among both medical practitioners and consumers regarding the education/training, licensing, and credentialing of midwives.

The medical community, along with the American College of Obstetrics and Gynecologists (ACOG), wield a significant amount of power in society and they assert that home birth is unsafe and do not recommend home birth as an option for any woman. Efforts at establishing a working relationship between midwives and doctors is typically thwarted by the American College of Obstetrics and Gynecologists who oppose home

birth or any practitioners of home birth. Recently, the American Medical Association (AMA) has joined forces in supporting ACOG's position on home birth. In 2008, the AMA passed a resolution stating that they are aligned with ACOG, arguing that midwives who work out of hospital are not deemed safe care providers. I argue that these professional organizations heavily influence medical practitioners' and the general public perceptions of DEMs and women who chose home birth and, therefore, in this dissertation, I keep in mind the ways in which the information that is disseminated by these groups has an impact on the transport experience for DEMs, mothers, and medical personnel.

Relations among direct-entry midwives and medical personnel, in particular OB/GYNs are often contentious despite the fact that they both are providing a service for similar events. Direct-entry midwives and OB/GYNs occupy different cultural and ideological spaces in our country. Simonds and Rothman (2007) contend that even though midwives and OB/GYNs perform a service around a similar event, the practice of their service is rooted in "radically opposed foundational ideologies" (p. 287). Beginning with the experience of hospital transport from the multiple vantage points of mother, midwife, or medical personnel, we can begin to uncover how this experience is embedded within and influenced by broader social forces. Simonds and Rothman (2007) illustrate the impact structural influences have on the relations between direct-entry midwives and certified nurse midwives:

> These are not just different occupational groups competing.   They are different worldviews, different value systems, despite their common source. And the difference is not necessarily between the types of midwives, but between the systems in which they operate. So while their attention may be drawn to each

> other and their fears may be for the damage each can do the other, it is the medical system that creates the conditions under which these conflicts arise (p. 291).

The experience of hospital transport and the relations between midwives and medical personnel are not simply one dimensional, but rather are the products of and part of the multilayered structural forces in which they are enmeshed. Therefore, I argue, that the interactions during a hospital transport can provide a window into the structural factors that influence care providers' behaviors.

Simonds' (2007) work is relevant to my research in that she interviewed OB/GYNs and labor and delivery nurses in order to understand their perceptions of home birth and direct-entry midwifery. Her study reveals the OB/GYNs' training and education influenced the views and perceptions that they formed of DEMs and home birth. According to Simonds, "these doctors equate home birth with the direst of consequences—life threatening situations for babies and mothers, and they equate hospital birth with safety for babies and mothers. They see midwives and women who attempt home birth as misguided…Even when doctors say that women have the 'right' to make this decision, closer attention reveals their frustration with what they see as insensibility." (p. 240). Simonds (2007) argues that the structure of the medical model positions practicing OBs to view non-hospital based births through the lens of risk: "Doctors' notion of risk inflates as a result of their interventive training and interventive experience as practitioners" (p. 241). In this dissertation I will explore the professional status of obstetricians in this dissertation exploring if professional level obligations that accompany the fulfillment of OB/GYNs' job duties, has an impact on their perception of, and their interaction with, DEMs during a home to hospital transport. In addition, I

examine midwives' perspectives of medical personnel and medical personnel's perspectives on midwives, noting the influence such perceptions have on the interaction between DEMs, OBs, and women during a transport.

Hospital Transport

Practicing midwives and proponents of home birth worldwide assert that one of the central keys to ensuring a safe home birth is the availability of hospital facilities when needed as well as proper care upon arrival (Fullerton, 2000; Davis-Floyd, 2003). Davis-Floyd et al. (2009) assert that there are indeed birth models that work for mothers and babies. Davis-Floyd et al. (2009) suggest that some characteristics of birth models that do not work are:

- Unnecessary iatrogenic physical, social, and emotional damage resulting from the overuse of drugs and technologies such as labor induction, oxytocin augmentation, electronic fetal monitoring, episiotomy, and cesarean section
- Disregard for the scientific evidence that does not support the routine use of such procedures
- Concomitant disregard for the scientific evidence that demonstrates better outcomes from humanistic, woman-centered, and physiological effective birth techniques such as labor companionship and upright positions for birth
- The technocratic and patriarchal ideology that assumes women's bodies are dysfunctional machines, and that birth is a problematic and risky process, justifying the overuse of technology in practitioners' minds
- Educational models and programs that socialize professional birth practitioners- physicians, midwives, and obstetrical nurses- into a technocratic approach to birth and allegiances to each other rather than to the women in their care
- Ineffective systems of home-to-hospital transport, and inadequate and often inhumane care upon arrival (p. 2-3).

In considering effective strategies and characteristics of safe home birth Davis-Floyd et al. (2009) argue that one of central factors necessary is the ability to transport to the hospital if the need arises *and* efficacious care upon arrival and throughout the duration of a mother's stay. Effective hospital transport is impeded in societies, like the

U.S., where biomedicine and home birth midwifery remain relegated in different cultural and social arenas and therefore practitioners tend to isolate themselves from one another (Davis-Floyd et al., 2009). This has the effect of making home-to-hospital transport an egregious situation for mother and the midwifery team who often encounter and must endure hospital protocols and staff that do not fully understand or value the midwifery model of care. Davis-Floyd et al. (2009) contend that one of the central problems associated with transports is that medical staff tends to disregard the knowledge a DEM has about her client:

> Birth models that don't work refuse to take the report of the transporting midwife into serious account, exclude her from staying with the mother, punish the mother either subtly or overtly for having attempted a home birth, and code any bad result of a transport as a "botched home birth" even when the problem that arose was exactly why the midwife transported and regardless of whether she gave good care.

Increased facilitation and collaboration of the transport process is a critical way that providers can improve maternal and infant outcomes. Institutionalized protocols have been developed and successfully utilized in places where home birth midwifery is legal and exists as a well integrated option into the health care system (de Jonge et al., 2009; Janssen et al., 2002; Davis-Floyd, 2003; Johnson & Davis-Floyd, 2006). The Netherlands, which has a home birth rate of 30%, requires that midwives complete a three year training program so that they are able to adequately assess and screen clients for high risk conditions that necessitate interfacing and referral to medical staff (de Jonge et al., 2009; Weigers et al., 1998). The social context, including the structure of the healthcare system, plays an important role in what maternity care options are valued and made available to consumers (DeVries, 1993, 2004; van Teijlindgen et al., 2009). Midwifery in the Netherlands is politically supported and government officials openly

recognize and support midwifery and home birth due to the positive benefits they provide mothers and babies. DeVries (2005) argues that the Dutch obstetric system is unique, in that, rather than viewing pregnancy and birth as medicalized events as in the U.S., the obstetric community in the Netherlands adheres to the normalcy of birth and asserts that low-risk births are best handled by midwives. Unlike the U.S., obstetrics in the Netherlands was slow to professionalize and once professionalization was achieved, the percentage of care providers trained as obstetricians remained quite low (DeVries, 2005). OBs in the Netherlands are required to be trained in skills needed for out-of-hospital births and they work alongside midwives in the hospital. Due to the integration of midwifery and medical models in the Netherlands, the structure of their health care system facilitates collaboration and communication between midwives and doctors.

In 2005, Johnson and Daviss published findings from a large prospective cohort study that examined the safety of home births in North America involving certified professional midwives. Even though the World Health Organization, the American Health Public Association, the American College of Nurse Midwives, as well as a handful of Canadian medical societies, have implemented policies that acknowledge the safety and efficacy of home birth, the biomedical stronghold- the American College of Obstetrics and Gynecologists- continues to oppose home birth. Noting these opposing, and often conflicting, views surrounding birth in the United States and Canada, Johnson and Daviss embarked on an exploration of the perinatal outcomes for planned home births with Certified Professional Midwifes (CPMs) in the year 2000. These results were then compared with the perinatal outcomes of all singleton births in hospital during 2000, as reported by the National Center of Health Statistics.

Part of Johnson and Daviss' data analysis focused on the rates and reasons for transport to the hospital during labor, after labor, and included in this analysis is neonatal mortality rates. According to Johnson and Daviss' findings, 12.1% of the 5418 women involved in the study transported to the hospital either during labor or after. This indicates that close to eighty-eight percent of women under the care of a certified professional midwife gave birth safely at home. The most common reasons for transport were pain relief, failure to progress in the first stage of labor, and maternal exhaustion. Of these 12.1% of women who transferred, the midwife viewed the transfer as urgent in only 3.4% of the cases of those who planned a home birth. The study also revealed that primiparous women (women who are giving birth for the first time) were more likely to be transported than multiparous women (women who have previously given birth to at least one child).

Sociological inquiry into the study of home birth midwifery, including hospital transport and the social impacts of this occurrence, has not been thoroughly explored. In this dissertation I draw on the various types of transport as developed by Davis-Floyd (2003) and Johnson and Davis-Floyd. Davis-Floyd (2003) and Johnson & Davis-Floyd (2006) provide a useful framework for understanding the interactions between medical personnel and midwives during a hospital transport. She analyzes interviews with American direct-entry midwives and traditional Mexican midwives focusing on the collision of ideology and power when the biomedical model and midwifery model encounter one another and how these collisions can have deleterious effects for both mother and baby.

In a later work Johnson and Davis-Floyd (2006) extend Davis-Floyd's (2003) earlier work on articulations between the medical model and midwifery model and focus specifically on those transport stories defined as "smooth articulations". Johnson and Davis-Floyd (2006) employ the conceptual tool of the *mandorla* to explore what they consider the more positive transport narratives. According to Johnson and Davis Floyd (2006) the mandorla is a symbol that captures the place where opposites can meet and honor one another. This intersection of opposite knowledge systems involves care providers that appropriately address the interests and needs of the other and has the potential to result in a successful reconciliation, which Johnson and Davis-Floyd (2006) argue, can have a positive impact on integrated maternity care in the U.S. Johnson Davis-Floyd and discovered that what the mandorla transport stories reveal "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 these stereotypes into systems of mutual understanding and trust" (p. 473). According to Johnson and Davis-Floyd, the narratives they analyzed illustrate the "potential for *flow,*" meaning that actors bring with them to the social scene prior knowledge and opinions and through a process of negotiating and navigating through differences, a shared meaning of the situation is achieved.

Johnson and Davis-Floyd have both conducted numerous in-depth interviews with midwives and their clients. Throughout the course of their research, they discovered that stories of transport illustrate "the continuum of possibilities" that occur when a marginalized system is forced to come into contact with a hegemonic system. The stories Johnson and Davis-Floyd focus on in their article are primarily those retold by mothers

who planned a home birth with a midwife but were transported to a hospital. One interview with a midwife and her experience of a mandorla transport is included to demonstrate the relations that can be forged between midwives practicing in a marginalized space and hospital staff who tend to occupy a more culturally dominant and normative position in regard to pregnancy and birth. The mothers' personal accounts are presented so as to gain a deeper understanding of what the transport experience means from the birthing woman's point of view. Transport stories, according to Davis-Floyd and Johnson (2006), allow one to uncover "the social processes through which adherents of a dominant knowledge system sometimes dismiss what adherents of a marginalized system have to say, and at other times honor and include them" (p. 475). Davis-Floyd and Johnson admit that they cannot be certain that what their participants retold was the truth but they took what was shared as noteworthy in that participants' rich narratives demonstrated the meaning women and midwives ascribe to the transport event and the retelling of such stories had the effect of bringing order and coherence to an unpredictable and highly emotional event.

In this study, I expand on Johnson and Davis-Floyd's work to include perspectives of medical personnel in my analysis of hospital transport. I stay attuned to whether or not the interactions between DEMs and medical staff interviewed are characterized by "mandorla"-like transports or resemble fractured articulations.

Johnson and Davis-Floyd reiterate the importance of alliance building and formation between midwives, consumers, and hospital staff in the United States and they assert that further mandorla transports in the United States can assist in strengthening connections between the midwifery and biomedical models. Davis-Floyd (2003)

employs the concept *seamless articulation* when referring to those countries, such as New Zealand and the Netherlands, that are characterized by a high home birth rate and "their midwives practice, and their health-care systems fully support, birth in all settings, creating ease of choice and continuity of care" (p. 502). Likewise in such regions characterized by seamless articulation, an acknowledgement of scientific evidence in conjunction with a strong alliance between home birth midwives and consumers has resulted in governmental support and legislation of home birth and the practice of midwifery.

Wagner (2006) also expresses the importance of providing evidence-based care for women during pregnancy and birth. He questions the efficacy of the U.S. maternity care system where trained surgical specialists- obstetricians- attend the majority of births. Wagner (2006) advocates "egalitarian consultation between midwives and obstetricians" and he references instances of transport in Denmark that exemplify the mutual respect that can occur between midwives and physicians thus instituting the best care for mother and baby (p. 204-205). Not only is communication between midwives and obstetricians important during a transport to the hospital, but Wagner asserts that egalitarian communication between midwives and doctors is important for home births as well since communication between the two practitioners can provide new insight and expertise. Also positive communication between midwives and physicians outside of the hospital has the effect of facilitating prompt transport to the hospital if conditions render it necessary. As Davis-Floyd (2003) discusses in her interviews with direct entry midwives in the United States and Mexico, a willingness to transport early was facilitated by good rapport and previous relations with hospital personnel.

Various organizations have cropped up in response to the overmedicalization of birth and are setting forth principles that center around restoring power to women in the birthplace. Wagner (2006) participated in the International Conference on Humanization of Birth in 2000, and one of the core principles approved by participants at the conference emphasizes the need for “midwives, nurses, and doctors all working together in harmony as equals” (p. 204). The study of hospital transport experiences could hopefully shed light on and serve as an entry point into establishing positive relations between practitioners of the midwifery model and those who are more closely aligned with the biomedical model.

To date, no study has directly examined the transport experience from the multiple perspectives of the home birth midwife, the mother, and the medical personnel who were present when the transport occurs. Davis-Floyd (2003) as well as Johnson and Davis-Floyd (2006) come closest to this type of inquiry. However, in both of their studies only midwives and some of the mothers who experienced a transport are interviewed. Cheyney’s (2005) research on a group of Midwestern midwives does document some transport experiences among women who planned home births. Among the doctors and midwives in the Midwest she interviewed, mutual respect and open communication were heightened as the groups continued to interact and work with one another revealing the possibility of collaboration among the practitioners. Cheyney (2005) notes that “A more comprehensive analysis of homebirth transports is necessary because the obstetricians who were interviewed for this study believe that most or all transports are what they call ‘train wreck’ births” (p. 309).

This study addresses the transport experience from multiple perspectives and sheds greater light on the impact the transport experience has on the mother, the home birth midwife and medical personnel. The study has the capacity to tell us more about the U.S. maternity care system, including ways to improve maternity care in this country.

Medical Sociology

The substantive field of medical sociology seeks to understand how health, medicine, and preventative care are social phenomena embedded within larger socio-structural forces such as the economy, politics, and technology (Brown, 1995; Conrad, 1992; McKinlay, 1997; Starr, 1982; Waitzkin, 1989). Mervyn Susser and colleagues (1985) assert that "Societies in part create the illnesses they experience and, further, they materially shape the way in which diseases are to be experienced" (p. 17). Therefore, the sociological examination of medicine and health must stay attuned to the context in which these phenomena take place. According to Lorber (1997), physical health is heavily influenced by sociological factors and what we experience as illness is actually a disturbance of our social lives. Thus, the perception that something is physically wrong and explanations for sickness are always experienced in a social context.

Patient-doctor encounters have been examined by sociologists revealing the power dynamics at play and indicating that the way a patient perceives him or herself and illness is strongly affected by the patient-doctor relationship (Arney 1982; Bird, Conrad, & Fremont, 2000; Starr, 1982; Waitzkin, 1989). Waitzkin (1989) employed the methodology of conversational analysis between medical professionals and patients to illustrate how medical discourse reinforces and perpetuates dominant U.S. values. One such example he found is that even thought the majority of medical issues stem from

social factors doctors tend to focus solely on individual solutions to illness and disease. Therefore, addressing structural or systemic forces becomes obscured by the doctor-patient interaction as the individual and his or her health is removed from the social conditions in which he or she is located.

An examination of power and dominant ideological systems is important in order to gain an accurate understanding of medicine in U.S. society. Theorist Paul Starr (1982) details the professionalization of biomedicine in the U.S. and asserts that "The development of medical care, like all other institutions, takes place within larger fields of power and social structure" (p. 8). Embarking on a study of hospital transport for planned home births illustrates how a very personal experience of childbirth is embedded and influenced by the political economy of healthcare in this country. My study considers how the current U.S. health care system, which is characterized by rising costs and neo-liberal practices that continue to prioritize private profit over providing quality care to citizens, has an impact on the way maternity care is structured. The dominance of the medical model of care resists efforts at integrating the midwifery-model of care into mainstream maternity care services. I consider the impact this has on practitioners of both models when they are forced to interact during a home-to-hospital transport.

Social researchers (Brown, 1995; Conrad, 1992) have argued that medical professionals' authority and knowledge are socially constructed phenomena. This has the effect of removing power from the individual patient and placing it in the hands of those practicing western biomedicine. Sociologists use the term *medicalization* to describe how certain everyday life events come to be defined as biomedical issues and fall under the purview and management of health care professionals (Lorber, 1997). Through the

process of medicalization differences in physiology become constructed as illnesses to be treated and cured by various examinations, technological interventions, and prescription medications. A consequence of medicalization is that the healthcare provider becomes positioned as the expert and patients will often defer to medical authority and what the patient knows about his or her body is typically not addressed or part of the treatment plan. This is indicative of how biomedicine often fails to take into account social context and claims to treat everyone the same regardless of one's position in the hierarchies of race, class, and gender.

Feminist theorists have questioned and challenged why natural processes of menstruation, pregnancy, childbirth, and menopause become defined as dysfunctional and pathologized by biomedicine (Morgen, 2002; Lorber, 1997). When certain biological functions are constructed as pathological, women may defer to male-dominated medical authority and their ability to assert their own views regarding care is constrained. Conrad (1992) found that medicalization impacts and affects some groups, such as women, more than others. In particular, the relationship between a woman and her doctor is often characterized by power imbalances that reflect enduring gender inequality in the broader society. Feminists have responded to these structural arrangements that impact everyday interaction in society through the creation of self-help feminists centers emphasizing education, "demystifying knowledge", and prevention (Morgen 2002; Sullivan & Wertz 1988: 43). It is within this context that sociological research theories about pregnancy and childbirth are situated.

A sociological approach to the study of pregnancy and birth allows us to see that "obstetrical knowledge, like all other knowledge, comes from *somewhere* it has a social,

historical, and political context. Medicine does not exist as "pure" of culture or free of ideology" (Rothman 2007a, p. 5). This is in contrast to the standard medical perspective that tends to view pregnancy and childbirth as individual-level processes that are susceptible to complications and therefore must be treated in the same way that a person who experiences illness is- monitored, diagnosed, and interventions are used when needed. Applying a gendered lens to pregnancy, as Lorber and Moore (2002) do to the study of health and illness, captures the way that the body is "*transformed through gendered social practices"*(p. 4). The natural processes of pregnancy and birth become construed as abnormal conditions in need of medical attention. In other words they become *medicalized* (Conrad & Schneider, 1997; Lorber & Moore, 2002) rendering pregnant women the passive recipients of medical doctors' advice and interventions. Goer (1995) and Davis-Floyd (1992) argue that pregnancy and childbirth take on the label "abnormal" because they are not processes or conditions experienced by men.

In sum, it is the sociological perspective that allows for an exploration of the power differentials that are at play in the larger society and how these are implicated in our daily lives, even during a physiological process such as birth. Even though birth is in part about the physical body and physiological processes between mother and fetus, it is at the same time a social experience and we continue to be embedded in systems of hierarchy and power even as we birth. This dissertation will add to the sociological literature on pregnancy and birth through an examination of the interactions that take place during a transport when the hegemonic medical model and the marginalized midwifery model are forced to interact, noting that this collision of models is a consequence of the structure of U.S. maternity care. As such, this dissertation considers maternity care and child birth to be social constructions.

CHAPTER III

METHODOLOGY

This dissertation is a qualitative, interview-based project that examines the experience of home to hospital transport from four different vantage points; mothers, direct-entry midwives, nurses, and obstetricians. I conducted forty-four in-depth interviews on individuals' experiences with hospital transport from mothers (n=14), one father, direct-entry midwives (n=13), nurses (n=8), and obstetricians (n=8). Data collection began in October 2008 and continued until January 2010. Qualitative methods were well-suited for this project since they aim to provide insight and understanding of how social actors make sense of their worlds (Berg, 2007; Creswell, 2007; Rubin & Rubin, 2005). Qualitative methods are particularly appropriate when attempting to uncover the meanings and perceptions that people ascribe to their experiences. Likewise, qualitative methods enable a researcher to gain rich detail about people's lives and experiences. Although some statistical data on the frequency of home to hospital transport does exist (Johnson & Daviss, 2001; 2005; de Jonge et al., 2009), this qualitative study adds an important piece by offering a detailed and complex understanding of transport from multiple vantage points.

Multiple data sources were included in this research as a means to increase the validity of my findings. Studying the phenomenon of hospital transport from the multiple perspectives of midwife, mother, and hospital personnel results in a more complex analysis of the phenomenon of transport (Rubin & Rubin, 2005). The experience of

hospital transport is multi-layered and in order to illustrate this complexity, I gathered data from those who support the midwifery model of care and those who hold a more critical perception of home birth and direct entry midwifery. Hearing stories from all sides introduced me to different points of view and ultimately these diverse responses helped construct a more complete picture of the interactions that take place during a home to hospital transport.

The interviews consisted of semi-structured, in-depth interviews conducted in participants' homes, places of work, and in my personal office. The interviews lasted from one to two and a half hours, were digitally recorded, and then transcribed shortly after each interview. In addition to interviews, I collected detailed field notes during and after each interview. Close attention was given to the setting in which the interview took place, the non-verbal communication and gestures made by the respondent, and any feelings and/or reflections that I experienced as a result of the interview. These extensive notes provided a rich source of detail and allowed me to truly situate and recall a respondent's facial expressions, emotions, and mannerisms during an interview.

Studying Home-to-Hospital Transport in Oregon

Oregon represents a unique context within which to study home-to-hospital transports for planned home births. Oregon is one of only twenty six states where direct-entry midwifery is legal and regulated through licensure, certification, registration, documentation, or permit (Midwives Alliance of North America, 2010) and Oregon and Utah are the only states in the U.S. where licensure is voluntary, meaning that unlicensed DEMs may practice legally. In Oregon, direct-entry midwives are licensed under the Oregon Health Licensing Agency (OHLA) and regulations governing the practice of

direct-entry midwifery in the state are found in Oregon Revised Statutes (ORS) 687.405-687.495 and 687.895.991. Also contained in Oregon Administrative Rule (OAR) chapter 332 is additional information pertaining to the regulation and practice of direct-entry midwifery in Oregon. Due to the legal and regulated status of direct-entry midwifery in Oregon, the state is considered to be one of the most progressive states in the country concerning the practice of DEM.

The community in Oregon where my research took place, has a relatively large number of practicing DEMs both licensed and unlicensed. Along with the large number of practicing DEMs, there are also a significant number of women and families who seek out the services of DEMs and plan home births. Recent studies illustrate that Oregon's home birth rate of 1.6% is above the national home birth average which hovers around one percent (MacDorman et al, 2010; Boucher et al, 2009). With these factors in mind, I argue that Oregon represents a unique context within which to study hospital transport and has the potential to illustrate a variety of interactions that unfold between DEMs, mothers, and medical personnel in a state characterized by progressive laws and considerable consumer demand for alternative birth services. Studying hospital transport in Oregon is useful since it provides insight into the ways in which midwifery and medicine interact within a state that has relatively liberal laws surrounding the practice of direct-entry midwifery and home birth. More specifically, focusing on a community in Oregon allows for an exploration as to whether or not DEMs and medical staff are more likely to collaborate and have interactions characterized by smooth articulations due to the legal status and state protection of direct-entry midwifery.

Study Samples and Data Sources

The Mothers

Women who planned a home birth with a midwife and were transported to the hospital constitute one of the four sample groups in this study. Fourteen mothers were interviewed; one father who was present during his son's transport is also included in this sample (See Table 3.1). The father was present during the interview with his wife and he offered his perspective on certain aspects of the transport. In total, fourteen women who transported participated in my study and one father who experienced a transport participated as well. It was not my intention to include fathers or other support people who were present during the transport in this study, but in the course of interviewing one woman, her husband happened to be present caring for their six month old son and throughout the interview he interjected his views and/or perspective of the event. I did consider this father's interview data in my analysis since he provided another important layer in understanding the transport experience. After hearing this dad's perspective on transport, it became clear to me that subsequent research on transport should include the perspectives of fathers or other support people who are present as they provide valuable insight on the transport experience. Arguably, the physiological, emotional, and social conditions of the mothers may have, at times, impacted their recollection of the particulars of the transport experience and therefore, having another perspective, such as fathers or other support people, may be quite useful in understanding the experience.

Various attempts were made to recruit mothers who transported into my study. I sent recruitment email letters to several list serves, posted flyers at public places that people with young children frequent (schools, libraries, children's toy and clothing

stores), and beginning in May 2009, offered $20 compensation. Several reasons may explain my initial difficulties in recruiting women who planned to birth at home but transported such as; the sensitive nature of the topic and, the inability of a woman

Table 3.1. Demographics of Women Who Transported

Variable	Percentage of Total Sample of Women who were Transported
Race/Ethnicity	White = 100%
Education	Some college = 14.3% Bachelor's degree* = 71.4% Master's degree = 14.3%
Reason for Transport	Prolonged labor = 57.4% Breech = 7.1% Twins = 7.1% Preeclampsia = 7.1% Toxemia = 7.1% Fetal heart condition = 7.1% Newborn respiratory stress = 7.1%
Type of Birth	Vaginal = 57% Cesarean section = 43%
Parity Status	Primiparous = 92.9% Mulitparous = 7.1%

This data reflects the women's statuses at the time of transport. *Indicates women who either held or were pursuing a Master's degree at the time of the interview.

to schedule an interview due to child care demands, and also the low percentage of home to hospital transports that actually occur.

The majority of midwives I interviewed suggested that their transport rate lingers between three and eight percent of all births each year. Considering that the home birth rate in the U.S. has hovered around 1% for several decades now, with some areas of the country reporting significantly higher rates of home birth, such as the west coast and southwest where rates of planned home births reach 6% (Klassen, 2001; Boucher et al. 2009), the numbers of women who plan a home birth and transport are also low.

Therefore, part of the difficulty I found in locating women stemmed from the fact that the majority of planned home births are typically successful and do not result in a transport to the hospital (Johnson & Daviss, 2001, 2005).

The primary way in which women who transported were recruited into this study was through snowball sampling. Snowball sampling is particularly suited for projects whose participants are difficult to locate (Berg, 2007; Rubin & Rubin, 2005). The most useful way to invite women into my study came through friends and/or acquaintances who knew women that had transported. Several friends/acquaintances referred me to women who had transported and passed along my recruitment letters and/or emails to potential participants. After interviewing DEMs, I would ask them if they were willing to pass out recruitment letters with details about the study and my contact information to former or current clients who had experienced a transport. Women who transported were also asked if they knew of anyone who may be interested in participating in my study. Due to the personal and private nature of birth and transport, finding women who transported was made easier by having others refer me to potential women who might be interested in participating. Individuals whom I have known vouched for my character and ensured participants I would guarantee their protection as they shared their transport stories.

Researchers have grappled with the difficulty of constructing a clear picture of the demographics of women who plan home births with DEMs in the United States due to the illegality of home birth in some states and, even in states where home birth is legal, birth certificates may be structured such that they do not provide categories that would capture intended place of birth and/or actual place of birth (MacDorman et al., 2010;

DeClercq et al., 1995, 2001, 2010; Klassen, 2001; Cheyney, 2005). More recent studies have identified some common characteristics of women who plan a home birth with a DEM. For example, Johnson and Daviss (2005) found in their study of planned home births with a Certified Professional Midwife (CPM) that the women were on average older, white, had more education, and were of lower socioeconomic status than women having full gestation low risk hospital births. DeClercq et al. (2010) most recent study examines the characteristics of women in nineteen U.S. states who planned a home birth versus those who had an unplanned home birth[7]. Among those who planned a home birth, mothers were overwhelmingly white (90%), over thirty years old, born in the U.S., have some college education, married, and gestational age is at least thirty-seven weeks at the time of birth.

These findings parallel the demographics of the women I interviewed for this study. Twelve of the fourteen women held a bachelor's degree or higher and, all were white. The women's ages ranged from twenty-five to thirty-seven years old at the time of their transport, with a mean age of 30.25 years at the time of transport. All but one of the women in my sample were partnered or married. Research (Johnson & Daviss, 2001, 2005) demonstrates that transport to the hospital for a planned home birth is more common among primaparous women (women who have not been pregnant before). All but two of the fourteen women interviewed were pregnant for the first time and the two that had previously been pregnant cited dissatisfaction with prior hospital experiences as a primary reason for choosing home birth.

[7] During 2003, standard birth certificate information in the U.S. was revised to include a category designed to distinguish between planned and unplanned home births. As of 2006, nineteen U.S. states had adopted the new revisions. DeClercq et al. (2010) analyzed 2006 birth certificate data from those nineteen states that differentiate between planned and unplanned home births.

According to DeClercq et al. (2010), white women were overrepresented among those who had planned home births. The study conducted by DeClercq et al. (2009) points out that only 5.6% of Hispanic women had planned home births. Such evidence points to the racial and class discrepancy among planned home births reaffirming the trend in which planned home births with an experienced direct-entry midwife still remains a primarily white, middle class phenomenon. In terms of the racial/ethnic composition of my participants, it is not surprising that all of the women were white Euro-Americans since Oregon is a predominantly white state. However, studies already mentioned have revealed that most women who birth at home with a DEM are white regardless of the racial/ethnic composition of the state in which they live. More research focusing on the motivations and experiences of non-white women who choose and those who resist home birth is needed to further understand and address such glaring discrepancies.

Due to the initial difficulty of recruiting women who transported into my study, I chose to include women who did not officially transport, but rather their care was transferred from a DEM to a practicing obstetrician prior to the onset of labor. Three women who fit into this category were included in the study. One woman was diagnosed with toxemia three weeks prior to her due date and based on the advice from her midwife and the OB her DEM consulted with, made the decision to be induced at the hospital. After having an ultrasound conducted, a mother and father discovered that their son had fluid surrounding his heart. The OB who performed the ultrasound stated that they could still attempt a home birth, but there was a potential risk of the baby experiencing distress during the labor and birth process. Therefore, the mother and father made the decision to

go to the hospital and the mother was induced. The third woman in this study who "transferred" care rather than transported, had a condition known as preeclampsia[8] which required a transfer to the hospital due to the potential risks to mother and baby. Although these women did not experience the type of transport that I originally set out to study, their experiences are important to include because each of the women's DEMs accompanied them to the hospital and were present with them during the majority of their hospital stay. In this way, their experiences had the potential to elucidate the character of the interaction between DEMs and medical staff. Due to these factors, I do not necessarily differentiate, in this study, between women who transferred and women who transported since both instances still involve DEMs and their clients interfacing with medical personnel within the context of the hospital. Even though the women who transferred had prior contact with an OB prior to arriving at the hospital, once at the hospital, these three women were still considered to be "undoctored" patients and within the hospital context their DEMs were no longer consider valid practitioners. It is this particular context and the type of interaction that takes place among providers and mothers within the hospital context that I am interested in studying.

The conditions that prompted transport in the other eleven women included prolonged labor (n=6), breech presentation (n=1), twins (n=2), umbilical cord issues (n=1), and newborn respiratory problems (n=1). Ten of the women I interviewed transported to the hospital once labor had begun, but prior to birth. One woman transported after giving birth at home when her midwife determined approximately one

[8] Preeclampsia is a condition in which hypertension arises in pregnancy accompanied by excess levels of protein in the urine. Pregnant women presenting with preeclampsia are typically required to induce labor or deliver via cesarean section so as to avoid potential complications to both the mother and baby.

hour after the birth, that the newborn was experiencing respiratory difficulties. Overall, the reasons for transport as cited by the women interviewed indicate that the majority of transports were due to prolonged labor (n=6) which was often accompanied by fetal distress in the form of heart decelerations. Therefore, my results parallel national studies that indicate the primary reasons for a home to hospital transport are due to non-emergent factors (Johnson & Daviss, 2001; 2005; Johnson and Davis-Floyd, 2006).

The Midwives

There are two main types of midwives that practice in the United States today; Certified Nurse Midwives (CNMs) and Direct-entry Midwives (DEMs). Certified Nurse Midwives (CNMs) first become Registered Nurses (R.N.) and then obtain additional training in midwifery according to standards set forth by the American College of Nurse Midwives (ACNM). CNMs are required to hold at least a baccalaureate degree; however the majority of practicing CNMs today hold Master's degrees (Rooks, 1997; ACNM, 2009). CNMs complete their training primarily in hospital settings and most go on to practice within a hospital setting. Some CNMs practice in birth centers that are affiliated with a hospital and a small percentage of CNMs attend home births. In order to practice within a hospital or in a birth center affiliated with a hospital, CNMs must have physician back-up and/or coverage and therefore, CNMs often collaborate with physicians throughout a client's pregnancy, especially if a client is categorized as high risk. Currently, CNMs legally practice in all fifty states.

DEMs are midwives who enter directly into the profession without first pursuing a nursing degree; this is similar to the model of midwifery practiced in Europe where

individuals become midwives without first becoming a nurse. Unlike CNMs, DEMs in the U.S. primarily attend births at home and some also attend births in freestanding birth centers[9]. I chose to focus on the transport experience for planned home births with a DEM due to the way that DEMs' relationships with the medical community tend to be more ambiguous than the already relatively established relationships between CNMs and medical professionals. In particular, I wanted to capture what the interaction is like between DEMs and medical staff when a woman must transport to the hospital. Most practicing DEMs do not have an existing professional relationship with medical staff and therefore, I am interested in uncovering how interaction unfolds between these two groups during a transport. DEMs typically do not have the luxury of prior professional relationships with medical staff that most CNMs are mandated to have in order to practice within hospital settings.

There are two basic categories of DEMs: 1) traditional or unlicensed DEMs; and 2) Certified Professional Midwives (CPM) or Licensed Direct-entry Midwives (LDM). Traditional or unlicensed DEMs refer to midwives who have completed training through community-based programs, apprenticeship, and/or more formal organizational training programs, but then make the decision not to pursue licensure and/or certification. Oregon and Utah are the only states where unlicensed DEMs are legally able to practice. Certified Professional Midwives (CPMs) or Licensed Direct-entry Midwives (LDMs) are direct-entry midwives who have completed both a didactic and apprenticeship component and make the decision to take a national examination in order to become credentialed

[9] A freestanding birth center is a non-hospital affiliated birth center. Care is provided to low-risk women in a home-like atmosphere devoid of medical interventions such as; induction and augmentation of labor with oxytocin, narcotics, electronic fetal monitoring, epidural anesthesia, and operative delivery.

and/or licensed. Licensure and/or certification requirements for DEMs are state-specific and currently, twenty-six states offer licensing and/or certification for DEMs (See Table 3.2). Unlicensed midwives can be just as educated and trained as licensed midwives. But, licensed midwives are required to meet state-specific requirements and often these requirements include passing a national examination (MANA, 2010).

Table 3.2. State-by-State Direct-entry Midwifery Legal Status and Licensure/Certification

Legal by Licensure (L), Certification (C), Registration (R), or Permit (P)	Legal by Judicial Interpretation or Statutory Inference	Not legally Defined, but Not Prohibited	Statute, but Licensure Unavailable	Prohibited By Statute, Judicial Interpretation, or Stricture of Practice
AK , AR , AZ , CA , CO , DE , FL , ID , LA , MN ,MT , NH ,NJ , NM ,NY , OR *,RI , SC ,TN , TX ,UT *, VT ,VA, WA ,WI , WY	KS, MA, ME, MI, MO, MS, NV, ND, OK	CT, NE, OH, WV	GA, HI	AL, DC, IA, IL, IN, KY, MD, NC, PA, SD

Source: Midwives Alliance of North America (MANA, 2010), *Voluntary Licensure

The routes to education vary for DEMs and include apprenticeship-based training; formal educational programs, and community-based training. Often, DEMs complete a combination of the above mentioned educational paths. The Midwives' Alliance of North America (MANA) was developed in 1982 and is a professional organization for all midwives (DEMs and CNMs). The organization recognizes that there are multiple educational routes to the practice of midwifery including different styles of practice. A

central goal of MANA is to unify the midwifery profession which in turn will expand birth options for women (www.mana.org). Beginning in 1983, MANA was in the initial stages of implementing national certification for direct-entry midwives or midwives who do not first complete nursing training:

> The main goal of a certification program is to establish entry-level knowledge, skills, and abilities necessary to practice competently with respect to public safety. A Certified Professional Midwife's (CPM) entry level competency is established through a prequalification mechanism requiring education and experience that assures minimal competency for public safety of midwives who practice "The Midwives Model of Care"predominately in out-of-hospital settings (www.narm.org)

In 1992, the North American Registry of Midwives was established as the credentialing agency for the Certified Professional Midwife (CPM) credential. According to NARM, a CPM is: "a knowledgeable, skilled, and professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and is qualified to provide the Midwifery Model of Care. The CPM is the only international credential that requires knowledge about and experience in out-of-hospital settings" (www.narm.org). Part of the impetus for the CPM credential came from outside criticism DEMs incurred for their lack of educational requirements and the inability to ensure competency among those practicing direct-entry midwifery. Some MANA members echoed these same concerns and dropped the label "lay" midwife which to them had connotations that those practicing midwifery were not skilled or educated. Lay midwifery was replaced with the label "direct-entry midwifery" to signify that they entered directly into the practice of midwifery without first becoming nurses. "Their [DEMs'] transformation during the

1990's from lay to direct-entry midwifery was paralleled by their increasing desire for a professional credential that would validate their knowledge of midwifery and help them interface with the medical system" (Davis-Floyd 2006, p. 3).

The regulation of DEMs in the United States varies state by state. (See Table 3.2) As of May 2010, the practice of direct-entry midwifery is legal and licensure is offered in twenty-six states (www.mana.org). Oregon and Utah represent the only states in the U.S. where licensure is voluntary meaning that an individual may legally practice midwifery without going through the licensing process. Of the twenty-six states that offer licensure, twenty-four require the CPM credential, including Oregon, as a prerequisite to state licensure and/or have state specific requirements for licensure, certification, documentation, and registration. In two (New York and Rhode Island) of the twenty-six states where midwifery is legal and licensure available, Certified Midwives (CM)[10] are the only direct-entry midwives permitted to practice.

The Oregon Health Licensing Agency (OHLA) Board of Direct-entry Midwifery sets the standards of practice and acts as the disciplinary body for licensed DEMs in Oregon. According to Oregon Administrative Rule 687.420, in order to meet the standards of licensure in the state of Oregon, licensed direct-entry midwives must have a written plan for emergency transport (See Appendix A for a sample transport form used by DEMs). Licensed direct-entry midwives (LDM) in Oregon must provide each client with a copy of the emergency transport form and have the client sign the form after receiving information about transport. In addition, the North American Registry of

[10] Certified Midwife (CM) is a midwife who has met certification requirements set forth by the American College of Nurse Midwives (ACNM) without first becoming a nurse. In certain states, the CM is the only type of direct-entry midwife that is legally recognized and permitted to practice.

Midwives (NARM), the certifying agency for the Certified Professional Midwife (CPM) credential, also requires that CPMs have a written plan for emergency transport. Even though unlicensed DEMs are not required by law to have a written plan for emergency transport, all of the unlicensed DEMs interviewed stated that they do discuss the possibility of transport with their clients often during the initial prenatal visit.

For the purposes of this study, I interviewed thirteen direct-entry midwives (DEMs), which represent approximately 70% of all practicing DEMs in the community where my research took place. After receiving IRB approval, I sent local direct-entry midwives recruitment letters explaining the study along with my contact information. I obtained contact information for direct-entry midwives by consulting websites and the local phone book. Several midwives responded to my letter either by telephoning me or sending an email at which time an interview was scheduled. Most interviews with midwives took place in their homes. Two midwives came to my home with their children. The relaxed atmosphere at either respondent's homes or in my home made for an open disclosure of details and emotions regarding midwifery care, transport, and healthcare in general. Children of midwives were present at many of the interviews and rather than serving as a distraction, their presence seamlessly wove into our conversations about labor, birth, and transport.

At the time of the interviews, six of the thirteen DEMs identified themselves as unlicensed DEMs. Three of the six unlicensed DEMs were in the process of pursuing licensure at the time of the interview and expressed that they would complete the requirements for the CPM credential and licensing requirements for the state of Oregon

within the next six months to one year. The other three unlicensed DEMs stated that they have consciously chosen not to pursue licensure or credentialing due to the way that state regulations for licensed DEMs may have a constraining influence on their practices. One DEM classified her decision not to become licensed as a political move to resist the push towards mandatory licensure for all DEMs in Oregon.

Among the seven DEMs who were licensed and had obtained the CPM credential at the time of the interview, most stated that their primary reason for pursuing licensure was to be able to bill third party insurance companies for their services, including clients who were covered by the Oregon Health Plan (OHP) the state subsidized health care program for low-income individuals. In fact, among the licensed DEMs interviewed, one third to one half of their clientele were OHP recipients and the DEMs expressed the importance of being able to serve women who traditionally may not possess the resources that would enable them to seek out the services of a DEM or plan a home birth.

In considering the demographics of the DEMs interviewed, all but one of the thirteen DEMs was white (See Table 3.3). Again, the large number of white respondents is characteristic of the overall racial composition in the state of Oregon. According to the U.S. Census Bureau[11], in 2008 90.1% of Oregon's residents were white, 11% were of Hispanic or Latino origin, 3.6% were Asian, 2% were black, and 1.4% was Native American. This study reveals that those who seek out the care of DEMs and those who become DEMs tend to be white women.

[11] See http://quickfacts.census/gov/qfd.states/41000html. for more information on the racial composition of Oregon and other U.S. states.

DEMs generously offered their time and openly shared both the challenges they have encountered as a result of transporting and interfacing with medical personnel, as well as the success stories wherein collaboration between medical staff and DEMs resulted in better care for their clients. Most of the DEMs I interviewed had children of their own and were partnered; some held jobs in addition to midwifery as a way to make ends meet. Overall, the DEMs I interviewed conveyed a tremendous sense of tenacity and a unrelenting commitment to serving women throughout the course of their pregnancies and births whether that birth took place at home which was characterized as the "ideal" or the "icing on the cake," or at the hospital, which, in some cases, could be just as rewarding not only for the DEMs, but the mothers as well, and pointed to the importance of being flexible to the unpredictability of the birth process. Three of the DEMs had completed some or all of the requirements for a nursing degree and two of these DEMs commented on the way that they found such background medical training to be useful to their midwifery practice. The ages of the DEMs at the time of the interviews ranged from thirty to sixty years old. Likewise, the amount of time that the DEMs have been practicing varied as well, with some having had their own practice for less than one year to others having been practicing for thirty years.

Table 3.3. Demographic Variables of Direct-entry Midwives

Demographic Variables	Percentage of Total DEM Sample
Sex	Female = 100% Male = 0%
Race/Ethnicity	White = 99% Hispanic = 1%
Years of Experience as a DEM	4 years or less = 15% 5-9 years = 23% 10 years or more = 62%
Licensure/Certification Status	Not licensed = 23% In progress* = 23% Licensed/Certified = 54%

*Indicates DEMs who were pursuing licensure at the time of the interview or who expressed that they would complete the requirements for LDM and the CPM within the next year.

Nurses

A total of eight nurses were interviewed; one was a retired labor and delivery nurse and the remaining seven worked in the labor and delivery unit of a local hospital (See Table 3.4). The bureaucratic structure of the hospital proved to be somewhat challenging in initiating contact with nurses. Before I could officially recruit nurses working at local hospitals into my study, it was necessary to contact the local hospitals' administrative boards in order to gain approval to distribute my recruitment flyers to hospital employees. I was only successful at gaining entrée to one of the local hospitals' (Parker Hospital) labor and delivery unit. The other hospital's IRB board did not approve my research project and therefore, would not allow me to post recruitment flyers in the labor and delivery unit. Interestingly, Parker Hospital was labeled by the nurses who work there, many of the midwives I interviewed, and some of the mothers who transported as the "home birth and midwife friendly hospital". Therefore, access to this

particular site and group of nurses may in part have been due to the overall political climate of that hospital in relation to my research topic.

Table 3.4. Demographic Variables of Nurses

Demographic Variable	Percentage of Total Sample of Nurses
Sex	Female = 100%
Race/ethnicity	White = 100%
Years of Practice	10 years or less* = 25% 11-15 years* = 25% 16-20 years* = 25% 21 or more years* = 25%

*These numbers represent the number of years interviewees have practiced nursing in the Oregon community where the research took place. It must be noted that some nurses included here have indeed practiced nursing in other locations for more years than is represented in the above table.

After receiving approval from an administrator at Parker Hospital, I contacted the coordinator of the labor and delivery unit, and met with her to discuss my project. I supplied the coordinator with recruitment letters which she distributed to all of the nurses (R.N.) and certified nurse assistants (C.N.A.) that work in labor/delivery, post-partum care, and the nursery. Approximately forty nurses work in the labor and delivery unit at Parker Hospital and seven nurses responded to my letter and participated in interviews. Of the seven nurses at Parker Hospital who were interviewed, six worked as Registered Nurses (R.N.s) and one woman identified herself as an “OB tech” (a Certified Nurse Assistant position with additional training in obstetrics). Labor and delivery nurses spend significant amounts of time with a woman and her family during and after birth (Simonds, 2007). Within the organizational context of the hospital, labor and delivery nurses provide much of the professional care to laboring and birthing women and, according to Debra Bone (2009), “are the most common attendants of women in labour”

with approximately 99% of labor and delivery nurses being women (p. 60). The labor and delivery nurses I interviewed provided unique insight into the transport experience. Although the nurses who volunteered to participate in my study tended to be those who are more likely to provide emotional support to patients (both women who plan a hospital birth and women who transport) and all critiqued the contemporary practices of hospital birth that rely on the use of interventions and technologies "that have displaced the emotional labour of supporting a woman during natural birth" (Bone, 2009, p. 56), their vantage point offers a perception of the ways that the changing organizational context of the hospital over time has resulted in a concomitant change in their job duties as nurses. As will be discussed in Chapters V, VI, and Vll, most of the nurses interviewed expressed satisfaction when working with transport patients since they found that with this group of women, who typically declined interventions and technologies during labor and birth, the nurses were able to tend more emotionally to these patients and establish meaningful connections with them during their birth experiences.

All eight of the nurses interviewed were white women and this reflects the high proportion of whites living in Oregon as well as the gendered nature of nursing work (Smith, 1988, 1991; Simonds, 2007). The ages of the nurses in this study ranged from thirty years old to sixty years old. The duration of employment for the nurses I interviewed ranged as well, with some women practicing as a labor and delivery nurse in the Oregon community for three years while others reported practicing for thirty years. Those who had been practicing for more than ten years at Parker Hospital commented on how their "senior" status positioned them differently than those nurses who had only

experienced nursing within the hospital context of high technological management of labor and birth.

Obstetricians

Obstetricians constitute a relatively under-examined perspective in terms of hospital transport for intended home births (Johnson & Davis-Floyd, 2006; Davis-Floyd, 2003; Johnson & Daviss, 2001, 2005). I sought out obstetricians since limited information was known about their perceptions of home birth and midwifery and scant attention has been given to their interpretations and perspectives of the home to hospital transports that they have been a part of.

I began locating participants for this group by contacting local obstetricians. Recruitment letters were sent beginning in September 2008 to all practicing OB/GYNs in the Oregon community where my study took place. Slowly emails and phone calls trickled in expressing interest in participating. Two OBs were located through personal contacts. After I would interview an OB/GYN, I would ask him or her if any of his or her colleagues would like to participate. I found this snowball method to be particularly helpful as respondents would pass on the word to their co-workers about the study.

Eight obstetricians participated in the study although I sent over thirty recruitment letters to local OB/GYNs (See Table 3.5). If I did not hear from an OB/GYN within two weeks after sending the initial recruitment letter, a follow-up letter was sent reminding them of the project. One significant source of the low response rate among this group may be the tremendous work schedules that most OB/GYNs must keep. Finding time to sit down for an hour long interview can be challenging and for some impractical. Likewise it is possible that the research topic was responsible for deterring some

OB/GYNs from participating. Relations among home birth midwives and obstetricians are sometimes contentious and discussing sensitive or emotionally laden experiences such as transport may have contributed to the low number of OB/GYNs in this study. I would also argue that OBs position as professionals in U.S. society may render them less likely to participate in a graduate student's research project.

Table 3.5. Demographic Variables of Obstetricians

Demographic Variables	Percentage of Total OB Sample
Sex	Female = 63% Male = 38%
Race/Ethnicity	White = 100% Non-white = 0%
Number of Years Practicing in Oregon	5 years or less = 62.5% 6-10 years = 12.5% 11 years or more = 25%

Some researchers have discussed the challenges associated with studying those who occupy powerful social positions such as obstetricians (Simonds, 2007; Cheyney, 2005; Nader, 1972). At the same time, many of these researchers cite the importance of embarking on empirical studies that document the experiences and views of those in power as a way to uncover the unequal distribution of power in society and the characteristics of those who wield significant amounts of power.

Anthropologist Laura Nader (1972) argues for "studying up" as a way to elucidate the social processes and power relations that maintain inequality in society. Nader, as have subsequent social scientists (Sprague, 2006; Fine, 1994), argue for the inclusion of the elite or those occupying powerful positions in society as way to compensate for a tendency, among researchers, to study those that are most impacted or oppressed by social structures and conditions. They advocate for simultaneously supplementing our

understanding of the relatively powerless with an understanding of the powerful, including how existing social structures work primarily toward their interest and benefit. Sprague's (2005) advice for feminist social researchers reminds us of the importance of shifting our focus to include an examination of those in power:

> No doubt questions about social problems are usually posed by scholars who feel sympathy for the plight of those who suffer from them. Without parallel concentration of research focusing on the problematic character of elites and the social institutions bolstering their privilege, the focus on what's wrong with disadvantaged people creates a picture in which those on the downside of hierarchies have, *and thus are,* problems (11).

I argue this is important to consider when studying transport in that the perspective of biomedicine tends to be the dominant voice in constructing views of and understandings of pregnancy and birth. In considering transport, it is especially important to include the perspectives of medical professionals as a way to illustrate how the professional status of obstetrics positions OBs as powerful actors who are influential in forming opinions surrounding home birth, midwives, and transport.

The OBs interviewed for this study were all white Euro-Americans; and five were women and three were men. The gender dynamics of OB/GYNs in my sample reflected the overall gender composition of all practicing OBs in the community where my research was conducted in that more female OB/GYNs were in practice than male OB/GYNs. In the Oregon community where my research took place, 60% of practicing OBs are women, while 40% are men. This parallels recent findings regarding the characteristics of medical school residents who specialize in OB/GYN. In 2001, 71.8% of medical residents specializing in OB/GYN were female (W.H. Pearse, 2001, ACOG, 2001). Researchers (Johnson et al., 2005) argue that by 2014, more practicing OB/GYNs will be female rather than male. Despite the increasing number of women

entering the field of obstetrics and the predicted outlook which suggests that women OB/GYNs will outnumber male OB/GYNs in the next four years, male OB/GYNs still tend to occupy those positions most associated with influential policy-formation and administrative power (Simonds, 2007; Wagner, 2006; Lorber, 1984, 1993). In my study, I also discovered through interviews with OBs, nurses, and DEMs, that male OBs tended to possess a greater degree of and perhaps more freely utilized their discretionary power than did their female colleagues. For example, one of the male OB/GYNs interviewed holds a powerful administrative position at a local hospital and plays an influential role in shaping hospital policy.

The OBs in this study ranged in age from thirty-eight to fifty six years old. Some had been practicing in the area just over one year at the time of the interview, while others have been practicing in Oregon for over fifteen years. A limitation of this sample is that only three OBs interviewed had been working in the area for three years or more. The other five OBs interviewed had been in practice for three years or less. Therefore, it is likely that this sample does not adequately capture the experiences of OBs who have worked in the area for longer periods of time. Also, those OBs who have been in practice for longer periods of time have had greater exposure to DEMs and hospital transports than their colleagues who have only recently begun practicing and this may have an impact on their overall view of direct-entry midwifery and their experiences with hospital transport.

I sat with OBs at their kitchen tables and with some in their offices and I thank them for generously volunteering their limited time to share with me their thoughts on midwifery, home birth, and their experiences with hospital transport. Their stories at

times revealed the tension doctors experience between meeting their professional obligations and their personal attitudes and ideas about what constitutes appropriate care for mothers and their babies. One OB lamented the way that U.S. society and the culture of biomedicine and the practice of obstetrics has “lost the sacredness of birth”. Some reflected on the way that their medical school training and other professional level and work level obligations influence how they view pregnancy, home birth, and transport. The interviews with OBs revealed that woven into their discussions of transport, midwifery, and home birth, were elements of their training and socialization into the practice of biomedicine. And for some more than others, it was challenging to leave behind the biomedical knowledge that frames their perceptions of home birth, midwifery, and transport.

Confidentiality Concerns

I have given each person who participated in the study, a pseudonym and attempted to leave out as much identifying information regarding individual participants as possible. Due to confidentiality concerns, I made the decision not to give participants pseudonyms, but, rather these groups are referred to as mothers, DEMs, nurses, or OBs respectively. This was done as a way to protect participants’ identities which may be revealed in individualizing their transport stories. Therefore, I found the strategy of not assigning names to be useful in helping to maintain participants’ anonymity. DEMs present a particular concern for confidentiality. The direct-entry midwives I interviewed constitute a relatively close-knit community in the Oregon area where my research was conducted. All of the DEMs know one another and many have worked with one another in some capacity in the past. Many of the DEMs I interviewed gather together for peer

review four or more times each year, attend midwifery conferences together, and often gather in more informal settings where experiences such as transporting clients to the hospital are shared and discussed. Even though I have made efforts to protect their confidentiality, the confidentiality of mothers who transported, and the confidentiality of medical staff, it is still possible that if DEMs in Oregon were to read this dissertation they may be able to identity individual respondents. DEMs may be identifiable to each other and to others who read this dissertation, including those who participated in this study.

Data Collection and Analysis

Qualitative interviewing is beneficial in that it positions the researcher to learn how individuals make sense of their experiences and the meanings that they attribute to such experiences, thus giving those who have experienced a transport a voice (Berg, 2007). Each interview schedule designed for the four groups of participants was semi-structured which allowed for an intended focus, but with the flexibility to pursue topics or lines of questioning that emerged throughout the course of the interview. I prepared questions to be included in each interview schedule in advance and the majority of the questions were open-ended granting participants the freedom to answer questions in their own words and to explain their view in as great of detail as they wished. Questions were formulated based upon the existing literature on home to hospital transports, including the interactions that take place between DEMs and medical staff, the lack of information regarding the perspective of medical personnel, along with my theoretical interests associated with the topic (See Appendix B for a complete list of interview questions).

Data analysis was inductive and I approached inquiry into the phenomenon of hospital transport by carefully paying attention to patterns and themes that emerged from

the interview data. Following a grounded theory approach to data collection and analysis (Charmaz 2006, Glaser, 1978; Glaser & Strauss, 1967), the two processes of data collection and analysis occurred in relation to one another. I follow the approach advocated by Charmaz (1995, 2000, 2006:10) and others (Guba & Lincoln, 1994; Schwandt, 1994) which suggests that theoretical frameworks used to situate and contextualize qualitative data, "offers an *interpretive* portrayal of the studied world, not an exact picture of it." (p. 19).

Interview data were transcribed and once data were coded they were analyzed using both computer software and coding and analysis was also done by hand. All of the interview transcripts were kept in computer files that were easily and quickly retrieved and organized based upon the coded categories and themes that emerged out of my data. Utilizing the qualitative software NVivo8, allowed me to import interview transcripts and organize data by themes. Coding the data by hand proved to be useful in that with qualitative analysis the emphasis is not necessarily on frequency with which a code or theme appears, "but the strength of the evidence on which those themes and concepts depend and on the importance of the concepts and themes in building theory" (Rubin & Rubin, 2005:243-244).

I began data analysis through a careful examination of interview transcripts looking for emergent themes which were then coded. Following a grounded theory approach (Charmaz, 2006), during initial coding I remained open to any theoretical possibilities that emerged from my data. As a result of comparing interview transcripts, I began to see certain patterns emerge, such as the importance of medical malpractice insurance among the OBs interviewed. Some beginning questions that guided me

through the initial coding process are put forth by Charmaz (2006), Glaser (1978), and Glaser and Strauss (1967). They encourage the researcher to ask:

* "What is this data a study of ?" (Glaser, 1978, p. 57; Glaser & Strauss, 1967).
* "What does the data suggest? Pronounce? From whose point of view?" (Charmaz, 2006, p. 47).
*"What theoretical category does this specific datum dictate?" (Glaser, 1978).

The type of coding I began with was *line-by-line* coding wherein each line of the interview transcripts was named (Glaser, 1978; Charmax, 2006). Line-by-line coding was done by hand and although this process was at times tedious, careful examination of each line alerted me to emerging themes in my data. In addition, initially coding all of the data by hand through line-by-line coding allowed me to better retain the context of interviewees' responses. According to Charmaz (2006), line-by-line coding is particularly effective when one has collected data "about fundamental empirical problems or processes" (p. 50). Since I studied the complex and emotionally-laden experience of hospital transport, conducting line-by-line coding illuminated important meanings and perspectives on the event.

After developing several strong analytical themes, such as medical education, the threat of litigation, and managing emotions, through my initial line-by-line coding, I began the process of focused coding whereby larger chunks of data were explained. The process of focused coding involves applying the most significant codes used in the initial coding phase to large amounts of my data as a way to ascertain the efficacy of those initial codes (Charmaz, 2006). During this stage of coding, large segments of data were organized in computer files according to corresponding codes. For example, the code 'the ways transport(s) changed views of medicine' included all interviews where respondents mentioned that the experience of transport had altered their views regarding

some aspect of medicine or practitioners in the medical community. This process allowed me to analyze data across the interviews, comparing responses and perspectives on similar experiences.

Once relationships between categories began to emerge in my data through focused coding, I began to write analytical notes or memos. Memos were hand written enabling me to quickly jot down ideas and also entered into computer files which allowed for easy storage, organization, and retrieval of data when needed. During the memo-writing phase, I began analyzing data and codes by writing about the connections I was noticing across the interview data, such as the way DEMs used strategies to prepare their clients for transport. Through writing memos, I expanded my thoughts that were developed in the code formation phase and begin to anchor what participants said in a more sophisticated analysis. For instance, a theme I found was that OBs expressed fears of litigation when taking on a transport patient. I then connected this fear or belief to the legal institution and structure of health care in this country. Through this process, I connected the particular experiences and perceptions of participants to broader social structures as a way to elucidate the complexity of the phenomenon including how social and economic forces influence providers' views and behaviors.

Overall, the computerized coding of data saved considerable amounts of time and provided organization of key themes and concepts, while coding by hand allowed me to better retain the context of interviewees' responses along with identifying emerging concepts and themes. I began the construction of an explanatory framework based upon careful analysis of the qualitative data I collected in an effort to offer new insights and extend, and/or challenge existing ideas regarding hospital transport.

<u>Researcher Positionality and Subjectivity</u>

My personal subjectivity as a woman who has been a consumer of a DEM-attended home births and having personally experienced a hospital transport positioned me as sharing some common experiences with the women I was interviewing. My role as researcher fused with my identity as a woman who has experienced a home to hospital transport, and as a mother who has given birth. In many ways, the identities that participants and I shared facilitated greater rapport and a sense of connection between the women interviewed and myself. These shared experiences and/or identities opened up a space where the women interviewed perhaps felt more comfortable divulging personal information about their transport experiences with someone who had also experienced a similar event. Birth and the experience of hospital transport are not common topics examined by social science research from the perspective of mothers. DeVault (1999) argues that, "a feminist sociology must open up standard topics from the discipline, building more from what we share with respondents as women than from disciplinary categories that we bring to research encounters" (p. 65).

Despite the commonalities I shared with many of the women I interviewed, as a researcher, I still wielded a significant amount of power in the context of the research. Reflexivity on the part of the researcher is important to consider and keep in mind throughout the entire research process. Doing so can alert us to the ways that as researchers we occupy particular social locations within the hierarchies of class, race, and gender and our particular position influences the questions we pose, the methodologies we employ to answer our questions, and the way that our analyses unfold.

Therefore, I made a concerted effort not to let my own personal transport experience serve as a lens through which I understood the transport stories that participants were telling me. In other words, I attempted to reserve my experience as a way to establish connection and a sense of commonality with women that, at times, entailed sharing information about my experiences throughout interviews when appropriate or when prompted by a question regarding my personal experiences from women during the course of an interview. However, I avoided using my personal transport experience as a reference point from which to understand the experiences that participants shared so as not to use my experience, imbued by my own social location as a point of comparison to those of my participants.

My role of insider/outsider shifted throughout the research depending upon the research setting and the participants I was interacting with. For instance, due to having had prior contact with several of the DEMs interviewed, I considered myself an insider with this group. Insider status has various benefits among which are the ease of rapport. However, one negative aspect of being an insider is the issue of participants expecting that they will receive immediate benefits from my research. Also, many of the participants in this study are somewhat invested in the research topic and are perhaps hopeful that findings from the project will benefit the practice of about midwifery in society. Sprague (2005) comments on this issue stating that "The more the researched is invested in the research topic and thus motivated to participate in a study, the more relative power the researcher has" (p. 58). Even though some of the medical staff I interviewed may possess more social power than I do as a researcher, they too are vulnerable in that they may be disclosing information regarding their colleagues or other

medical practitioners that could potentially jeopardize or be damaging to their status and prestige among those they work with and interact with as professionals on a daily basis.

In- depth interviews have the potential to be tools of empowerment especially when interviewing those who come from underprivileged backgrounds or from marginalized spaces in society. Direct-entry midwives represent one such group and it is my hope that this research will allow their voice to be heard. They are so often silenced as alternative care providers and their experiences, perceptions of, and insights on pregnancy, childbirth, and hospital transport typically remained marginalized in U.S. healthcare policy and the broader society. In-depth interviews allow multiple voices to be heard. I make every attempt in data collection, analysis, and dissemination of findings to give credence and equal attention to all of the groups I interviewed. This is done recognizing that some interview respondents occupy relatively powerful positions in U.S. society. Even though obstetricians possess more social power in relation to most direct-entry midwives, nurses and mothers, I still give their experiences and perceptions of transport a voice in this research. This is done despite the fact that it is all too often the authoritative voice of the medical model including ACOG, that determines and in large part shapes the way maternity care is structured in this country. In other words, I carefully give voice to those obstetricians I interviewed because their story is an important piece in the transport puzzle, but yet I am cognizant and cautious not to let hegemonic discourses and ideologies stemming from the medical community override and again silence the experiences and realities of midwives and women who seek out their care. Giving voice to the so-called key players involved in hospital transport alerts one to the ridges that still need to be smoothed and ways that transport can be improved

and in some instances transformed so that home to hospital transport is not a dreaded outcome for the midwife, mother and her family, and medical personnel. It is my goal that this research will lend new insight into the ways that the home hospital divide can be transcended and ultimately lead to collaborative care among midwives and medical personnel resulting in better outcomes for mothers and their babies.

CHAPTER IV

TRANSPORT STORIES: LISTENING TO THE WOMEN

Introduction

This study is about hospital transport for intended home births. Transport stories are examined and analyzed as a way to gain insight into the interaction that takes place when a woman who planned a home birth with a DEM must transport to the hospital and interface with medical staff. In this chapter, I provide examples of transport stories from my research as a way to elucidate the complex interactions, meanings, and feelings that emerge during a home-to-hospital transport. This chapter will focus exclusively on the transport experiences of the mothers or women who were transported. The particular stories I present in this chapter are told by women who planned to birth at home with a midwife, but were then transported to the hospital. I argue that it is important to highlight the transport experience from the perspective of women since they have experienced a transport firsthand and in the retelling of their experiences, insights are gained into what the interaction between DEMs and medical staff is like from the women's point of view. DEMs', doctors', and nurses' perspectives are important pieces for understanding the transport puzzle as well; therefore, their experiences will be addressed in Chapters V and VI. Here, I will however, briefly identify the qualities that *all* participants suggested constitute positive transport experiences and those identified by participants that represent negative transport experiences in an effort to give context to the accounts of interactions that are retold by the women.

Women's experiences with transport indicate a wellspring of emotions that emerge as women must cope not only physiologically with the processes of labor and birth, but also socially as they and their care providers must shift from the "with woman" context of home to the institutional context of the hospital. Although I give individual attention to women's transport stories, examining the details of how women explain the interaction between their midwives and the medical personnel, and the effect that interaction had on their experiences, the interactions are also constituent of a broader discussion about the dominance of biomedicine over midwifery, the influential impact organizational and professional level factors have on practitioners' behavior, and the emotional labor (Hochschild, 1983) involved when practitioners engage in boundary work during a transport. This chapter documents some of the ways that these broader structural forces play out in women's transport experiences and affect whether or not a woman defines her transport, and ultimately, her birth experience as positive or negative.

In this chapter, I examine transport experiences borrowing Davis-Floyd's (2003) typologies of transport as smooth articulations, fractured articulations, or disarticulations. Women's transport stories reveal the way that interaction between DEMs and medical staff occurs "along a spectrum of possibilities from dis[articulation]-to smooth articulation" (Davis-Floyd, 2003, p. 1913).

The Process of Home-to-Hospital Transport

So what exactly happens when a home to hospital transport becomes necessary? Although formal protocols for home to hospital transport are not in place, based upon the data generated from interviews with OBs, DEMs, nurses, and women who were

transported, when a transport does become necessary, the following events typically unfold :

1) A direct-entry midwife calls the charge nurse on the labor and delivery unit and informs them that a client is being transported to the hospital.
2) The charge nurse phones or pages the doctor who is on-call during that shift.
3) The doctor on call is given information regarding the status of the transport patient.
4) The midwife, sometimes an assistant(s), the mother, family, and sometimes friends arrive at the hospital, the mother is checked in, and receives her room.
5) The doctor evaluates the mother and/or baby and assesses the next steps.
6) In some cases, the doctor receives information from the midwife and/or her assistant(s) regarding the pregnancy and/or labor up until arrival at the hospital. Often midwives provide medical staff with charts, records, and other forms of pertinent documentation such as ultrasound and lab results to the doctor and nurse who are present
7) The doctor makes his or her recommendations for the mother and/or baby.

Types of Transports

Following Davis-Floyd's conceptual framework, I organize the women's transport experiences according to whether they represent disarticulations, fractured articulations, or smooth articulations. An important finding from my research is that all women who transported reported that their experiences contained both positive and negative elements. For instance, one woman was transferred to the hospital and induced upon learning that she had toxemia. According to this woman, the interaction between

her DEM and the medical staff was respectful, and her DEM was present during most of her stay at the hospital. In this woman's view, the respectful dialogue between her DEM and the medical staff facilitated a smooth transition from planning a home birth to having to birth in the hospital. Although, in reflecting on her experience, this woman stated that following the birth of her daughter, the interaction between the medical staff, her DEM, and herself became strained. She recalled that the nurses simply whisked her daughter off to the nursery where she received a vitamin K injection and antibiotic eye ointment, two procedures that she and her DEM had talked about in advance, both of which she declined. However, the nurses never consulted with the mother or her DEM, who was present, and instead simply followed hospital protocols regarding newborns. The lack of interaction on the part of the nurses following the birth of the mother's daughter left her feeling frustrated and as though the plan she and her DEM had created was not valued or considered important in light of hospital protocols.

Or consider another mother's experience, who stated that her midwifery team and the medical staff communicated respectfully, accommodating the needs and interests of the other, resulting in exemplary care for her and her baby. However, despite the positive interactions between her midwifery team and medical staff, this mother expressed how she feels disappointed in *herself* for not being more assertive about what she wanted to do to facilitate her labor within the hospital. This feeling is not uncommon since many women who seek out the care of a DEM and plan a home birth are committed to empowerment through birth and playing a central role in their own care (Boucher et al, 2009; Cheyney, 2008, 2005; Davis-Floyd, 2003; Johnson & Davis-Floyd, 2006; Fullerton et al, 2007). These ideals are not always so easily attainable within the organizational

context of the hospital and instead some women indicated compromising authority over their birth in order ensure their baby's safety and meeting the needs of the hospital organization. Following the central question I ask in this research, I will examine women's transport experiences in this chapter as a way to uncover what the interaction was like between DEMs and medical staff. The type of interaction that takes place between these two groups of care providers arguably has an impact on a woman's overall experience with transport, and in some instances, their birth experiences, and for some women, their first experiences as mothers.

My data do not include "disarticulations" in the way that Davis-Floyd defined such transports, wherein the negative transports have the potential to result in the death of mother and/or baby. According to Davis-Floyd (2003), "transports that involve fracture or dis-articulation between biomedicine and midwifery can amplify the problems already generated by the complication that motivated the transport; sometimes those disjunctures alone are enough to cause a death that would not otherwise have occurred." (p. 1926). Based upon my research, none of the transport stories as retold by mothers represented a complete absence of communication between DEMs and medical staff that resulted in death of a mother and/or baby. Granted, women did report that there were instances of strained communication between their DEMs and medical staff, but none of those interactions compromised the life of the mom or baby as told in Davis-Floyd's (2003) research on midwives in the U.S. and Mexico. However, I do argue that some of the women's transport stories still do contain elements of disarticulations in that the communication between the DEMs and medical staff resulted in DEMs not sharing valuable information about their clients and /or medical staff not acknowledging or

considering the information DEMs brought with them to the hospital. Therefore, my data offer a more nuanced version of disarticulations in that such situations did not result in the death of a mother or baby, but still represented situations where the interaction between DEMs and medical staff was constrained preventing the establishment of collaborative relations, which could potentially compromise the mother's and/or her baby's care. In these situations, negotiation between DEMs and medical staff, which may help the mother experience a smoother transition of care from home to hospital, fails to occur.

Only a small number, 3-4%, of home birth transports in the U.S. are due to an emergency situation that requires immediate transport to a hospital and prompt medical attention (Johnson & Daviss, 2005; Johnson & Davis-Floyd, 2006; Davis-Floyd, 2003). Most home-to-hospital transports are less urgent, and Davis-Floyd (2003) argues that "when a home-birth transport is treated as effectively as a problem that takes place within a hospital, the chances for survival of mother and baby are greatly enhanced." (p. 1926). The transport stories I collected from interviews, did not represent emergency situations and this is largely a reflection of the small percentage of transports that actually occur due to emergency situations, and it is also indicative of the way that my sample does not represent all transport experiences. It is possible that the legal status of DEMs in the state of Oregon and the high number of practicing DEMs in the locale where my research took place may also have played a role in the lack of emergency transports since DEMs, who enjoy legal status and state regulation, may be more likely to transport to medical facilities earlier than those DEMs who practice in states and localities where direct-entry midwifery is illegal.

The more empowering or positive transport experiences, according to Davis-Floyd (2003) and Johnson and Davis- Floyd (2006), entail "smooth articulation" between DEMs and medical personnel. During a transport characterized by smooth articulation, practitioners of biomedicine and midwifery communicate, and at times their approaches to a particular situation overlap and meld so as to encourage "decision-making in which the actions taken by one person or group build on the information supplied by another" (Davis-Floyd, 2003, p. 1927). In these situations, the prior knowledge that a DEM brings to the hospital includes oral documentation, written records documenting the history of the pregnancy and any lab work that may have been done, and labor charts that detail the progression of the woman's labor prior to arriving at the hospital.

I began this study operating under the assumption, as have other researchers studying pregnancy and birth in the U.S (Davis-Floyd, 2003; Johnson & Davis-Floyd, 2006; Rothman, 1982, 2007), that transport represents a "collision" of worldviews as practitioners of the midwifery model of care and her clients must cross the boundary from home and enter into the turf of biomedicine. Davis-Floyd (2003) as well as Johnson and Davis-Floyd (2006) do speak of the ways in which the two models of care overlap, and transport offers a context where the two divergent, yet overlapping systems can converge and create a new shared meaning of a situation. What emerged from the transport stories told by participants in my study are the ways in which midwifery and biomedicine *intersect* during a home-to-hospital transport and the degree to which they intersect is dependent on the urgency of a transport and how practitioners approach a transport situation. By 'intersect', I mean the way in which DEMs are able to "do midwifery" within the context of a hospital transport. In this way, the skills of DEMs and the skills

of medical staff intersect as both groups have a hand in a woman's care. This idea of intersection was reiterated in the words of DEMs as they spoke of "meeting in the middle" and one midwife who spoke of her philosophy regarding transport: "I transport a complication, not a crisis." This has the effect of setting up a more positive, less tense, situation where both the DEM and medical staff could *intersect* rather than collide during a transport.

Fractured Articulations and Disarticulations as Negative Experiences

"*fractured articulations* of biomedical and midwifery knowledge systems…result from partial and incomplete correspondences..." (Davis-Floyd, 2003, p.1912)
"*disarticulations…*occur when there is no correspondence of information or action between the midwife and the hospital staff" (Davis-Floyd, 2003, p. 1912).

A thirty-four year old white woman, with a Master's degree stated that she and her husband chose to birth at home with a midwife due to the way in which they would be able to establish a close relationship with their care provider. She stated that one thing she and her husband found reassuring about their midwife was the way in which she addressed the issue of transport during one of their initial prenatal visits:

> I remember one thing we liked about our midwife was that it wasn't like she seemed to have this big agenda, like no matter what you're having this kid here. It was like, well, "If I don't feel like I can handle it or there's something unsafe about what's going on then I won't hesitate to take you to the hospital."…She'll try as hard as she can with her skills to allow you to have the experience of having the baby at home, but as soon as it's not safe for some reason, then she would transport.

This particular woman and her husband were reassured that that their DEM had the skills to assess a situation and appropriately transport to a medical facility when necessary. During her initial prenatal visits, she felt that her DEM did not express reluctance to interface with the medical community. However, as will be illustrated later,

the DEM was reluctant to engage respectfully once in the context of the hospital organization during this mother's transport.

The mother's water broke on a Wednesday and she began having contractions on Friday, two days later. On Friday, various attempts to speed up labor were tried by the DEM and her assistant, but to no avail. The mother recalled, at that point, her DEM stated that they needed to go to the hospital. One detail worth noting is that the hospital where this particular mother could receive insurance coverage was Rosemont, a hospital where her midwife did not feel comfortable interfacing due to prior experiences with the organizational culture of the hospital, not necessarily due to the OB that would be assisting them that day. According to this mother, even though they were not at the hospital of choice, she was still given some leeway in how her labor would proceed, noting that once at the hospital, she was able to labor for four more hours unmedicated.

> The doctor, I told him, "Well, this is not what I wanted [a hospital birth]. I was really hoping for a home birth as much as possible; still maintain some of that experience." And he was really cool and he left us basically and just let me labor for a while longer. And then the same thing, he was like, ok, if you don't make progress in this amount of time, then we're going to have to go to a c-section. Otherwise, he really gave us our space and just checked on us every once and a while…We still did have our wits about us to really talk to the doctor and not just be completely at their mercy and still have some control while we were there…And he [the doctor] did seem to be understanding; I don't know if he'd dealt with many other home birth wannabes, but he seemed like he got it. Like he knew; he wanted to give us as much of our experience as possible as far as taking control. I think they turned the lights down lower in the room for us and just seemed to be really listening [to our needs].

The experience retold by this mother revealed that the attending OB was able to establish a sense of rapport with her and relate to her situation. To the birthing mother, the OB did seem to be obligated to fulfill some hospital and job-related protocols, hence the time frame he placed on the mother's labor progression. Despite that though, the OB

was quite willing to individualize care to meet the mother's needs and the mother attributed some of this to her and her husband's ability to be assertive in stating their needs and interests. The medical staff that was present were described as being "great" and "open-minded enough to really give us some space to try." These qualities are important to women who transport since most women who chose a home birth have a vested interest in natural childbirth and retaining power over their birthing experiences. Even the small touch of dimming the lights in the hospital room can go a long way to making a transport patient feel more comfortable and listened to. When hospital staff can meet women and their DEMs at this intersection, then transport becomes smoother and typically results in a more pleasant birth experience for women. This mother explained that due to the position of her baby, it was determined that a vaginal delivery would not be possible:

> Finally, I don't know what time exactly, they took me down into the [operating room]. And then a cool thing they did was, for the c-section, normally they just let you have one or maybe two people in the room, but I wanted to have Nate [my husband], Karen [a friend], and my DEM's assistant at that time come. So they let us have all three people in the room. They kind of bent the policy. It might have been partly because it was the middle of the night and it was a little slower, but all the people I worked with in the hospital were really good people.

The mother expressed satisfaction with her transport experience since medical staff was able to accommodate her and her husband's interests. She spoke of the way that hospital personnel taking care of her that night "bent policy" to provide care more aligned with her desires and wishes.

This particular mother's transport story exemplifies the fractured articulations that take place when practitioners of both models do not fully engage and interact with one

another. I argue that there are elements of smooth articulations in the transport story, but these were primarily a result of the interactions the mother and her husband had with medical staff, rather than the work that her DEM did. In fact, later in the interview, the mother commented on the way that her DEM was not really in the picture while at the hospital. The mother attributed her DEM's lack of involvement to her discontent with the hospital, which the mother stated she had noticed previously:

> I had picked this up before we ever even got to the day of the birth that she was pretty anti-hospital; getting there, it was clear she had almost a hostile kind of energy about her with the nurses and the doctors that didn't affect me too much I don't think, but other people could feel it. Karen [my friend] could feel it. And I'm sure the nurses and doctors could feel it. I think she was exhausted. I don't know how many hours she had been up, her being awake, just for my birth, not to mention other births that she'd been up for recently. So there's that kind of energy. Clearly she didn't want to be there and these guys are the enemy kind of, a little bit of that feeling going on. I'm sure they [hospital staff] didn't appreciate that feeling either. I can't remember words that she said, but definitely there was that energy going on…So that did make it a little bit more difficult for us to have that because at that point these doctors and the nurses are really gonna take care of us and they seemed to be responding to our wanting to meet with them on a more human-to-human level.

Here the mother described the way her midwife "checked out" and through non-verbal communication, made it known to the hospital staff that she was not interested in interacting in an accommodating manner. When I asked the mother if this affected her transport experience, she stated that her and her husband's focus was on the birth of their child so their DEM's reluctance to communicate respectfully did not significantly impact them. The mother did state that she is appreciative of modern medicine and after transporting further understands the important role it plays: "I guess appreciating modern science for the fact that it, you know, really can be a life saver, and then also having

found the humanity in the doctors and nurse and really feeling like they, you know, in their system, were doing the best they could."

The previous transport experience reveals the way that different kinds of articulations (in this case, smooth and fractured) manifest simultaneously in a given situation. The way her DEM carried herself was somewhat troubling to the mother, especially if it would have impacted the empathetic treatment she was receiving from medical staff. In this particular case, the DEM was unresponsive in the hospital context and did not articulate with medical staff. Upon returning to their home, the mother explained that her DEM provided follow up care for her and her baby. In this mother's view, her DEM's actions in the hospital stemmed from her being tired and not in her "domain", so, in this way, they made sense to her. This mother understood that DEMs may harbor feelings of distrust and frustration towards the dominant medical system that tends to marginalize the work of DEMs. The transport story told by the mother illustrates the ways in which some medical staff are willing, at times, to suspend and bend institutional and job obligations in order to meet DEMs and their clients at the intersection of home and hospital. Such actions also speak to the level of discretionary power that many medical professionals hold within the context of the hospital.

"*disarticulations*…occur when there is no correspondence of information or action between the midwife and the hospital staff (Davis-Floyd, 2003, p. 1912).

After having an ultrasound one and a half weeks before their baby was due, a couple found out that their baby had fluid surrounding his heart. The couple consulted with the OB who performed the ultrasound in order to establish whether or not an out-of-hospital birth would still be an option for them. The OB stated that an out-of-hospital

birth was still an option, but cautioned the couple that babies who present with such conditions can become distressed during the labor and birth process. The couple also discussed their options with their midwife whom they described as very supportive regardless of their decision concerning place of birth. Ultimately, the couple decided the safest place to give birth would be the hospital, so two days after having the ultrasound, the mother was admitted to Parker Hospital and was scheduled for an induction.

As discussed in Chapter III, this mother's story does not represent a transport per se, in that she made a conscious decision to birth in the hospital prior to the onset of labor, thus, she *transferred* care from her DEM to the on call doctor. However, the DEM and her two assistants accompanied the couple to the hospital in order to provide them with continuity of care as they transitioned from home to hospital. At first, the couple appreciated the fact that their DEM and her assistants were willing to accompany them to the hospital and continue supporting them through the birth process, but in hindsight, they found the interaction between the midwife and the medical staff to be problematic. When I asked the mother to describe the interaction between her midwifery team and the medical staff, she stated "there wasn't interaction" at which point the father commented:

> Father: It was a fiasco, an absolute fiasco. From the midwives' side, I think they were very unprofessional. It seemed like there was a war going on!
>
> Mother: There was [a war going on] because there was a birth that happened two days before mine, or the day before mine, that came from my midwife with the on-call doctor, so I think there [was] a whole issue that happened and it started *way* before I walked in the door.

The couple makes an important point here in relation to the impact that previous transports have on the psyches' of practitioners, and how both positive and negative prior

experiences influence how a care provider approaches subsequent transports. The couple realized that the interaction, or lack thereof, between their DEM and the OB was fractured and incomplete due to prior interactions they had. The interactions that the couple described illustrate the ways that systems have the potential to collide when practitioners of the midwifery model and medical model confront one another.

> Father: There were no words spoken between them [the DEM and assistants] and the doctor. It was all through us. It was more like huddling us together to buttress us against what the doctor wanted to do. The doctor just ignored her [the DEM]. Basically the doctor would ram herself into the room, say what she felt like she needed to say and then she would leave. It was way too much tension in the room. Too many cooks in the kitchen.
>
> Mother: For someone who is delivering a baby, these people [the OB and the midwifery team] did not behave in the way that was conducive of being supportive to the person who is delivering a baby, even the midwives. And that's why she [her DEM] was there. We thought that is what she would be doing.
> Paul Kirk: Yeah, it seemed that our DEM was more concerned with collecting free pamphlets and pilfering hospital supplies. Being present and advocating , I don't have a good opinion.

The couple stated that verbal interaction between their midwifery team and the doctor was nonexistent. This lack of positive communication and heightened tension in the room was cited by the mother as having a negative impact on her experience. According to the mother, such behavior on part of the midwives and OB did not offer her the support she thought she was going to receive during her labor and birth process. When asked if the interaction between her midwifery team and the OB affected her birth experience, the mother replied:

> Mother: Yeah, that *was* the experience.

> Father: …it seemed like she was just a pawn between two opposing ideologies. She was almost like hindsight, "Oh yeah, somebody is going to have a baby here."…I don't think the doctor even had a chance. I mean she walked in the room and there are three people [the DEM and her assistants] who are completely stoically natural childbirth ideologies [supporters], I mean she didn't even have a fighting chance. I'm not saying I was completely in the doctor's corner, but just from viewing it, it was like three against one. As soon as the doctor would leave the room everybody [the DEM and her assistants] would contradict everything she said.

The couple stated that they finally asked their midwifery team to leave after it became clear that their presence was not helping the mother with her labor process. The midwifery team left willingly, and the couple mentioned that the doctor seemed less tense following their departure. The interaction between the DEM and the OB reveals the mistrust that can characterize providers' perceptions of one another. The DEM wanted to be certain that her client was not subjected to any unnecessary interventions or technologies, while the doctor, who did not have access to the ultrasound report, was attempting to perform her job with limited information regarding the status of the mother and father's baby. According to this mother, the ultrasound report remained at the office of the OB who ordered the ultrasound test. Reflecting on her birth experience, the mother stated:

> I was disappointed. I was just disappointed with the situation. I was disappointed in some of the people around me. It's tricky because my DEM is not just a midwife. She's a *lay* midwife, and I think they receive a little bit less respect in the world than a nurse midwife would. I just think the midwife needs to accept sometimes you have to let go of your thing to just be there… try not to be intimidated by the doctor and state your case and just be there. I mean she has delivered many, many babies. She knows what she's doing, so I know she knows what she is doing. Just to have the confidence when you do talk to a doctor in yourself…maybe normally they [DEMs] do, but I didn't see that in my experience. I mean she gave all the paperwork and stuff, and she knew what I wanted. Maybe since she assumed that I had decided to have him in the hospital, she maybe thought other things would have changed.

In the above excerpt, the mother recognized that medical staff may not view DEMs as valid practitioners with useful knowledge and, therefore, they may not interact with DEMs in the same way as they would with another medical practitioner. The way that this mother described her DEM's presence in the hospital indicated that perhaps her midwife felt intimated by the particular OB on staff and, therefore, the way she dealt with this feeling was by being unresponsive to the mother. In addition, as the mother stated, it could be the case that her DEM backed off from playing an active role since the couple made the decision to have a hospital birth.

One mother was pregnant for the second time. Her first pregnancy was ectopic and therefore, she was advised to consult with an OB/GYN for the first trimester of her second pregnancy to rule out any complications. The mother spoke fondly of her OB, stating, "Once everything was fine and we could see that the embryo was in-utero, she [her OB] said, "You're fine. You're a great candidate for home birth. Go and do what you want to do."…If she [her OB/GYN] could do home births, I would do that. She shares my birthing interests, but sometimes she works in a system that doesn't allow her to have that flexibility." This mother makes an important point here in regard to the way that practitioners of medicine are often walled off from attending home births by external factors such as malpractice suits.

One of this mother's primary reasons for choosing home birth with a midwife stemmed from her desire to have a natural birth surrounded by people she knew in a familiar environment. The mother stated that in order to choose a DEM, she interviewed three midwives and their approach and perspective on transport was a deciding factor for her:

In interviewing midwives that [transport] was a big question for me was: In what circumstances do you transport? How often do you transport? What things are you comfortable dealing with at home? What things do you feel like are a reason to transport?

The mother valued the information sharing that took place during her interviews with DEMs. Her decision to choose a particular midwife stemmed from the way the midwife openly discussed that she knew what her skills were and when she needed to seek out medical advice. This mother stated that having had prior experiences with hospital protocols and routines during her ectopic pregnancy, she knew, on some level, what to expect when she transported. However, the mother argued that many of her expectations of the hospital and the care she would received there were negative:

I definitely went in with a very, I mean, granted I'd been in labor for 36 or 30—I think by the time we transported I'd been in labor for 30 hours. So I was pretty worn out and I hadn't really rested and I was pretty disgruntled anyway, but I was really not about being at the hospital. I didn't want to be there. And I didn't end up with a doctor who was receptive to my midwife at all. It was a really negative experience. And in retrospect I can see how my attitude maybe contributed to that somewhat, but the doctor really set the tone by walking in and not talking to, or making eye contact with her, or acknowledging my midwife or her assistant until my husband literally said, "Could you please ask the midwife these questions because she's our care provider and we're really tired, and we need to include her in this process." And she begrudgingly talked to the midwife and then proceeded to explain why she couldn't call her a midwife. She had to call her a "lay midwife", that the hospital would not recognize her as midwife and on and on and on. It was really hurtful.

The way in which the OB behaved demonstrates the significant amount of discretionary power that OBs have within the context of the hospital. Although they are obligated by law to provide care to transport patients, the legal system does not tell OBs *how* they must behave. The role that discretionary power plays in influencing transports will be addressed in Chapter VI. The OB's actions clearly hurt the mother and had a

stunning effect on her and her husband. The mother and her husband, who had spent the last nine months interacting and forming a relationship with their midwife, were counting on the OB to consult with, and acknowledge, their DEM. Instead, the OB ignored their midwife and began issuing orders to the mother regarding the next steps in her care. Here is a prime example where an OB does not consider the information and knowledge that a DEM has about her client which may help in providing safe care to a woman and her baby. It also is illustrative of the way that some OBs, who practice according to the medical model, do not always listen to the needs and/or interests of the patient. The medical model constructs the relationship between physician and patient in a hierarchical arrangement where the physician is positioned as the expert and the one with the authority to make decisions regarding a woman's care. While the relationship with a patient and DEM is collaborative. The communication between the DEM and the OB, as described by this mother, was so strained and disrticulated that the OB simply ignored any information the DEM attempted to provide:

> And also not knowing what all my options were once I got to the hospital. I mean, I kind of knew, but I didn't know. I didn't necessarily know everything that was going to happen, and so I wanted a doctor who would communicate that, who would discuss decisions with us. And the doctor…I mean, it's partly because we came in with the midwife, and she made it very clear that she had a bias against that. That she didn't approve of home birthing. By ignoring the midwife, I think that was really clear. But she [the OB] then proceeded to not discuss options, procedures, explain things. She just basically said, "This is what we're doing." And when we [she, her husband and DEM] said, "Wait a minute. We need to think about this. We need to talk about it." She literally walked out of the room.
> I'll just go back and tell you more about how horrible she was. Not because it's her personality, but just because it was like, this dynamic, and it was the dynamic that exists that has made this into this polarized birthing community. That is so stupid because I mean, in other places where they work together they have so many better outcomes. And we have this system where they're totally polarized and things like this happen where you walk in and the doctor immediately has made assumptions about us. It was just disrespectful. I mean, she was just disrespectful to me and to my midwife, and it was very uncomfortable for us. From the minute she did the

> whole thing of ignoring the midwife and then begrudgingly talking to her and then proceeding to argue with the midwife. And the midwife, they were arguing with each other. My poor midwife was completely verbally disrespected. She was trying to defend herself.

The mother described the OB's resistance to interacting and respectfully communicating with her and her midwife as stemming more from a "polarized birthing community" rather than the individual OB's personality. Here she makes reference to the structural forces in place regarding maternity care in U.S. society that make transport precarious situations for women, who often encounter judgment, suspicion, and mistreatment due to seeking out the care of a home birth midwife. Towards the end of the interview, this mother made reference to the impact the legal system has on OBs, constraining their practices and views of direct-entry midwifery, home birth, and the women who choose home birth. In this mother's transport situation, the OB and midwife were not able to accommodate each other and this was primarily the result of the initial interaction the OB had with the DEM and the mother which set the tone for the remainder of the transport.

> So it got to the point where she, the doctor came in and she said specifically, "I want to rupture your waters." And literally the guy was finishing taping up my epidural. He was just getting me situated, and I was just about to lay down again. And I said, "I just am feeling really overwhelmed right now, and I need a minute to think about this." And in my head, I'm thinking, this is really weird. Everyone's telling me that I'm leaking fluid and now she's telling me she wants to rupture my waters. I'm totally confused, and I just said that, "I'm really overwhelmed and confused, and I just need a minute to think about it." And she said, "Well, I'm leaving. I have another woman in labor at the other hospital and I'm leaving right now." And we said, "Wait a minute. We really want your help. I just need a minute." And she said, "Well, I don't have a minute and if you don't want to do this now, if you don't want to rupture your waters right now, you can wait to see the next doctor who comes on at 7:00 a.m." It was 2:00 in the morning.

Unfortunately, the mother stated that the interaction between the OB and her midwife did not improve and then, due to signs of fetal distress, the OB recommended a cesarean. The mother commented on the way that the OB suddenly shifted when she consented to the surgery:

> She was so mean to me and then the minute I consented to a cesarean, she was like, "Great, we're having a baby!" and all of a sudden she was holding my hand and trying to be all warm and friendly. And I was like, "You've got to be kidding." It made it so much worse. I was just like, "Oh, it's so obvious what you want."

Here, the mother interprets the doctor's friendly actions as a sign that she wanted the mother to have a c-section all along. Although this explanation may be correct, another piece of the puzzle to consider is how an OB often experiences fear and anxiety during a transport primarily due to the fear of litigation. Interestingly enough, several of the DEMs interviewed stated during the time they have lived and worked in the community, there has been no record of a transport patient filing a lawsuit against the OB who participated in the home-to-hospital transport. The point I want to draw out here is the influential role the structure of the U.S. legal system coupled with the health care system has on OBs' perceptions of DEMs and home birth, including OBs' behaviors during transport situations. Therefore, an OB's particular location within professional level and organizational structures has an influence on how they behave and interact during a transport. These ideas will be discussed in greater detail in subsequent chapters.

The mother later spoke about the way her DEM did not hand over records documenting the mother's prenatal history. She wondered if her midwife's failure to provide medical records to the hospital staff had an impact on the overall interaction with the OB. Interviews with OBs and nurses suggest that medical personnel find such

information to be quite helpful, especially for determining what the next steps in a woman's care will be.

> My midwife did not have my medical records, including my ultrasound, with her. So this doctor was looking at me as someone who came in the middle of the night without any medical history. And from a doctor's perspective, that kind of raises red flags. Of course, I'd had ultrasounds, and I had medical records, and I'd seen a doctor and all that stuff, but she didn't have access to them. So I think that made her that much more dubious about my history…it was a perfectly healthy pregnancy and everything, but she didn't have anything to document that, and so I think it made her more nervous as far as her responsibility goes, of liability I should say…

At one point during the transport, the OB confronted the DEM and asked to see the mother's records. The following interaction took place:

> And then the doctor proceeded to ask the midwife for her records, for her own prenatal care records, I think the doctor sent the nurse in and had the nurse ask my DEM for her prenatal records and she said, "I don't think the doctor is interested in what I have to say so I'd rather not give her my records." So the nurse, you could tell, the poor nurse is in the middle so she's like, great. So she walks out, goes to tell the doctor. The doctor comes in and says, "I would like to have your records" and my DEM said, "No. I have been advised for legal reasons that I should never release my medical records to the hospital." So that ended any dialogue or conversation. That cemented the fact that they were not gonna communicate at all. The doctor was really mad about that and did not have any interest in asking her anything else after that…I think she was asking for her records because we didn't have my ultrasounds or my medical records. I didn't know why she [the DEM] didn't have my ultrasound in her file. It just seemed really strange to me. I think the doctor wanted something to show that I'd had a normal pregnancy, that there weren't red flags that she should be looking for or things like that. But, my DEM refused to give her *her* medical records, which I think at that point I would have preferred that she give them to her so we could have some credibility.

Overall, this transport experience can be classified as a *disarticulation,* where there was little dialogue or exchange of information between the OB and midwife. The failure for the two practitioners to engage in respectful communication clearly had an impact on this mother's transport experience. However, the mother did mention that the nursing staff made up for what the doctor did not provide:

> I'll also say about my hospital experience that the nursing staff practically made up for it. You know, they were amazing. They were awesome and loving and kind and compassionate, and all the things that she [the OB] wasn't. They communicated with me. They were genuine. All the things that the doctor didn't do, the nursing staff did and if it wasn't for them, I would never go in the hospital again.

According to this mother, the treatment she received from the OB was so unsatisfactory that it profoundly affected her view of biomedicine. However, she was grateful to have received such support from the nurses which provided her with the framework of trust and respect that she had been looking for in her interactions with the OB.

Women who were transported considered their experiences to be negative when they were mistreated by medical staff. Mistreatment took the form of medical staff being reluctant to empathize and, at times, ignoring a woman's questions or needs as well as completely ignoring the presence of a woman's DEM. Some women interviewed stated that they felt judged by hospital staff and were made to feel irresponsible for attempting a home birth. Women also expressed dissatisfaction with hospital protocols that they experienced as "invasive". The women interviewed distinguished between individual hospital workers and the overall hospital organization stating that staff were often kind, respectful, and helpful, but the overall protocol- driven climate of the hospital had a negative effect on their transport experiences.

DEMs echoed some of the same concerns that women who were transported pointed to in that DEMs define a transport as negative when a client's needs and desires were not acknowledged or negotiated by hospital staff. The DEMs interviewed expressed frustration when they were ignored by OBs and treated as lay people who have little knowledge or experience with a patient. According to DEMs, these actions have the

potential to make a transport more precarious and make it unlikely that a woman will walk away from her experience satisfied and empowered. The organizational context of the hospital was also cited by DEMs as a potential factor in rendering a transport negative since individualized care of a client often becomes secondary to the institutional protocols that govern the hospital organization.

When a DEM brings a client to the hospital, she typically carries along client records and charts in order to assist medical staff with diagnosing and providing care to a mother and/or her baby. However, there are times when the hegemonic medical model does not take into consideration the information practitioners of the more marginalized midwifery model present. This leads to *fractured articulations* or *disarticulations* when there is incomplete, partial, or an absence of communication between medical staff and DEMs (Davis-Floyd, 2003). Based upon my research findings, I show that DEMs, at times, may act unresponsively toward medical staff by refusing to provide accurate information regarding their clients for fear of having medical staff file a complaint against them for inappropriate conduct. Also, DEMs' past experiences with transport where medical staff did not treat DEMs or their clients respectively may explain some of the reluctance on DEMs' part to establish mutually accommodating relations.

The nurses interviewed classified transports as negative when DEMs come to the hospital with "a chip on their shoulder" and made communication with medical staff challenging. Nurses expressed dissatisfaction with certain DEMs who set up the hospital as being a horrific place to their clients creating defensiveness within clients as nurses try to provide care and do their jobs during a transport. The failure of DEMs to bring and/or provide medical staff with client records and charts sets the scene for a negative transport

because nurses are now in a position of having to collect pertinent information such as a client's blood type, Group B strep status, and any other pertinent lab work, during a vulnerable time for a patient. The nurses interviewed argued that having that type of information up front makes their jobs much easier and is also more beneficial for the patient who will not have to be subject to excessive testing and diagnostics.

The elements that render a transport negative from the obstetric perspective are when improper candidates attempt a home birth that result in an obstetric emergency. OBs argued that when "high risk" women attempt a home birth it is a "disaster waiting to happen" and OBs expressed frustration with taking on such clients as patients during a transport since they are ultimately held liable should a negative outcome occur. The OBs stated that when DEMs transport women late or when a situation is already a crisis condition, this puts OBs on the defensive and reluctant, but obligated to help. A transport becomes negative for OBs when they feel that DEMs withhold information about their clients or provide incomplete or inaccurate information about the pregnancy and the progression of labor. These actions, OBs argue make it more difficult for them to do their jobs and can ultimately compromise the safety and health of a woman and her baby.

Smooth Articulations and Mandorla-like Transports

"*smooth articulations* of systems…results when mutual accommodation characterizes the interactions between midwife and medical personnel" (Davis-Floyd, 2003, p. 471)

The *mandorla* is an ancient symbol for the place where opposites can meet and honor one another, and in this reconciliation forge new reality that is greater than the sum of its parts…What emerges from the mandorla transport narratives…are the way in which everyday life interactions carry within them not only the possibility of conformity to stereotypes, but also the possibility of transformation of these stereotypes into systems of mutual understanding and trust. (Johnson & Davis-Floyd, 2006, p. 472-3).

One mother stated that prior to becoming pregnant, she wanted her birth to be "as natural as possible" and the idea of a home birth resonated well with her and her partner even before they conceived their first child nine years ago. When talking about her decision to have a home birth, this mother said, "I felt like it [home birth] was a no-brainer, that I just didn't want to go to the hospital unless I had to, and I didn't have fears, really about the home birth. I felt pretty confident that everything would go just smoothly and I was built to have babies and it will be easy." The mother stated that she and her husband considered and chose what hospital they would transport to if necessary while pregnant: "I remember just choosing the one that at the time, among the people I had spoken to, I thought, had the better reputation, which was Parker, as far as working well with midwives. That was, if we had to transport I had the feeling that that would be the better hospital, that we would maybe have more choices there." The prior research and planning that this mother and her partner engaged in before labor positioned them as more prepared for when the time came to actually go to the hospital. One of the key components of the midwifery model of care involves informed consent. The mother and her husband took control of their pregnancy and birthing options and informed themselves of what a hospital delivery may be like. The OBs and nurses interviewed often remarked on the importance for women who were planning home births to visit local hospitals as a way to prepare oneself and family for the possibility of transport.

The mother began having contractions on a summer evening and she notified her midwife, who suggested trying to get some sleep before labor became more active. The contractions she was having did not exhibit any patterns of regularity or intensity, but she did not feel concerned about this at the time:

> But they [contractions] weren't very strong at the beginning. And so we had this really lovely day. That next day I remember going for a walk and just knowing that it was coming. And then I had a really long night that night. So that day it was just kind of like waiting. I think—my midwife wasn't really into being invasive so she didn't really want to go in and check how dilated I was until she felt like things were really moving. And so she didn't, but then that night I spent most of the night, I think, in the tub and I was just incredibly uncomfortable, which I guess is how labor is. But, my contractions would get really intense for a period of time and then just kind of seem to disappear or just get really light and further apart. And so I was going through this back and forth between getting much more intense and then kind of disappearing. And so I was getting frustrated. And so that was a really long night with candles lit and I have been up for quite a while at this point, pretty much like twenty-four hours. And then we went through another whole day. And when we were halfway through the next day and still there wasn't any regularity to my contractions, I started to get a little bit worried. And I started getting really paranoid… So she [her DEM] eventually did check me and she determined that the baby's head was asynclitic[12] so that it wasn't presenting directly onto the cervix.

Due to concerns about the way the baby was presenting and a prolonged labor, the mother decided she was ready to go to the hospital stating that "I felt like I was making the decision at that point that felt safe to me. I felt like I was done taking any risks and I just wanted to go to the place where I knew that the baby would get born one way or another." Even though the mother's midwife was not the one who initially suggested that they transport, the mother contended that her midwife was very supportive of her interests and was happy to accompany them to the hospital. The mother described the progression of her labor and the interaction with medical staff once admitted to the hospital:

> I'd say we got there at 3:00 in the afternoon and I wound up starting to push at about midnight. But I pushed for two and a half hours and had her about 3:00 a.m. So all in all it was like a fifty-hour labor… I didn't sleep except for right before I pushed, I chose to get an intrathecal and then, in that time, I think I went from nine to ten centimeters and I slept for like forty-five minutes. I felt like that was what I

[12] Asynclitic or asynclitisicm refers to the way the baby is positioned in the uterus. An asynclitic birth or positioning results in the tilting of the baby's head one side or the other wherein the head is no longer aligned with the birth canal.

> needed to be able to push her out…We had an on call doctor, and he was really hands off. He showed up once every hour to check me and other than that let the midwife do what she did. And so when I was pushing, he was gone for a lot of that. And actually her head was out and it was just the midwife and us. And at that point, the c-section team had shown up. They were ready to take me [to surgery]. It had gone too long by their standards. And so they were gonna take me to get my c-section and the doctor came in. And the doctor and the midwife—I have pictures of them both with their hands coming in to catch the baby. And so, they delivered her together.

The mother stated that she felt she got what she needed at the hospital in order to birth her baby. She is pleased with her experience because she felt that the OB who attended the birth was very "hands off", and her midwife and the doctor actually worked alongside one another to assist the mother with her birth. The OB and midwife established respectful communication and were able to work together despite hospital protocols which state that DEMs are not valid care providers. The OB in this instance did not feel it necessary to abide by all hospital protocols and rules and instead helped mold the situation to fit the mother's needs. This mother reflected on the benefits of having her midwife accompany her to the hospital and stated that her midwife was still able to provide care, advice, and support to her within the context of the hospital.

> I remember meeting the doctor. I thought that they were all really nice. I felt welcomed there. They switched a lot and there were a lot of them. I mean, there was a lot of changing so I didn't feel like I got to really got to bond, that was the nice thing about the midwife and the doula, is like, you know your team. So I lost that piece, you know, with the rotation. But I still had my midwife and my doula there with me. And I felt in the end there were times when my midwife had been sleeping during the labor where I felt like, what is she doing? I'm in labor here you know. She's asleep. Everybody's asleep around here. But then when it came down to the time when it's like I needed the help she was so ready to help me. She was so awake and so I felt like she was really kind of a midwife genius by the end. Where she really knew the rhythms and how to take care of herself so she could take care of me. She gave me all kinds of homeopathic stuff. She was sneaking it to me in the hospital…At that point I felt really safe. I was glad she stuck with me.

Participants who discussed their DEM's presence at the hospital often alluded to the strategies that DEMs have developed over time as a result of transporting. The mother was put off at first noticing her midwife was sleeping, but then understood that her midwife was recouping energy so that she could fully support the mother in her birth experience. In the above excerpt, the mother described her DEM as a "midwife genius" due to her approach that involved staying attuned to her own body so that she could be of service to her client. Through quiet alertness this mother's DEM was able to retain an active role in her care even within the context of the hospital. Medical staff felt comfortable with the midwife's presence and did not object to her active role in her client's care. The mother described the techniques and skills that her midwife brought to the transport context which enabled her to still receive midwifery care and experience a sense of continuity of care.

> She [her DEM] had some suggestions that the doctors wouldn't have had for me to do in my pushing. There was a part of the cervix that didn't efface, so it was still blocked. And so she [DEM] told me to get into this position called the stranded beetle where my knees were up by my ears and my feet were here [points towards her hips]. It was a position that you need five people for, but we had plenty of people and I had to push my feet into other people's hands. And somebody had to push my head up and it worked! That was like what cleared the head finally. So without her, I think I would have had the c-section. Now I just had the hospital birth.

Later in the interview, this mother reflected on the ways that made her transport experience positive. She argued that her midwife was strategic about being able to retain power and do midwifery in the hospital. The way in which she was able to do this, was to "hang back" and listen respectfully to medical staff and by doing so she eventually was able to retain autonomy as a practitioner and continue offering care to her client.

> I remember, I think it was just; her style is she really hung back. I think she wanted to have as much power as she could so she strategized so that when they [medical staff] were in the room, when they were around, to really let them say what they needed to say and only ask questions when she needed to, for my benefit, I think that at Parker they have nurse midwives[13] and I felt like we were pretty accepted there. I didn't feel any criticism or judgment. I felt like there was pretty good communication, but pretty sparse. It was kind of like we were getting this information. We were glad to have it, like all of the, whatever those tests were telling us, all the numbers, where we could monitor everything.

This mother attributes much of her positive experience to the ways in which her midwife laid the foundation for respect from the medical staff. Her midwife had discovered through previous transports that an effective way to establish respect and support from medical personnel is to be respectfully assertive and attentive and to be cognizant of not crossing boundaries when making the initial contact with hospital staff. The transport described by the mother cited above contains elements of mandorla transports in that the DEM, the mother, and medical staff were able to accommodate one another and all parties interacted respectfully.

One mother said that she felt prepared prior to transporting since her midwives had already discussed the potential possibility of transport, and she attended a childbirth education class where she addressed her top five fears of birth and one of those was transport. This particular mother recalled discussing her fears surrounding transport with a close friend:

> One of my five [fears associated with home birth] was having a transport. I think that what I remember in talking about it with my best friend, who was my birth coach, "Ok if we do end up transporting, how do I want to deal with that?" What we ended up talking about was that if we ended up transporting still being actively involved in the decisions that were being made, still feeling like we had some

[13] It must be noted that during the time period that this research was conducted, CNMs were no longer able to practice at Parker Hospital due to the lack of support from local OB/GYNs and their refusal to provide back-up services to practicing CNMs—a prerequisite for CNMs to have hospital privileges.

> kind of ability to make choices and still wanting to have a lot of support and people around me so that I didn't feel like I was alone and kind of at their mercy of western medical staff. So I had intellectually thought through: "Well this could happen. If it happens here's how I'll try to handle it." But I think the reality was still I mean I could intellectually prepare myself, but there was no way to really be ready for the actual experience of it I think.

Even though this mother had thought out in advance what transport might be like, it is often difficult to be fully prepared for the range of emotions and feelings that actually emerge when the event takes place. Not only may women who transport from home to hospital feel the physiological aspects of labor, but they may also feel emotional uncertainty. Women who plan home births and transport must cross the boundary from home-to-hospital. The home and the hospital represent two different settings with varying protocols and routines. Having to navigate this transition can be challenging for a woman who is in the midst of labor. The mother stated that her DEMs carefully monitored her throughout her labor and kept her fully informed about the status of her baby:

> I mean I was really happy to be at home I had my closest friends there. I felt great. I felt like I was handling things really well. Then the point where things started moving really quickly, they were listening to fetal heart tones during contractions and noticed that the heart tones were dropping at the end of the contractions, and they said that that by itself it wouldn't necessarily be a reason to transport now, and the meconium, in the amniotic fluid, would not necessarily be a reason to transport now, but the two together can be a potential sign of fetal distress. Their basic philosophy, they said, "That because this is a potential sign of fetal distress we would rather go in now rather than wait until we are sure there is a problem. Because there is an indication that there might be a problem, we would rather go now rather than wait until we're sure there is a problem and have less time to deal with it." And because of the way they phrased it, it made perfect sense to me, and I really trusted them.

Participants often spoke of the way that their midwives consciously kept them informed of their baby's status during the labor, taking the time to explain and openly

address any concerns or issues that they felt were presenting. The mother's DEMs were cognizant of the benefits associated with transporting a woman early on or as soon as a potential complication surfaces rather than waiting until a condition became a "problem". Her DEMs understood that if they took the mother to the hospital at a point where things had not moved into a crisis condition, they, in collaboration with medical staff, would be able to provide more options to the mother and allow her to retain an element of control over her birth process. The DEMs, as a result of participating in transports before, realized the importance of transporting early from the perspective of medical staff. According to the midwives, transporting as soon as something is moving outside the realm of normal for a home birth, indicates to medical personnel, OBs in particular, that DEMs are providing educated, safe care to their clients; such transports influence the impressions that medical staff formulate regarding particular DEMs.

This mother's transport story illustrates the way that her midwifery team and the medical staff developed smooth articulations through the process of negotiation. The medical staff felt assured that they were safely fulfilling their job obligations by monitoring the baby's heartbeat, and the midwives were able to continue offering the mother suggestions regarding alternative labor positions. This mother described how her labor progressed in the hospital:

> [W]e got to the hospital around 6:00pm and I remember around nine o'clock, that night, the doctor kept coming in. He was coming in really often. He kept doing cervical exams. He kept talking to the nurses and then the midwives would kind of be standing there trying to listen in and he just kept saying things aren't moving along. And I was sort of getting the hint from him that he was thinking c-section. My midwives were saying, "Here is what they [medical staff] want to do and why…And they [her midwives] were sort of saying to me, "If we let them do all of this monitoring, then they will be more likely to let us do what we want." The way they always put it was, "If they [medical staff] can get their numbers and their data and see that things are fine, then they will let us kind of do what we

want." So what they suggested was, "Let's let them do all this monitoring, so they can see that everything is fine, so we can go back to doing things the way we want to." And that made sense to me and I definitely didn't want to come across as difficult [to medical staff] because I didn't want to get pushed into things… I wanted to compromise and go along with some of what the hospital staff wanted in order to get more of what I wanted. And that kind of ended up being the game the whole way through…it became this whole negotiation process because he [the OB] was thinking c-section. The way to not go there yet was to do pitocin…it was sort of this thing where all the things I hadn't wanted to do: I hadn't wanted to do fetal monitoring. I hadn't wanted to hold still. I hadn't wanted to do pitocin. I hadn't wanted to do an epidural. I hadn't wanted to do any of that, and I sort of agreed to each of these little steps because it was the way, the only way, they were going to let me keep trying for a vaginal birth was if I agreed to these little things along the way.

Every time the OB would come in, I could sort of tell that it was just like we are running out of time; he's gonna do a c-section. So finally around midnight my DEMs very quietly said, "Listen we know you really don't want to do anything. We know you don't want any more interventions, but at this point, we need to buy ourselves some time. We think an epidural might allow your pelvic muscles to relax enough that she could turn the rest of the way and come down…We feel like at this point an epidural might be the way you get a vaginal birth." And they said it may come down to the decision we are no longer looking at natural birth or medicated birth. We are now looking at vaginal birth or c-section. And at that point they said, "We feel like your best bet for getting a vaginal birth is to agree to the epidural. See if it lets your muscles relax. See if it can get the contractions a little more space to work, and stick to the vaginal birth."…So I agreed to the epidural, and my DEMs stayed with me. We insisted that they do the lowest level they could and one DEM was saying, "If we give ourselves a couple of hours to let her turn the rest of the way down and dilate the rest of the way…By the time you actually are ready to push, it will have worn off [the epidural] and you can feel what you are doing." And that is what ended up happening…The good news is that by agreeing to the epidural…by stalling them and not letting them rush me into a c-section, I think we bought ourselves some time, and she [her baby] did turn the rest of the way. She did come the rest of the way down, and then the contractions were very productive, and I dilated really quickly.

This mother's experience highlights the way that positive communication between her DEMs and the medical staff resulted in the mother being able to have a vaginal birth. As this mother's story illustrates, smooth articulation between the midwifery and medical knowledge systems occurs through instances of negotiation and

communication wherein the information and needs of one group is taken into consideration and acted upon by the other.

The women who were transported argued that their experiences were positive when their midwives had informed them of what to expect during a transport. Having this prior knowledge often made transition from home to hospital less uncertain and women experienced having less fear if they had been notified about hospital procedures and staff in advance. Another factor that made transport more positive for women was having their midwives and/or midwifery team accompany them to the hospital and stay with them during the majority of their stay. Although all women reported that their DEMs accompanied them to the hospital, some stated that their midwife had to leave momentarily or for several hours due to attending other women's births. Sleep was another factor. It was often the case that DEMs and their clients would arrive at the hospital with very little sleep after laboring for hours or days. Some DEMs left their transport clients at the hospital so they could sleep while other women reported that their DEM would simply find a place to rest at the hospital.

The substance of a DEMs' presence was important as well in developing smooth articulations with medical staff. Three women stated that they felt their DEM was present physically, but not available to provide emotional support to their clients. Therefore, women associated positive transports with times when their DEMs still played an active role in their care. This often took the form of a DEM fulfilling an advocacy role while in the hospital, assisting their clients in the process of navigating and negotiating hospital routines and protocols, including communicating with medical staff. Kennedy (2009) states that advocacy is one of the ways that midwives fulfill the tenets of

the midwifery model of care. According to Kennedy, advocacy can take the form of "working to get a birth tub into a labor room, other times to promote a care plan that seems outside the realm of 'normal' obstetrics as practiced in the United States" (p. 426). As demonstrated in the transport stories retold by many of the mothers in this study, the midwife as advocate was one of the most integral elements to ensuring a positive transport.

The women who were transported also pointed to the important roles that medical staff plays in making a transport experience positive, thus constructing mandorla-like transports. For instance, positive transports were characterized by medical staff that empathized with women who had planned a home birth, but now were in the hospital. Nurses contributed to making a positive transport experience by listening to and meeting women's needs and desires, and often this would involve suspending or bending certain hospital protocols, such as relaxing the use of electronic fetal monitoring (EFM) and letting a baby stay with its mother immediately after birth, in order to meet the needs of the women they were caring for.

Women who reported having a positive transport experience stated that the demeanor of the OB was a critical aspect. OBs that expressed kindness and empathized with the woman were viewed as setting a positive tone for the overall transport experience. Also important was the manner in which an OB interacted with a woman's midwife. Women who plan to birth at home with a midwife have typically developed a close relationship over an eight month period while receiving prenatal care. This was cited by the women interviewed as one of the primary reasons they sought out the care of a DEM. Therefore, women stressed the importance of having OBs and other medical

staff treats their DEMs respectfully and includes them in their care. The ways in which midwives and medical staff interacted affected the transport experience, with women stating when both their midwives and medical staff engaged in respectful dialogue and DEMs' knowledge about their clients was considered, women reported a sense of continuity of care and the feeling that their best interests were in the forefront.

DEMs stated that transports are positive when their clients have come to terms with the decision to transport and arrive at the hospital harboring little or no resistance to the medical staff and the recommendations they make. DEMs commented on the importance of medical staff recognizing midwives as valid care providers. This often took the form of medical staff introducing themselves to the midwife and this then allowed for an exchange of information regarding a patient's status between the practitioners and mutual accommodation between DEMs and medical staff. DEMs considered transports to be positive when tensions were non-existent or at a minimum as OBs, nurses, and DEMs provided care for the woman. The DEMs interviewed expressed satisfaction with transports when they were able to continue doing midwifery within the context of the hospital, and in this way, they were able to provide continuity of care or, as one midwife put it, "I can complete that story for the family."

Nurses stated that in recent times, the majority of transports have been positive. In large part they attribute this to the way in which DEMs call the hospital in advance and let staff know that they are bringing a transport patient in. This gives the nursing staff a "heads up" and allows them to make the proper preparations for their arrival. Nurses also suggested that clients who have been well informed about the care they can expect to receive, including their rights as patients, allows for a smoother transition.

The obstetricians interviewed consider a transport to be positive when their recommendations and advice are respectfully considered by DEMs and women. OBs also pointed to the importance of receiving client records and having a "transparent" discussion with the midwife about the history of the pregnancy and labor. One of the most critical aspects to making a transport experience positive, argued OBs, is when DEMs transport clients in a timely manner. OBs stated that appropriately transporting clients at the first indication something is not going right at home makes for a smoother transport. Transports that have not moved into a crisis situation provide OBs with the time to evaluate patients, begin to establish a degree of rapport with them, and ultimately, provide women who transport with more options than if their DEMs wait until a critical moment.

Some common themes emerged out of participants' identification of elements that constitute positive transport experiences. Women and DEMs typically associated positive transports as situations where women could still be empowered and retain elements of their original birth plan. In this way, women and DEMs were interested in retaining elements of the midwifery model of care within the hospital context and found that positive transports still allowed for a "with woman" philosophy of midwifery care to exist alongside biomedicine, rather than being subsumed by the hospital organization. Medical staff typically labeled a transport as positive when it did not represent an urgent situation, and they were able to continue working as usual. Medical staff stated that non-urgent transports did not constrain them from fulfilling their job obligations, even though transport patients were labeled by hospital staff as "undoctored" indicating that up to the transport moment, the women had not received formal medical care. The nurses and OBs

appreciated it when clients and DEMs were informed about what to expect once at the hospital, and if DEMs understood that although they may still play an active role in the care of their client, it would not be the central role in her care. Client records and a succinct summary of the labor progression were cited by medical staff as important components of making a transport unfold smoothly.

My research indicates, that over the past ten years, practitioners have learned about what makes transport positive from the other groups' perspectives, and as such they were then able to incorporate these elements into their own practices when transporting thus rendering transport a smoother, and potentially seamless, experience for all involved. For instance, DEMs recognized the importance that medical staff places on having patient records and charts. Therefore, all of the DEMs interviewed stated they make a concerted effort, time permitting, to bring client records along during a transport and to willingly hand them over to medical staff. Likewise, some members of the medical staff have recognized the sense of powerlessness that some DEMs feel as a result of being within the context of the hospital with no formal privileges. To remedy feelings of alienation among DEMs, medical staff reported making attempts to include DEMs in conversations about the evaluation of patients and to acknowledge the records that a midwife brings to the hospital.

Conclusion

The transport experiences of the mothers whom I interviewed illustrate many of the elements of interaction Davis-Floyd (2003) captures in her conceptual framework of transports as *disarticulations, fractured articulations,* and *smooth articulations.* An examination of women's transport stories shows the various innovative ways that women

attempted to render their transport experience positive. Many participants strived to maintain an active role in their care; however, their stories also reveal disappointment and constraint brought on by fractured articulations or disarticulations with midwives and medical staff or by the fractured interactions and disarticulations between their DEMs and medical staff.

Attending to women's transport stories elucidates and uncovers, from the perspective of women who have experienced a transport firsthand, the character of the interaction between DEMs and medical staff. Their stories shed light on the strategic work that DEMs do. At times, women's stories illustrate the organizational and professional level factors that appear to get in the way of DEMs' and medical staff's ability to interact respectfully during a transport. Other times, their stories illuminate moments when medical staff bend rules in order to personalize care for a woman and when simultaneously attentive action on the part of a woman's midwife has the potential to transform transport into an empowering birth within the hospital.

An interesting finding from examining transport stories that took place in an Oregon community, is that even in a state where midwifery is legal and licensure is voluntary, structural guidelines surrounding conduct and practice for DEMs and medical personnel during a transport remain relatively absent. I argue this stems in large part from the lack of integration of direct-entry midwifery into the broader maternity care system coupled with the cultural devaluation of the midwifery model of care (Davis-Floyd, 1992; Rothman, 2007). In the next chapter, I turn to the professional level factors that influence provider behaviors during transport situations.

CHAPTER V

THE ROLE OF PROFESSIONAL FACTORS IN INFLUENCING CARE PROVIDERS' VIEWS AND BEHAVIORS DURING TRANSPORT

Introduction

This chapter explores how practitioners of the dominant medical model view and interact with direct-entry midwives (DEMs) who occupy a more marginalized position within the structure of U.S. health care. In this chapter, I consider what factors influence obstetricians' (OBs), DEMs', and nurses' views and behaviors during home to hospital transports. As practitioners of biomedicine, I ask what influences structural factors, related to the obstetric profession and the work OBs do, have on OBs' views of home birth and direct-entry midwifery. Subsequently, I consider if their views of home birth and direct-entry midwifery, along with their positions as professionals in society, have an impact on their behavior during a transport. I also question what structural factors influence the work DEMs do. Does their position as autonomous practitioners in society influence their behavior during a home to hospital transport? Also, what effect, if any, does the professionalization of midwifery have on their experiences with transport? Labor and delivery nurses are typically trained according to the tenets to the medical model of care. In this chapter, I consider what effect medical training has on their views regarding home birth and direct-entry midwifery. These questions will be explored in

this chapter examining how a particular care provider's position within professional structures (Hirschkorn & Bourgeault, 2008) influences their views and behaviors.

Obstetricians

In this section, I examine OBs' views and attitudes towards home birth and direct-entry midwifery as a way to illustrate the role that structural influences play in OBs' perceptions and treatment of, home birth and DEMs. Studies have found that health care providers' attitudes toward options in maternity care influence the character of informed-decision making and women's choices regarding place of birth and type of care provider (Lindgren et al., 2008; Cheyney, 2008; McGurgan et al., 2001). According to Vedam et al. (2009), "Home birth rates differ according to practitioner and may represent differences in his or her attitudes, practice settings preferences or both" (p. 275). Therefore, sharply differing provider attitudes toward home birth in the U.S. may in part explain the low home birth rate of one percent (American Public Health Association, 2001; Young, 2008; ACOG, 2008). In contrast, the Netherlands has a home birth rate of 30 percent and midwifery is the standard of care for low-risk women. It must be noted that the structure of the health care system in which midwives practice in the Netherlands fully supports home birth and facilitates the integration of midwifery and medicine (de Jonge et al., 2009; Christiaens & Bracke, 2009; DeVries, 2005). Also, the Netherlands' health care system with universal-access to care diverges markedly from the market-driven U.S. health care system that leaves health care costs and insurance coverage up to individual consumers.

Studies that examine provider attitudes in regard to home birth are limited and those that have been conducted have tended to focus on the context of maternity care in

European nations. Vedam et al. (2009) offer one of the first studies of attitudes toward home birth among North American care providers. They administered surveys to practicing Certified Nurse Midwives (CNMs) in the U.S. as a way to examine their attitudes towards planned home birth and the factors that were associated with their preferred practice sites. Vedam et al. (2009) found that CNMs' comfort with planned home birth and choice of practice site were strongly influenced by a practitioner's educational background and training and their level of exposure to planned home birth in their clinical practices. I argue that this study adds to the limited body of research that addresses provider attitudes towards out-of-hospital birth through an examination of OBs' views towards home birth and direct-entry midwifery.

In this section, by examining OBs views towards home birth and midwifery, I will consider whether their practice philosophy (the medical model of care) plays a role in the formulation of these views. I argue that it is important to understand the various views that OBs have concerning home birth and direct-entry midwifery, as these views may affect how OBs interact with DEMs and their clients during a home to hospital transport.

Obstetricians' Views on Birth

Obstetricians represent the primary care providers for pregnant women in the U.S. and attend approximately 90% of the births in the United States (Wagner, 2006; DeVries, 2005). In order to understand OBs' views concerning the birth process, one of the initial questions I asked OBs during the interviews was to describe what they do during a birth. When discussing their view of birth and their role during the birth process, they tended to limit their discussions of birth to the experiences they have had with their own patients. The majority of the OBs spoke about birth as an individualized phenomenon, noting the

variability in births that they have been a part of. Consider one OB's response when asked what an obstetrician does during a birth:

> It's not a static thing that I do the exact thing every single time. There's some families that come in that have a plan in place, and I am there and help support them and help to deliver their baby or birth their baby. I don't really do anything for the most part. I'm just there to kind of watch for warning signs for things that are not going correct. There's other families that come in who need some help. They are either in a lot of pain or they're not prepared for what is happening, so I kind of calm them down and let them know what is going on and give them suggestions. That's all we do. We don't write orders, we give suggestions and they [patients] either get to follow them or they don't follow them. So it's all case dependent you know. A seventeen year old first-time mom compared to a thirty-five year old fourth-time mom. It's [birth] different each time. It's a hard question to give you a straightforward answer. Each one is unique and cool, and it's awesome to be a part of. I mean it's kind of one of the most intimate things that a woman or a woman and her family can go through and to be allowed to be a part of it, it's pretty cool. There are not many other things that are that intimate that complete strangers can be a part of and that's kind of neat… for the most part, obstetrics [patients] are young healthy happy people. And I'm a young, healthy, happy person. So for most of the time I get to help do this really cool milestone in someone's life. I get to be there, sometimes from start to finish, from some point in time to finish. I get to be a part of something really cool.
> In the above excerpt, the OB expressed the way in which each birth is different.

The OB makes reference to the way in which the services and care provided to the individual women is often tailored to the particular needs of a woman and/or her family. Included in the OB's discussion of birth was an appreciation of being able to assist a family and be a part of the intimate act of birth. This aspect of work was one that this particular OB found pleasing and the OB emphasized how obstetrics, for the most part, is about helping normal, healthy people through an important phase in their reproductive lives. Another OB also spoke of the way that birth tends to be a different experience for each woman that is served:

> Some people need a lot of coaching, and then the nurses and I do our best to help the patient with that. And then some people don't need anything at all, and the

> babies just fly right out. It just kind of depends. Some people want more and some people want less. Some people have doulas and coaches that they bring in with them, and they don't hardly need me at all except to catch the kid. I find it very different for all families, and for all women it seems to be completely different for all of the women that I take care of. Some of them want the baby on their chests right away, and some of them don't want anything to do with that. They want the baby over there (get cleaned up) and everything cleaned up, and then they want the baby. Everybody is different. My job is just to make sure they get the experience they want, as long as there is no concern over the mother or the baby. It's their experience. Again I'm really just there to catch the kid. I don't have any job but to keep everybody healthy and to really be the catcher, and even then if the dads want to catch them I'm ok with that…Again, delivering babies is not that hard. You are just kind of standing there. It's the emergencies we are trained in.

The above comments illustrate the attention given to the individual needs and interests of birthing women. The OB referred to the variation in patient needs and interests and stated that the job obligation of the attending obstetrician is to make sure that the women "get the experience they want".

As illustrated by the excerpts above, some of the OBs may seem to deviate significantly from the philosophical underpinnings of the medical model which tend to encourage the standardization of birth for all women (Rothman, 1982, 2007; Davis-Floyd, 1992). However, I highlight them here to illustrate the way that individual provider attitudes influence OBs' views surrounding birth. Also in their discussions of birth with the women they have served, some OBs made reference to the way they listen to the needs and interests of their patients, which is more midwifery-oriented, rather than medically focused. For instance, one OB mentioned, "I don't really do anything for the most part" while another stated that their job is really just to "catch the kid" and, if it is a woman's desire to have her husband catch the baby, an OB mentioned that patients' requests are adhered to. Even though one OB's views surrounding birth were empirically

grounded; “Delivering babies is not that hard. You are kind of just standing there,” this particular OB does mention that medical training differs from a more natural or “hands off” approach to care in stating “It’s the emergencies we are trained in”. It is interesting that from this OB’s perspective, delivering the babies of low-risk women is not difficult work and perhaps does not necessitate specialized training. The OB seemed to suggest that specialized training is not needed for low-risk births, or at least the OB was not trained in the skills needed for attending low-risk births, but rather, her obstetrical training was specifically focused on the skills needed to assist with high-risk pregnancies and births.

Obstetricians continually described birth as an individualized event even though physicians are typically trained to approach labor and birth in terms of statistical norms derived from medical research, taking a more standardized approach to labor and delivery (DeVries, 2005; van Teijlingen et al., 2009; Davis-Floyd, 1987, 1992; Rothman, 1982, 2007a, 2007b). One OB stated that birth “is certainly individualized. Every birth is a different birth so what I do is going to be different for every woman.” Here the OB appears to be deviating from the medical model approach of standardizing care as reference is made to providing individualized care to the women served. Although many of the OBs interviewed spoke of birth in ways more aligned with the midwifery model of care, only two of the OBs interviewed actually made reference to the midwifery model noting its effectiveness in providing emotional support to women which often facilitates a smoother labor and birth process. One of the two OB’s who made reference to the midwifery model of care stated:

> I have to admit for low risk births the midwifery model is the best you know. Because with proper care and backup they have a higher chance of natural

> childbirth and a lower chance of cesarean sections…Overall I think that it is true that obstetrics has become too technological. The sacredness of birth has been lost and there is too much use of analgelisics which reduce the trust in a woman's body. The reason why I went into holistic medicine is that…women need to learn from their bodies and use the whole opportunity, not only in childbirth, but with menopause and everything…women's bodies and women's wisdom…Take advantage of that as a natural process and learn from it.

In addition to working as an OB/GYN, this OB's personal interest in holistic medicine led to board certification in holistic medicine in 1992, emphasizing the benefits of the natural childbirth. Of all of the OBs interviewed, this particular OB offered the staunchest critique of the medicalization of obstetrics which likely stemmed from and facilitated the pursuit of holistic medicine. In discussing obstetric work, this OB cautioned against the obstetric tendency of medicalizing natural events:

> One thing about birth and menopause is that they are both natural processes, and I always feel that they should not be medicalized. Yes, we have made major strides in making birth safer, but if too much technology is applied then not only do the c-section rates go up, but the chance for other problems can go up, and costs go up as well. I think that there are non-monetary benefits of natural childbirth that a mother gets especially in the confidence that a mother gets and the bonding that occurs between a mother and child that needs to be considered.

The above OB's description of work involved critiquing the medicalization of natural female body processes. Even though the OB was trained in the medical model of care and practiced as an OB for fifteen years, this OB was critical of the excessive use of interventions and was cognizant of the deleterious effects that can occur when women are subject to multiple interventions during the labor and birth process (Goer, 1995, 1998; Rothman, 1982; Wagner, 2006). Again, it is likely that this particular OB's critique of the medical model and the overreliance on technology and interventions derives in large

part from the exposure to and personal interest in alternatives to biomedicine. This was a characteristic that none of the other seven OBs interviewed espoused.

Although some female and male OBs did admit that obstetrical complications are rare, they still expressed the importance of being on guard throughout a pregnancy and birth due to the way that complications can emerge quickly and require immediate management to prevent injury or death. The female obstetricians that Simonds (2007) interviewed also espoused a general distrust of the birthing process and this distrust often translates into heightened vigilance as OBs work at managing birth, "Doctors did not represent birth as *only* pathological or risky, by any means, but they depicted it as *always potentially* pathological or risky. If you never know when disaster can strike, you must always be sentinel." (p. 219). Based upon one OB's description of all births as potentially risky, it is not unlikely that OBs view home birth as even more risky than an obstetric-managed, hospital-based birth. The event of transport may at times involve OBs calling on this discourse of risk in their perceptions and treatment of DEMs and women who attempt home births.

Obstetricians' Views on Home Birth

Ironically, as some OBs spoke about their work as obstetricians and their feelings towards home birth, they tended to replace their more midwifery-oriented depictions of birth with a discourse of risk (Cheyney & Everson, 2009) as they constructed one of their central duties as an obstetrician to be safeguarding mothers and babies from the potential pathologies of pregnancy and birth. When asked to describe the work they do as OBs, two doctors replied in the following ways:

> [M]anaging pregnancy from beginning through the end, clinic visits, screening for problems, answering questions about normal healthy pregnancies…then in

> the hospital, managing the labor process, making sure that both mom and baby are tolerating the labor process well, a nice normal delivery most of the time and interventions; forceps, c-section, and vacuum if there's a problem. And managing the rare, but can be life threatening, complications that can occur during labor and delivery; hemorrhage and shoulder dystocia, fetal distress. Obstetric complications can have bad outcomes. They can happen quickly and things can go downhill quickly. The crap hits the fan quickly [and] that's how obstetric complications can go…I guess that's part of my job as a doctor. I think about what's the bad things that could happen. Is there something bad happening now? You keep an eye out for any red flags of the bad things that can happen.
>
> I'd say we do a lot of routine pregnancy care, kind of following established protocols, looking for the abnormal thing. I'd say we provide fairly technical management of labor and delivery.

In the first excerpt above, the OB described the physician's role as one of managing the pregnancy and delivery process and being on the lookout for complications. The elements of the medical model of care frame this OB's discussion of an OB's job duties and how medical training equips OBs with the knowledge to identify obstetrical complications. The second excerpt above emphasized that one of the central duties of an OB is to look for "the abnormal thing" condition in pregnancy and birth. This medical approach to pregnancy and birth differs from the midwifery model which views pregnancy and birth as normal, natural processes. Such differing philosophical views regarding pregnancy, labor, and birth among care providers has the potential to create contentious relations during a home to hospital transport since practitioners of medicine may be preoccupied with diagnosing and treating pathologies, while DEMs tend to emphasize the female body's natural ability to birth successfully without interventions and advocating for a more "hands off" approach.

The potential for complications was voiced more intensely by OBs in their discussions of home birth. When considering their views of home birth, OBs tended to

equate home birth with increased risk to the health and safety of mothers and babies. The way in which risk was defined by OBs in regard to home births tended to uphold the medical model's emphasis on birth as inherently dangerous and thus, potentially in the need of obstetrical management and hospital facilities. Only one obstetrician interviewed stated that as a resident she was interested in observing a home birth. However, according to that OB, this was impossible to do because of time constraints compounded with legal obligations associated with malpractice insurance:

> I thought about trying to get out on a home birth with a midwife, but, time was an issue, and I was a little concerned about my liability, which of course, the residency would be very interested in… Like, how do you [DEMs] do this[home birth] at all? Because to me, not having the OR (Operating Room) five steps from me is a terrifying thought. *That's* because of my training.

The OB highlighted in the above quote stated that an interest in attending a home birth stemmed from a curiosity in understanding how DEMs assist with home birth, an event the OB said produces feelings of anxiety. The OB did realize that the fear of home birth and the overall view of birth as potentially dangerous stemmed from medical school education and training. The OB described how the practice of obstetrics involves perceiving the birth process as a risk:

> Everything in obstetrics is risky. Honestly, the safest thing for every baby would be a c-section at 39 to 40 weeks. That would be the safest thing. It's ridiculous, but it's probably true. But, we don't do that, so in a way vaginal birth is a little bit of a risk—it's a risk that you assume. So, in that way, I think a home birth is just a little more risky than a vaginal birth in the hospital. I have had patients that had home births and that's a great experience. So if you're going for the experience, if you want a little more experience and little more risk…

Various OBs explained that the discourse of risk underscores the practice of obstetrics; essentially, even vaginal births from the obstetric perspective are riskier than cesarean sections. Here, it is important to note that in their discussion of safety, many

OBs focused on the condition of the baby. Although in the minds of some OBs, a c-section may constitute the safest delivery option for babies, it is not the safest procedure for every woman (Goer, 1995, 1998; Gaskin, 2003). Some OBs labeled women who chose to birth at home as willing to take more risks than women who plan hospital births. However, what is important to consider here are the ways in which women who plan home births define risk. For advocates and consumers of home birth, the definition of risk is significantly different than the obstetric definition of risk. For practicing OBs, risk pertains to outcomes with the end goal a healthy mom and baby regardless of the way the birth happens; vaginally, forceps, cesarean section. In contrast, women who seek out home birth with DEMs often associate hospital-based births with increased risks due to obstetric and technological interventions (Boucher et al., 2009; Cheyney, 2008; Goer 1995, 1999).

For many low-risk women[14] who plan to birth at home, risk is avoided through planning a natural birth with an experienced midwife. In addition, some women label compromising their autonomy and the spiritual experience of birth by birthing in a hospital as a greater risk, one that can be avoided by planning a home birth with a DEM. This is not to say that DEMs and mothers who birth at home are not concerned with outcomes, but the birth process itself is an important element as well (Simonds, 2007; Cheyney, 2008 ; Boucher et al. 2009).

One of the OBs interviewed incorporated the discourse of risk into her discussion of home birth, stating: "I think everybody has their own tolerance for risk. In terms of

[14] Low-risk is a term used to refer to a pregnancy that is anticipated to be void of complications of problematic conditions. A woman is assessed as low-risk based upon her medical history, gynecological/obstetric history, and the current status of the pregnancy. What is important to note here, is that OBs and DEMs have different definitions as to what constitutes low-risk pregnancies.
For further reading on OBs' and DEMs' perception of risk see Cheyney and Everson (2009).

me as an individual, the risks related to home birth are not worth the benefits. But I think different people have different risk tolerance related to different situations." In doctors' discussions of home birth, the underpinnings of the medical model, the ideology of patriarchy and the ideology of technology, surfaced. According to the medical model, risk is conceptualized as emanating from women's bodies (Rothman, 1982, 2007; Davis-Floyd, 1992). Women's pregnant and laboring bodies are seen as potentially pathological and thus, defective. Based upon this line of thinking, women's bodies therefore, are the source of complications during the birth process. From the medical perspective, home birth is considered unsafe due to the potential for a woman's body to fail, thus necessitating medical intervention. In some OBs' accounts, obstetrics and technology were characterized as important medical developments associated with progression and modernity. An OB made the argument that home birth is safe and appropriate for a certain group of low-risk women, but the OB's support of home birth was prefaced by stating the possible obstetrical complications that can arise unexpectedly, thus rendering home birth a risky choice for women:

> [T]he problem with home births is, if you're doing a home birth, you are in reality, choosing to take upon yourself and your delivery, the mortality statistics of the past. Because the mortality statistics of the present day exist because deliveries occur in or near medical places that have blood for blood transfusions, that have an operating room to go to if needed, that have professionals trained in the complications, that have medications available to make the uterus clamp down and stop bleeding. The problem with home births is that very rare, but real possibility of a significant complication with a bad outcome, including death for mother or baby…I don't know if you are *completely* taking on the death rate that used to exist for mothers and babies a hundred years ago because you can't get to the hospital, so it's somewhere in between.

Although not all OBs shared these views of home birth as antiquated in comparison to medicine, it was a theme nonetheless wherein direct-entry midwifery care

was seen as inadequate in terms of its practitioners' knowledge base and practices. Thus, the ways in which OBs conceptualized risk was, at times, quite different from the manner in which DEMs and home birth clients defined risk. In this way, the midwifery model was often cast as less valuable and more risky than the practice of obstetrics. I argue that these different philosophical orientation to pregnancy and birth impact how the interaction between DEMs and OBs unfold during a transport.

Factors Influencing Obstetricians' Views and Behaviors

So where exactly do these perceptions of home birth and direct-entry midwifery come from? How do the perceptions and views that OBs hold affect their interaction with DEMs and mothers during a transport? The data collected for this study indicate that OBs' views and attitudes toward home birth and direct-entry midwifery were formulated by a combination of personal attitudes in dialogue with professional and work/organizations obligations and responsibilities. I use Hirschkorn and Bourgeault's (2008) theoretical framework to examine structural influences that exert influence on health care providers' decisions and behavior as a way of understanding how the experience of hospital transport is a product of both individual provider attitudes *and* structural forces.

Hirschkorn and Bourgeault (2008) study the use and referral of complementary and alternative medicine (CAM) among doctors, nurses, and midwives in Canada, arguing that previous studies of provider use of CAM have tended to look primarily at the role of individual provider attitudes in shaping professional behavior (Astin, 1998; Botting & Cook, 2000). Although Hirschkorn and Bourgeault acknowledge that providers' personal attitudes do play a role in shaping professional behavior, they argue

that professional behavior is more complicated than previous studies have indicated. Rather, based on their qualitative research with doctors, midwives, and nurses, Hirschkorn and Bourgeault discovered that “professional behavior is a product of a more complex set of relationships between the individual provider, the client, and a series of broader structures that set the parameters by which professionals are socialized and work on an ongoing basis.” (2008: p. 194). Therefore, in their attempts to understand the use and referral of CAM among participants, they found respondents pointed to the influence that broader structural forces such as liability, colleagues, and hospital protocols have on individual providers’ behavior.

Based upon findings indicating the influence of structural forces, Hirschkorn and Bourgeault (2008) distinguish between professional and work/organizational structural factors that influence an individual practitioner’s decision to refer or use CAM: “Professional factors are those that stem from the organization of professional regulatory colleges and professional education (i.e., the particular governance and socialization frameworks that exist exclusively for the professions). The other structural factors…relate to the context of professional work, notably work/organizational factors (e.g. hospital-level policies as well as physical factors such as hospital facilities, compared to the home setting).” (p. 194). Professional structures exist external to the *individual* and include professional socialization, philosophies of practice, legal responsibilities, and licensed scopes of practice. Work/organizational structures exist external to the *profession* and include the hospital setting, the home setting, and clinic setting. (Hirschkorn & Bourgeault, 2008: p. 201). Borrowing this distinction between professional and work/organizational factors, in this chapter, I examine the professional

level factors that influence OBs' behaviors in their own practices and during transports. In Chapter VI, I explore the influence work/organizational level factors have on care providers' behavior during home-to-hospital transports. My study extends Hirschkorn and Bourgeault's (2008) work by examining the role that professional and work/organizational factors have in forming views regarding direct-entry midwifery and home birth among maternity care providers. I also add to this literature by exploring whether or not the experience and interaction during a hospital transport is constrained by providers' particular locations in relation to professional and work/organizational factors (See Table 5.1).

Professional Level Influences

My study on transport parallels some of the findings from Hirschkorn and Bourgeault's (2008) research since the majority of OBs interviewed pointed to a series of broader structural forces that constrained the work they do as obstetricians and also these same structural forces influenced how they performed during a home to hospital transport. The professional structures mentioned by the OBs interviewed include medical school education, professional culture and socialization, and malpractice liability. Each of these factors will be discussed noting their influence on OBs' perceptions of direct-entry midwifery, home birth, and OBs' behavior during a home to hospital transport.

Medical School Education

As discussed in the previous section, OBs often upheld the discourse of risk as they described their job duties as obstetricians. Some of the OBs also utilized the discourse of risk to question the safety of home birth. There were several OBs who stated their view of home birth as potentially dangerous stemmed from medical school

Table 5.1. Professional and Work/Organizational Factors by Provider

Provider	Philosophy of Practice	Professional Level Factors	Work/Organizational Level Factors and Context
Obstetricians	Medical Model	Medical School Education American Congress of Obstetrics and Gynecologists (ACOG) Bioethical Principles of Medicine Malpractice Liability	Hospital Policies and Protocols Private Clinic Practice Colleagues
Licensed (LDM) and/or Certified (CPM) Direct-entry Midwives	Midwifery Model	North American Registry of Midwives (NARM) Midwives Alliance of North America (MANA) Oregon Health and Licensing Agency (OHLA)	Private Practice Freestanding birth center and/or home Hospital Policies and Protocols*
Unlicensed Direct-entry Midwives	Midwifery Model	Midwives Alliance of North America (MANA)	Private Practice Home Hospital Policies and Protocols *
Nurses	Medical Model	Nursing School and/or Degree Program	Hospital Administration Hospital Policies and Protocols Collegial Oversight Peers

*Only applicable when a transport takes place. Here I elaborate on the framework developed by Hirschkorn & Bourgeault (2008) to illustrate the structural factors cited by my interview participants.

education, in particular, obstetrical training. Simonds (2007) suggests that the combined influences of medical school training and clinical experiences are responsible for imbuing OBs' views regarding pregnancy and birth with risk. She states, "Doctors notion of risk inflates as a result of their interventive training and interventive experience as practitioners." (p. 241).

During the interviews, I asked each OB to describe their perspective surrounding home birth and direct-entry midwives. Many of the OBs' responses contained apprehension about the safety of home birth in light of the obstetrical complications that can arise, stating that as trained professionals they would not feel comfortable taking on the responsibility of attending a home birth. Consider the following response from an OB:

> I just don't feel comfortable, myself, being responsible for that [home birth] just because I feel like things can go wrong when you do not anticipate it, and I prefer to have, for myself, for patients I am taking care of, all of those resources available. I prefer to have them there and use none of them. Not have an IV, have people do whatever they want as long as I feel comfortable and the baby is doing well just because I have had some, when you do your residency, you deliver so many babies. If you ever have to resuscitate a mom or a baby, or have a bad outcome, it's horrifying. And sometimes you can't always anticipate it even though, for the most part, things go really smoothly.

In the above excerpt, the OB alludes to an ongoing tension brought about by medical school and residency training which has equipped this particular OB with the reality that during pregnancy, labor, and delivery unanticipated things can go wrong quickly. According to many of the OBs, emergencies always have the potential to happen and thus, home birth, from the obstetric viewpoint, constitutes unnecessary risk because not all life-saving resources are available at home. The previous excerpt from an OB illustrates how, at times, OBs were involved in the process of casting their practical

experiences against their medical and residency training, noting a disconnect between what they have learned in school and what they experience in their daily clinical work. For instance, the OB in the above excerpt stated that even though OBs undergo rigorous training in obstetric complications, most deliveries proceed just fine: babies come out. This particular OB reflected on how knowledge and training have impacted how she views pregnancy and birth including how she will provide care to her patients. But also, her clinical experience, as both a CNM and obstetrician, her exposure to midwives and home births during transport situations, and her daily experience with pregnant moms and birthing moms, has taught her that, most of the time, things go smoothly.

Obstetricians receive extensive education and training in the management of pregnancy, labor, and birth. OBs constitute a vital resource in the U.S. as they are skilled in diagnosing and treating complications and conditions associated with high risk pregnancies and births. As such, they provide an invaluable service to many women and families in this country. The educational training of OBs involves a combination of rigorous didactic and clinic practices, including specialized training to diagnose and manage complications such as placenta previa and preeclampsia. Another component of obstetric education involves surgical training in the performance of cesarean sections. In addition, OBs are instructed in the uses of various medical technologies such as genetic testing and ultrasounds (APA, 2010).

Obstetrical training socializes medical students into the biomedical model of birth. Obstetricians are taught to take on the role of expert as they view pregnancy and childbirth as potential pathologies that can be handled by applying various technologies and interventions. The reliance on technology and the use of interventions help to ensure

that obstetricians retain a level of control and predictability over pregnancy and childbirth. Obstetricians are taught, and tend to perceive birth, as a cognitive threat due to its unpredictable and uncontrollable nature (Davis-Floyd, 1987; Wagner, 2006). Throughout medical school training, obstetricians are taught that standardization of care and following obstetric protocols are necessary and the best way to ensure patient safety while simultaneously making pregnancy and birth more manageable for physicians.

Davis-Floyd's (1987) examination of obstetric training as a "rite of passage" illustrates the way medical students experience isolation from other "ways of knowing" as they tend to be exposed to only one type of training and one way of viewing pregnancy and birth. Other ways of knowing, such as alternatives to hospital-based birth, are effectively removed from the medical student's worldview as they become socialized into the profession of obstetrics. Davis-Floyd (1987, 1992) refers to this process as "cognitive retrogression" where medical students learn to focus solely on the material they are exposed to and being taught. Through the process of cognitive retrogression, the scope of students' intellectual capacities becomes constrained, and they emerge from the initial years of medical school indoctrinated into the biomedical model of pregnancy and birth.

In U.S. society, obstetrical training is viewed as a legitimate form of knowledge whereas direct-entry midwifery education is seen, at best, as secondary, if not an inferior form of knowledge. According to Brigitte Jordan (1997), "frequently, one kind of knowledge gains ascendance and legitimacy. A consequence of the legitimation of one kind of knowing as authoritative is the devaluation, often the dismissal of all other kinds of knowing" (p. 56). None of the eight obstetricians interviewed recalled discussing home birth or direct-entry midwifery while attending medical school. One OB stated that

his medical school training did not offer education regarding out-of-hospital births or care providers who attend home births:

> That [information about DEMs and home births] was actually sorely missing. At medical school, we were taught it [home birth] is a very dangerous option and we had no interactions with any midwives who were doing home births…I think that is true for the majority of OB/GYN programs, that there is very little interaction with them unless there is a midwifery [CNM] training program in the same institution.

Theoretical or clinical training regarding out-of-hospital birth and direct-entry midwifery care are typically not a part of U.S. medical school curricula and, as such, have the effect of obscuring the practice of direct-entry midwifery and occurrence choice of home birth. In the above excerpt, the OB stated that the only information he recalls learning about home birth was the danger that it entailed. For most OBs interviewed, exposure to midwives happened during their residency programs only if certified nurse midwives (CNMs) also practiced at the same hospital where OBs were receiving their training.

One OB recalled that the discussion of DEMs centered on the risks associated with home birth: "I think that what I was taught was that the risk of fetal mortality is about twice in a home birth situation than it is here [at the hospital under the care of an OB]. I'll be honest, I've never gone and looked up that original, whatever research study suggested that [home birth mortality rates being twice as high]." A significant body of research has shown no significant differences in maternal and fetal mortality rates between planned hospital birth and planned home birth for women who have been defined as low-risk, have qualified care providers, and have access to medical facilities when necessary (de Jonge et al., 2009; Janssen et al., 2009; Hutton & Kaufman, 2006;

Chamberlain & Crowley, 1999; Johnson & Daviss, 2005; Ackermann-Liebrich et al., 1996; Weigers et al., 1996; Murphy & Fullerton, 1998). Professional bodies such as The Society of Obstetricians and Gynaecologists of Canada, the Canadian Association of Midwives, U.S. midwifery professional organizations (Midwives Alliance of North America, American College of Nurse Midwives, and the National Association of Certified Professional Midwives), along with public health organizations[15] (American Public Health Association and World Health Organization) adhere to the evidence from the above mentioned studies and have formulated policy statements supporting planned home births. As one OB mentioned, OBs are often not as well informed about direct-entry midwifery or home birth as medical students and I argue that this may negatively affect the interaction during a transport when OBs have limited knowledge regarding the care that DEMs have provided their clients prior to arriving at the hospital.

Interestingly, one of the OBs interviewed worked as a CNM for four years prior to attending medical school. When asked if she recalled discussing midwifery or home birth during medical school, she stated that as a CNM, she worked alongside several DEMs, but, as an OB, discussion of midwifery tended to focus exclusively on CNMs. This particular OB stated that she sought out a particular residency program in the southwest due to the large number of CNMs who worked there and served as instructors to residents:

[15] See the following organizations' statements and policy recommendations regarding out-of-hospital birth with qualified care providers: American College of Nurse-Midwives Position Statement on Home Birth. Washington, DC: ACMN. December, 2005; American Public Health Administration (APHA) "Increasing Access to out-of-hospital maternity care services through state-regulated and nationally-certified direct-entry midwives." APHA Public Policy Statement, 1948 to present, cumulative Washington, DC, 2001; "Maternal and Newborn Health/Safe Motherhood Unit of the World Health Organization (WHO), Care in Normal Birth: A practical guide." World Health Organization, 1997.

> I did my four years of residency in the southwest and one of the reasons I chose that place was that they had a good nurse midwifery program associated with it. The residents, when they train, actually work with the nurse midwives and learn to do deliveries first and kind of help support people through their labor…and it was just a really nice supportive atmosphere which I think is not maybe true for all residency training programs. At least for the most part it was very different than other places that I have been, and they kind of really respected people's different cultural differences and would ask people "Do you want your placenta? Should I bag it up for you?" And in the southeast it was like "No, it's a biohazard! You can't have it!" It was very frustrating having to deal with that. So it [southwest] was a nice place to train.

Another OB stated that it was during residency when he first interacted with CNMs. He considered his training as a resident to be very much shaped by CNMs since there was such a large group of them practicing at the hospital where he trained:

> In residency, the southwest has got probably one of the top five CNM programs in the nation and so we actually learned, all of our vaginal deliveries were with midwives to start with. So we actually had an awesome, very close, working relationship, and they had 12 or 14 CNMs, and they had their own practice. They had their own clinic right next to ours. They labored their own patients and delivered their own patients with us on the labor and delivery, and then we served as back up for them. So for the residents, it was pretty neat. A pretty neat working environment it was really. It was very good.

In the following excerpt, the OB reflected on how his training with CNMs at the southwest hospital differed from his medical school education, which primarily focused on high risk conditions during pregnancy and birth:

> That [medical school] acuity of training and treatment was very different from, "This is pregnancy. This is labor". With the midwives, we learned about laboring in different positions and "Hey have you thought about doing this?" "Do you really need to do that?" And kind of a slowed down approach which is what I think draws a lot of women and families to lay midwives. They are non-interventional and we had a very nice happy medium with the certified nurse midwives, "Have you thought about doing this?" "Hey, what about this?" "Oh well, you can use mineral oil for this. Have you thought about hands and knees? Why don't you let them labor on the ball? Or, have you ever delivered a baby in a squatting position?" You know things that in traditional obstetrics, at least in my program, weren't necessarily around.

Although in the above excerpt the OB highly values the training he received from CNMs during residency, the OB does not make similar statements regarding the skills and experience level of DEMs. It was common for OBs in this study to praise CNMs and acknowledge them as qualified practitioners. However, when it came to OBs views of DEMs, OBs tended to be critical of DEMs' skills, training, and their exclusive attendance at out-of-hospital births. In this respect, the location of birth became targeted as the source of complications and negative outcomes for OBs whose training has led them to question the safety of birth in out-of-hospital settings. Many of the views surrounding home birth and direct-entry midwifery among the OBs in this study differ markedly from the perspectives of OBs who practice in countries where midwives attend the majority of births, where universal healthcare prevails, and where the normalcy and safety of home birth is not called into question.

For instance, the integration of midwifery and medicine in the Netherlands is evident when examining obstetric education in that country. One of the main obstetric textbooks used in all of the OB/GYN training programs in the Netherlands questions the U.S.' model of maternity care that typically places the interests and preferences of doctors before those of women (DeVries, 2005). According to the textbook, home birth for low-risk women is advantageous in that:

> …it underscores the physiological character of the event and stimulates the self-consciousness and self-reliance of the woman in labor; the cosy and homey nature of her environment, to which her husband also has total access, works in the same direction (Kloosterman, 1981, p. 390; quoted in DeVries, 2005, p. 77-78).

The Dutch obstetric text does address the use of technology and interventions as away to speed up labor or to reduce pain in the laboring woman. However, the education of OBs and the entire ideology undergirding their health care system emphasizes birth as a normal, physiological event that, in most cases, does not require obstetric intervention. In fact, in another textbook by Kloosterman and Theiry (1977), it is stated that the goal of a healthy mom and baby, “is not promoted by these interventions, but is in fact threatened by them” (quoted in DeVries, 2005, p. 83). DeVries (2005) argues that unlike other medical education programs for OBs practicing in contemporary medical systems, students studying obstetrics in the Netherlands are exposed to and taught the necessary skills and equipment needed to attend home births.

Of course, the findings from the Netherlands’ maternity care system, or any other country’s maternity care system for that matter, cannot be directly extrapolated to the U.S. maternity care system. However, the ways in which different countries view birth and the provision of maternity care services illustrates how birth and maternity care are social constructions. The particular ideologies underpinning societies play an important role regarding the health care structure and maternity care options. As demonstrated by my interview data, even though the OBs obtained their medical school education and residency training in various geographical regions of the U.S. and some were trained by CNMs, the overwhelming pattern espoused by OBs was a lack of discussion and information regarding home birth and DEM. This finding is not surprising considering that medical school curriculum, in large part, reflects the dominant ideology of the medical institution (Davis-Floyd, 1987, 1992; Hafferty, 2000; Light, 1983, 1988).

In response to what they believe constitutes insufficient data supporting the safety of home birth, the American Congress of Obstetricians and Gynecologists (ACOG) has developed and published a staunch policy statement denouncing planned home births. ACOG's 2008 statement on home birth reads the following way:

> The American College of Obstetricians and Gynecologists (ACOG) reiterates its long-standing opposition to home births. While childbirth is a normal physiologic process that most women experience without problems, monitoring of both the woman and the fetus during labor and delivery in a hospital or accredited birthing center is essential because complications can arise with little or no warning even among women with low-risk pregnancies.
> ACOG acknowledges a woman's right to make informed decisions regarding her delivery and to have a choice in choosing her health care provider, but ACOG does not support programs that advocate for, or individuals who provide, home births. Nor does ACOG support the provision of care by midwives who are not certified by the American College of Nurse-Midwives (ACNM) or the American Midwifery Certification Board (AMCB) (ACOG, 2008).

This policy statement is supported by both the American Association of Pediatrics (AAP) and the American Medical Association (AMA). These professional bodies wield a significant amount of power and influence on the U.S. maternity care system. Professional organizations such as The American Congress of Obstetricians and Gynecologists (ACOG) along with The American Medical Association (AMA) have a strong influence in impacting the way that pregnancy and birth are viewed in this country[16].

Professional Culture and Socialization

The professional culture of obstetrics reinforces the attitudes and beliefs learned during medical school. The majority of OBs interviewed made reference to ACOG's

[16] For further information on ACOG and the AMA's position statements on home birth see: ACOG Statement of Policy as issued by the ACOG Executive Board. Home Births in the United States. Washington, DC: ACOG. May 4, 2007.
Also see American Medical Association House of Delegates. Resolution 205 (A-08) - Home Deliveries. 4/28/08.

recommendations regarding safe obstetric practices. Many OBs interviewed questioned the safety and regulation regarding home birth breech, twin, and vaginal birth(s) after cesarean section (VBAC). One OB commented on the way that ACOG guidelines and recommendations coupled with the potential for litigation influence the way he practices regarding twin births:

> Twin birth, primip [mother's first pregnancy] at home? It's malpractice if I did that. Absolute hands down malpractice if I did that. No questions asked. If I even attempted to deliver twin birth, vaginally, in a first time mom at home. Done. Done! It's the American College of OB/GYN recommendation [against home birth] and that's how I practice in my clinic. They are a lot smarter than I am. I mean there are some smart people making those recommendations for very good reasons.

OBs are obligated to follow the practice guidelines and recommendations set forth by ACOG since it is the governing body for the profession. This is despite personal attitudes and opinions individual obstetricians may have which may actually support home birth and direct-entry midwifery.

Bioethical principles in health care are an important aspect of health care professionals' culture. There are four major principles of medical ethics that practicing physicians are expected to abide by in their practices: 1) Respect for Autonomy, 2) the Principle of Nonmaleficence, 3) the Principle of Beneficence, and 4) the Principal of Justice. These rules or principles are not absolute, but, rather, they serve as powerful guidelines within which a physician structures his or her clinical practice (Beauchamp & Childress, 1994). Of particular importance to this study are the principles respect for autonomy, nonmaleficence, and beneficence.

Respect for autonomy represents the first principle of bioethics and refers to the idea that a patient has the capacity to make decisions regarding his or her health care

from an informed position without being under influential control that would discourage an act from being free and voluntary. The principle of respect for autonomy serves as the basis for informed consent. Medical doctors and DEMs both adhere to the principle of patient autonomy whereby it is the duty of practitioners to fully inform their clients of both sides of a possible condition, complication, risk, or a treatment in the most unbiased manner possible so that the individual client is able to make the most informed and educated decision possible regarding her care.

Inherent in the principle of nonmaleficence is the need for medical competence. Practitioners are expected to avoid inflicting needless harm or injury to a patient and providing a standard of care that minimizes risk to the patient is upheld by the legal institutions of society in order to protect patients from negligence. The principle of nonmalefience requires physicians to avoid intentional harm or injury to a patient either through acts of "commission or omission" (Beauchamp & Childress, 1994). According to medical ethics, nonmaleficence indicates that physicians must refrain from harming patients either through ineffective treatments or in acting toward patients with malice. Under this principle, physicians must make the ethical decision as to whether or not a specific medical procedure, such as a cesarean section, will offer a patient and baby greater benefit than burden or harm.

The principle of beneficence refers to physicians taking measures that ensure the patients' best interests are met. Beneficence and nonmaleficence are often considered together as one of central moral obligations of biomedicine: provide the highest benefit to patients with minimal harm. A common belief in medicine is that rigorous education and training before and during one's professional career will equip providers with the

necessary skills to successfully ensure beneficence. While striving to provide the most benefits to patients, it is also important to consider patient autonomy since what constitutes a benefit for one person, may be considered harm for another. Health professionals rely on empirical data assessing the probabilities of benefits and harms that may result from certain medical interventions as a way to ascertain if a particular treatment or intervention will result in greater benefit than harm. Some obstetricians interviewed argued that DEMs are not required to abide by the principles of beneficence and nonmaleficence, and this ultimately puts their clients and babies at risk for the sake of preserving patient autonomy.

The fourth major principle of medical ethics is justice, and this refers to fairness in health care. Justice entails the equitable distribution of goods in society and as applied to medicine, justice implies that "equal" people should have access to equal treatment. This principle has a controversial nature in U.S. society where health care remains more an individual's obligation rather than a social entitlement.

In his discussion of DEMs' training and education, one OB described the ways in which practicing physicians must abide by the principles of medical ethics. According to this particular OB, DEMs, who are highly dedicated to their clients, practice the principle of patient autonomy, but do not follow the principle of beneficence. The OB's perceptions of the behaviors and actions of DEMs are filtered through his socialization into the professional culture of obstetrics. According to the OB:

> If a patient comes in and wants a home birth and the midwife can tell that it is not a good candidate for a home birth…For a home birth, about 1-2% of clients who are not good candidates for a home birth still attempt one and this happens even if a midwife informs a client of the possible risks associated with a home birth for her particular condition. Midwives tend to rely on anecdotal medicine, "My last set of twins was fine. Let's deliver at home!"

In the above excerpt, the OB acknowledged that DEMs do provide their clients with information regarding possible complications or risks associated with home birth, especially for a mother who presents with particular conditions during pregnancy (breech, twins, diabetes, advanced maternal age). The OB quoted above, as did other obstetricians interviewed, expressed concern with midwives who practice strictly according to the principle of patient autonomy, and adhere to a patients' desires and wishes; the obstetrical fear in these cases being freedom of choice overriding a patient and/or baby's health and safety. What is important to note here, is the influence professional socialization has on OBs' perceptions and interpretations of DEMs skills and practices. OBs are positioned as professionals and therefore are obligated to abide by particular rules and routines that are particular to their job (March & Olsen, 1989). As practicing medical professionals, OBs are expected, as are other medical doctors, to abide by the principles of medical ethics. Medical ethics serve as guidelines for the way that doctors practice. Biomedical ethics exist within the context of the legal system. Therefore, upholding biomedical ethics is a way that OBs insure they are complying obligations to avoid with malpractice. As medical professionals, OBs occupy a different position than nurses and DEMs in that, as professionals, they must abide by and thus, experience greater influence from professional level structures than do nurses and DEMs whose jobs do not involve the same degree of professional regulation and oversight[17] (Simonds, 2007; Hirschkorn & Bourgeault, 2008; Vedam et al., 2009).

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[17] This is not to say that nurses and DEMs do not have professional obligations. For instance, nurses must complete formal training programs and some nurses interviewed reported being active members of the American Nurses Association (ANA). The ANA represents Registered Nurses and promotes quality nursing practices among its members. DEMs also reported being affiliated with professional midwifery

Some OBs interviewed had difficulty fathoming DEM practices that allow for greater adherence to patient autonomy rather than practicing the principle of beneficence. The practice of obstetrics in the United States is structured such that patient desires typically do not override the authority or decision-making power of doctors (Simonds, 2007) Hospital protocols are in place as a way to safeguard the organization, physicians, and their patients from potential problems and negative outcomes that may result in litigation. With the threat of liability looming over them, obstetricians tend to practice within the guidelines set forth by their governing body ACOG. The general public and DEMs alike may not truly understand or grasp the institutional constraints that are placed upon practicing physicians in the U.S. In other words, based upon the interviews with obstetricians, it is not necessarily that obstetricians agree with *all* of the protocols regarding pregnancy, labor, and childbirth that are in place, but, rather, their professional obligations make compliance to those protocols more likely.

Many of the obstetricians interviewed voiced that there is a lack of understanding on the part of midwives as to the professional standards that obstetricians are obligated to abide by. Such statements were made by OBs who compared themselves to DEMs, arguing that DEMs are not bound by the same institutional constraints and standards of care that obstetricians are. Some OBs made reference to the influence that their governing body, ACOG, has on their practices. One OB who has been practicing in Oregon for four years, stated that she and her colleagues would feel more secure if DEMs followed a similar standard of care that obstetricians are obliged to follow.

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organizations such as; The Midwives Alliance of North America (MANA). However, in my research, the OBs cited professional level obligations as exerting greater constraints over the way they practice than nurses and DEMs reported.

> …if we thought their [DEMs] decision making was safer. As far as what we consider the standard of care, which is imposed upon us by the American College of Obstetrics and Gynecologists, based on studies on outcomes. So when they look at outcomes of babies that were born breech and babies that weren't. The outcomes that were born vaginally breech and were born by c-section breech the outcomes are better with c-section. It's not like we are making it up. That's the thing. So for us, because the governing body dictates our practice in a number of ways, we would feel better and have a better relationship if those strict standards were followed.

The OB made reference to the way ACOG's recommendations are based on scientific evidence. Little is known about DEMs among OBs since, often, the only contact or interaction they have with each other is within the context of a home to hospital transport. OBs stated that they feel DEMs should be held to the similar standards as OBs and OBs have a feeling that DEMs are unregulated and do not follow practice standards.

Another OB questioned the regulation of practicing DEMs, stating that she is uncertain as to whether there is an "oversight mechanism" that governs their practice. This particular OB contrasted her perception of DEMs as unregulated with the highly regulated profession of obstetrics where consequences for practicing outside the standards of care often entail harsh penalties:

> I don't know what the oversight mechanism is and if some are licensed and some are not. I would like there to be an effective oversight mechanism because our oversight mechanism is sometimes lawsuits, licensing. It's not always clear to me that there is always oversight…Here [in the community], there is a certain midwife, who more than any other midwife, seems to be transporting people at the last moment when things are turning very tragic, and you wonder where is the oversight and who is going to change the behavior there? And we don't feel like, from the obstetricians' perspective, like there is any effective mechanism for that.

My research demonstrates that with a limited discussion of direct-entry midwifery and home birth in medical school training and their clinical practices, transport becomes a

particularly important context within which obstetricians formulate views of DEMs and their practices. I argue that there are consequences to OBs' limited exposure to DEMs and home birth. In particular, when OBs' primary exposure to DEMs and home birth is limited to transports, this has the potential for OBs to generalize and apply their transport experiences to the practice of direct-entry midwifery and home birth as a whole.

All of the obstetricians I interviewed referred to a particular transport that ended in the death of a baby as they reflected on the practice of DEM, home birth, and hospital transport. In 2007, a DEM transported a client who had attempted to give birth to twins at home. Even though the mother was transported to the hospital, one of the twins did not survive. The majority of the OBs interviewed stated that if the DEM had transferred care to an OB when it was discovered that the mother was carrying twins, or at least transported the mother sooner, her baby may have survived. This experience has significantly colored many obstetricians' views of DEMs, home birth, and the women who choose home birth. All of the obstetricians were critical of the midwife who provided care for that particular patient and questioned if the mother was truly informed about the possible risks and complications associated with birthing twins at home. It is noteworthy that the attending DEM who attempted the twin home birth has been a practicing midwife in the area for over twenty years, and she is a non-white midwife who practices in the Oregon community where my research took place. As previously discussed in Chapter II, the historical legacy of midwifery in the U.S. has consequences for practicing midwives today. Stereotypical and racist images of midwives fueled physicians' ideological campaigns to eradicate midwifery during the late nineteenth and early twentieth century. I argue that today's DEMs must still live with the enduring

power of these stereotypes in that direct-entry midwifery still remains a marginalized profession even though it has experienced a slight resurgence since the 1970's (Davis-Floyd, 2006; Rooks, 1997; Rothman, 1982, 2007). This event also speaks to the way in which the medical community along, with the general public, tend to formulate attitudes and views regarding the practice of direct-entry midwifery and home birth based on the small number of "bad outcomes" without considering the large number of "good" outcomes, as measured by infant and maternal mortality rates along with mothers' satisfaction with the birth experience, that most midwives and consumers of home birth report (Boucher et al., 2009; Johnson & Daviss, 2005). The media now represents the primary tool to promulgate negative and historically stereotypical images of today's DEMs and home birth (Davis-Floyd, 2006; Cheyney, 2005; 2008).

Every OB made reference to this tragic outcome. One OB stated DEMs are not held to the same standards of practice as OBs, and this has the result of DEMs taking on high-risk clients. According to this particular OB's perspective, the attempted home birth of twins is reminiscent of maternity care in developed nations:

> …this nebulous zone between these uncertified people doing things that are quasi-medical. Oh, I just don't see why they do it. Why? Because there is no standard to hold you [DEMs] to. Maybe they like this amorphous zone…I think some standard would be helpful where we could all agree. Like it'd be nice if all midwives agreed, "No, you don't do a twin home birth." You know, if they all agreed there was some standard among them…I think care would be improved. And like what are you providing your clients? You might as well be living in the slums of Calcutta! I mean that is a terrible thing to say, but this is the modern world, you know?

The negative outcome of the 2007 transport was used by OBs as a way to 'other' the practice of direct-entry midwifery and to question the skills and experiences of *all* home births and DEMs. OBs relied on the tragic outcome as a way to contrast their work

and to uphold the ideology of the medical institution that states obstetric-supervised, hospital-based births represent the safest birth option for women and their babies. The 2007 incident lives in the minds of OBs in the Oregon community where my research was conducted. Most of the OBs interviewed do not know about the large number of home births that result in positive outcomes for moms and babies each year in the community. The obstetricians I interviewed tended to view this particular incident with the dominant biomedical lens. Perhaps obstetricians would not view home birth midwifery and transport through the lens of this particular negative incident if more accurate information about home birth was readily available and presented in the mainstream media or to the OBs during training.

In one OB's discussion of the attempted home birth of twins, she stated she has not necessarily noticed a significant difference in how DEMs practice following a meeting that was held to consider ways that communication between DEMs and medical staff could be improved during transports:

> I haven't had anyone coming in from attempting to deliver twins at home, but I don't know. That doesn't mean that it's not going on at home…It's one of those things. Again, we only see the bad which I think is part of the problem, especially for those of us who haven't had any experience with it [home birth and transport] prior to coming here.

This OB recognized that the only time she interacts with DEMs is during transport situations and characterized this as a time when "we only see the bad." She indicated that home births unfold just fine for many women, but from her position as an obstetrician, in a community where interaction between midwives and doctors is limited to transport situations, her perception of home birth and midwifery is skewed by the handful of transports she is a part of each year as an on-call physician.

Another OB commented on the way that the medical community often grounds their perception and subsequent treatment of DEMs on its experiences with hospital transport. The OB stated the consequence is that the entire practice of direct-entry midwifery comes under the scrutiny of the medical community, "I think in general, they [DEMs] don't trust the medical system. They get blamed for problems. It is the observational bias of obstetrics—we only see the home births that don't go so well, so that impacts how we view midwives and the work they do."

The DEMs in this study understood that one negative transport experience impacts the medical community's view of home birth and midwifery. Four of the DEMs interviewed openly made reference the to ways in which negative outcomes during transport affects the interaction and treatment of clients during subsequent transports. One midwife described the effect negative perceptions of DEMs and transport has on her when she brings a client to the hospital:

> Sometimes I have to go in, and there's a couple of doctors who I know, and I also understand why they feel the way that they do. They are not going be able to distinguish between me and the midwife who got them to where they're feeling. They will see me as a midwife. I am just a metaphor for everybody who's going against the system and doing home births. They're not going to be able to determine how I'm different from another midwife or how my client is different from another client. And so I will have to deal with whatever the baggage is that they're bringing…I think it's their past experience. I think when there are rare unforeseen instances where you're at home and things are going relatively fine and maybe the midwife has missed something, or maybe she hasn't, and a catastrophic hemorrhage comes, or a shoulder dystocia or, a baby that was doing well and now suddenly is not, and you go in and it's a train wreck. It is really scary and either, maybe the baby does die or maybe it's a close call. And that obstetrician is forever deeply impacted by that experience and the terror they felt and could potentially play a role in that baby not making it. And it is very hard for people to leave that behind. And I don't care how many other positive birth stories they've heard, you're going to be impacted by the one that radically—that scared the crap out of you basically.

When OBs are witness to negative outcomes, such as the home to hospital transport of twins in 2007, where one of the twins died, and such experiences are not balanced with accurate information regarding the “good outcomes” that typify most home births, these experiences have a profound lasting emotional effect on OBs. In some cases, negative outcomes may result in OBs intensifying their adherence to the biomedical model and practicing with extreme caution so as to avoid tragic outcomes. As OBs spoke about their education and training, most made reference to the way that they are trained to recognize and treat the rare, yet potential, obstetrical conditions and complications. Due to this type of training, many viewed direct-entry midwifery and home birth with suspicion. Thus, when OBs’ professional socialization through medical education entails viewing pregnancy and birth as potential pathologies, OBs are likely to construct perceptions of and interact with other practitioners from this hegemonic vantage point of risk and risk management.

Malpractice

Unlike countries where state supported health care is available to cover the costs when something goes awry during the birth process, the U.S. lacks state-funded health insurance and some families resort to suing the OB/GYN, hospital, or other care provider to contend with death or the costs of caring for an injured child and/or mother (Wagner, 2006; van Teijlindgen et al., 2009). Due to the medical/legal situation in the U.S., most states require all practicing physicians to purchase professional liability or malpractice insurance. In those states where malpractice insurance is not required, physicians typically must carry malpractice coverage in order to have hospital privileges (Mello,

2006). Malpractice insurance is usually purchased by individual doctors or group practices from a commercial insurance company or a "physician-owned mutual" company (Mello, 2006, p. 1). In Oregon, all practicing physicians are required to carry malpractice insurance for their clinical practices and coverage is also necessary for physicians to have hospital privileges[18]. Medical malpractice refers to professional negligence due to an act or omission by a health care provider wherein care does meet the medical community's standards of practice resulting in injury or death to a patient. MacLennan et al. (2005) found that 76% of U.S. obstetricians have had medical malpractice lawsuits filed against them. According to van Teijlingen et al. (2009, p. 3), "For US practitioners…the issue of safety in childbirth is enmeshed in a legal system looking to blame someone for 'bad outcomes' that inevitably occur." The threat of litigation constitutes one of the primary reasons why U.S. OBs discontinue practicing obstetrics (MacLennan et al., 2005). The structure of the U.S. medical/legal system represents a professional level constraint that influences obstetricians, rendering them more likely to practice defensive medicine in an attempt to avoid litigation.

The fear of litigation influences OBs' use of extensive prenatal testing, monitoring during labor, and interventions during the birth process (Annandale, 1996; Wagner, 2006). Throughout the course of interviewing obstetricians, it became apparent that the medical/legal system and obstetricians' obligations to their practice (colleagues, ACOG recommendations and guidelines) dictate to a large degree, the way that obstetricians practice and behave toward other practitioners and their patients. Wagner (2006) comments on the interrelationship between ACOG and litigation stating,

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[18] For more information on the state of Oregon's malpractice insurance requirements and rates for practicing physicians see insurance.oregon.gov/news_releases/2009/42709-medmal_rates.pdf.

"If doctors and hospitals go against one of their (ACOG's) recommendations, they are more vulnerable to litigation" (p. 27). My interview data with obstetricians reveals that malpractice affects 1) individual obstetricians' practices with their own patients; 2) how OBs view the practices of DEMs and home birth; and 3) how OBs will perform or behave during a home to hospital transport.

Obstetricians in the U.S are often constrained by malpractice obligations and strictly following protocols and regulations set forth by the insurance industry. If they do not follow the standards of care, which often entails practicing defensively, they risk being sued, losing their license, and the ability to practice. When asked if there were any aspects of his work that he would like to change, one OB responded in the following way:

> Malpractice. It dictates everything we do. It dictates *everything* we do. I mean that's the reason why the c-section rate is up around 30%. It's the reason why we order thousands of dollars worth of tests for a one in 10,000 diagnosis. If someone has it and you didn't order the $10,000 test, we'll see you in court! You know nobody goes in…well I can't say it. I've never met anyone that goes into medicine, with a, with this maleficence around them of "I'm out to hurt people." It just doesn't happen. I think lawyers and the judicial system think that we don't give 110% and that we don't care and if you miss the one in 10,000 chance you are a horrible physician and you need to be punished for it. You know what, shitty things happen. I'm really sorry. Some you can't do anything about. It just happens, and it's nobody's fault and the court of law doesn't see that. And that sucks. That's why some of the older OBs don't do it [practice obstetrics] anymore. They keep their fingers crossed that they can make it through 15 or 20 years of practice, establish a good practice, get their patients, get the gynecological practice going, and get the heck out. Because all it takes is one [negative outcome], whether you did something wrong or not. So that's the number one thing I would change.

In the above conversation, the OB intensely described the influence that litigation plays in the way he practices obstetrics. He points to the use of extensive technologies

and the ordering of expensive tests as way to safeguard himself against litigation and to rule out any possible conditions or complications, although rare, that may arise. The OB argues malpractice and the fear of being sued fuels obstetricians liberal use of technologies and testing prenatally. He acknowledged that many of the extensive tests that are available are designed to diagnose rather rare conditions and complications, but this particular OB, as well as many other obstetricians throughout the country, makes the decision to perform tests as a precautionary act, safeguarding him from the potential of litigation. It evident, in the OB's following comment, that at the professional level the factor of malpractice constrains his ability to support home birth; "if the U.S. wasn't so litigious, I would advocate for it [home birth]. I would totally advocate for it. *I would totally advocate for it*. If I knew, I wasn't gonna get sued, sure." Thus, even though the OB expressed a personal desire to be an advocate of home birth, his professional obligations preclude him from doing so.

One OB expressed concern over the existing medical/legal system in the following way:

> There are also physicians who do a very good job and something bad happens, and they get sued. They lose their license, and they can no longer afford to practice because of a negative outcome that was through no fault of their own. And until that happens, until that kind of change [in the medical/legal system] occurs, you're not gonna see a drop in the c-section rate, you're not gonna see a change in the way we practice…

In the above excerpt, the OB echoed some of the same concerns regarding malpractice that an earlier quote from an OB referenced. Here, the OB cited the current structural and institutional forces in U.S. society that make malpractice and litigation such pressing concerns for practicing physicians. In this OB's view, OBs are unlikely to

alter the way they practice until significant structural changes are made regarding U.S. healthcare that would eliminate the need for malpractice coverage. The OB argued that the application of interventions, including cesareans, typifies obstetrics in America as obstetricians will often choose to perform a cesarean rather than attempt a vaginal delivery just to be on the safe side, even though a c-section is a major surgery. This particular OB commented on the way that malpractice leads obstetricians to conduct a "certain amount of unnecessary testing due to the fear of litigation. If that weren't the case that would be nice. Like ultrasounds and things. The baby measures a little small but you feel the belly, probably ok, but you are thinking what if I'm wrong? I'll get an ultrasound it doesn't hurt anybody, but it costs…but I think that is the hardest part, you can do the best job that you can and still have a negative outcome and end up in court."

The defensive practices on the part of OBs sets them up for feeling apprehensive when taking on a transport patient since they do not know the patient prior to the transport and often in the back of their minds lingers this potential for litigation should something go wrong. This in turn, affects how physicians interact with midwives and their clients during a transport including what recommendations and advice an OB will offer. Some OBs reported feeling resentment when a transport occurs during the middle of the night and the OB is legally obligated to provide care for a patient they have never met and know very little about. The OBs interviewed stated that establishing relationships with patients was as an important way to avoid litigation. From the perspective of many of the OBs, patients are more likely to trust their doctors and heed their recommendations during labor and birth if they have established a sense of rapport and built a relationship throughout the prenatal period. This type of relationship is often

difficult to establish during a transport due to the limited amount of time OBs and patients have to interact and the often stressful circumstances that surround home-to-hospital transports.

Two of the OBs interviewed commented on the way that medical education teaches aspiring OBs particular skills, (such as cesarean section), while neglecting to teach others, (such as vaginal breech and twin deliveries) as a way to avoid malpractice litigation. When most U.S. obstetric residency programs do not to teach students vaginal breech or vaginal twin births, the results are entire cohorts of obstetricians who are devoid of valuable skills. The Canadian Council of Obstetrics and Gynecologists recently put forth a position statement recommending that in low-risk pregnancies, doctors attempt vaginal breech births. The reasoning behind this position statement is that current literature and scientific evidence points to the safety of vaginal breeches and the fact that the benefits of vaginal breech birth outweigh the risks in many situations. One OB cited the governing body ACOG as responsible for constraining the way that OBs practice and obligating OBs to perform interventions, such as cesareans, in order to deter litigation. According to this particular OB, "obstetricians are losing skills they used to have like with breech babies, with delivery of vaginal twins with forceps, where it's basically a spontaneous birth or c-section. There is very little in between. Where we used to be able to do a lot of different things. In my career, I've done a lot of vaginal breech births, and twin births and if things are done carefully, it can be done safely." This OB commented on the declining rate of VBACs as well stating, "VBACs have been much less common because the American College of Obstetrics and Gynecologists had

some strict guidelines and some of that was political. So, in 1999, the number of VBACs all of a sudden went down."

Another OB discussed the constraining influence that fear of litigation has on limiting the skills of many obstetricians when it comes to assisting patients with a vaginal breech delivery:

> The current status of breech deliveries, part of the problem is that nobody knows how to do them anymore. Nobody knows how to do them anymore because of litigation. So you have a whole era of OBs who just aren't trained to deliver babies backwards. And that happened because…the only place that you get enough experience to do that [vaginal breech deliveries] is in hospital settings where they do enough of those deliveries, but as that got to be less and less and fewer and fewer obstetricians wanted to do it, they taught fewer and fewer obstetricians to do it. Then, you ended up with a whole generation of OBs who have just never done it."

In the above excerpt, the OB makes an important point in that she remarks on the dearth of obstetricians today who know how to assist with vaginal breech deliveries and also she speaks to the fear of litigation that deters many OBs from attempting vaginal breech deliveries. The OB considered her training to be somewhat unique in that during her residency she did learn how to assist with a vaginal breech birth. She attributes these skills to her instructors whom she described as "old school guys." Although this OB did assist with and learned about vaginal breech deliveries during medical school, she stated that in her own practice she is not completely comfortable attempting vaginal breech deliveries so she either performs a c-section or offers the mother an external cephalic version, a procedure whereby practitioners attempt to manually move a breech baby into a cephalic or headfirst position.

What is important to consider here is the predicament that this places women in. When their childbirth choices are limited because they are carrying twins, have had a

previous c-section or will be delivering breech, within the context of the hospital under the care of an OB. Some women feel they have no other choice than to birth at home with a DEM, unassisted, or else be subject to a c-section in the hospital. Therefore, DEMs fulfill the needs and desires of a certain niche of consumers who may be carrying twins, a breech baby, or attempting a VBAC and would like the opportunity to try delivering vaginally. DEMs perform an important role in providing care and service to women who may not otherwise have the authority to make the choice in how their labor and birth will unfold. This illustrates that some women's choice to deliver at home is not really a choice at all. For example, a woman may choose a home VBAC because a hospital VBAC is impossible or unlikely.

Recently, there is promise that more practicing OB/GYNs will allow a greater number of women to attempt a VBAC. In August 2010, ACOG released a policy statement revising their recommendations for VBAC births. The 2010 policy addresses some of the concerns regarding increasing cesarean section rates in this country and advocates for an increased amount of Trial Labor After Cesarean (TOLAC) and VBAC births based upon scientific evidence that points to the safety of TOLAC and VBAC births among certain groups of women[19] .

The labor and delivery nurses interviewed stated that they were aware of the malpractice constraints that impact the work OBs do. One nurse stated that the escalating c-section rate is due to a combination of legal factors and patient desires:

> It's partly liability driven because the courts now, it has to do with the Medical Association and the court's mindset. If the court thinks it's safer to do a c-section, you're [OBs] not going to get so many judgments against you. So you do what the

[19] To read more information regarding the ACOG's recent position statement on vaginal birth after cesarean (VBAC) see ACOG Practice Bulletin 115 at http://www.acog.org/from_home/publications/green_journal/PBListoftitles.pdf.

> courts want. It's more court driven and also consumer driven and Medical Association driven. So that kind of forces the doctors into figuring out what their liability is…However, the other thing, the other piece of it though, is that there is a financial gain to be gotten from c-sections, both for the hospital and for the doctor…Well, plus it takes way less time. They [OBs] don't have to sit around and labor-sit and stare at the monitor to be sure the baby is not stressed. They can just get it over with and be done and make all this money. It makes way more sense.

From the perspective of a labor and delivery nurse, she notices the ways in which OBs are constrained by legal obligations to perform c-sections. However, the increase in cesareans is more complex than an OB's legal obligations according to this particular nurse, in that she pointed out the financial incentives involved for both hospitals and doctors when c-sections are performed. From her vantage point, OBs are interested in doing c-sections as a way to make money and to meet the multiple demands of their clinical practices.

Direct-entry Midwives

The previous section of this chapter was devoted to discussing how OBs, as practitioners of medicine in the U.S., are influenced by various professional factors when it comes to formulating views regarding home birth, direct-entry midwifery, and interacting with DEMs and mothers during home-to-hospital transports. I now turn to the work of direct-entry midwifery asking: What are the professional level factors that may influence how a DEM interacts with medical staff during a transport? Also, how does the position of DEM in relation to professional level structures affect their status as care providers within the context of a home to hospital transport?

Professional Level Influences

Licensure

The primary professional level factor that influences the work of DEMs pertains to licensure requirements. The DEMs interviewed pointed to ways that licensure offered

them opportunities as practicing DEMs' in Oregon and some DEMs argued that licensure had a constraining effect on their practices. I will discuss both the opportunities afforded to licensed DEMs in Oregon as well as the ways that licensure represented constraints to some of the DEMs interviewed.

In the United States, the regulation of DEMs is left in the hands of individual states (See Chapter III) and therefore, a significant degree of variation exists in DEMs legal status and ability to obtain licensure. In fact, the status and availability of home birth midwives varies by state, city, and local communities (Vedam et al., 2007). This wide variation in the provision and regulation of midwifery has resulted in perhaps more types of midwives in the U.S. than in any other nation. For instance, there are CNMs (Certified Nurse Midwives), CMs (Certified Midwives), Lay midwives or traditional midwives (DEMs), DEMs that are licensed midwives (LM), and DEMs that are Certified Professional Midwives (CPM). The multiple types of midwives are in part a result of the midwifery community's recognition that there are a variety of educational paths to practicing midwifery. I argue, that part of this diversity in types and qualifications of midwives also derives from, and is a reflection of, the way that home birth midwifery has never developed as a profession the same way that obstetrics has in the U.S. The lack of national recognition of direct-entry midwifery as a valid profession contributes to its continued marginalization and the difficulty women have in accessing qualified home birth providers in some regions of the U.S. (Vedam et al., 2009; Vedam et al., 2007; Davis-Floyd, 2006).

The regulatory situation of DEMs in the U.S. stands in contrast to countries such as Canada, England, and the Netherlands, where midwifery is regulated on a national

level and midwives are integrated into the national health care systems, attending the majority of low-risk births in those countries (de Jonge et al., 2009; Janssen et al., 2002; Johnson & Daviss, 2005). The health care systems in the Netherlands, Canada, and England regulate and educate midwives differently than in the U.S. This reveals the way that maternity care and child birth are social constructions and how the valuation and status of home birth midwifery varies by social context. The educational training of OBs in the Netherlands occurs within the context of a health care system characterized by an independent and strong profession of midwifery (DeVries, 2005). In terms of the educational training of midwives in the Netherlands, midwives must complete four years of training at a midwifery educational facility. Midwifery education in the Netherlands is more uniform than the training that some DEMs in the U.S. receive in that the Dutch system requires that all midwives are trained in the same way and in the same skills. DeVries (2005) comments specifically on the content of Dutch midwifery education stating that during their four years of midwifery educational training:

> ….students are trained in antenatal and postnatal care; the management of normal "physiological" birth (in home and in the polykliniek); the identification of high risk situations in the antepartum, intrapartum, and postpartum periods; and techniques of scientific research. In the first year the focus is on the normal, physiological course of pregnancy, delivery, and the postpartum period. In the second year, the curriculum shifts to obstetric pathology and related fields. In the third and fourth year, students work on integrating the theoretical and prenatal knowledge acquired in the previous two years (p. 70).

In Chapter II, I discussed how some practicing midwives (both CNMs and DEMs) during the 1980's expressed concern over a lack of standardization in the training of home birth midwives in the U.S. and this led to the development of the CPM credential.

According to the North American Registry of Midwives (NARM), a certified professional midwife is:

> …a knowledgeable, skilled and professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and is qualified to provide the Midwives Model of Care. The CPM is the only international credential that requires knowledge about and experience in out-of-hospital settings.

Some of the DEMs interviewed stated that the professional level factor of state licensure and the international CPM credential offered them opportunities in their practices. DEMs made reference to various opportunities that licensure provided them such as a more professional-level status due to being credentialed, the right to carry certain pharmaceuticals, and the ability to bill insurance companies for their services. It must be stated that these views were vocalized by DEMs who had already obtained licensure and the CPM, as well as by three DEMs who were unlicensed at the time of the interview, but were either in the process of applying for licensure or stated that they would complete licensure requirements within one year.

One DEM who was unlicensed at the time of the interview, stated that she plans to become a Certified Professional Midwife (CPM) and LDM in Oregon. The reasons cited for pursuing licensure by this DEM centered on the way that the CPM credential and LDM indicate to other care providers and consumers that she has met standardized competency and educational requirements which are valued in contemporary U.S. society:

> Traditional midwifery is something that I personally don't believe exists anymore. Let's face it. We're modern midwives. We're not traditional midwives. So it's important that we have some sort of standardization. And anybody in Oregon can call themselves a midwife. This could kind of set midwives apart from others, I guess, in some ways. Well, it just shows that you've done something, you know?

> It shows that you've achieved some sort of standard. And I think that's good. And also it's accepted anywhere in the United States, as a standard title, so I think I'll end up doing it.

In the above excerpt, the DEM expressed the importance in the way that the CPM credential and licensing provides a source of standardization for DEMs in the U.S. The value that this particular DEM attributed to standardized education and the credentialing of DEMs reveals that she is aligned, to some extent, with the OBs interviewed who advocated for educational measures to standardize and assess the competency of DEMs. Earlier in the chapter I discussed how all of the OBs, although to varying degrees, expressed the need for greater standardization in regard to the training and scope of practice for DEMs. OBs stated they are concerned when DEMs are able to attend births that are considered "high risk" (VBAC, twins, breech) and then are not held accountable for their actions. One DEM stated how licensure and certification can have a screening effect where more trained DEMs are "set apart" from DEMs who are not practicing according to the standards of safety.

Five of the DEMs interviewed stated that one of the primary reasons that they pursued licensure was to be able to bill insurance companies, in particular OHP, which opened up their clientele base to low-income families, who may not otherwise possess the financial means to choose a home birth with a DEM. Currently, most midwife-attended home births are to white, middle-class, college-educated women. Aware of these discrepancies in the lack of access to home birth and midwifery care among working class families, some DEMs viewed licensure as an opportunity which enables them to better serve women from all social backgrounds.

A DEM made reference to the opportunity that licensure gave her in terms of serving clients who may have traditionally been underserved by midwifery and who, due to their social class status, may have been unable to access the care of DEMs and plan home births:

> One of the advantages of licensing in the state of Oregon is that you can charge third party insurance…which includes the Oregon Health Plan. There are quite a few home birth clients who don't have the means to pay for home birth…if you're a licensed midwife and a pregnant woman gets an open card, which means she doesn't apply for OHP until her third trimester, and then it will pay for her birth. So that made it important enough to me to open the doors, for those women that couldn't afford to have a home birth otherwise…And since I think our country should have universal health care anyway, anything that comes close to giving people access to the kind of health care they want, that's paid for by the state, I'm in agreement of.

The DEM quoted above, stated that licensure offered her the opportunity to provide desired services to certain segments of the population who might otherwise be denied access due to the inability to pay. In the DEM's account, she espoused how licensure was, in part, a political decision. The DEM recognized that universal access to health care often opens up opportunities to most consumers and citizens and makes it more likely that they will receive the type of care they desire. This is in comparison to the U.S. profit-driven model which leaves health care up to the individual consumer and the choice to health care services is typically reserved to those who have the ability to pay.

Although most DEMs expressed enthusiasm related to the benefits that came with licensure, not all DEMs viewed the credentialing process and licensure as an opportunity to improve the status of the DEM profession. Some felt that state regulation of their practices would ultimately constrain the way that they do their jobs, including the clients

that they would be able to serve. Davis-Floyd (2006) considers the ways that licensure may restrict a DEM's practice stating:

> When lay practitioners become professionals and obtain the benefits of legalization and licensure (which include not only insurance reimbursement, but also not having to worry about being arrested), there is usually a price to be paid. Licensure means regulation, and regulation means restrictions on one's decision-making power and thus on one's autonomy (p. 185).

One of the DEMs who chose not to become licensed stated she is critical of the licensure process due to the potential of state regulations co-opting her practices:

> I believe that midwifery care constitutes an exchange of energy between me and the people that I'm caring for. And for me, it's not a profit-making enterprise. I didn't want to put it [my midwifery practice] into the realm of business. I also think that it's a really serious thing to sign on to a set of protocols and licensure requires signing on to a set of protocols. I'm just like that person that compulsively gets A's on tests. I don't even jaywalk. If I signed onto those protocols, I would practice within them very, very stringently. And I think that that would limit some of the options of my clients. I don't usually practice outside of the standard protocols of licensed midwives in Oregon, but there are times when I have clients who would ask for something else. And I'd like to be able to honor that request if I think that it's coming from an informed space.

Above, the DEM argued that being *unlicensed* and therefore, not under the purview of the state, grants her opportunities to assist women with births that fall outside of the boundaries the state dictates. For example, this particular DEM spoke of attending the births of women who were either prior to thirty-seven weeks gestational age and those that were beyond forty-three weeks gestational age, stating that, "those two dates are absolute contraindications for doing a home birth according to the protocols of a licensed midwife." In her description of her reasons not to become licensed, the DEM argued that the state, and those governing bodies who make decisions regarding DEMs scope of

practice, may not always have midwives' and home birth consumers' best interests in mind:

> Anytime we place what we do under the auspices of insurance companies and boards that set standards based on advice from insurance companies, or from professionals that are outside our philosophical perspective, we run the risk of having restraints placed upon us from the outside.

This DEM makes an important point here: even though MANA and NARM have worked at establishing international, standardized educational components to assess and demonstrate DEMs' proficiencies, state governments still retain a significant degree of discretion in terms of how licensure is or is not structured in a given state. The point I want to draw out here, is that in order for states to legalize and regulate midwifery and to allow DEMs to continue practicing at home legally, this typically involves compromises. Currently, licensed and unlicensed DEMs are able to attend VBAC, breech, and twin births at home. Although, it is important to note that the Oregon legislature is reviewing these practices with the possibility of restricting licensed DEMs from attending such births. Therefore, since Oregon offers voluntary licensure, the type of births that a midwife attends can be left to an individual midwife's choice. However, licensed midwives may find that their scope of practice and the clients that they may serve are further constrained by licensure, a chance some DEMs are more willing to take than others as a way to "mainstream" midwifery and thus shift home birth from the margins into the broader health care system.

What does this mean for transports? One interesting finding from this research is that licensure status did not necessarily result in better or timelier transports in the eyes of the medical staff interviewed or from the perspective of DEMs. In fact, in identifying

good midwives or those that transported appropriately, OBs cited some midwives who were licensed and some who were not licensed as the ones they felt were practicing safely and from an educated standpoint. The medical staff interviewed had very little understanding of the different types of DEMs, their training, and the various regulations that licensed DEMs are obligated to comply with. Therefore, OBs did not differentiate between licensed and unlicensed DEMs when discussing their experiences with transport. Rather, OBs tended to associate qualities with "good" midwives versus "bad" midwives based upon the reasons for transport, the timeliness of a DEM's decision to transport, their interaction with medical staff, and whether or not DEMs openly disclosed information regarding their client's health history and labor progression to medical staff. In other words, midwives who were not licensed were as likely as those who were licensed to transport clients and seek out medical care in times of need, thus this research does not indicate a significant difference in the practice styles of unlicensed DEMs versus licensed DEMs. It is likely that licensure status and state regulations governing conduct for DEMs do not automatically result in earlier transports or facilitate the transport of clients; however, the prior relationships and interactions that DEMs have had with particular OBs, as a result of interfacing and/or transporting clients to the hospital, has a greater impact on their decision to transport and their comfort with transporting. Likewise, DEMs spoke highly of one another demonstrating the close knit community that typically characterizes DEMs throughout the country. The DEMs interviewed stated that regularly attending peer review with other practicing DEMs allows for open communication and a discussion of good transport practices in order to provide safe, continuous care for mothers and their babies.

Although many licensed DEMs found that licensure offered them opportunities in terms of being able to demonstrate a level of educational standardization and competency along with being able to serve a wide range of clients from various social locations, licensure did have some constraining influences for the licensed DEMs interviewed. The fear of being turned into the OHLA (Oregon Health and Licensing Agency) a state protection consumer agency that issues licenses to DEMs, was a concern cited by some licensed DEMs. The OHLA serves as a regulatory agency for various health-related professions in the state. OHLA possesses the authority to revoke and/or suspend a DEM's license. Licensed DEMs stated that transport represents a situation when they become concerned and anxious about being turned in if medical personnel deem they did not practice safely and according to the established guidelines set forth by OHLA. The majority of complaints filed against DEMs come from hospital staff that has been present with a DEM during a transport. The power of the OHLA represents a professional level factor that DEMs must contend with. OHLA exerts a certain amount of influence over the work that DEMs do. Some DEMs spoke of having to tread carefully during a transport so as to avoid disciplinary action.

One DEM described the challenges she and her peers face as autonomous practitioners without a powerful organization like the AMA or ACOG representing them:

> I feel like I have a good relationship with other DEMs. I feel like I can peer review with people and be really honest with them. We all kind of watch each others' backs which is all we have…we don't have an AMA and we don't have a panic button we can push to pass the buck and we don't have malpractice insurance covering our practices so we just have each other and we have to rely on our own common sense and intuition.

In the above excerpt, the DEM inverted some of the structural constraints that OBs cited were responsible for restricting and dictating the way they practice, such as professional organizations (AMA and ACOG) and malpractice insurance. The very structural constraints upheld by OBs as being problematic are labeled by this particular OB as safety features midwives do not have access to due to the marginalization of direct-entry midwifery by the U.S. medical system. As a marginalized profession, DEMs occupy a particular vantage point from which they can easily identify the power OBs' professional association and governing bodies impart on their members. DEMs typically have a relatively good understanding of biomedicine since it is the dominant way pregnancy and birth are practiced and viewed in this country. One reason DEMs know biomedicine so well is that they critique many components inherent in its philosophy and approach to care. Likewise, DEMs must have an understanding of the medical model and know how and when to interface with the medical community out of necessity. Being able to decipher when medical resources and expertise is needed is an integral aspect of DEMs' practice so they are able to provide safe, quality care to clients and their babies. Although it may be beneficial, OBs do not find themselves in positions where accessing DEMs' knowledge and interfacing with DEMs is a necessity. Rather, under current structural forces, as practitioners of a socially dominant model of care, OBs are absolved of having to develop an accurate understanding of the work of DEMs, including the benefits of the midwifery model of care. Also it is often the case that it is easier for those in marginalized positions to call into question and critique the powers that be, rather than, for those occupying positions of privilege to recognize, acknowledge, and critique that very privilege on which their dominant status rests (McIntosh, 1988; Davis-Floyd, 1992;

Rothman, 2007). Davis-Floyd and Davis (1997) argue that DEMs become "hypereducated" in the medical model of care as a way to formulate a powerful critique of the model that marginalizes the practice of direct-entry midwifery:

> The fact that the legal system so completely supports the praxis of technobirth has forced those midwifery practitioners who take the risk of opposing it to become almost hypereducated in the science of obstetrics so that they can both defend themselves against legal persecution by the medical establishment and work to change the laws that keep them legally marginal (p. 244).

Some DEMs described the challenges DEMs face as autonomous practitioners without a powerful organization such as the AMA. Most DEMs interviewed have ties to professional midwifery organizations such as MANA, NARM, and the National Association of Certified Professional Midwives (NACPM). However, these organizations do not wield as much power as the AMA or ACOG and therefore, may be less influential in shaping U.S. maternity care policy than dominant medical organizations. In addition, DEMs' legal status in the state of Oregon as autonomous practitioners has a constraining effect in that DEMs are not considered valid practitioners within the context of biomedicine. At other times, their freedom from complex organizational routines and protocols offers them opportunities to exercise their autonomy.

Conclusion

In this chapter, I examined OBs' views regarding direct-entry midwifery, home birth and transport, noting that their perceptions of DEMs and home birth and their behavior during a transport is influenced by a combination of individual practitioner attitudes and professional obligations. OBs would often use their professional socialization and professional obligations as practitioners of obstetrics/gynecology as a reference point in constructing their perceptions of home birth and midwifery. DEMs

argued that licensure offers them opportunities in being able to serve women from all social backgrounds, and licensing and credentialing offers a degree of standardization for DEMs. At the same time, some DEMs found licensing to be constraining due to the limitations and compromises that accompany state regulation. The data collected for this study indicate that a particular provider's position within professional structures influences their work and behaviors during home to hospital transports.

It is clear from the interview data that OBs would benefit from developing a greater understanding of direct-entry midwifery. Practicing in a community with a significant number of DEMs and home births necessitates the need for OBs and nurses to foster a more accurate understanding of how DEMs are trained and what they do in their practices. Taking steps to educate all care providers could help facilitate smooth articulations between hospital staff and DEMs during transport situations. In addition, familiarity and exposure to the research documenting the safety of home birth would help dispel some of the inaccurate perceptions regarding out-of-hospital births with qualified care providers. Such changes could help alleviate some of the tensions between the medical community and the DEMs and open up the space where home-to-hospital transports could bridge the gap between the philosophical and ideological differences between DEMs and medical staff.

OB respondents who had greater exposure to the midwifery model of care and the practices of DEMs were more favorable of and willing to support DEMs and their clients during a transport. Vedam et al. (2009) considers the effects of professional curricula designed for OB/GYNs and CNMs that do not include theoretical or clinical information regarding out of hospital births:

> The differences among health professional curricula for maternity providers are likely to affect the development of attitudes. Medical educational programs throughout North America rarely offer theoretical or clinical education on appropriate care in out-of-hospital settings. Certified professional midwifery programs in the United States currently offer *only* home birth and birth center preparation. All American nurse-midwifery programs require hospital intrapartum experience, but home birth curricula and clinical experiences are rarely incorporated into core requirements (p. 280).

According to Vedam et al. (2009) OB/GYN and CNM midwifery training would benefit from "mandatory requirements for planned home birth clinical experiences, and out-of-hospital management and skills competency assessment, similar to those that exist in other nations" (p. 280). As mentioned earlier in the chapter, obstetrical training in the Netherlands involves didactic and clinical programs that prepare OB/GYNs for birth in hospital and home settings. The Dutch health care system has a long history characterized by the integration of midwifery and medicine and this social arrangement encourages collaborative relations on a national level between practicing physicians and midwives (DeVries, 2005; van Teijlingen et al., 2009).

Likewise, based upon the findings from this study, it may be the case that DEMs in the U.S. will need increased regulation and mechanisms that ensure competency standards are met among all practicing DEMs. If both practitioners of medicine and home birth midwifery are willing to make some compromises, the divide that currently characterizes medicine and midwifery in the U.S. has the potential to be narrowed.

CHAPTER VI

THE INFLUENCE OF WORK OBLIGATIONS ON PROVIDERS' VIEWS AND BEHAVIORS DURING TRANSPORT

Introduction

When a home-to-hospital transport occurs, multiple social actors converge at the hospital site in order to provide care to a laboring woman and her baby. Each care provider who participates in a home-to-hospital transport has a particular relationship to the hospital organization in which the transport takes place. In this chapter, I examine what influence care providers' job obligations have on their behaviors during transports. As hospital employees, I ask what influences work obligations have on OBs' and nurses' views of home birth and direct-entry midwifery. Subsequently, I consider if their views of home birth and direct-entry midwifery, along with their job obligations as hospital employees, have an impact on their behavior during a transport. Labor and delivery nurses are typically trained according to the tenets of the medical model of care. In this chapter, I consider what effect medical training has on their views regarding home birth and direct-entry midwifery. In addition, I examine whether labor and delivery nurses' job obligations affect their interaction with DEMs and mothers during a hospital transport.

DEMs constitute an important group of care providers who interact with medical staff at the intersection of home and hospital. I consider what impact DEMs' job obligations have on how they prepare themselves and their clients for a transport from

home to hospital. Additionally, I examine instances when DEMs are constrained from fulfilling job obligations as practicing DEMs due to the structure of the hospital organization coupled with the necessity of interfacing with medical staff. Examining the transport experiences of DEMs also reveals instances when interactions with medical staff within the hospital context served as opportunities for DEMs to fulfill work obligations to their clients. These questions will be explored in this chapter examining how a particular care provider's position within work/organizational structures (Hirschkorn & Bourgeault, 2008) influences their views and behaviors.

In Chapter V, I explore the influence professional level factors have on care providers' behavior during home-to-hospital transports. In this chapter, I examine factors that are specific to the context of work. As mentioned in the previous chapter, professional structures exist external to the *individual* and include professional socialization, philosophies of practice, legal responsibilities, and licensed scopes of practice. Whereas work/organizational structures, the focus of this chapter, exist external to the *profession* and include the hospital setting, the home setting, and clinic setting. (Hirschkorn & Bourgeault, 2008, p. 201). Borrowing this distinction between professional and work/organizational factors from Hirschkorn and Bourgeault (2008), in this chapter, I discuss the work/organizational level factors that influence OBs', nurses', and DEMs' behaviors in their own practices and during transports. My study extends Hirschkorn and Bourgeault's (2008) work by examining the role work/organizational factors have in forming views regarding direct-entry midwifery and home birth among maternity care providers. I also add to this literature by exploring whether or not the

experience and interaction during a hospital transport is constrained by providers' particular locations in relation work/organizational factors (See Table 5.1)

Obstetricians

Work/Organizational Level Factors

The previous chapter focused on the professional level factors that influence OBs. This chapter focuses on influences that are related to workplaces and organizations. Colleagues and the hospital context represent the central work/organizational factors that influenced OBs' views towards DEM and home birth and their behaviors during a home to hospital transport. Patricia Yancey Martin's (2005) study of "rape work" and the ways victims of rape experience a "second assault by those who work with rape victims, are also applicable to my study. Martin discovered that "the central cause of unresponsive rape work is *not* biased, ill-willed workers, but, rather jobs, organizations, and their situational contexts" (p. 18). She identifies the organizational factors and conditions that situate groups of workers to treat rape victims "unresponsively," despite their individual attitudes and beliefs towards victims. Martin states that "Rape workers are situated in *jobs, organizations, communities,* and *institutions* that determine their obligations and options, including how to behave" (p. 22). Following Martin's (2005) framework, the medical institution grants legitimacy to OBs and nurses to examine, evaluate, and treat pregnant and laboring women. The organization of the hospital recognizes OBs and nurses as legitimate practitioners, but, as will be discussed later, does not recognize DEMs as legitimate practitioners.

Organizations operate on the basis of constructing a series of rules and routines for members to follow. In this way, organizations dictate obligations to members through

a series of rules and routines (Martin, 2005; March & Olsen, 1989). In the case of the hospital, rules and routines constitute work/organizational factors that affect the behaviors of OBs during a transport. Even though work behavior within organizations is rule based and most of the time workers comply with established routines and protocols, I examine how the professional status of OBs has an effect on the degree of discretionary power they may exercise in deciding when and whether to comply with organizational rules and routines. According to Martin's work, "members make judgments about a course of action depending on their jobs, what they believe they should do, and the imperative this allows" (p. 40), and thus, workers first orient their behavior according to their professional organizational obligations, and, depending on the level of power a worker holds, to their personal beliefs and attitudes about a given course of action. Although I discuss professional level and work/organizational level factors separately, it is important to note that often professional level and work/organizational level factors overlap in the work lives of OBs, nurses, and DEMs (Hirschkorn & Bourgeault, 2008).

Colleagues

OBs' perception of DEMs, home birth, and their behavior during transport are influenced by work obligations to the colleagues with whom they practice. Therefore, when an OB works in a group practice, and all of the OBs interviewed did, responsibilities and obligations to their fellow colleagues influenced how OBs viewed and acted toward DEMs, home birth, and transport. One OB discussed how his colleagues were often critical of some of his decisions to informally "back-up" DEMs in times of need due to the fear of litigation which would not only impact this single OB, but his colleagues as well, since it is commonplace for obstetric groups to carry group

malpractice insurance (Mello, 2006). In the following passage, the OB highlighted the way that work/organizational obligations to colleagues overlap with his professional level obligations to avoid litigation. This particular OB described the unique relationship he built with local DEMs, stating that he found it beneficial to offer consult; however, his colleagues found such a relationship to be problematic as far as legal obligations were concerned:

> Miller: Would you ever consult with DEMs prenatally?
>
> OB: Sure, sure. Now that became an issue because my colleagues said that if I saw a patient in pregnancy, in consult, they would be considered my patient and if something happened there, I would be responsible. Even though I always said I cannot provide back-up for home births, I can provide consultation and referral services, but I can't be responsible for what happens at home when I'm not there. But they [his colleagues] thought that once there is contact with that individual then if something happens in labor, then I would be responsible for that and my partners didn't want to deal with that, and so that became an issue.

The unique relationship this OB had with local DEMs when it came to transport will be addressed later in the chapter. However, it is important to note here, that due to pressures from his colleagues' concerns over malpractice, this OB stepped down from practicing obstetrics in 2006.

Colleagues played an important role in informing obstetricians about DEMs and conduct during a home to hospital transport. The information that obstetricians received from colleagues was often colored by the experiences a particular colleague has had with DEMs and transport. The obstetricians interviewed stated that those colleagues who had been witness to, and participated, in what are considered negative outcomes associated with a home to hospital transport (fetal or maternal death, urgent obstetrical emergency, or some sort of permanent physiological injury to mother and or baby), openly expressed

these feelings. Davis-Floyd (1987) found a similar trend in her research with obstetric medical students, stating that: "one emotionally experienced 'disaster' can influence the beliefs and behavior of an obstetrician far more profoundly and powerfully than hundreds of normal deliveries. This single phenomenon goes a long way toward explaining why obstetricians cling so tenaciously to the birth rituals which have been consistently presented to them as the only means of preventing those disasters." (p. 302). In the following quote, an OB spoke about the lasting emotional impact that a "bad outcome" has on psyche of a doctor:

> And we all hate the last minute horrible wicked complication that comes through the door and ruins all of our day. Like the one twin who came in and died. It's horrific and it's horrific for that shift, but it's not just horrific when you're there on your shift, you like carry it with you. You know, it weighs on you for a period of time and you almost have to like work through it. I mean the couple bad outcomes I have had that is how it is.

Another OB contrasted her experiences with transport to those some of her colleagues have had: "I think one of our colleagues has just been unlucky and she has had pretty disastrous transports and so she is a little more of this, twin babies and them dying, and it's just very hard because I know that has happened to people and they have had a couple of fetal deaths or babies who have died after they have delivered. That is really scary that I could potentially be dealing with a situation like that so that's really because that's stressful." This OB suggested that even though she has not encountered negative outcomes in the transports she has participated in, the transport stories told by her colleague instill a sense of fear and apprehension about subsequent transports due to the potential of a bad outcome.

Although some OB spoke of their transport experiences in a positive light and felt reassured that the DEMs they interacted with were doing good work by transporting patients appropriately, many were still cognizant of colleagues' interpretations and attitudes towards transport and home birth midwifery. Thus, one OB tempered her positive transport experiences with her colleagues' warning of the potential of crisis and negative outcomes that can unfold during a transport. This particular OB contended that her colleagues' views do impact how she views home birth midwifery, stating that:

> I think they [her colleagues] just feel like, and I have not had an experience, but I feel like their concern is that sometimes patients are inappropriately chosen for home birth and I know that there are some patients, "I don't care. I'm going do my VBAC at home." Sometimes you have to say, "No. This is not safe for you." The ultimate goal is to have a healthy mom and healthy baby and having them walk out that way, and it's horrifying when that doesn't happen. Not that even if you are in the hospital everything is perfect and we can prevent everything, but I think the instances that they [her colleagues] have told me about they were definitely preventable and that's really scary to be faced with something like that.

Colleagues play an important role in disseminating information regarding the "group culture" to other OBs working in the same group practice, especially those who were new to the job. As previously mentioned, all of the OBs interviewed worked in group practices. The duration of time interviewees had been practicing in Oregon at the time of the interview ranged from eight months to twenty years. The majority of OBs (n=5) who participated in this study had been working as obstetricians in Oregon for three years or less. I will call those OBs who worked in the field for ten years or more "senior" OBs (n=3) and those who have worked in the field for three years or less "junior" OBs (n=5). Senior colleagues often influenced junior OBs' perceptions and views regarding DEMs and home birth transports by retelling or sharing their transport experiences. However, as already discussed, the stories that tend to be told and live in

the culture of the group practices, are the train wreck stories associated with negative outcomes during home-to-hospital transports. Four of the OBs interviewed stated that their first experience with a home birth transport occurred during the first six months on the job while on call. All four of these OBs stated that they were taken by surprise when they received a page from their office stating they needed to come in and assume care for a woman who had attempted a home birth.

The influence colleagues had on an OB's behavior during hospital transports was apparent in several of the junior OBs' accounts. Senior colleagues who had prior interactions with DEMs characterized by disarticulations, would typically assert their discontent with particular DEMs and attempted home births to junior colleagues. On the flipside, some senior colleagues were responsible for setting the tone in their group practices which facilitated smooth articulations or mandorla-like transports with DEMs and their clients. For instance, one junior OB, described the first home to hospital transport that she experienced. According to the junior OB, one of the senior colleagues in her practice was instrumental in providing her with the information on the way that transport unfolds. This particular junior OB stated that the information her colleague provided her with influenced the way that she behaved during the transport:

> One of my first or second nights on call, there was a patient a lay midwife was taking care of, and she called one of our docs and said "I think she has preeclampsia" and he saw her and she did indeed have preeclampsia… Preeclampsia is a disease of pregnancy where the blood pressure rises, and the kidneys start spilling protein into the urine. [Y]ou are constantly watching the blood pressure throughout pregnancy, and if the blood pressure rises, then you check the urine and if there is indeed protein spilling, then that is preeclampsia The lay midwife identified that in her patient…she [the DEM] called the doctor and said, "This patient has preeclampsia." So he went ahead and induced [the mother] at the hospital and…of course, the lay midwives don't have privileges at the hospital, but he passed off that she [the mother] had already had the induction and she had a lay midwife. And so I said, "Well does a lay midwife essentially

> function as a doula then at the hospital?" And he said, "Yes." …He said he can let her [the DEM] do the delivery if [I] want, and I said, "Okay, well that's fine."…I didn't actually see her [the patient] until the next morning. I went in to check and see how she was doing. She had progressed to four or five centimeters so she was doing good. Ok, should we break her water? No, she wanted to wait. So I was meeting with the patient, interacting with the patient. How is her labor going to go? And then they [DEM and nurse] called me. She had progressed quickly to eight centimeters. I hadn't met the lay midwife [yet], but then she came in. She had left for a short time, but then came back …And so I did meet the lay midwife. She is fabulous. Her assistant was there too who was also great and the patient was fine…once the midwife was there, I just sort of stood back and let her [the DEM] do the cervix check and just sort of kept an eye on the tracing. And then, I went and stayed in there for all of the pushing, she [the mother] didn't take too long, and I let the midwife do the delivery and I sort of just watched the tracing and watched everything and it was fine. Then, afterwards [I] examined her tears and there was a tear and I went ahead did the repair. And it was a very nice experience. The midwife and her assistant were great. I think that we had… it was a good working relationship. I tried to kind of allow them to support the patient, but ultimately I'm the one that has the privileges to deliver at the hospital and so it was fine…I think if I would have had to intervene it would have been fine, no problems, but the delivery went great… And the only surprise thing to me, she then passed the baby to mom's belly, but didn't cut the cord. I immediately cut the cord, so I wasn't comfortable with having the cord just kind of hanging there because blood could flow backward to the baby, so I just sort of held onto the cord to allow the patient to wait to cut the cord when she wanted to. But, I had the cord clamped which is essentially the same thing as cutting it, and so I was able to be ok with how the situation progressed. And so I just held onto the cord until she cut it, and I think they cut it after the placenta came out…really the only thing I did was watch the tracing and then later hold onto the cord, and the midwife and her assistant did everything as far as the baby.

The vignette above from an OB's initial experience with transport reveals some important information that I would like to draw out in this chapter. First of all, prior to that experience, the OB had not received any information from the colleagues that she practices with regarding the procedures or protocols governing how an OB acts or what role a DEM plays during a hospital transport. This illustrates that with a lack of institutional protocols governing conduct between DEMs and OBs during a transport, the event is typically left in the hands of whatever doctor and medical personnel are on staff

at that moment. Thus, the way a transport unfolds is often left up to the urgency of the situation coupled with the discretion of the doctor present at the time. Secondly, the OB's experience reveals the influence that colleagues have on an OBs' actions during a transport, including how an OB will interact with a DEM and her client. In this case, a senior colleague orchestrated the smooth transport by informing the junior OB that it is acceptable for the DEM to deliver the baby. The junior OB followed the instructions regarding transport that her senior colleague passed down and shared with her. The senior colleague may be considered more radical in that he advocated DEMs serving as the primary care provider for their clients even in the context of the hospital. The OB took the advice of her colleague and as she stated, let the DEM provide support to her client during labor and ultimately, let the DEM handle the baby's delivery, resulting in a smooth articulation where the OB and DEM were able to engage in collegial dialogue and provide collaborative care to the mother and baby. The experience of transport as retold by this junior OB indicates that she was supportive of the midwifery team present and was pleased with the manner in which they handled the birth within the context of the hospital. It is questionable that this junior OB would have interacted with the DEM and the mother in the same way if had her colleague been more reluctant to allow the DEM to retain her status as a care provider within the context of the hospital. In other words, had the senior colleague encouraged actions, such as: not acknowledging the DEM as a valid care provider with vital information regarding the mother's health status, the junior OB's course of action during her first home-to-hospital transport may have contained elements of interactions characterized by disrespect and alienation (i.e. a fractured articulation). I argue that the OB's colleague positively influenced her and encouraged her to interact

with the DEM and mother in ways that were mutually accommodating. In this case, the senior colleague was responsible for constructing hospital transport and the work of DEMs as an event wherein collaborative care is a possibility. This translated into the OB taking the information her colleague provided her and acting accordingly; the DEM delivered the baby and the OB was present as support and did assist in the repair of a small tear which occurred during the pushing phase of labor. The degree to which this exposure to a transport characterized by seamless articulations between the medical staff and the DEM team has had a lasting impact cannot be ascertained by the data collected in this research; however, it is likely that the senior colleague with whom this OB interacted played an instrumental role in influencing how she will perform in subsequent transports, thus, making it more likely that efforts will be made to collaborate with DEMs and their clients during a transport.

When I asked this particular junior colleague if she would behave in a similar fashion during subsequent transports, she agreed that her senior colleague's advice regarding transport and his prior experience with such events had a lasting impact on her believing transport is an opportunity where positive relations can be forged between DEMs and OBs:

> Miller: Do you think in future transports, in similar situations, you would do the same?
>
> OB: Yeah, and it was helpful for having the case already started, being passed off to me by my senior colleague because I was not yet familiar with what participation lay midwives can have when deliveries happen in the hospital. He told me, "You can let a dad do a delivery. You can let a midwife." And there's a precedent, meaning that he has let midwives do that before, and so I thought I am fine with that as long as everything is uncomplicated.

In addition, I argue that this particular transport illustrates that the DEM and her assistant who were present interacted with hospital staff in a collegial manner that allowed for the establishment and enactment of co-care between the OB and midwifery team. This means that the DEM had the knowledge and skills needed to assess her patient; and her attentiveness to the symptoms of preeclampsia facilitated the DEM to interface with the medical community as a measure to keep her client and her client's baby safe. As a result of participating in her first transport, I asked the junior OB if her initial experience with hospital transport for a planned home birth had changed her view of home birth or direct-entry midwifery:

> I guess I was impressed with the lay midwife and her assistant…they seemed more knowledgeable than I assumed lay midwives were and I don't know if that goes across the lay midwifery community. There's likely more and less experience, but overall I was impressed with their experience level.

The OB's comments illustrate the impact that exposure to DEMs, and the work they do, has the potential to positively impact OBs' views and behavior towards DEMs. As discussed in Chapter V, when OBs have limited discussion of direct-entry midwifery and home birth during their medical training and once on the job, their perceptions of DEMs tend to resemble the stereotypical images of DEMs as uneducated and irresponsible. The impact that greater exposure to DEMs and the midwifery model of care has on OB's views regarding and behavior towards DEMs during transports will be discussed in Chapter VIII, where I argue that increased exposure facilitates collaborative relations between DEMs and OBs.

However, not all OBs interviewed stated that their colleagues positively influenced their views of DEMs and home birth. Three of the junior OBs interviewed

worked in the same group practice and mentioned that two of their senior colleagues participated in transports that had negative outcomes. Therefore, these senior colleagues tended to openly disseminate negative perceptions regarding DEMs and home birth in among OBs in that particular group practice.

The Hospital

The organization of the hospital involves certain rules and protocols including paperwork and documentation and, therefore, an OB is obligated to comply to these while working in the hospital context. However, professional level structures proved to be much more salient to obstetricians than work/organizational level structures, namely because of the power associated with the profession of obstetrics. Hirschkorn & Bourgeault (2008) reported a similar finding in regard to the care providers in their research on CAM use and referral:

> …while work/organizational context is shared across many provider groups (in so far as some nurses, midwives, and physicians work in similar kinds of settings), factors are differentially experienced or noticed by provider groups. For example, while nurses and midwives were likely to identify hospital policies and facilities as influential- both positively and negatively (although more likely negatively) in their incorporation of CAM, this did not emerge as a notable theme for physicians (p. 205-6).

Much of the literature that examines professions in relation to organizations points to the limiting influence employment in bureaucratic organizations has on a given profession's status and autonomy (Broadbent & Laughlin, 1997; Johnson, 1972; Leicht & Fennell, 1997, 2001). However, dominant professions, like obstetrics, are attributed with a high level of power and status in U.S. society, that they actually "import standards into organizations" (Hirschkorn & Bourgeault, 2008, p. 197; DiMaggio & Powell 1991;

Leicht & Fennell, 2001). Obstetricians, by virtue of their status as highly regarded professionals and the power that is accrued to those practicing biomedicine, are often positioned such that they play an active role in shaping hospital policies and protocols to suit the needs and interests of their profession. The autonomy accorded to the profession of obstetrics, in relation to hospital policies and protocols, is of particular interest to this study of transport since interview data indicates that, in most instances, OBs possess the discretionary power to influence how a home-to-hospital transport will proceed. In a later section, I discuss the ways in which providers' varying degrees of discretionary power influence how a transport will proceed.

The hospital was the primary context within which DEMs and OBs would interact since it is during a home-to-hospital transport that providers of the medical model and midwifery model are forced to confront each other. As a result of participating in hospital transports, OBs indentified two factors of concern in regard to the practice of direct-entry midwifery: 1) the variation in DEMs' training and experience; and 2) the level of counsel that DEMs provide their clients about the potential risks associated with home birth. These concerns were raised after transports occurred and raised questions in the minds of some OBs about the competency and skills of some practicing DEMs.

Variation in DEMs' Training and Experience

All of the OBs interviewed expressed concern over the variability in DEMs' skills and training. OBs constructed a continuum on which they situated the "good midwives" from the "bad midwives." The good midwives were those who were more skilled, transported early, and in general practiced more conservatively. At the opposite end of the continuum, "bad midwives" were situated as those who took more risks, had

questionable skills, and transported obstetrical emergencies to the hospital (See Table 6.1).

Many of the OB's interviewed utilized their medical education and training as a lens through which they commented on the variation in DEMs. Consider the following response from an OB:

> The quality of midwives ranges from very experienced midwives to…anybody can deliver a baby. And if you see a few normal births and you say "oh, this is easy." But the reason why we go through four years of residency is that there is a whole bunch of things that can occur and you need to know how to recognize it, how to manage it, and how to prevent it.

In the excerpt above, the OB argued that obstetricians have been well trained in complications and their education positions them as competent to notice and handle potential conditions that require urgent intervention and medical expertise. Other OBs voiced a similar concern, defining DEMs as "quasi-medical" and as occupying a nebulous zone between a medical practitioner and layperson. The majority of obstetricians did not believe that the training DEMs receive is adequate enough to render them qualified care providers for pregnant and laboring women. One OB argued that it is a DEMs' responsibility to inform clients of their education. Although this OB stated he is an advocate for women's choice when it comes to reproductive freedoms, he expressed skepticism regarding the information that DEMs provide their clients regarding their skills and competencies:

> I just get so leery about so you've [DEMs] watched somebody do this once and now you are doing it? Have you told your patients that? Have you told them? I mean if you have and they want to do it that's fine everybody is an adult. If that's the decision you want to make that's great I support you 100%. If it's not, and you didn't tell them, then I think that's a problem. I think that's gross malpractice, and I think you should be punished for it. People are trusting you.

Table 6.1. Qualities Associated with “Good Midwives” and “Bad Midwives” As Identified by Obstetricians

Qualities Associated with “Good Midwives”	Qualities Associated with “Bad Midwives”
Utilizes criteria to determine low risk candidates	Exclusively practices the principle of patient autonomy
Does not take on high risk clients (VBAC, breech, or twins)	Takes on clients that may present with conditions that would render them unsafe candidates for home birth (i.e. advanced maternal age, diabetes, VBAC, breech presentation, twins)
Consults with medical community or refers client to medical community for consultation	Avoids interfacing with the medical community until emergency situations arise
Appropriately transports to a hospital and transports in a timely manner when options are still available for the mother and/or baby.	Leaves few choices or options due to the urgency of the situation upon arrival at hospital
Reason for transports limited to maternal exhaustion, prolonged labor, and pain management	Reasons for transports have escalated into crisis situation with the mother’s and/or baby’s health compromised or at stake
More conservative, more medical; emphasizing the importance of a safe birth for mom and baby whether at home or in the hospital	More liberal, strongly holds to the ideal of having a home birth as a form of empowerment regardless of the costs
Takes into account patient interests and desires, but these are carefully weighed against potential benefits and/or risks	Adheres to patient’s interests and desires even when these may compromise patient and/or baby safety
Willing to take action in order to secure the health and safety of mother and baby even if this goes against a client’s desires	Reluctant to transport due to the harboring of negative feelings toward the hospital and/or medical staff
In the context of transport, divulges honest information about the client, including how the labor has been progressing	In the context of transport, is not transparent about the pregnancy and labor process
Records, charts, and lab results are available and made accessible to medical personal; collaborates with medical staff	Withholds client records and/or charts
Respectful communication, listens to doctor’s advice and recommendations	Defensive demeanor, questions the recommendations and advice of medical staff
Strives to play an active role in a client’s care, but does so in a collaborative way rather than trying to be an autonomous practitioner	Does not make a collegial effort to work alongside medical staff; attempts to remain the primary care provider

Another OB stated that the training of DEMs is not intense enough. He argued that "People with the highest risk situations [home births] need the most training…the CPM credential is great, but inadequate. It [DEMs' training] needs to be much more extensive." He argued that practitioners attending home births should be well trained in potential complications that can arise since he characterizes birthing at home as a high risk situation. Even though this particular OB does value the work DEMs do in terms of providing clients with emotional support during pregnancy and childbirth, he still fears that DEMs are not sufficiently trained in obstetrical emergencies and/or complications. In discussing home birth and DEMs, this particular OB mentioned several studies that illustrate the safety of home birth for low-risk pregnancies and articulated that DEMs provide an invaluable service to their clients. He was aware of the CPM (Certified Professional Midwife) credential and yet skeptical of the extensiveness of training and preparation that such certification provides DEMs. In eyes of this OB, DEMs fulfill a role more in line with doulas than practitioners for pregnant and laboring women due to their perceived inadequate training and experience level, including the lack of exposure to obstetrical complications.

This OB's comments illustrate an important point. The "soft", nurturing, emotional support that DEMs provided their clients is considered valuable, but not exactly a necessary component of care during the labor and birth process to most OBs interviewed. In contrast, the complex, scientific, medical work of obstetrics is constructed as superior and vital to providing maternity care.

One OB who has been practicing for thirteen years commented on the variation in DEMs that she has experienced since working in Oregon.

> I think that there is a variety of training available for lay midwives. And I think that some of the lay midwives are well trained and some of them are less experienced. And perhaps have less training. I think that most of them go into it with the intent of empowering women and having very positive views of the childbirth experience and very positive views of women in general. I think that is admirable, but I don't always agree with the way that that's expressed.

Another OB openly critiqued DEMs' educational training asserting, "Some people don't realize that lay midwives don't have any medical training at all. Not a lick! Bought a shingle from the Board of Cosmetology for 50 bucks and that's scary. That's scary to me." What was interesting in most of the OBs' accounts regarding the variability of DEMs' experience was the way biomedical education was used as the standard against which midwifery was judged. I argue that this illustrates the way OBs' perceptions of and interactions with DEMs are influenced by socialization into biomedicine and adherence to a singular way of viewing the care of pregnancy and birth. Likewise, this speaks to the powerful position that practitioners of the medical model hold in U.S. society. Biomedicine, the culturally ascendant model serves as the normative way of viewing pregnancy and birth. As such, alternatives to the medical model, such as out-of-hospital birth under the care of a DEM tend to be questioned. Even though recent scientific research documents their efficacy and safety, their cultural acceptability continues to be marginalized as accurate information regarding home birth and the midwifery model of care are obscured by powerful groups who benefit from and whose interests are secured by maintaining biomedicine's hegemonic position in U.S. society.

Level of Counsel

Tied to OBs critique of the variation among DEMs, was the contention that DEMs do not adequately counsel their patients regarding the potential risks associated with home birth. Many of the obstetricians I interviewed questioned if DEMs truly counsel their patients about the potential risks associated with home birth, especially for women who may be identified as "high risk" by biomedical standards (breech, multiple gestation, VBAC, gestational diabetes, and hypertension). One OB discussed the negative twin outcome as she questioned if DEMs' clients are appropriately educated regarding potential risks associated with home birth:

> So a patient is allowed to labor at home with twins and so I said to my partners, "Why?" And they said, "Because she wouldn't come to the hospital."…how was she counseled by her lay midwives? Was she really counseled about the risks of a twin home delivery? Was she really counseled about what could happen? I mean she has never had a baby before…a woman who has never had a baby before delivering twins is like bad news waiting to happen. And so was she truly counseled on the true risks that she was taking for her babies by laboring this at home? [To] deliver is natural, but two hundred years ago a lot of babies died, but it's because we do c-sections instead of delivering twin babies. So did she fully understand that and say, "Okay, I'm willing to do that. Maybe my babies are going to die." Did she know that?

Another OB argued that, even though her transport experiences have been positive, some DEMs in the community are not practicing as safely as they should:

> There are people out there who do risky things and we [OBs] just can't understand why would you deliver twins at home? Even if you did it at your own home just the risk of a twin being compromised and death of that baby is so high. Either you don't know the numbers or you are just willing to take risks…have you told that patient that your child has a one in five chance of neurological injury? Are you counseling them? What's going on? I don't know if it's a lack of counseling or a lack of judgment or a lack of priorities.

Direct-entry Midwives

I now turn to the work of direct-entry midwifery asking and answering the questions: What are the organizational level factors that influence how a DEM interacts with medical staff during a transport? Also, how does the position of direct-entry midwifery within the context of the hospital affect DEMs' status as care providers during home-to-hospital transports? In other words, what job duties associated with the practice of direct-entry midwifery are DEMs still able to fulfill within the hospital context?

Work/Organizational Level Factors

The key work/organizational level factors that influenced the work of DEMs were: 1) peers, 2) interfacing with the medical community, and 3) the hospital context. In terms of peers, DEMs stated that they often participated in peer review and in the Oregon community where my research took place, many of the DEMs routinely met in formal venues such as peer review or more informal contexts where they would share their experiences as a DEM. Monthly peer review meetings were held in the Oregon community where my research took place and licensed DEMs as well as unlicensed DEMs reported attending such meetings. Peer review sessions involved DEMs sharing their experiences, offering advice, support, and, at times, critiquing particular DEMs' actions if it was believed they were not practicing safely or within the guidelines as established by OHLA, MANA or NARM.

Overall, the DEMs interviewed espoused having good working relationships with other DEMs in the community. As one DEM mentioned in Chapter V, DEMs have to "watch each others' backs" as a way to protect the practice of direct-entry midwifery

from attack and further marginalization by the dominant medical community. DEMs' marginalized status encourages them to uphold a sisterhood mentality where individuals of the group are protected and find support in the local midwifery community (Rooks, 1997). One DEM commented on the way interacting with peers provides her with opportunities to ask questions and gather new information about conditions or situations that may present in her clients:

> It's nice to have people I can call and ask questions. That's nice if there's things outside of what I know or outside of what I am comfortable with…I like to have others to talk with. We have our state organization the Oregon Midwifery Council, and we have local meetings, and we get together and midwives talk and share things.

Interfacing with the Medical Community

In considering interfacing with OBs, I found that DEMs constructed the services they provide and those of OBs as more complementary than in a hierarchical manner that the OBs displayed. Recall that OBs often considered midwifery to be valuable in terms of the emotional support or doula-like services that a DEM could provide a laboring and birthing woman. However, these skills were often seen as secondary to the specialized, medical training that OBs received. The DEMs spoke of ways that midwifery and medicine were interrelated, and if DEMs were to provide the best care for their clients, then this may require interfacing with the medical community. In this way, DEMs tended to view their philosophy of practice and work as *complementary* to the profession of obstetrics, rather than obstetrics being superior to the care that DEMs offered. Therefore, DEMs often thought of transport and/or consulting with medical personnel as matter of fact and as something their jobs as DEMs entailed in order to provide the best care for their clients and their babies.

Theoretically, the midwifery and the medical models are positioned as opposites; however, in practice, midwives and OBs alike draw upon and utilize elements of each model based upon the need at hand. In the following account, a DEM stated during one transport the OB was surprised that she used the same equipment as practicing OBs. In this excerpt the DEM made reference to the ways that practitioners fluidly move in and out of the models of care picking and choosing the elements that serve their purpose in a given moment.

> I transported somebody for low variability, and we got in there, and he [the OB] was like, "Oh, she's fine. You know, she can keep laboring." He then said "Well, let's try changing positions and stuff." I was like, "Come on. We've been at home for three days, if changing positions was going to make this baby come out, we would have this baby by now."…And so I'm over there trying to get her pitocin and an epidural, and he's over there trying to show me how in to home birth, women's choice, and how hands off he is…And so I'm advocating for interventions more than he is. What eventually started happening is that we were seeing late decels. And I said, "There's late decels" and he commented, "You're right. You know, I guess that change in variability you were getting at home was a precursor to this." Anyway she had a great outcome, but afterward the OB said, "How did you know that she had decreasing variability" And I said, "Well I took my hands and I went over the top of her belly and I went ooooooh, like that" and he just stared at me and I said, " I used a Doppler." And he said "Well, how did you get a Doppler?" I said, "On the internet with my credit card." He had been backing me up and didn't have any idea that I was listening to heart tones. And he seemed to believe me for at least a few seconds about doing some kind of weird midwifery magical interpretation of the heart tones. No, I listened to them with a Doppler, just like you do. I mean, we know the same way.

Another DEM stated that two OBs, whom she had good working relationships with, argued that DEMs and OBs both practice according to the same philosophy:

> The two doctors that I have the closest personal relationship with are really entertained with the fact that we're completely different beings operating under the same philosophy. One of them once said, "You know, our religion is the same. Healthy mothers, healthy babies, that's what we both worship."

Transport became problematic, at times, for some DEMs when medical staff did not acknowledge them as care providers. Practicing DEMs' philosophy of practice emphasizes the normalcy of pregnancy, labor, and childbirth. DEMs stated that during transport situations it became quite noticeable that OBs, and, at times, nurses, did not recognize that DEMs are trained and share some of the same knowledge as medical practitioners. As experts in normal, low-risk pregnancy and birth, DEMs carefully monitor clients assessing their health status along with their emotional needs and most, but not all, are skilled to recognize conditions that manifest in pregnancy which would benefit from medical consult or referral to an OB. A DEM commented on the way that during a transport she provided information regarding her client's status and the OB proceeded to question the information which was provided:

> We have a lot of knowledge. They are always shocked when they say, "Well have you checked her?" And I say, "Yeah. I checked her about an hour before we came in and she was at 7 posterior, minus one." They go, and they check her and I say, "What did you find?" "7 posterior minus one." "Well, look at that, it's actually not rocket science. It actually cracks me up when they have to confirm.

Interfacing with medical personnel was one of the ways that DEMs stated they were able to provide their clients with informed consent regarding certain conditions and/or complications that manifested during pregnancy. Some DEMs stated that they were constrained from providing quality care to their clients if they could not easily and readily interface with medical personnel. In this way, the structure of the health care system and the way that midwifery and medicine are not well integrated served as a barrier to providing quality care.

My data indicate that a DEMs' willingness to disclose information, such as the potential risks associated with home VBAC, breech, twin, post-due, and advanced

maternal age births to their clients is much more complicated than the picture that obstetricians paint. Most DEMs do discuss risks with their clients while striving to adhere as much as safety permits to a particular client's needs and interests. A great deal of time and attention goes into the education process shared between a DEM and her client. The midwife and her client often form a close relationship established over time during lengthy prenatal visits where DEMs are attuned not only to the physiological state of the pregnancy, but also tend to the mothers' emotional and spiritual needs as well. Consider the way the DEM in the following excerpt stated she strives to give clients all the necessary information to make an informed decision:

> I think it is important for people to consult [with OBs]…People are afraid to consult because they are afraid the doctor is going to say something that they don't want to hear. But for me, I feel like it still goes back to informed choice for those patients. How can they make a truly informed choice if they don't have all the information? And if you don't have all that information, because that's not your background. [If] our [DEMs] background isn't in complicated high-risk pregnancy, then we need to consult the high-risk specialists, which are the OBs…then you can give the mom the information she needs to make a truly informed consent. "I've consulted with this doctor and this is what he says. This is what my research leads me to believe. This is what my clinical experience of this is right now. These are my observations of wellness and not wellness. These are all the potential risks for doing nothing, of doing this, of a, b, c, and everything in the middle, what do you want to do?" And then we figure out the next reasonable thing together. Clients are not able to make informed choices if they do not have all the information and that is why I consult with doctors to give them access to certain information.

In the quote above, the DEM described the way that informed consent is an interactive process between DEMs, clients, and at times when needed, OBs. Many of the nurses interviewed commented on the way that transport patients are well-informed and educated about their choices and options for care while in the hospital.

Interfacing with medical staff and viewing the two models as complementary, helps to ensure that DEMs are providing informed consent to their clients. All of the midwives spoke of the way that they are grateful medical staff and hospital facilities are available and can be relatively easily accessed when needed. One of the DEMs commented on the way that midwifery and medicine do not exist in isolation from one another in practice despite their ideological positioning as opposites in U.S. society:

> Midwifery is a whole different world and the medical model is a whole other world. It doesn't mix, but I think it can meet. It can approximate way more than it is right now. And making that step shorter so that we can bring our moms there and our babies there in more of a timely manner without fear of doing so and being judged.

One DEM addressed the way that DEMs must be willing to interact with medical staff, however, they often feel constrained by the interactions when medical staff does not treat them as valid care providers:

> I think that it's very, very important that we're all acknowledged as care providers. And that can take lots of different forms…it's very important that it's acknowledged that we all care about moms and babies, and we all want the same thing, which is safety. Now, sometimes midwives want additional things such as, respect for the psychic and emotional experience of pregnancy and birth. And sometimes doctors want extra things like, medical procedures that some people maybe do not want. So we all have extra things that come on our list, but there is a middle ground, there is a meeting point. And that's basically the relationship that really needs to happen for everyone to be safe and happy. Now, anything above and beyond that is just icing on the cake, and sure, that's great…

Two of the DEMs interviewed both stated that they view midwifery and medicine to share a "middle ground" recognizing that it is possible for practitioners of the two models to "meet" rather than collide as is the case in some transports. According to one of these DEMs, the best way to facilitate meeting in the middle involves shifting medical

staff's views of DEMs as lay practitioners or labor support to "qualified maternity care providers":

> We need to be acknowledged for what we are, which are experienced qualified maternity care providers. Now if they're [medical staff] not acknowledging that that exists then there's a problem there…I think that it would be really helpful for doctors and nurses and anesthesiologists and all people, that we might interface with, to understand what we do. What medications we carry. What our care looks like…if they're asking basic questions like, do you sterilize your instruments, then there's a real problem there. That's a problem. That shows that we don't understand each other as different animals. [OB asking}"Do you listen to babies' heartbeats?"…when basic questions come up like that, that just shows that they have no idea who we are, what we're doing. And gosh, that probably accounts for a lot of their fear because, what do they think?...They want to know that we're doing those things that are basic components of quality care. And I think if they understood that we *do* do that, and they understood what our care looked like then I think that we would all have a little more respect for each other and be able to interface a little more easily.

The DEM highlighted in the excerpt above, made some important points in regard to the constraining effect that medical staff's inaccurate perceptions of DEMs can have. She argued, as did other DEMs interviewed, that educating medical staff about the work DEMs do would go a long way to dispelling inaccurate images of DEMs and could facilitate more respectful and collaborative relationships with DEMs and medical personnel. This DEM recognized OBs' education and ties to professional organizations such as the AMA are in part responsible for constructing images of DEMs as unqualified:

> I can see why they're scared if they don't know what we do. Well, it certainly doesn't help that the AMA is against us. I mean, their major professional organization is saying under no circumstances should we exist. We don't have a right to exist. So, older doctors who maybe are coming from a different era, different philosophy, have been around the block a few more times and have to deal with us a little bit more, well, they're going to have a different perspective. But, a new doctor just coming out of his residency or her residency who hasn't been trained in normal birth and has the AMA standing over their head saying, DEMs are quacks and they don't have the right to exist, well, I can see where that would be a little bit of a barrier to their understanding of what we do. But whose job is that? Is it the midwives' job to educate the doctors? So far it is and we do. We do that at every turn. Or is it their job to be responsible for learning about other types of care

> practitioners? Well, gosh, now these days they have to learn about acupuncturists, and they have to learn about different herbs, and this is becoming more of their reality, supposedly alternative modes of care. They need a pamphlet. They need a little slide show. They need to be educated. And I think it would make everybody a little bit more comfortable and happy.

In the above excerpt, the DEM situated the problem of misperceptions regarding direct-entry midwifery and home birth in the structure of medical school education and the way that OBs become socialized into the medical model. From this DEM's perspective, DEMs are currently the ones who have taken on the herculean task of educating medical staff regarding the practices and work of DEMs, stating that DEMs "do that at every turn." The education of medical staff has become the task many DEMs have taken on as a way to survive in a health care system that continues to ignore and obscure home birth as a child birth option and the practitioners who provide such services.

Another DEM also pointed to the structural forces of the U.S. maternity care system that at times constrain and serve as barriers to DEMs and OBs from interacting and forming collaborative relations. This DEM argued that the midwifery and medical model are different ways of practicing. In her view, one is not necessarily better than the other, but are simply different philosophical views and ways of approaching the common events of pregnancy, labor, and birth:

> …an OB goes to school for many years, and they invest a lot of time and a lot of money. And to see us, home birth midwives, [grass]roots organizations grow out of our own experiences, women's rights, to them [OBs], that's a little scary…They think we are practicing witchcraft or some crazy magic, but really we have the same textbooks available…It's [midwifery] just a different way of serving people. If we can just respect our different ways it would be a really good thing. That's what we're doing. We're serving women and babies, both of us. We just have different ways of doing it, and it doesn't mean its right or wrong…It's not even so much that it's different. It's that physicians recognize that midwives know normal, natural

> birth, and they are the experts at it, but when it is outside their range of care, they receive those clients because they are the professionals trained in what's not normal. Then, it's their turn to do what they know. So they complement each other. And there is respect there. And in this country, we don't have that. There is no respect. There is no complementary health care going on. And that's really unfortunate.

The Hospital

The hospital organization and the underlying ideology of the medical model, which does not value direct-entry midwifery or recognize DEMs as valid practitioners, has a constraining effect on DEMs during transport. It must be stated that the hospital became a work/organizational context for DEMs only during a transport; however, since most DEMs understood that with any home birth there is always a chance that a transport will become necessary, the hospital is not a far removed work/organizational factor in the daily work lives of DEMs.

Obstetricians within the context of the hospital still retain power as professionals and therefore their status and autonomy is not significantly constrained by the hospital institution. Conversely, DEMs' autonomy and status as practitioners is limited when they are situated within the context of a hospital. Here, the demands and needs of the institution tend to subsume the autonomy of DEMs thus, constraining their ability to do midwifery during a transport. DEMs must manage the dissonance between home and hospital settings where different ideologies exist regarding how pregnancy and birth are viewed and treated. Traversing the intersection of home and hospital represents a primary source of emotional labor for DEMs as will be discussed in Chapter VII. The legal status of DEMs in Oregon allows them to freely practice in home settings and freestanding birth centers; however, once they are in the context of a hospital, their status

as autonomous practitioners becomes subsumed by the hospital institution. This places DEMs in a paradoxical position. On the one hand they are considered legal, autonomous health practitioners within the context of broader society. They legally attend births in freestanding birth centers, homes, they attend professional midwifery, pregnancy, and childbirth conferences with other maternity care providers, and they teach childbirth education classes. However, once they step foot into the hospital, they are no longer viewed as practitioners by the standards of the hospital institution. Therefore, hospital staff is not obligated to, and as a result often does not, treat them as providers. This disjuncture, between their statuses in home settings versus the context of a hospital institution, has the effect of constraining the role that DEMs play during a transport. However, I also argue that being autonomous practitioners also offers DEMs opportunities to do midwifery during a home to hospital transport.

One DEM described the constraining effect the hospital organization coupled with OBs' perceptions of DEMs has on her when she transports clients:

> …when we do transport, we are going there [to the hospital] because we need help. We have exhausted our resources as home birth midwives; we are going there because we are trying to provide safe health care to a mother and child. And when we go there, to the hospital, the general feeling is, "Oh, just a home birth midwife. You don't really know what you are doing." I mean there have been times when a physician won't even look at me. And you are trying to exchange information so the woman can have a really smooth transaction of switching care because when home birth midwives go into the hospital, we have no rights as health care providers. Essentially, we turn into doulas or support people…it really depends on who you get [as an OB]. The physicians have a very hard time meeting eye-to-eye and exchanging information respectfully. And that is really the biggest problem when it comes to transports.

Most DEMs stated that they are fully aware of their status change once in the context of the hospital. This status was seen as an opportunity in that DEMs legally have a right to accompany their clients to the hospital and stay with them during the majority

of their stay. DEMs stated that this allows them the opportunity to continue providing care to their clients, advocating for them and helping them strategize how best to navigate the hospital protocols and bureaucracy. However, DEMs reported that being seen and treated as labor support or doulas constrained their ability to do midwifery within the context of the hospital, especially if they experienced resistance from medical staff when making recommendations or suggestions regarding their client's care.

Another DEM described the way her role as labor support within the context of the hospital constrains her from providing care to her clients to certain degree, but, over time, she has learned to put on "different hats' for different situations in order to contend with the treatment she had received from medical staff.

> DEM: …once we get there [the hospital], we become a doula so they [medical staff] don't ask us anything directly…they don't even treat us as care providers at that point…We're just labor support, that's it.
>
> Miller: So what does that feel like to lose your status as a person's primary care provider?
>
> DEM: It doesn't bother me because I know what's coming, so I know that there are certain hoops that you have to jump through, and you can wear all kinds of different hats. And so that's just where I put on a different hat when we walk through the door.

According to this DEM, once in the hospital environment, it is common for OBs and nurses to direct their attention to the patient thus dismissing important knowledge and information that a DEM has about her client. In the above excerpt the DEM described how she tries to deal with the disjuncture between her status as a LDM and CPM outside the hospital and her shifting status as labor support within the hospital. The DEM stated that in some ways she has resigned herself to accepting this is the way it is once in the hospital, but expressed "it gets hard to bite your tongue" when OBs make

inaccurate statements regarding the work DEMs do. In this way, DEMs, experience alienation from fulfilling their roles as midwives, a topic I explore further in the next chapter.

Nurses

Work/Organizational Level Factors

In this section, I examine the work/organizational factors that influence nurses. Since the nurses I interviewed worked exclusively in the context of the hospital, and thus were employed by a hospital, I have chosen to limit my discussion to the influence their job duties and the hospital organization have on their views of DEMs, home birth, (including how they interact with DEMs) and mothers during a transport. However, this is not to say that they are not influenced by professional-level factors. In this section, I consider the influence transport has on nurses' ability to fulfill their job obligations.

The Hospital

The organization of the hospital involves certain rules and protocols including copious amounts of paperwork and documentation and, therefore, medical staff is obligated to comply with these while obligations working in the hospital context. Labor and delivery nurses commented on the way that hospital protocols are, at times, more difficult to follow with a transport patient. One nurse spoke of the ways that transport patients can make it more challenging to do her job:

> I actually don't look forward to it [transport] and that's only because they're already really busy. They're not at the beginning of their labor and then we still have to get all the same information out of them. We still have to set them up with all the same stuff so it's a lot to try and get done when they're worn out. They're worn out or busy or painful or whatever, and we still have to do all these things. So I mean it wouldn't be my pick, but there you go…there's a hundred thousand questions we need to ask and stuff…or needing to go in for a c-section or getting an epidural, or whatever. So hopefully if it's just an epidural you can

> get a minimal amount of information and get them their epidural and then do all the work.

The nurse quoted above stated that she still is obligated, as a hospital worker, to document and chart information about patients even if they are not at the beginning of their labor, which is often the case with transport patients. She spoke about how fulfilling her job obligations can be more challenging with a patient who is experiencing a great amount of pain or is "busy" laboring. However, Deanna is responsible for upholding the rules and routines of the hospital organization. Therefore, the bureaucratic organization of the hospital entails medical staff doing an extensive amount of documenting and charting and fulfilling these job duties may result in less time to spend with patients and less time to emotionally engage with them. The structure of the hospital organization precludes medical staff from interacting with patients in a meaningful way when the organization requires copious amounts of documentation and paperwork. A mother who transported to the hospital shortly after the birth of her daughter, expressed frustration with the hospital bureaucracy and protocols. She stated that she and her family found the hospital protocols intrusive and these had an impact on her and her family's experience in the hospital:

> It's just like this maintenance piece, they were just doing their job, but it didn't fit with post-birth. …just resting and enjoying that whole sacred time. It totally didn't fit with that [relaxed post-birth], but they treated us fine, but it clashed with what we thought it would be. They were monitoring her heart rate [and] they said it was too low or too high and the heart rate would go down a little bit and boom they came in. After a while, we just asked if they could lay off a little, she [her baby] is fine. They let us after a while when we got how it [hospital protocols] worked, when we got that down, the procedures and all.

In the above excerpt, the mother described how hospital policies and protocols intruded on her family's ability to relax and revel in the birth experience. She recognized that the nurses were "just doing their job," but to an outsider of hospital-based birth, and as a consumer of home birth, she stated that the hospital protocols which involved monitoring and testing her baby clashed with and constrained her and her partner from receiving the experience they desired.

Some of the nurses described the way that increased monitoring of patients and documentation is a reflection of today's "medical culture." This led many of the more senior nurses, those who have been working for ten or more years, to question, what they perceive as an overreliance on interventions and technology in the birth place. Five of the eight nurses interviewed openly critiqued doctors' and patients' overreliance on interventions and the use of technology during the labor and birth process. Those nurses who offered this critique stated that the aspect of their job that entails individualized care and the emotional support of patients during labor and birth is constrained by excessive interventions and technologies in the birth place. Edwards (2009) addresses the impact that increasing technological interventions have had on hospital-based births, noting the way that adherence to the body as a machine has artificially replaced the need for human emotion and interaction:

> …the technological thinking bound up with contemporary capitalist practices creates increasingly industrial, task-oriented practices that claim to contain, manage and fix bodies as efficiently as possible, rather than focus on the ways of relating to sentient beings. Bodies are seen as mechanistic rather than complex body-mind dialogue that practitioners need to listen and engage with…Thus, the empirical reality of 'doing' tasks rather than feeling or being with hides behind the professional rhetoric of caring (p. 42).

The routine use of interventions during labor and birth in hospital-based births has been documented by one recent study that found 94% of the women studied were hooked up to fetal monitoring, 86% received some form of analgesic or pain relief medication, and nearly 30% of women who had hospital births in 2005 had c-sections (DeClercq et al., 2006). The investigators of the study argued that the routine interventions during labor and birth are not justified by evidence-based science and rather, pose certain risks to mothers and babies (DeClercq et al. 2005; Goer, 1995, 1999).

One nurse commented on the way that natural birth is becoming less frequent and when it does happen “it’s such a privilege…you just don’t see births like that anymore.” The nurses who had been working in the profession for ten years or more offered the most staunch critique of the use of interventions such as epidural pain management and pitocin inductions. Another nurse commented on the effect that epidural pain management has on the work nurses do:

> You don’t have labor support. And truly, the younger nurses, they don’t have a clue how to support labor. They never have done it. They don’t know how to do hands on [labor support]. They don’t know how to palpate for contractions and just do intermittent auscultation. They don’t know how to do it because they grew up and they have always practiced in the culture of electronic fetal monitoring the entire time…They [medical staff] don’t even do blood pressure manually anymore for heaven’s sakes. Everything is mechanical…There are nurses who really prefer epidurals because then you don’t have a painful patient so you can concentrate on your documentation, and you just do all the tasks.

The nurse in the above quote discussed the impact that the routine use of interventions has had on the work that nurses do and from her perspective, many nurses do not know how to provide emotional labor support to a woman who chooses to birth naturally. The particular culture on the labor and delivery unit at Parker Hospital, where all but one of the nurses interviewed worked, was characterized by nurses, DEMs,

mothers, and OBs as the more midwife-friendly hospital. This particular nurse also commented on the culture of the unit stating that an emphasis on meeting the individualized needs of the patient predominates and since she occupies a managerial position, she stated that she felt it her duty to enforce that the standards of that culture are represented in the work nurses do. This nurse made reference to an incident where she had begun care of a patient during her shift, and then the care was transferred to another nurse working the night shift, who in Karen's view, was not providing quality care:

> We have this new-ish nurse that works on night shift…so she [the newer nurse] came to take care of the labor patient. I'm already connected [to the patient]. I don't want to leave until they have their baby…I hear her [the newer nurse] say, "I will be watching your baby from the desk because we have our monitor system, and it shows up out there." And she did! She had that screen turned toward her saying, "I know the patient's comfortable, and she doesn't need anything right now." And I was just amazed…the next day, I talked to the supervisor and said, she needs to be talked to. That's not how we give good care. I was offended by it…that's not the way we do things around here. The way we give care is we're at bedside, we're hands on.

For some nurses transport represented a time when they could provide emotional and patient-centered support to clients throughout the labor and birth process. Often, when circumstances provided, transport patients would decline interventions and/or technologies so that they could have a natural birth in the hospital. Also, some nurses commented on the way that transport patients were very informed and educated regarding interventions and technologies, stating that women who planned home births were typically more informed than women who plan a hospital-based birth. One nurse stated:

> I think they [transport patients] receive a lot of information…overall, I think the patients I have seen come to us and have been transferred, have been very well educated on what to expect from labor and delivery and post partum and they have a lot of good information. Sometimes a significant amount more than the average hospital patient. Some of our patients that come in for an induction don't even know what they are coming in for. They have no idea. So, I think overall, they [transport patients] do tend to have a significant amount of education about

> what they are doing…Overall, [transport patients] have a significant amount of education about what they are doing.

In the above account, the nurse made a distinction between transport patients and women who plan hospital births, who, from her perspective, are more educated in hospital protocols and interventions.

Certain aspects of transport made it easier for nurses to fulfill those aspects of their jobs that the majority of labor and delivery nurses cited were the most meaningful: the emotional support and emotional labor provided to women during labor and birth. Based upon the interviews with labor and delivery nurses in this study, transport represents a context where labor and delivery nurses are not typically constrained from providing emotional support to women since most women who plan a home birth and transport are still interested in having a natural birth. They tend to be well-educated on what hospital interventions and/or procedures they are willing to accept and most women who transport are looking for maternity support that adheres to individualized care and support. In this way, transport serves as a moment where some nurses can re-center their focus on the emotional needs of their patients rather than on the management of technological interventions. I discuss the emotion work of transport in Chapter VII.

Discretionary Power

> DEM: The medical establishment has to set the tone for the relationship and I know that they think we do, but once we go into their territory they have the authority. They have the power, and I really feel like obstetricians need to make the first gesture of kindness. If they refuse to introduce themselves or look at the midwife or look at her chart it's pretty much ruined…Now the midwife is going to be on the defensive. It's like coming into someone's home, and it's really sort of up to the host or the hostess to make that person feel welcome. I know that's

> asking a lot but if they could do that I think they would go a long way to smoothing relationships. There would still be some midwives who didn't like them or didn't want to work with them or—there are home birthers who have ornery personalities, just like there are hospital birthers who have ornery personalities that are difficult to work with. But, for the most part, if they could set the tone with cordiality and welcome midwives, DEMs would not be so afraid to transport. They wouldn't wait too long to transport. So they [OBs] actually hold a lot of power for setting the tone of the relationship.

As discussed in the beginning of this chapter, OBs posses a significant amount of discretionary power since as a whole, they enjoy greater autonomy in relation to external organizations, such as hospitals, and due to their position, they are able to use their professional status to influence hospital protocols (Hirschkorn & Bourgeault 2008, p. 198). Reference is made in the above excerpt, from a DEM, to the power that OBs have within the context of the hospital during a transport. All of the DEMs interviewed stated that when a transport becomes necessary, they typically call ahead to the hospitals and inquire who the on-call OB is during that shift. DEMs cited the doctor on call as a more crucial factor than the particular hospital they transported clients to in determining the reception that they and their client would receive. DEMs have learned, over time, which OBs are more supportive of DEMs and their clients, and therefore, DEMs use this prior knowledge to determine at which place their client will receive the best care and where interactions are characterized by smooth articulations and mutual accommodation. DEMs spoke of transport situations where certain OBs would let them catch the baby and be actively involved in their client's birth. Such transports where the interests and experiences of all parties are negotiated and put into action resulted in mandorla-like transports. Based upon the interviews with the DEMs, upon realizing that a home-to-hospital transport was imminent, and during those times when a mother or baby's

condition did not require immediate transport to the closest medical facility, DEMs discussed how they would implement the “call ahead strategy” in order to ascertain and hopefully secure care from an OB with whom they had previously experienced a smooth articulation or mandorla-like transport. One DEM described her strategy stating that she first considers the urgency of the transport and then the doctor on call when making her decision of where to transport.

> Who is on call is really important and what the situation is at hand. If I believe we are having an issue with the baby I go to Rosemont. It doesn’t matter who is on call. If it’s just the mom being tired or something like that, then of course I’m going to find out which hospital has the better doctor who is more midwife-friendly or may be more supportive of women who choose home birth because I want my women to be respected and if I have a choice, I’m going to choose somebody a little bit more supportive.

The variation among OBs in terms of their willingness to support DEMs and their clients during a transport is also indicative of the way OBs have the autonomy to utilize discretion during their interactions with DEMs and women. One OB described how he was able to establish collaborative relationships with local DEMs.

> Well because of my interest in holistic medicine when I moved to this town I met a lot of the midwives and told them that I was supportive of the natural childbirth process, and I thought it was a win-win situation, and it was a win-win situation. I would get referrals from them and do surgeries for their patients like tubal ligations and other things that were needed and their benefit was that they would get someone who understand the reason why a mother would choose a home birth in the first place and would be sympathetic to that and would be able to guide a mother through that experience in the hospital without feeling blamed or ashamed or anything like that.

The above excerpt illustrates how a particular OB exercised his discretionary power as a medical doctor and benefited from the relationship he constructed with DEMs. This

OB's personal interest in and pursuit of holistic health aligned him with members of the midwifery community who shared similar views toward pregnancy and birth.

One DEM shared a recent experience she had establishing co-care for a client with an OB. The OB's willingness to assist the midwife and the client in face of his professional level and organizational obligations illustrates the power he has within his job to help a midwife and her client if he is inclined to do so. The client presented with a condition that rendered a home birth an unsafe option. The woman continued to receive care from both her DEM and her OB still hoping to birth at home. In the DEM's view, a home birth was not a good choice, and it could have potentially threatened the DEM's license if a negative outcome occurred. At one point while receiving care, the OB suggested a "home birth in the hospital" as an option for her so she could still have the care of her DEM and the reassurance of the hospital staff in case they are needed. According to the DEM:

> And she'll [the mother] say, "I had a home birth in the hospital. It was amazing." I don't know if that doctor really realizes what his bending of the rules did for her. But it allowed her to deal with a potentially devastating situation in an incredibly positive way that is absolutely impacting her positionality as a parent now because she is parenting from a position of power and feeling like she got to make decisions, and she got to have that intensity of the relationship we've established honored. And it takes a special physician to do that because their own medical association, ACOG, absolutely is 100 percent against home birth.

The DEM commented on the way this particular OB had to temporarily suspend some of his professional and work-related obligations in order to provide care for a patient and assist a DEM. Such actions illustrate that OBs do at times defy work related obligations in order to collaborate with a DEM and her client. The DEM who had the mandorla-like transport experience stated that "his willingness to tweak the rules a little made just an enormous difference." However, it is important to note that even though

some OBs reported defying hospital policies and protocols to meet the needs of DEMs and transport patients, they are not always able to do this. For instance, pressures from colleagues often influence an OB to discontinue supporting DEMs and their clients, as in the case of one OB in this study. Thus, OBs have some discretion, but, work-related (pressures from colleagues) factors combined with professional level obligations (fear of litigation) indicate that OBs do not possess unlimited power within the hospital context.

One DEM spoke about working collaboratively with a local OB for nearly five years. The collaborative relationship this DEM developed served as a bridge between home and hospital that she would steadily cross knowing that she and her client would be well received. This type of relationship with the medical community enabled the DEM and medical staff to engage in interactions characterized by smooth articulations where the DEM could retain her power as a practitioner in the hospital context.

> I ended up doing a transport one night and he [the OB] was there, and I just point blank asked him after we were done if I could work with him, and he said yes. And we developed this amazing practice together where…he would be the back-up doctor for me. And if the women chose to deliver in the hospital or we ended up transporting, I would just do the delivery, and he'd be there. And we had a really good record. And during that time I was starting to do a lot of water births. And I actually got him to let me bring the birth tub into Rosemont Hospital a couple times. We brought it in the back door because we didn't want to make a big ruckus. And then, we got shut down overnight. Shut down overnight. Not because of the water births, but because we got so popular. I was doing fifteen to twenty births a month with him, where we were interchanging. I mean, I was going, going, going. And he loved it, and I loved it. And he was just fantastic about letting me have complete autonomy with my women, and also just stepping in if there was a problem.

The collaborative work described by this DEM came to a close due to pressures from the OB's colleagues, the OB's malpractice obligations, and the hospital organization. Several things can be gleaned from these experiences. The first is that

individual OBs and DEMs have established working relationships that in many ways constituted collaborative care. Arguably, this took a great deal of tenacity on the part of both care providers as they each altered their practices in ways that allowed them to intersect and fuse. These stories of collaboration also illustrate the ways that OBs, as professional practitioners, and DEMs as autonomous practitioners, were organizationally free to shape their own practices. OBs' professional status granted them discretionary power to collaborate with DEMs, while DEMs status as autonomous practitioners allowed DEMs to join forces with OBs, without organizational/work level constraints on their ability to do so. However, professional level obligations that enabled OBs to collaborate with DEMs were also the very forces that ultimately dissolved those relations. OBs spoke of the constraints malpractice obligations and obligations to colleagues placed upon their ability to maintain collaborative relations with DEMs. Also important, is the fact that the collaboration among DEMs and OBs was not, and is not to this day, institutionalized. Therefore, those practitioners had no guarantee that they would be able to continue their co-care. And as the DEM quoted above stated, "we were shut down over night."

There is, however, promise in the more recent experiences with transport as cited by all interviewees. Medical staff reported noticing a significant improvement in the way that DEMs are handling transport and, according to OBs, the recent transports they have been a part of have assured them that clients are being well-taken care of by their DEMs. Likewise, most DEMs stated that within the last three to five years transports have been smoother for DEMs and their clients as both groups of providers experience greater exposure and interaction with the other, often resulting in smooth articulations. This

finding is interesting in that even though transports have gone more smoothly, and there is more exposure and interaction among OBs and DEMs, OBs still question DEMs training and practices. Some OBs and DEMs continue to cultivate and maintain working relationships with one another. The degree to which these connections will remain viable is uncertain. In Chapter VII, I discuss the elements that facilitate collaborative relations among DEMs and OBs.

The discretionary power on the part of OBs in this study speaks to the role that gender plays in exercising discretionary power in a given context. For instance, based upon the interviews with DEMs and OBs, only male OBs have forged these sorts of collaborative relations in this community, even though more female OBs practice in the community. This is not to say that female OBs do not work at establishing collaborative relations with DEMs prior to and during transport. In fact, one DEM spoke of the way that during a recent transport a female OB most likely deviated from hospital protocols and obstetric standards of practice when she let a transport patient labor longer than protocols would typically warrant, retaining the client's choice in attempting a vaginal birth. However men's gender status may afford them more space to exercise their discretionary power in the face of their professional and organizational/work obligations. Even as professionals, female OBs may not have access to leadership positions within their own group practices and as such this may have an effect on how they exercise discretionary power (Lorber, 1984, 1993).

Conclusion

In this chapter, I examined OBs views regarding DEMs, home birth and transport, noting that their perceptions of DEMs and home birth and their behavior during a

transport is affected not only by individual practitioner attitudes, but also influenced by the jobs they hold and the organizational contexts in which they work. OBs' views and attitudes toward home birth and direct-entry midwifery were formulated by a combination of personal attitudes in the context of work/organizations obligations and responsibilities.

CHAPTER VII

THE EMOTION WORK OF TRANSPORT

Introduction

The ways in which pregnancy and birth are emotional events for women and their families has been well researched (Rothman, 1982, 2007a; Davis-Floyd, 1992; Gaskin, 1975, 2003; Cheyney, 2005, 2008). Less often acknowledged is the way that maternity care providers also experience emotions as they care for pregnant, laboring, and birthing women. Only recently has research exploring the emotion work of maternity care providers been conducted. Much of the research undertaken on the experiences of emotion in the workplace among maternity care providers comes from the United Kingdom (Hunter, 2002, 2004; Deery, 2003, 2005) where the structure of the maternity care system is characterized by integration between midwifery and medicine. The studies conducted by Hunter (2002, 2004) and Deery (2003, 2005) focus explicitly on how midwives practicing in the U.K. experience emotion in the workplace. I add to the bourgeoning body of research on the emotion work of maternity care providers through an examination of how DEMs, OBs, and nurses experience and manage emotions during home to hospital transports.

In this chapter, I operate from the assumption that the phenomenon of hospital transport generates emotions in practitioners who provide care to transport patients. The fact that hospital transport forces practitioners of the midwifery model of care to interact with practitioners of the medical model entails emotion work since it is uncommon for practitioners of these two models to interact except during situations when a planned

home birth has gone awry. The experience of hospital transport conjures up many emotions in DEMs, nurses, and OBs as they enter into a situation where they must interact with one another in order to provide care to laboring and birthing women. When practitioners of direct-entry midwifery must enter the hospital, a context where they are no longer viewed as valid care providers, they experience emotion as they navigate the dissonance between the two models of care. Not only must they manage their own emotions in the interactions they have with medical staff, but, often, they must also manage the emotions of their clients as they strive to bridge the gap between home and hospital. OBs experience emotion as well in their interactions with DEMs, nurses, and mothers during a transport and, often, the type of emotion they experience is related to their job obligations as professionals. It is commonly held that inherent in nurses' job duties is the expectation that nurses will provide empathy, support, and care to patients (Simonds, 2007; Bone, 1997, 2009). I argue that transport represents a particularly important context for examining the emotions that nurse's experience. Nurses often find themselves in transport situations where they must interact with DEMs and their clients and this may require a different type of emotional labor than they are accustomed to experiencing with women planning hospital based births.

In this chapter, I identify and analyze the emotions that DEMs, OBs, nurses, and women who transport are expected to display and/or feel in addition to those emotions that manifest in interactions with others during a home-to-hospital transport. In Chapters V and VI, I explored how professional and organizational level factors influence the work and interactions between OBs, DEMs, and nurses. In this chapter, I build on the idea that professional and work/organizational level factors influence providers' behaviors by

illustrating that providers' differential positioning in relation to their professional obligations and job obligations influences the type of emotion work they do.

Of course, the focus in this chapter is on the jobs that OBs, nurses, and DEMs fulfill, noting that such jobs obligate workers to experience and manage certain emotions (Martin, 2005; Hunter, 2001, 2004; Hunter & Deery, 2009; Smith, 2009). It is important to point out that all jobs obligate workers to experience and manage emotions. Also, I adhere to Edwards' (2009) contention that "emotional work is a feature of all human relationships both within and outside the workplace" (p. 37). Some jobs, such as nursing and midwifery, expect the individuals that fulfill such roles to support and empathize with women who transport, while OBs are often allowed, due to their professional status in relation to the hospital organization and in relation to other workers (DEMs and nurses) within the hospital context, to ignore or display emotions that are "unresponsive" to transport patients' needs. Martin (2005) focuses on the emotional labor that workers are "required to do (via feeling rules and display rules), and the work feelings that emerge in the course of doing a job" (p. 187), illustrating that a particular job a person holds and the organizational context in which that job takes place shapes the emotional labor and work feelings of workers. Following the analysis conducted by Martin (2005) on the emotional labor of rape workers, I ask what particular emotions do OBs, DEMs, nurses, and women who transport feel. What conditions prompt the emergence of emotions and how are they managed? In what ways do OBs, DEMs, and nurses protect women who transport and themselves from experiencing hurt by their emotions? What I will explore in this chapter are the ways that emotions involved with transport vary by job or by practitioner (OB, DEM, or nurse) noting that this variation stems in large part from the

position of an individual job in relation to the hospital organization and the degree of discretionary power a given practitioner has. For instance, the emotional labor that a DEM does is dictated by her job's position in relation to the hospital organization (autonomous practitioner) and the job obligations that midwifery entails (a "with woman" approach).

Studies documenting the ways in which organizations affect workers' emotions have demonstrated that job obligations and the organizations in which work takes place produce emotions (Fineman, 1993; Pogrebin & Poole, 1995; Martin, 1999). Arlie Hochschild's (1983) book *The Managed Heart* first explored the concept of emotional labor, which she defines as a process by which workers must manage and shape their feelings or emotions in accordance with "organizationally defined rules and guidelines" (Wharton, 2009, p. 147). Emotional labor is done in accordance with "feeling rules", which are the social norms that indicate what feelings are to be displayed in a particular situation and what an individual *should* feel in a given situation (Hochschild, 1979, p. 563; Hunter & Deery, 2009, p. 5). Labor and delivery units in hospitals have their own "feeling rules" regarding the emotions that are appropriate for nurses and OBs to express. DEMs, as autonomous practitioners, also have feeling rules that guide their actions. DEMs' feeling rules stem largely from the collective philosophy of care they share with other practitioners which emphasizes a "with woman" approach. DEMs must often advocate for their patients' needs and appear professional while still caring during a transport, even though they may feel vulnerable and/or anxious about the transport situation and how they and their clients will be received by hospital staff.

In addition to feeling rules, Martin (2005) also makes reference to "display rules" that "regulate the range, intensity, etc. of emotional behaviors" (Thoits, 1989, p. 322 as cited in Martin, 2005, p. 191), suggesting that "feeling and display rules of a setting shape how one is expected to manage the feelings one has. These rules vary from job to job and organization to organization, telling people whether an emotion is appropriate and, if it emerges, how to handle it. Because different organizations and different jobs have distinctive rules, worker's emotional experiences and displays vary" (p. 191). Martin's (2005) ideas here are particularly relevant to my examination of the way that DEMs, OBs, and nurses are differentially positioned within the context of transport and as such how they manage the emotions that emerge while doing their jobs.

Hochschild argues that emotional labor "requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others." (1983, p. 7). She makes a distinction between emotional labor and emotion work, but in following suit with the way recent scholars examine emotional labor in the workplace, I too will use these terms interchangeably (Martin, 2005; Hunter, 2001, 2005; Hunter & Deery, 2009).

Emotional labor involves both positive and negative emotions and varies by job and one's social location (Hunter & Deery, 2009). In the case of hospital transport, DEMs, nurses, and OBs not only must manage their own emotions, but are also involved in emotional labor as they manage the emotions of transport patients. How the emotions of transport patients are managed depends on, and varies according to the type of job an individual holds. For instance, in the event of hospital transport, DEMs and OBs both reported feeling anxious, but the emotion of anxiety developed for different reasons

based upon the worker's job. As marginalized practitioners in relation to biomedicine, DEMs often felt anxious about how they and their clients would be treated and received by hospital staff. OBs, on the other hand, stated their feelings of anxiousness stemmed from not knowing what the status of a transport patient would be once at the hospital coupled with anxiety stemming from malpractice risk as medical professionals.

Here it is important to consider the concept of "work feelings", which refer to those emotions that are not necessarily required by an individual's job duties, but, rather, emerge through social interaction at work and vary by job (Wharton, 1999). In my study, I found that practitioners involved with transport experience many work feelings and as mentioned above, the particular work feelings an individual experiences varies by job. The primary focus in this chapter will be on the ways that OBs, nurses, and DEMs manage their own feelings and the feelings of others during a home-to-hospital transport. The chapter is organized around the predominant emotions that participants stated they felt when participating in a transport. Even though there were some emotions that were expressed by all practitioners, for organizational purposes, I have chosen to discuss the emotion work of OBs and nurses in one section since they both are viewed as valid care providers within the hospital context and the emotion work of DEMs in a separate section due the way that they are autonomous practitioners, and not bound to the same organizational obligations as are OBs and nurses. I now turn to the emotion work of transport.

The Emotion Work of Obstetricians and Nurses

The Negative Emotions of Transport: Anxiety, Anger, and Frustration

Anxiety

Receiving word from a charge nurse that a woman who planned and attempted a home birth is transporting to the hospital provoked feelings of anxiety in many of the obstetricians interviewed. I identified three predominant reasons why OBs stated they feel anxious when hearing that a home birth transport is coming in: 1) they do not have a clear picture of the patient and/or baby's condition; 2) they wonder how they will establish rapport with a patient in a short amount of time; and 3) they are anxious about the potential for liability.

The majority of DEMs interviewed stated that they make a concerted effort to call the hospital in advance and let them know they are bringing a patient in for care. DEMs stated that they view calling ahead and informing hospital staff of a client's condition as part of their service to women in ensuring they receive optimal care. Nurses also validated DEMs' assertion that they call ahead to the hospital prior to arriving and give staff a "heads up" on a client's condition. However, some OBs argued that they still are uncertain as to how a patient and/or her baby will present based upon the information conveyed during the phone call. One OB described how she believes obstetricians feel when they hear that a home to hospital transport is on its way:

> Well, we don't get calls that often for transports and I think that when it does occur…you get a page that you are the doctor on call for a transport, I think it makes most obstetricians anxious. So you are anxious because if somebody is coming in from a home birth, you already know the situation is not going well and you don't really have a good understanding why it's not going well. And so you don't know when the patient comes in if it's going to be a really critical and bad situation with the life of the baby or the mother at risk, or if it's a more routine, less critical situation.

Another OB stated that when he receives notification that a home birth transport is coming in, he expects the DEM to provide him records or information about the patient so he is able to assess the situation as best he can:

> Whenever you get the phone call you just go show up at the hospital and just start at ground zero when they [DEM and client] show up. Hopefully the midwife will give you some type of information. Based on past experience, I'm a bit skeptical on what to believe, on any of it. You know, I just have this kind of mindset that it is going to be this battle that I don't want to face, but I went into medicine to help people out and so I'm in this position where I can probably do that. I would like to do that with the most minimal amount of headache and in the most expeditious way that I possibly can…like I said, that's the worst phone call in the world you can get because you don't know what you are getting and now all of a sudden you're on the line. Your name is in a chart and you have no idea what you are getting.

Here the OB expressed feelings of uncertainty about not knowing a patient's condition upon arrival at the hospital and having to start at "ground zero". Although he stated he realized there is a potential for a tense situation between him and the DEM, the OB understood that his job as a hospital physician obligates him to provide care to those in need, so even though the OB stated he has experienced anxiety due to the unknown and the potential for a conflict to unfold, he manages his anxiety-producing emotions by providing his medical expertise to a transport patient.

Establishing Rapport

In the case of a transport, OBs must comply with the hospital organization's protocols and rules while simultaneously abiding by their professional level obligations. The OBs interviewed reported that transport represents a situation when the threat of malpractice is exacerbated, in large part due to the difficulty of establishing rapport with patients. Most OBs spoke empathetically about the emotional situation transport patients are in during a home to hospital transport, noting that patients are already disappointed

because something did not go right at home and now there is the potential for the individual's birth plan and experience to be dramatically changed. OBs questioned whether their advice would be taken seriously or if they could establish a sense of trust with patients during this emotionally and physiologically transformative time, especially when a patient is likely experiencing a significant amount of fear about what the hospital experience is going to be like and how they can work at maintaining some elements of their birth plan while still ensuring their baby's and their own safety. OBs defined the work of establishing rapport with patients in a short period of time as a somewhat daunting task.

In the following excerpt, an OB stated that she finds it challenging to establish rapport with transport patients since she has not spent a significant amount of time with them and according to this OB, the ability to establish rapport is constrained because many transport patients have the perception that OBs "only want to do c-sections".

> I think we get the unsuccessful attempts so it tends to be hard for the patient…they don't normally want to be there. They don't usually want anything to do with us and they have, I think, an impression that our goal is to do c-sections. And so it's often a hard situation to be in because they don't really trust us. And most of my patients have… I've taken care of them throughout their pregnancy, so if I say, "This is the advice I give you, based on my experience." They say "Well, you know, this has been my doctor for the last nine months and I trust her. So if she tells me that's what I should do, then that's probably what I should do." And it's a lot easier for them to take that advice. These people [transport patients] came in, [and] have no idea who I am. [They have] never spoken to me or my partners, or the practice that we run, or the beliefs that we have as far as delivery is concerned. They have no reason to trust us, so it is often very difficult when I give them advice…there is no reason for them to think that it is good advice because they have not spent that time with me.

The experiences of establishing rapport with transport patients were contrasted with the trust-building rapport the OB establishes with her own client population. This

particular OB remarked that with her own patients she has the opportunity to sit with them during prenatal visits and discuss topics such as the use of pain management, when and why she would use vacuum extraction, and what conditions would necessitate a c-section, unlike during a transport situation where she may have only several minutes to explain a particular type of medication or the reasons for a certain intervention that she was recommending.

Similarly, another OB described how he has plenty of time to establish rapport with his patients and inform them of the possible need for interventions during labor and delivery. The rapport he is able to establish with his own clients is contrasted with the shakier version of rapport that is established in a short duration of time with women who transport:

> I mean at our visits we get to talk about all sorts of things. Here is what fetal heart tone monitoring is. Here is why I would think about using pitocin. These are the reasons why I think you should have at least an IV…I mean I have three lectures set up for every one of my patients; these are forceps, this is a vacuum, this is when I would thinking about using them. ..Nice, calm setting. Nobody is in labor. Baby is doing great. "What questions do you have?" Nice calm environment like you and I are having right now. I do it at about 34 or 35 weeks, they still have a month in a half to think about it, look on the internet, talk to their friends, come back and say "You know what, doctor, if it gets to a point and if you can get the baby out with the vacuum or c-section, I'll take the risks of the vacuum" "Great". The chances of us needing to do that? Very small, but you know what, we have a plan in place. And I know that and my patient knows that. Here is when I would think about doing a c-section this is why. Here are the risks with a c-section. My patient knows that and I know that and I think it's a benefit to my partners who come in… This decision has been made. They don't have to take four or five minutes to describe a vacuum, the patient is informed, educated, they can get it done and do what is best for them. That's a huge difference between your baby looks like garbage, you need help right now. I don't know what you have talked about before. I have no idea.

One OB also spoke of the importance of establishing rapport with patients and how in the situation with transport her abilities to do so are often constrained unlike in

her own patient population, producing a sense of anxiety as she grapples with how to connect with a patient she has no connection with:

> I think right away my anxiety level goes up right away if I get a call for a lay midwife transport. And it also goes up because in my own patient population I work very hard to establish rapport with the patients. And one of the reasons why our group does its own deliveries is to, because that way you have already established rapport with your own patients and that way they trust you. And during a labor things can change quickly and if you have rapport with the patient, you can give advice and they will usually be receptive… I practice obstetrics in this setting because one of my favorite things is to get to know a person very well over a long period of time during pregnancy. Maybe before that, maybe I am delivering their second or third kid. I get to go to their delivery and it's very fun. So I never like a transport as much as I like my own practice when I'm delivering one of my own patients. It's just never as fun, its more anxiety provoking…you don't have the emotional connection,

Many of the OBs interviewed made reference to the way that not being able to establish rapport was tied up with concerns over liability risks.

Liability

> OB: Perhaps with a transport you are always wondering how you are going to be able to establish rapport that allows that patient to accept your advice as valid…and rapport is one of the best ways to deter malpractice suits and I think everybody has that in the back of their mind when they get a transport. Because it's automatically, the situation is not going as the patient wanted it so there's already the potential that they are unhappy with the circumstances and then if something goes poorly, it's the obstetrician. I think it's in the back of their minds that they could be the target of a lawsuit.

Fears over litigation translated into feelings of anxiousness as OBs wondered how they would manage to quickly establish rapport with patients as a way to improve the chances of their advice being accepted as valid. OBs were fearful that patients would not trust the recommendations that they were making and if a patient declines a particular type of care or intervention, OBs become even more anxious about the liability implications that they may be facing. As discussed in Chapter V, many OBs pointed to

the constraining effect that the threat of malpractice has on the way they practice. Therefore, some OBs spoke of conducting diagnostic tests and intervening more during labor as ways to safeguard them from liability. The OB's account above illustrates the way that transport has the potential to magnify OBs' fears regarding litigation and these fears.

Not Providing Charts or Withholding Information

Some of the OBs interviewed admitted to having angry work feelings when they believe a midwife is withholding information about a client or when a midwife and/or her client resist the recommendations and advice that OBs suggest. Recall in Chapter IV, one DEM refused to provide hospital staff with records documenting her client's care. From this mother's vantage point, this action "cemented the fact that they were not going communicate at all" and resulted in a rather tense and hostile climate for the duration of that mother's stay in the hospital.

Professional-level obligations of OBs require them to do an extensive documentation and charting in order to ensure that certain standards are met and that patient safety ensured. In addition, work-level obligations in clinics and in hospitals require OBs to chart, document, and record in-depth information about a patient's medical status. OBs articulated the benefit of receiving charts and records from DEMs during a transport. Those DEMs' charts that most closely resembled the charts used by hospital staff were appreciated by most OBs, as this allowed for a smoother exchange of information and communication in more medical terminology and discourse. Since charting and documentation are a central aspect of the workings of hospital organizations, OBs argued that "good charting" is an important skill for DEMs to possess in their own

practices. As will be discussed in the next section, the majority of DEMs do "good charting" and recognized the importance of charts in ensuring beneficial care for their clients and in communicating with medical staff. In the minds of OBs, a transport has the potential to be more seamless when DEMs convey accurate information regarding their client's status through written documentation or charts. An OB argued that he believes DEMs are reluctant in part to turn records over because they fear OBs will automatically want to perform a c-section. This OB commented on the frustration he has felt as an OB when patient information is absent or withheld:

> In my impression, from my experience, a lot of data gets withheld. Lay midwives do not want to turn over their records they do not want to turn over their labor curves. They do not want to turn over their notes of what has been happening for past however long they have been helping this patient. Um because I think there is this battle between lay midwives and physicians and it's a battle in impressions of what the other side thinks of what you are doing. And I think that the lay midwifery community just assumes that we are going to cut everybody that comes in and do a c-section on everybody that comes in. "All these interventions." That's the big chord …"Interventions. Interventions."

The OB stated that he becomes frustrated when a transport situation is compounded with a DEM who is reluctant to hand over client records and when a DEM and/or client resists or questions the medical staff's recommendations and advice:

> It [notification that a transport is happening] just totally blindsides ya and I guess it's a little frustrating that you know I'd like to be well rested. I do have clinic the day after I am on call. I try not to operate, but I do have clinic. Um so now I'm getting called at three in the morning for a patient that isn't mine, for a shitty situation. It's frustrating and then you don't get all the information. And then you know you are going to have to fight with somebody when you want to make recommendations. I mean it's just. It's a headache.

Here the OB alluded to the way that having to take care of a transport patient makes it more difficult to do his job. According to this OB, he becomes frustrated when

he has to take on a transport, especially if it is in the middle of the night, since he still has clinical obligations to fulfill the next day. In this way, transport evokes feelings of frustration in the OB not only because he does not know what the state of a client will be, or because he may not have access to client records, but also his job obligations as a clinical practitioner are more challenging to fulfill if he has been up during the night assisting with a transport.

This particular OB went on to describe the interaction between himself and a DEM during a recent transport where he did not receive a client's medical records:

> I asked for charts, "Do you have a labor curve?"
>
> DEM: "Well here I'll tell it to you."
>
> OB: "Have you been writing it down? "
>
> DEM: "Yeah."
>
> OB: "Can I see it?"
>
> DEM: "We left it at home."
>
> OB: "Do you have any of her prenatal records? She got labs done."
>
> DEM: "Yeah, well we don't have those."
> You know and I get it. I get it. There is a big battle between the two sides and you don't want anybody else to…But it doesn't help the patient. It doesn't help the patient and that's ultimately what we are here for so it's a frustrating interaction.

When asked how transports could be improved, this OB stated that if DEMs trusted medical staff more and if DEMs were always honest about a client's history the transports would precede more smoothly:

> Trust us a little bit more. Be honest with what is really going on. If you're really in this for your patient tell us what you have done. Even it was the wrong thing, tell us what you've done. Because our decisions are going to be based on it, you

> know. Did you take some crazy Japanese herb that thins your blood that you thought makes you go into labor? Ok, that's fine. I'm not gonna bash you for that, but if I'm gonna operate on her I want to know that. "Did you take any medications?" "No just some herbs." "Well, what herbs?" "Well they are just herbs." Well herbs are medications, I don't care what you say they can change your physiology, I need to know about them. "You don't need to know about them." If you're scared enough to send your patient, at least have the decency to trust what we are doing and that will change your transport. That will change the stigma on it. If you call and say, "Hey, this is what I've got, this is what I've done. I've been laboring this patient like this for this long and this is what I think is going on." Fine. Don't try to sugar coat it, just say what it is. We'll deal with, you know, I don't want to place blame, but if we have to place blame, we'll do it later.

In the above excerpt, the OB described his interaction as frustrating, but in the course of interacting with the DEM, he stated that he does not let his frustration escalate into an argument in the moment as that could be detrimental to the care of the patient. According to this OB, a way he has dealt with frustration with DEMs and to encourage them to disclose important information about their clients, is not to place blame in the context of the transport, but perhaps save that conversation for a different context.

Resistance to Medical Recommendations

In the following vignette, an OB described a recent transport where the DEM questioned a significant portion of the recommendations the doctor was making for the woman. In this OB's view, most women who transport are "down for whatever you recommend" because they are tired, in pain, and most importantly, have concern over their baby's safety. However, the OB reported receiving the bulk of resistance from the DEMs accompanying women on a transport:

> Mom who's 42.5 weeks pregnant. Supposedly been laboring for 27 hours had been progressed to 6cm and then stalled out for 5 or 6 hours. And then picked back up and made it to 8cm, but now she has been stuck for 24, 26 hours. Fever, tachycardic, so she presents to me and it's obvious she's got a big baby (laughs). She's got a real big baby and she's a very, very small woman. This one was her

first. You know put on the fetal heart monitor and the baby is very tachyocardic, decreased variability, nothing reassuring on the strip. And do an exam and the baby's head is not even in the pelvis. She is 6cm not even engaged. You know, I recommend a c-section. If you're a primip lady and your baby's head is not engaged and you're at 8cm. No. There is cephalopelvic disproportion. This ain't gonna happen. I'm really sorry. It's not gonna happen. And then people start making suggestions:

DEM: Well, we don't want to do that.

OB: Well, you came to me for help, here's my suggestion.

DEM: Well we don't want to do that yet. Can't you do this?

OB: Well what do you want me to do here? I've now assumed care of this patient please. I'm willing to work with you a little bit but I know you are an advocate of your patient. But right now it is detrimental to the care of your patient. I'm really sorry. And so now all of a sudden and it's, I try my best not to let it happen. It's not about lay midwives, certified nurse midwives, MDs, nurses, *it's* about the patient who wants to have a good outcome. So, I try to minimize bickering and fighting and just kind of focus on ok, this is what we have to care of right now. So the patient is saying "I do, I want a c-section. I'm done with this, just give me something for pain. Anything." "No, you don't need that quite yet. You don't need that." And it's like, whose birth is this, you know? And that becomes very frustrating so now I've assumed risk of a post-date patient with chorioamnionitus who's got an active infection, you know, all of these are raising her surgical risks. So now I've inherited a high risk patient that I have no relationship with, never met, and a very high pressure, intense situation. She hasn't slept for a day and now I have to do a major surgery. Do you think that is the ideal patient that I want to take care of? There's no way! I'm very happy that I have the skills to be able to do that and everything turned out ok, but that is a set-up for disaster. That's a set-up for disaster.

This vignette illustrates the emotions that surface in OBs as they assist with a transport. Here the OB expressed frustration when his recommendations are questioned. In this situation, he also empathized with the patient whom he argued was ready for a c-section. In order to establish rapport with the patient and help ensure that his recommendations will be taken the OB talked about the way he holds back feelings of frustration and tries to "minimize bickering" between himself and the DEM. The OB

highlighted in this vignette also alluded to the legal obligations that affect his willingness to participate in a transport and the way that malpractice concerns can make him anxious when taking on a transport patient.

Enjoying the Challenge: Positive Work Feelings

There were some medical personnel who stated that they experienced satisfaction and contentment when assisting with a transport. Some OBs interviewed spoke positively of transport and enjoyed helping mothers and DEMs out in times of need. Nurses also expressed satisfaction in working with transport patients and their midwives. Both practitioners described this as a challenge that they enjoy. In this way, emotion work was energizing and had a positive effect on them.

One OB, who, as discussed in Chapter V, was forced to retire from practicing obstetrics due to legal issues, stated that he quite enjoyed assisting with transports and derived a sense of enjoyment from helping women.

> When I was around I would actually take most of those transfers when I was available. And I enjoyed that. I enjoyed the challenge of those mothers who wanted home birth and they would come in so disappointed and you would still make it a good experience for them and hopefully end up with a good outcome and the great majority were very grateful for the services that I was able to provide. To either let them have a vaginal birth or perform do a cesarean section.

All of the nurses interviewed stated that in the last five years, they have noticed a consistent improvement in transports. The majority of OBs echoed a similar observation, stating that it is common for a DEM to bring client records and to establish respectful dialogue with medical staff. One contributing factor to these changes is the increased exposure DEMs and medical staff have in regard to one another. Another factor which may be responsible stems from a meeting in 2007 that took place among local OBs and

DEMs in an effort to establish dialogue regarding the death of one twin during an attempted twin home birth. An OB described the positive aspects associated with participating in a transport:

> It can be a great experience. It can be somebody who just needs a little pit or needs an epidural to relax their muscles and then they are completely happy. They are, I've had people who have had uh their intention be to have their baby at home who have come to the hospital and I've delivered their second baby at the hospital because they were very happy with their experience and the fear that they had over having their baby at the hospital they found to not be as overwhelming as they thought it was going to be and then they have their babies with us again.

One nurse at Parker Hospital, the hospital considered to be more "midwife and home birth friendly," commented on the "challenge" to "win families over" during a transport:

> We've had several [transports] recently and they've been lovely. And the thing that's really nice is that, we kind of see it a little bit as a challenge just to win over the families. And I can say that it's rare and I can't remember one that we haven't. You know. I think they're really expecting us to not be nice to them or not do things the way *they* want and we really don't take issues with that. And we really do defer to the nurses who we know are going to be the best, you know, liaison for the hospital to take care of that person. I mean, some people just do it better. They're not the ones that are so hung, you know, like happy about epidural. You know? They're the ones that, probably older like me, have the culture of, you know, how to do labor support and how to really connect with people. It's a different style of nursing, and maybe we're losing some of that, you know, with nurses that have never really had that as the norm. But generally by the time somebody's been in our hospital for very long they love us. They say, "Oh my gosh, I was afraid that you'd make us do this or not let us do that or whatever." And they just don't find that because really and truly "We do love taking care of you", our little slogan. We really want to, it's not our experience, you know? It's an incredible life experience and of course, if your managers didn't have that buy in you wouldn't be able to as a unit, but they do. It's an incredible life experience and we want to make it the best experience possible for each family. And so it's their experience, not ours. You know? We're there to do a job and we need to keep you safe. But the experience is yours and so how do we make it what you want it to be? And that's truly what the goal is. And most of the time I think they make appropriate decisions and so then we're able to do that part. And so it ends up being, I think most of the time it's a win-win, you know?

In the above excerpt, the nurse made reference to several factors involved in her work that helps to ensure patients have a good experience. First of all, similar to some OBs, this nurse described working with transport patients as a challenge she enjoys. The nurse also alluded to the way in which the hospital community is supportive of honoring and accommodating a birthing mother's interests regardless if she planned a hospital birth or attempted a home birth. She spoke of the staffing strategy that the nursing staff employs to make certain that those nurses who are most supportive of home birth and are the ones who are assigned to care for transport patients. In this way, transports proceed smoothly from the nurses' perspectives when clients are appropriately brought to the hospital and nurses are assigned that help facilitate a woman-centered approach to labor and birth.

Bone (1997) contends that nurses' job obligations have often required them to perform "therapeutic emotional labour while carefully managing the layers of emotion called forth during childbirth" (Bone, 2009, p.56). However, Bone (2009) argues that changes in the provision of health care in U.S. hospitals, in particular an increase in technological interventions and monitoring, has resulted in constraining maternity nurses from "providing valuable forms of emotional labor" (p. 57). She cites the use of epidural analgesia during labor as a primary factor responsible for displacing nurses' performance of "therapeutic emotional labor". According to Bone (2009), "The epidural provides pain relief to the laboring woman and redirects the efforts of the maternity nurse toward technical interventions" (p. 57) and even though emotions are an important aspect involved in providing patients quality care, the emotional component of a job is not always valued in relation to its task-oriented duties. Many of the nurses I interviewed

critiqued the way that a bulk of women who plan hospital births automatically plan inductions and the majority of women who labor and birth in the hospital receive epidurals as a way to manage pain. Several of the nurses interviewed commented on the way that technologies and interventions during labor and birth constrain them from providing "bedside" emotional support during labor and birth.

The skills of emotional support during labor are often understated and contingent upon an individual provider's discretion. As such, there exists a range of variation in the care that nurses, OBs, and DEMs reported in providing laboring and birthing women. The emotional labor associated with jobs often goes unnoticed and is not considered real work, especially when situated within the context of U.S. health care that emphasizes reason, science, and the use of technology over caring. Some authors have addressed the social construction of authoritative knowledge in childbirth, suggesting that the hegemony of the obstetric profession has effectively replaced women's intuition and control over the birth process with the medical management and control of reproductive processes (Davis-Floyd, 1992; Davis-Floyd & Davis, 1997; Jordan, 1997). Proponents of the midwifery model of care argue that intuitive thinking constitutes a valid from of authoritative knowledge (Davis-Floyd & Davis, 1997; Cheyney, 2005, 2008). Bone (2009) argues that "maternity nurses are often caught between their allegiance to techno-medicine and their desire to comprehend and advocate for the patient using the 'soft skills' of emotional labour, intuition, experiential knowledge, and caring" (p. 60). I would add that some OBs also struggle with the dissonance between adhering to the tenets of biomedicine and practicing more midwifery-oriented care and therefore, some nurses and OBs found that certain transports represented a context when they could apply

their “soft skills” in caring for patients. The context of transport allowed for this since many of the women who planned a home birth but transported still continued with their plans for natural childbirth in the hospital. Therefore, some nurses and OBs were able to provide guidance, support, and care for laboring and birthing women that went beyond and circumvented the technological monitoring of mother and baby, and this they found satisfying.

Managing Emotions

Empathizing with Women

The medical institution assesses transport patients in “light of the legitimacy standards of the medical profession and hospitals” (Martin, 2005, p. 80). The typical approach to labor and birth in the hospital is the biomedical model and thus OBs and nurses will often treat and evaluate transport patients against this standard. However, three of the OBs interviewed spoke of recognizing that the biomedical approach, with extensive monitoring and interventions, cannot always be applied to transport patients. Since women who transport have planned a home birth with a midwife they are often critical of the medical management of pregnancy and birth, some OBs spoke of treating transport patients differently. Thus, establishing rapport with transport patients and providing care that is empathetic, often involved OBs suspending treatment of patients from a strictly biomedical standpoint and relaxing some of the standard hospital rules and routines in order to meet an individual patient’s needs. It must be noted that this was often achieved with the help of DEMs who often advocated for their clients, as will be addressed later in this chapter. Also clients themselves, as empowered decision-makers, often asserted those interventions they wanted while declining other standard hospital

procedures. Therefore, it was a concerted effort on the part of medical staff, DEMs, clients, and their families to maintain a degree of patient autonomy while working within the context of the hospital organization during a transport.

One of the ways that medical staff in my study seemed to work at building rapport with women who transported was to empathize with them and try to understand the emotions that they experienced as a result of being in the hospital. As was illustrated in Chapter IV, the efforts made by medical staff to empathize with patients was reported by women who transported as having a positive impact on their experience and feeling like their needs and interests were taken into consideration.

Many of the nurses spoke of empathizing with transport patients, stating that they would often go to great lengths to make a transport patient feel comfortable. According to an OB tech,

> I think I kind of get into this role of like, ok, I want to make sure that these people know that we support them in what they're doing and that I'm not the person against them. So I think in your interactions, I always worry that we sometimes come off as kind of phony because I feel like we're trying so hard to make sure that they know, we are here to support you and it's just got to be so hard for them to have everything, nothing has gone the way they've planned it.

Some of the OBs also spoke of empathizing with the women who transported as a way to acknowledge their situation. An OB stated that she makes an attempt to empathize with transport patients, recognizing that they have been receiving care based on the tenets of the midwifery model and she tries to offer continuity for women:

> I think when they [transport patients] come from that background [midwifery model of care] I felt like giving them more time to kind of adjust and help them make decisions as well…But really just gave her [a recent transport patient] the option of well your baby looks fine and as long as the baby looks fine it's ok to do that [let the woman labor naturally] …I think it also helps them psychologically feel like they can process it better.

Here the OB illustrated the way she gave a transport patient more time to labor naturally, rather than quickly intervening by administering pitocin or recommending medication to provide pain relief. At times, OBs were willing to empathize with women's situations as home birth transports and suspend some of the protocols that typically influence their work.

Staffing Strategies

The nurses I interviewed all worked at the same hospital (Parker Hospital) in the labor and delivery unit. All of the nurses commented on the overall climate of the unit stating that they pride themselves on being very accommodating to patients' needs. When considering hospital transport, the nurses spoke about a staffing strategy that takes place upon learning that a woman who had been attempting a home birth is coming to their unit. The nurses stated that certain nurses are better equipped emotionally to meet the needs of transport patients. According to the nurses, when a transport comes in nurses organize and figure out which nurse or nurses who are on during that shift will be the best match for a transport patient. Those nurses who are supportive of home birth and natural childbirth are typically the ones assigned to care for transport patients due to their ability to empathize and establish emotional closeness with a woman. According to one nurse:

> I guess the smooth ones [transports] to me now are they come in and know and accept some of our little rituals. And I think that we amongst ourselves work hard to have the more flexible of us [provide care]. I mean there's one nurse we have, Paula, would be horrible with a home transport. Because this is how you do it. I mean, but she's that way. I thought if Paula was my labor nurse I would never have to worry about a thing because you know what, anything that could possibly go wrong, she would have already thought about it and taken care of it. I mean, she worries about everything, you know, and is rigid. And those of us that are a little bit more laid back, we tend to step up and take them [transport patients] so that it's, I think that that's something that helps.

Here the nurse spoke of the way in which staffing was an important component in managing the emotions of women who transported. Another nurse stated that one way she provides emotional support to transport patients involves honoring their desires concerning their newborn's care:

> It's very common that a lot of people will refuse a lot of the routine newborn care. They don't want the baby to have a bath, and they don't want any vaccinations or antibiotics administered or anything like that…The direct-entry midwives can do those [the vaccinations] also and a lot of times people [women who transport] just want their midwife to do them so they will often refuse to have that done in the hospital…I think sometimes we get so into the routine of "oh, this is just routine" and we do it…I think it's just needing to communicate a little more with people…so people refuse to have their baby have a bath…because the baby gets cold and then it has to be under the warmer and it has to be away from the mom…and I've got solutions to that. We can do that, you know, we can do the bath right on the mom. So I think it's just ways of understanding, what are their objections to it? And maybe there's a way to do this, you know, that is not the way we normally do it that would make them feel more comfortable with it…I think one of the nice things about the home birth transports is they do tend to be fairly well educated on their rights as a patient. I think more so than the average patient.

The fact that nursing staff can bend rules and protocols to meet the individual needs of clients speaks to the discretionary power they hold in their jobs. Keeping clients comfortable during labor by dimming lights or honoring parents' wishes not to bathe a newborn, all constitute ways that nursing staff bent typical hospital routines for home birth transport patients. Many nurses expressed satisfaction with their jobs when patients' emotional needs were met, and most recognized such emotion work as being an integral component of their jobs.

The Emotion Work of Midwives

Attention to the emotional work of midwives is a relatively recent phenomenon in academic research and literature (Hunter, 2001, 2004). Therefore, my research will

contribute to the existing body of literature investigating midwives' experiences of emotion in the workplace. Even though midwives typically identify themselves and their clients identify them as experts in normal pregnancy and childbirth, this identity has the potential to become ambiguous as they enter the organizational context of the hospital that tends to be characterized by the medicalization of pregnancy and birth. Also, within the context of the hospital DEMs are not considered valid health care practitioners so their abilities to do midwifery and continue caring for their client become constrained. These factors position DEMs to do emotion work during a transport situation.

Curtis (1991) discovered how midwives in England avoided potential conflict with hospital staff by creating and employing strategies that "limited medical access to women, and controlling and censoring the information given to doctors in order to prevent medical take-over of care" (Hunter 2001, p. 442). In my research, I also found that DEMs craft various strategies to remain care providers to their clients during a transport. DEMs worked at managing the emotions of hospital staff, their clients, and themselves through a series of strategies and impression management techniques. These strategies reveal how quiet resistance to medical authority and the tenacity to retain and assert their authority as practitioners within the organizational context of the hospital enabled DEMs, many times, to continue doing midwifery at the intersection of home and hospital.

The Negative Emotions of Transport: Anxiety, Frustration, and Powerlessness

Anxiety

Some of the DEMs interviewed stated that they feel "stressed out" or anxious about transporting to the hospital. DEMs stated that they were anxious about transporting

because they were uncertain how they would be received by medical staff, in particular OBs. Therefore, one strategy DEMs employed was the call ahead strategy in order to find out who the OB on call was at a given hospital. Based upon a DEM's prior information and/or experience with a particular OB, the decision was often made to transport to a specific hospital based on who was working at that time. Those OBs that were perceived to be more midwife and home birth friendly were typically sought out. Consider the following excerpt where a DEM stated that she is anxious about transporting due to the way she must prepare herself emotionally for the experience while simultaneously emotionally preparing her client:

> The thing I hate most about going to the hospital is that I'm not a very diplomatic person and it's not from not wanting to be. I try hard, but I have a hard time expressing myself in a stressful situation without coming across as aggressive or threatening or defensive in some way and I don't want to…sometimes I feel like gosh I don't want to be aggressive I don't mean to be aggressive, if I'm diplomatic well get more of what we need…

Here the DEM expressed how she realized her anxiety about having to interact with hospital staff in a congenial manner may cause her to appear aggressive or defensive. However, this DEM has learned through past experiences with transport that the way to receive more respect, and, ultimately, the care that her clients desire during a transport is to act diplomatic. Therefore, the DEM's deep feeling may be one of anxiety or stress, but she may engage in surface acting in order to get more positive reception from the hospital staff and ensure that her client's needs are met. The DEM also spoke of managing her client's emotions as a way to avert her client from experiencing self-blame or guilt following a transport.

> So that is part of what is really difficult for me going to the hospital because now I have to advocate for this mom and try to get want we want and minimize the

> interventions, but another part of it that is difficult is that often times when I transport I know we are getting a c-section, it's just a matter of time. Yet the moms are not always ready to go there. They're ready to go to the hospital "Ok, yes I accept that we have to be in the hospital and maybe we'll get an epidural and we'll get some pitocin and we'll see if we can bring this baby down."…usually we are tired, we've already been up for a day and lost a night's sleep, at least one night's sleep, and maybe two with this mom, so I'm going in there trying to keep her hope alive and trying to walk her to this place of what I think is inevitably going to happen…
> It's really important to me that when we transport that if we end up in a c-section, or even before, when we end up transporting to that point and then it's whatever interventions we get and then if we ultimately have a c-section that at each one of those junctures the mother feels like, "Yeah, there's really no way out of this, is there? There's nothing else I can do, there is nothing anybody else can do for me, I just have to surrender. This is what my reality is now this is what my baby needs." Because then ultimately, women *do* feel strong and empowered and maybe sad and disappointed by their birth experience, but there's very little if any self-blame, regret or anger, any outward anger blaming the system. It's just that thing that you have to accept about life. So when I go to the hospital that's what I'm trying to achieve is getting the help that we need and helping a mother come to her own conclusions about this and make the decisions that we need.

In the above excerpt, the DEM recognized the importance of addressing her clients' needs so that they could emerge from the transport experience with very little guilt or disappointment over their birth experience. Although most DEMs interviewed espoused the importance of their clients being "ok" with their transport experiences, the ways in which DEMs would go about making sure their clients' needs were met varied. Some DEMs played more of an assertive role outwardly stating to hospital staff the next steps needed in their clients' care, while others tended to negotiate more with hospital staff so as not to appear "crazy" or to alienate hospital staff from providing care according to a woman's interests and desires. Despite these variations in the ways DEMs would attempt to remain active care providers and secure woman-centered care for their clients, most DEMs' strategies involved subterfuge whereby they would mask particular

feelings harbored toward medicine, and at times, practitioners of medicine, to keep hospital staff happy and their clients not only content, but safe.

Frustration and Powerlessness

Some DEMs reported experiencing frustration when transporting a client to the hospital due to the disrespect and the lack of collegiality among OBs. As a woman's care provider, DEMs have typically developed a history and close connection with the women they care for over the course of the pregnancy. DEMs expressed a sense of powerlessness and alienation from their client and the care they provided when medical staff disregards any information a DEM attempts to share regarding their client, or, at times, DEMs reported being completely ignored or excluded in the involvement of their client's care. The DEM in the following quote expressed the value in being recognized as a woman's care provider in the context of a transport situation:

> It would be really terrific if we could transport and have the physician look at us and say, "We're so glad you made this choice. What is it that you are thinking? What do you think that your client needs?" I mean we've been caring for them for ten months. We know their health history. We know their past birth experiences. We know them as people and as birthing women. And it would just be so nice to have respect that is mutual. Even though it is a different type of care, it's still really about the mother and child and if we could just get past all of the bureaucracy stuff I think it could be so much better.

Some DEMs expressed feelings of powerlessness and alienation as they described transport situations when medical staff was reluctant to include them in the woman's care. The ability to provide continuity of care to clients was highly valued by most DEMs stating that it was emotionally satisfying not only for their clients, but for them as well. A DEM described the sense of alienation that some DEMs may have the potential of encountering during a transport:

> I still want to be part of the team. I recognize that I am here because I need medical intervention, because I can't do a pit drip at home, I can't get an epidural at home. I can't do surgery at home. All for very good reasons and, but I want to be part of this team. I want to be part of these decisions. I want to be part of helping. Maybe I could catch the baby, what's the harm in that? That's completing the story for these people. That's what they wanted. They [medical staff] don't get it.

Another DEM spoke of the alienation she has felt during a transport and no longer having a role in her client's care:

> Oftentimes I used to feel isolated, like an umbilical cord was cut right off from this mom and this baby, but I was attached to that, I was emotionally connected to this baby because we're different. We care about these moms. We care about these babies. We want to see them nursing. We want to see them succeed and so there's like a rough cut off that was happening, and I think that that's changing in us. It's changing with me anyway. Because I am making sure that I'm available, that I'm there before [the birth of the baby] and that I come and see them and I see what's going on, and that relationship continues, instead of allowing the thought, now they're here [at the hospital] and going away. Or feeling pushed away. I don't care if I'm pushed away. If anybody gives me dirty looks, it's not about me. It's about the families and I have a job and I have a place.

As the above excerpt illustrates, over time this particular DEM has been able to manage her emotions of alienation and powerlessness by asserting herself in the hospital context. She recognized that, even within the context of the hospital, she still plays an important role in the birth experiences of her clients. Although DEMs had different ways of securing midwifery-oriented care for their clients and retaining their status as practitioners in the hospital context, most of the DEMs espoused a "strong sense of collective identity" (Hunter, 2004, p. 262) as DEMs ("We care about these babies." "We care about these moms"). DEMs, as marginalized practitioners in relation to obstetrics, often upheld a collective identity as experts in the normal processes of pregnancy and birth so as to insert their philosophy of woman-centered care into the transport moment

with the intent of influencing the actions of medical staff regarding the care of their clients. Many of the DEMs spoke of becoming savvier over time as a result of participating in transports and interfacing with the medical community learning what actions or strategies will garner them greater respect and power within the context of the hospital.

Just as some OBs expressed frustration with DEMs not providing medical staff with client records, DEMs also illustrated frustration when their knowledge regarding a client is minimized or completely disregarded. A DEM shared how she feels when the documentation and/or information she has about her client is not considered. More importantly, this DEM demonstrated the way that a significant number of OBs ignore DEMs during a transport; however, she stated that she asserts herself as a way to avoid feeling a sense of powerlessness.

> Miller: Do medical staff look at your charts?
>
> DEM: No, they don't look at them. They don't say things to me, they ask the moms. I'd say more doctors than not walk into the room and never introduce themselves. Never say hello, never act like they have met me before and I don't tolerate it. I grew up at a feminist health clinic where the doctors worked for *me* so I have a really different attitude than a lot of midwives. I actually have no patience for it. I think to myself, "I'm sorry, we are peers as far as I'm concerned. We are equals in this woman's care right now. You better treat me like a professional." So they walk in and they sit down and they maybe introduce themselves to my clients, sometimes. Rarely do they introduce themselves to the dads and almost never introduce themselves to me. So I interrupt them, "Excuse me doctor, I'm the midwife. If you have any questions you can ask me." "So how long have you been in labor?" "The mom is having contractions every four minutes, she can't answer these questions right now. Don't make her." That is almost always what happens. They rarely introduce themselves to us. But, one OB, he introduced himself to me and she shook my hand, "It's nice to meet you. Ok so what is going on? Of course you can catch the baby." It was so memorable to me because it is so non-existent from other doctors who do not introduce themselves to me.

In the above excerpt the DEM also alluded to the way that by encouraging the OBs to interact with her, she manages the emotions of her patients, absolving them from having to communicate information when they are in the process of labor or childbirth.

One DEM described how after experiencing negative treatment from hospital staff following several transports, she decided to ask the doctors why they were harboring so much anxiety and defensiveness towards DEMs and their clients. The DEM stated that she wanted to address not only the OBs' feelings surrounding home birth and midwifery, but she was also inquiring for her peers' benefit and the women she served.

> I was sitting down when I did a transport and saying to the doctors, you know, what would you like to see that would help? What don't you like about transport? The nurses would be whispering on the side and I'd walk up to them and say, "What can I do to make it better for you? What are you talking about? So that I can hear it and I can better understand what's going on. " And at first they're just like, "Oh my God , you are just out there in left field so why would you even ask?" Because their world is so different. But then I started saying, what do you consider a good transport? And when I started kind of re-terming things and kind of speaking their language a little bit more they would say, "Well it's not really like, we don't have a problem with what you're transporting. We feel like you do timely transports." In other words, I'm bringing them in before all hell's breaking loose. "But we feel like your people are judgmental about what we're going do and so you need to start going to your people and explaining to them what transport means and that if you take the time to go into a hospital, you're going to have to bridge that gap a ways. And if they're [mothers] going come in and fight us over what we're going do to them then…", and I was like "Well, there's the issue right there, that you're doing stuff to them. I don't do stuff to them. I ask them. I explain things to them. I don't just do." And so they started being more respectful about explaining things. And I started being more respectful by saying "Okay, you've been in labor for 24 hours and the baby is decelerating and we need to get this baby out. And so probably what's going happen, I can't tell you for sure, but we're going go in, get an epidural. We're going to let you rest. We're going give you some pitocin. We're going get this baby born."

This particular DEM found that approaching OBs and gaining insight into their perspective on transport, allowed her to develop strategies in her own practice, such as informing clients of what to expect when transporting, that were often times

complemented by OBs providing transport clients with more information regarding their care. The strategies this DEM employed were used as a way to navigate around the fissure between midwifery and medicine, rather than having to contend with, and preventing her clients from having to contend with, the negative effects that can result during a transport when midwifery and medicine collide.

Venting

Sharing one's feelings or venting was a strategy used by DEMs as a way to process transport. Most often midwives talked with other midwives about their transport experiences asking for advice on how they could have handled the interaction differently or in sharing a positive experience where an OB agreed to let the DEM remain an active participant in a woman's care. One midwife stated that she has to retell a transport story three times to three different people before she can begin to process it. A DEM discussed the way that transport leads to burn out, yet she tried to find outlets where she can process transport experiences:

> Some of the times I want to quit midwifery and I feel really burned out. Now I try to not let it affect me. I try to move forward because there are other women who are going to have their babies and I don't hold onto that experience…I attend peer review with another midwife or other midwives to kind of get it off my chest and talk about what happened. Through this process, sometimes I find out that we have all had that shared experience. Sometimes it just helps to talk about it. What could I have done different? How could we have handled this different?

The direct-entry midwives in the community where I conducted my research are a tight-knit group. Many have friendships outside the practice of midwifery and this allows an arena where DEMs can offer each other support. In addition, as addressed in Chapter VI, many DEMs in the community participate in peer review at least once a month where

local DEMs gather and discuss recent cases, voice any issues or concerns, seek out advice, and receive constructive criticism.

Emotion Work and Impression Management

As practitioners of a marginalized profession, and also, I argue, by virtue of their gender status, DEMs engage in impression management during a transport as they consciously attempt to influence the perceptions and impressions that medical staff have of them and their clients. Hochschild's (1979, 1983) work on emotions explicitly built on Goffman's (1969) analysis of social interaction. Goffman (1969) discusses the suppression and expression of feelings as an important component of impression management. The motivations behind impression management for DEMs center primarily around being able to construct themselves as valid practitioners in the eyes of medical staff so that they may better secure the necessary elements of medical expertise that their clients need and desire. I argue that in some ways the impression management strategies employed by the DEMs interviewed are subversive in that DEMs, at times, spoke of altering their images to appear more medical-like or speaking in the discourse of biomedicine as a way to retain an element of power within the hospital and contesting biomedical impressions that suggest DEMs are untrained, inexperienced, and incompetent. The most common impression management strategies employed by DEMs were charting and one's demeanor while interfacing with medical staff during a transport.

DEMs argued that medical staff would take them more seriously if their records and charts documenting pertinent information about their client are made easily accessible to medical staff. At times, this involved DEMs utilizing medical terminology and discourse as a way to establish a common ground between midwifery and

biomedicine. One DEM described her reasoning behind the charting format she uses and how she conveys such to medical staff during a transport in the following way:

> I have a transport form that's in all of my files and I fill out as much of it as I can before the mom goes into labor. And then if it's looking like, a transport might be imminent I fill the rest of it in and I give that to them along with the labs and the ultrasound report, the prenatal flow sheet and then whatever notes I've taken on the delivery. There's a lot of stuff in our charts that doesn't make sense to the medical establishment because we chart a lot of psychosocial things. That maybe they don't think is relevant to the care. And it's certainly not something that they would have the time to read through during a transport. And so for me it's been about figuring out what they really need to know to feel comfortable to provide care to my mom. For instance, they're really going to want to know her blood type. They will want to know if she had an ultrasound. They want to know how far along she is. They want to know how long her water's been ruptured, whether she's GBS positive. So those are all things that are right on the forefront of that transport form. And they can read through the transport form and say, okay, these are all the things that are most relevant clinically. And I think sometimes that puts them at ease. And then I can walk them through the rest of the chart and help them find whatever else they need.

Dress and demeanor were equally important in the minds of some DEMs. Some DEMs spoke of the way they would adjust their appearance and/or demeanor prior to arriving at the hospital so as to appear more "diplomatic" or "professional". Consider the way one mother recalled her DEMs quickly changing clothes prior to arriving at the hospital as a way to manage the impressions of medical staff while also ensuring their client's comfort by suggesting she wear a skirt as a way to avoid putting on a hospital gown:

> There was a very funny scene where everybody was changing their clothes. They [her DEMs] said if I was wearing a skirt I wouldn't have to wear a hospital gown. So I put on this very loose, long sort of like comfortable skirt. One midwife changed out her woven hippy-like pants into jeans because that was going to look more respectful. The other midwife changed out of her jeans into very nice dress slacks and so they sort of each went up a notch. And that is actually one of the funniest memoires I have is you know I am kind of leaning on the bed in the middle of a contraction with my skirt like half way up and I look up and both of my midwives are changing their clothes.

Another strategy incorporated by DEMs to ensure that their clients were treated well and to help facilitate clients' in retaining decision-making power in the hospital involved "prepping" clients not to discredit or discount medical advice. Therefore, as a way to manage the impressions that OBs had of DEMs and home birth clients, DEMs would instruct their clients not to reject and resist medical advice, but, rather, to listen to what was being recommended and then they would have the opportunity to make an informed decision. This is an important strategy since frustration and skepticism on the part of OBs was expressed when they encounter DEMs and/or their clients who refuse any medical advice. I also consider this an emotional management strategy as will be discussed below.

Managing Clients' Emotions

The work that direct-entry midwives do obligates them to manage not only their own emotions, but those of their clients as well. Most DEMs interviewed expressed the ways their clients were distraught, scared, defensive, or disappointed about the prospect of transporting. DEMs said that one of their responsibilities as midwives was to ensure that women come to terms with their birth experiences whether they take place at home or in the hospital. Therefore, managing the emotions of their clients prior to, during, and after a transport is a must. DEMs must often keep clients relaxed, comfortable, well-informed, calm, and help them make the transition, both physically and emotionally, from home to hospital.

Prepping Clients

DEMs often knew that the emotions their clients displayed at the hospital not only affected the impressions hospital staff made of DEMs, but also had the potential to affect

the treatment and care that a client received. Over time, DEMs discussed how they have become skilled at navigating interactions with hospital staff and the institutional protocols of the hospital. Prepping clients often involved educating clients not only about what to expect during a transport, but how they should act in order to secure more of what they want while in hospital.

One mother explained how her DEMs informed her about how to negotiate hospital policies and protocols during a transport:

> They [her midwives] would say here is what they want they want you to do and why here's what it will do and here's the risks and benefits. And I would say I really don't want to do that and they would say if we agree to this then we can kind of stall them on the next thing. Sort of with each intervention it was well if we let them do this then we buy ourselves a little time to avoid the next intervention. And so that is sort of how it went the whole way through so that I would sort of end up agreeing to things.
> What was amazing was actually once the hospital staff saw how that I was kind of being reasonable and I wasn't some crazy wild eyes straight out of the woods home birther they backed off a little bit. Once they saw we were seriously considering everything they said and discussing it and making educated decisions they were willing to let us do a little bit more of what we wanted to do. So they were letting the midwives do cervical checks they were the doctor at some point kind of changed gears and actually starting talking to the midwives and started talking to me instead of talking about me to the nurses. I think we won them over a lot. I think that was actually one of the success parts of this story is that this is an OB that always hated home birth he was just very harsh and I think because of the way that my DEMs and I, the way that we conducted ourselves, we won him over quite a bit.

This mother's story reveals the way that her DEMs worked at encouraging her, and perhaps their other clients who have transported, to play the dance of give and take which ultimately resulted in the mother being able to have a vaginal birth with her DEMs playing an active role in her care.

Many DEMs expressed the importance of informing their clients about the logistics of home-to-hospital transport as a way to prepare mothers both psychologically

and physically for the transition from home to hospital. The following excerpt illustrates how one DEM prepares clients for transport, making certain that they understand the reasons why they are seeking out medical advice.

> They've got a lot wrapped up in whether they want to go to the hospital. So you have that and now you potentially are going to have to transport and you're going to get to the hospital and you may have a care provider who is really angry that they have to help you. And actually that anger is a mask for what they're really feeling, which is they are terrified. Because they are so afraid they are going to be sued. I mean, none of us would want to care for somebody that we've never met before. And we're asking them to assume our risk. So we go in there and say, we've cared for this woman. I've done everything I think is right for her and now I can't help her any more. I'm going to pass her over to you. And me, I wouldn't want that. I understand that they don't want that. So what can I do to make sure that that transport is smooth? One of the things I can do is tell them, if we do have to go to the hospital it's because we need to be there. There is no point to go to the hospital and then refuse every intervention that they offer you. That makes home birthers look crazy. Flat out. That's what it does. And so if you're choosing to transport it is tacit agreement that there is something else that you need. And so now we have to transition. And so what I try to work on with my moms is appropriate technology. I say it's not that midwives are opposed to all interventions in the birth place. We just don't think every single woman needs them. We don't think 90 percent of women need them. If you become one of that 5 percent that does I will happily drive you there and help you to get them. And I want them to be able to make that jump. Part of it is allowing them to not have to deal with immobilizing guilt afterward, like they failed in some way. So I address it from the very beginning and just tell them, you know, birth is as safe as life gets and I cannot guarantee you the perfect home birth. I promise you that I will do everything I can in my power to make sure that you have a safe and fulfilling birth. And if that means recommending that we go to the hospital that's exactly what I'm going to do.

This DEM stressed the importance of talking about transport with her clients when they first begin receiving prenatal care so the possibility of transport is planted in their minds and does not, perhaps, seem quite as foreign when it actually does occur. The DEM recognized the position that OBs are in due to their medical/legal constraints that make them hesitant at times to provide respectful care to transport patients. Thus, when DEMs informed clients about the appropriate behavior and emotions during transport,

oftentimes, clients were able to have their DEMs continue playing an integral role in their care. An OB affirmed the importance of DEMs educating their clients:

> I think the most important thing they need more than information or anything else is the understanding that when we get to the hospital you are the doctor's patient. I can be there as your support. I can help you interpret things, but she is going to treat you as her patient and she is going to make recommendations for you that she would make for her own patient. I think that is the number one best thing. And you know you might even say um I'm transporting you because I can't deliver you at home.

Informing clients about what to expect at the hospital was a strategy employed by most of the DEMs interviewed as a way to educate their clients and to help ensure that they will receive efficacious treatment during their hospital stay. It is evident from the interview data, that many OBs and nurses found this strategy to be beneficial for all of those involved with a transport and this likely contributed to medical staff's views that transports have been improving over time.

As discussed in Chapter IV, transport evokes a lot of emotions for women who planned a home birth for many months and then end up in the hospital. OBs, nurses, and DEMs alike expressed how challenging it must be for women to have to alter their birth plans so drastically. Here, however, I focus only on the ways that DEMs helped their clients come to terms with hospital transport. One DEM stated that she felt that a "legitimate part of home birth midwifery is transport". Therefore, this DEM spoke of the way that she helps to make certain her clients walk away from a transport experience with the reconciliation that they are good decision makers.

> I'm concerned if any of my clients have negative feelings about a transport situation. I want for all the people that I work with to have positive self history, and to identify themselves as being good decision makers.

Some DEMs helped their clients adjust to the reality of transport by reminding them that they were still having a baby. Even though the birth may not unfold exactly as they planned, they would still be meeting their baby. One DEM stated that she often notices her clients seem disappointed or sad about the loss of their home birth, but she does her best to try and overshadow those feelings with the excitement that their baby will be born soon.

> Well, I think oftentimes it is a disappointment and I work really hard at reassuring them… showing them that it's okay to transport because at the end we want a happy mom and a happy baby… And I notice that some moms are saying, "You know what?, I'm okay with it." And that's a good feeling. That's a good feeling for us, the midwife, to hear a mom say that. This is okay. This is not what I wanted but its okay. So my goal is to work towards that.

This DEM talked in particular about moms who transport and undergo cesarean sections. As a result of these women's experiences, the DEM and her assistants have noticed that women are receiving very little information about c-sections and the recovery process from hospitals. Therefore, to help empower women and educate them about the details of cesarean surgery, this DEM and her assistants are in the process of developing a pamphlet that they can hand out to moms who have c-sections:

> We are currently working on a handout that we want to give our moms with information about cesareans because we notice that the women don't receive much, if any, information. And a cesarean is a huge surgery. They don't receive any handout at all… I mean, we have a baby and we leave a newborn information sheet, a whole sheet and a half about mother's care… But surgery, that's major surgery. You'd think that one can say, well, it helps if you hold a baby like this. Or, you can expect that it could hurt from this time to that, maybe this many weeks…This is the information we're gathering right now so we can tell our mothers… and we're asking them, what could have helped you? What did they not tell you that you wish you would have known?

In the above account, the DEM espoused how informed consent is a valuable component of midwifery care. She considered part of her job as a DEM involved extending her midwifery-oriented care across the home hospital divide. Thus, disseminating information regarding the c-section surgery and the after effects of the procedure to clients is a strategy she employs.

Conclusion

This chapter illustrates that hospital transport elicits strong emotions in the women who transport and the practitioners who provide care for them. The emotional labor and work feelings that practitioners experience are in large part shaped by their jobs. OBs often spoke of transport as anxiety-producing since they had to juggle professional level responsibilities of liability and hospital protocols, at times making it more challenging to empathize with patients or to interact with DEMs. Likewise, OBs, positioned as medical professionals, operated within a culture that expected and allowed greater detachment from their patients.

The nurses and DEMs interviewed were organizationally positioned such that they were able to empathize with transport patients and establish emotional closeness with women more than OBs. Gender plays a role in this dynamic as well in that nursing and midwifery are predominantly female occupations and as such those fulfilling these positions are typically expected to perform more emotion work (Hochschild, 1983). However, I argue that at times, the emotion work on the part of nurses and DEMs had a liberating effect in the sense that both groups of practitioners worked at securing a woman-centered approach to a patient's care as nurses engaged in bending, challenging

and/or suspending hospital protocols so women could have an empowering birth experience. This is not to say that OBs never played a hand in creating a situation where women's needs were met, but it seemed that nurses and DEMs, who tended to have more contact with patients, were more invested in manifesting such an experience.

My research illustrates that DEMs have become quite crafty at negotiating with medical staff as a way to advocate for and meet the needs of their clients. It appears that the ways in which DEMs interact with medical staff during a transport, in particular how they manage the work feelings that emerge in these interactions, are significant in determining the quality of a woman's transport experience, and are equally crucial in determining the midwife's transport experience.

Although hospital-based birth and birth in home settings exist as options for some women and in some regions of U.S. society, the tension derived from social isolation between these two places of birth and two types of care is evidenced during a hospital transport for planned home birth. Navigating the home hospital divide entails emotional work for DEMs, OBs, and nurses as care providers strive to provide physiological and emotional safety to mothers and their babies and approach the fulfillment of this safety in varying ways based upon their jobs, professional obligations, and philosophies of practice. In the next chapter, I turn to the emotion work associated with home-to-hospital transport as care providers find themselves in situations where they must manage their own emotions and the emotions of mothers as they navigate the transition between home and hospital.

CHAPTER VIII

CONCLUSIONS-TRANSCENDING THE HOME HOPSITAL DIVIDE: HOSPITAL TRANSPORT AND THE POTENTIAL FOR COLLABORATIVE RELATIONS

This dissertation has documented the interactions that take place among care providers and the women they serve during home-to-hospital transports. The current maternity care system in the United States is characterized by a lack of integration between the medical model of care and the midwifery model which has implications for the women who transport and the care providers who are present.

Summary

I began the dissertation with an examination of women's transport stories as a way to elucidate the impact that the interaction between DEMs and medical staff had on their transport experiences. In listening to women's transport stories, it became clear that there was variation in the reasons for transport in the interaction among DEMs and medical staff, and in how that interaction affected the woman, and, ultimately, her birth experience. What emerged from the transport stories told by participants in my study are the ways in which midwifery and biomedicine *intersect* during a home-to-hospital transport and how the degree to which they intersect is dependent on the urgency of a transport and how practitioners approach a transport situation. By intersect, I refer to the way in which DEMs are able to "do midwifery" within the context of a hospital transport. When transports do not go smoothly and, rather, are characterized by fractured articulations or a lack of respectful communication and dialogue, women are often negatively impacted and may characterize their birth experience as traumatic or

disappointing. DEMs played an important role in helping their clients come to terms with and accept their birth experiences. Many of the women who transported spoke of the ways that their DEMs played an instrumental role in informing them about what to expect during the process of transport.

In Chapters V and VI, I moved from an analysis of the types of transports that women experienced to an examination of what factors influence care providers' views and behaviors during home-to-hospital transports. I discussed how medical staff's perceptions of and behavior towards direct-entry midwifery and home birth clients is not only affected by practitioner attitudes, but is also influenced by the jobs they hold, their professional status, and the organizational contexts in which they work. For instance, OBs' views and attitudes toward home birth and direct-entry midwifery were formulated by a combination of personal attitudes in dialogue with professional and work-related obligations. In Chapters V and VI, interview data indicated that OBs are under considerable pressure to meet the professional level and work/organizational level demands associated with their jobs. At times, the situation of transport had the effect of exacerbating the constraining influence of professional and work/organizational factors, especially in relation to litigation, when OBs' jobs required them to assume care of a transport patient whom they had never met before. I explored how a care provider's position within professional and work/organizational structures influences the degree of discretionary power a provider has within the hospital context. Discretionary power plays out in transport situations where we see that some OBs were more comfortable in exercising their discretionary power in ways that involved temporarily suspending

hospital protocols so DEMs could deliver their client's baby or continue providing care to their clients within the hospital context.

In extending the idea that professional and work/organizational factors influence provider behavior during transport, in Chapter VII, I explored the ways that transport involves emotion work. The ways in which DEMs, nurses, and OBs mange their own emotions and the emotions of the women they care for were examined, noting that emotion work involved both negative and positive feelings among providers. As evidenced by the interview data, a primary source of emotion work for OBs, DEMs, and nurses was the conflict between the ideologies and practices of the two models of care. Those providers who were able to reconcile the division between the medical and midwifery models of care and work at the intersection of home and hospital were more likely to speak of their emotion work as rewarding. My data suggest that subsequent studies of transport would benefit from examining the way that transport represents a source of emotion work for mothers who transport as well. With a transport, women must go to a place that they have spent a great deal of time "unlearning," on both physical and emotional levels. How this disjuncture is reconciled, or at least acknowledged, emerges from women's stories of processing transport and is a site where the emotion work of transport is revealed.

An important thing to keep in mind when considering these findings is that this dissertation may paint a more positive picture of transport and the interactions between DEMs, OBs, and nurses than might be observed in other states and other localities. The state of Oregon has some of the most progressive laws surrounding direct-entry midwifery in the U.S. and is currently only one of two states where licensure is voluntary.

Researchers conducting studies on home birth and direct-entry midwifery often make reference to Oregon and the ways in which more liberal laws surrounding the practice of direct-entry midwifery results in Oregon having a higher home birth rate than the national average (MacDorman et al., 2010; Davis-Floyd, 2006; Boucher et al., 2009). As stated earlier, the community in which my research was conducted is characterized by a relatively large number of DEMs and families who plan home births. Due to these factors, the experiences of transport documented in this dissertation may differ significantly from transport experiences in states where direct-entry midwifery and home birth are not regulated and offered some degree of protection by state law. For example, the legal status of direct-entry midwifery may make it more likely that DEMs in Oregon will assert themselves and their clients' needs during a transport. In addition, in a state where direct-entry midwifery is legally protected and relatively popular, OBs and nurses may be more willing to accommodate DEMs and their clients during a transport and work at establishing collaborative care.

Another limitation of this study pertains to sample sizes. As previously mentioned, only eight OBs were interviewed and the majority (n=5) had been working in the field for three years or less. Therefore, it is likely that my sample of OBs does not fully capture the perspectives and experiences of more senior OBs in regard to home-to-hospital transport. Future studies on hospital transport would benefit from including not only more OBs in their samples, but also including an equal number of junior and senior OBs to better capture whether or not job longevity influences a provider's experiences with transport.

The fact that the nurses interviewed all worked at the same hospital and tended to be supportive of midwifery and home birth also constitutes a limitation of this study. The nurses all worked at Parker Hospital and this hospital was cited by many of the mothers, DEMs, OBs, and nurses as the more midwife-friendly hospital. Overall, the respondent-driven sampling strategy may have resulted in a greater proportion of medical staff participants who were more supportive of direct-entry midwifery and home birth.

In terms of race/ethnicity and class, this study does not provide significant information regarding the transport experiences of women from varying social locations and how such social identities may complicate the transport process. Also, recall that all of the OBs and nurses were white and all but one of the DEMs identified as white. Therefore, this dissertation is unable to discern if race plays a role in the interactions that take place during a home-to-hospital transport. As discussed previously, even though my sample groups are not racially and ethnically diverse, the racial diversity in the community where my research took place is low and, therefore, my sample groups represent the community well. In this study, class was not analyzed in terms of income or wealth, which limits my analysis of the role that these social class indicators play in transport situations. However, education as an indicator of social class was analyzed and particularly salient among the women who transported in that the majority held bachelor's degrees or higher at the time of the transport. This illustrates the way that education seems to play a role in a woman's decision to seek out the care of a direct-entry midwife and birth at home. The findings from this dissertation are similar to other studies (MacDorman et al., 2010; DeClercq et al., 2010; Johnson & Daviss, 2005; Boucher et al., 2009) that have revealed a select group of women; white, middle-class,

college-educated, married, and over the age of thirty-five; are more likely to seek out the care of DEMs and plan home births. This is part and parcel of a for-profit healthcare system that fails to value and integrate the midwifery model into the broader medical system, thus limiting access to midwifery care and home birth to those that culturally value it and can afford it. Therefore, the very topic of my study excludes an analysis of the experiences of non-white women, women of working class backgrounds, and women with limited educational attainment.

One of the central findings of this study is that a lack of institutionalized protocols governing conduct between DEMs and OBs during transports leaves individual practitioners on their own in constructing collaborative relations with care providers. Therefore, this study indicates that collaborative relations were developed over time in micro-level interactions with particular DEMs and OBs, noting that not all care providers interviewed had experienced or established collaborative relations with others. So what exactly facilitated collaborative relations between DEMs and OBs? Davis-Floyd (2003) and Johnson and Davis-Floyd (2006) identify three key factors that motivate a physician to reject medical dominance in favor of establishing collaborative relations with midwives during hospital transports: "(1) exposure to midwifery care, (2) exposure to midwives, and (3) attention to the scientific evidence" (2003:1928; 2006:500). Here I consider these three factors as they relate to this dissertation.

The first factor, "exposure to midwifery care" can have the effect of introducing physicians to a different way of approaching labor and delivery wherein the laboring woman makes decisions alongside her midwife. This exposure, Davis-Floyd (2003) and Johnson and Davis-Floyd (2006) contend, can be an ideologically transforming

experience, and physicians may integrate this more personal and egalitarian approach into their practices. Some of the OBs interviewed stated that they had worked alongside certified nurse midwives (CNMs) as residents. One OB discussed how he was trained by CNMs during residency and was taught to look for "reassuring things" during labor and delivery rather than approaching the processes of labor and delivery as potentially pathologic. According to this OB, such training and exposure to midwifery-oriented care influences how he practices obstetrics today. Two of the OBs interviewed were characterized by some DEMs, women who transported, and nurses as being supportive of midwifery and home birth. Recall that one OB worked as a CNM for four years prior to becoming an obstetrician. Having trained and practiced according to the tenets of the midwifery model of care likely positions this OB as more supportive of collaborating with DEMs and their clients during a home to hospital transport. Another OB's personal interest in holistic medicine led him to become acquainted with local DEMs who were practicing natural childbirth. The influence that exposure to midwifery care had on this OB's practice is evident in the way he described how he would encourage patients to labor naturally:

> I've always been a strong proponent of encouraging natural childbirth whenever possible. I would say around 50% of my patients would have natural childbirth and I would do what I can to encourage that. And the things I have learned is to encourage ambulation in labor as long as possible, you know, not having women lay down and to use water as a therapeutic thing. Not just showers and baths in labor, but actually in 2000, I went to an International Water Birth Conference and I did 150 water births so I was an advocate of water births before I stopped [practicing obstetrics] in 2006.

In the above excerpt, the midwifery model of care constitutes a superior approach to pregnancy and birth for low risk women since it is woman-centered and encourages women to be active agents in their care, rather than relying on medical interventions and

expertise. It is likely that since this particular OB took the initiative to learn about childbirth alternatives and the midwifery model of care, he was more willing to establish collaborative relations with DEMs and their clients during transport situations. As a supporter of the midwifery model of care, this OB was willing to serve as an informal "back-up" doctor for local DEMs and worked at establishing collaborative relations as a way to smooth transport situations until 2006, at which time he discontinued practicing obstetrics due to litigation concerns.

"Exposure to midwives" represents the second factor that Davis-Floyd (2003) and Johnson and Davis-Floyd (2006) argue is necessary for physicians to become supporters of direct-entry midwifery and home birth. Although closely related, this factor differs slightly from "exposure to midwifery care" in that "exposure to midwives" refers to a particular type of practitioner, in this case midwives, whereas being exposed to midwifery care indicates that any type of practitioner may implement the tenets of the midwifery model without identifying themselves as a midwife. As discussed in Chapter V, all of the OBs interviewed stated that they were not exposed to any theoretical or clinical information regarding the practice of direct-entry midwifery during medical school. The interaction they did have with midwives took place during their residency training and was limited to CNMs who primarily attend hospital-based births. Due to a lack of exposure to out-of-hospital birth and DEMs as medical students, hospital transport was a particularly important context within which OBs first interacted with DEMs and were exposed to direct-entry midwifery care and home birth. It is important to note that these situations are probably not the best context for positive impressions of

midwives to develop, because they are often stressful, hurried, or even “train-wreck” situations.

Based upon the interview data, OBs and nurses commented on the way that over the past ten years they have noticed an improvement in hospital transports. In particular, medical staff voiced appreciation for the way that most transports now proceed smoothly with the majority of DEMs transporting clients early so as to avoid unnecessary complications. Likewise, OBs and nurses reported that most DEMs in the past ten years bring client records and charts which assists medical staff in providing quality care to transport patients. When DEMs transport clients to the hospital prior to an emergent situation and bring important health information to medical staff regarding their client’s health history, it enhances a DEMs opportunity to do midwifery within the context of the hospital. Also it is important to note that an OB’s prior experiences with certain DEMs affects their willingness to establish collaborative relations during subsequent transports. For instance, OBs took notice of those DEMs they classified as “good”, noting that such practitioners provided good care to their clients, appropriately transported clients at the first indication that a home birth was no longer safe, and effectively communicated their client’s status and needs to medical personnel. I argue that continued exposure to DEMs over time facilitated the view among many medical practitioners that most DEMs are doing good work. DEMs were able to ascertain, as a result of transporting and interfacing with OBs, which OBs they could trust and which OBs would allow them to continue providing care for their clients within the context of the hospital during a home to hospital transport. Consider an OB in Chapter Five, who had not been exposed to direct-entry midwifery, home birth, or transports prior to her senior colleague’s

discussion of such topics during her first night as an on-call physician. According to that OB, participating in that initial home to hospital transport made her realize that DEMs are skilled practitioners, “they [DEMs she interacted with] seemed more knowledgeable than I guess I assumed lay midwives were.” After her first experience with a hospital transport for a planned home birth, this OB stated that she would again be willing to let DEMs play an active role in their clients’ care, provided that there were no complications during the labor or birth process. In fact, as a result of participating in a transport, she expressed an interest in OBs and DEMs meeting outside of the transport context as a way to facilitate better collaborative relations between the two groups of providers:

> I think it would be important if there was desire on the part of lay midwives to have some sort of educational relationship. Like have some lectures or, I don’t know the head doctor well enough, if he would put on a conference that everyone came to or something like that. You know, the more interaction you have with people the easier it is to interact with them in a stressful time so if there were lectures, you know, joint conferences that would likely be helpful so you’ve maybe met the person who is on the other end of the phone.
> I would be willing to give a lecture on any kind of obstetrical complication to a group of midwives, like shoulder dystocia maneuvers, hemorrhage, or whatever. Anything they feel like they don’t know enough about they would like to know more about. And also I was thinking we [OBs] should probably be willing to do the opposite which is hear a lecture about cord clamping and the physiology of clamping down and what studies they have to support their view on not cutting the cord until later. I’d go to a lecture like that.

The excerpt above illustrates how the OB’s experience working with a DEM and her assistant during a home to hospital transport sparked the OB’s interest in establishing an “educational relationship” with local DEMs. After being exposed to midwifery care and DEMs, this OB recognized how OBs and DEMs can learn from each other and the benefits of OBs interacting with DEMs outside the transport context could have a positive influence on their relations during subsequent transports.

Several of the DEMs interviewed also recognized the importance that increased exposure to midwifery care and DEMs during transports have on establishing collaborative relations with medical staff. One DEM commented on the way that transports have improved over the past eighteen years:

> I feel like it's [transports] been good and my clients are happy with the treatment they get. In fact, I'm happy too because a lot of the times they [medical staff] listen to us, which is not how it was 16 years ago. They wouldn't even look at us like, here I am, they'd be like this [blank look on their face] I'd be standing right next to the father. Yes, it was really trippy, but now they talk to me. They say, "How long has she been at six centimeters?" Or "What do you think of this?" "What do you think of that?" They engage you. It's just really cool…We have knowledge that is valuable and will help them. I think that they're probably getting used to us and they're seeing that we're present. I think that our presence, my presence has been here how long now? Since 1990, okay, eighteen years I've been going to the hospital. And even when I don't want anybody to notice me, all these people say, "Hi Lisa." So people know people's faces and I think that helps.

This DEM contrasted her transport experiences she had eighteen years ago with the way that transports in more recent times tend to proceed rather smoothly and she attributed better relations among DEMs and medical staff to DEMs' increased presence stating that "they're [medical staff] probably getting used to us."

Other DEMs also acknowledged the influence that DEMs' continued presence has on medical staff. One DEM expressed the importance of DEMs over time who have "paved" the way to facilitating mutually accommodating interactions during transport situations:

> My experience [with transport] has almost always been really positive. I haven't had a negative experience and I think that, you know, part of that's just because that path has been paved by people who have come before me. The doctors here are used to us. They know us. They get the drill. They may or may not like us. They may or may not be friendly towards our philosophy but they're used to us. They know us. They know the midwives in town. They've been dealing with us for a long time and I haven't had a bad experience. People are generally really accommodating.

This DEM recognized the variation among OBs in terms of their support regarding the practice of direct-entry midwifery and home birth. Based upon the interview data, collaborative relations have been established among particular DEMs and particular OBs over time and the level of exposure medical staff has had in regard to midwifery care and DEMs plays an influential role in determining whether or not an OB is willing to collaborate with DEMs and their clients during a home to hospital transport. However, as discussed in Chapter V and VI, OBs do not have complete power within the hospital context and at times, their professional level obligations and the organizational demands of their jobs constrain their ability to establish collaborative relations with DEMs. Thus, OBs still exercise their discretionary power in accordance with legal obligations and keep other work-related obligations in mind. In addition, as Davis-Floyd (2003) reminds us, those OBs who tend to be more supportive of home birth and direct-entry midwifery tend to be the most marginalized within the profession of obstetrics and as such this limits their ability to "create needed structures for smooth articulation" (p. 1926). However, my data do counter Davis-Floyd's contention that most physicians who support home birth and midwives are marginalized within their profession. For instance, in my study those OBs who tended to be the most supportive were men, and not marginalized men either. Two supportive male obstetricians interviewed hold relatively powerful positions and are influential in the local obstetric community.

The third factor identified by Davis-Floyd (2003) and Johnson and Davis-Floyd (2006) is that physicians who examine the scientific evidence rather than relying exclusively on their biomedical training are more likely to acknowledge the benefits of the midwifery model of care. This, they argue, can have the effect of shifting the view

that only obstetrics offers the best care for women during pregnancy and delivery. Many interventions during labor and childbirth have been shown to be ineffective or harmful and do not result in improved outcomes for mothers and babies (Rothman 1982; Goer, 1995,1999). One study revealed that of women who birth in hospitals, 85% are connected to fetal monitors (Martin et al. 2003) even though evidence suggests that such monitoring often results in unwarranted interventions (Goer 1999; Simonds, Rothman, & Norman 2007). The midwifery model of care rejects these interventions and the view that the female body is a machine in need of medical expertise and technological intervention. (Johnson and Davis-Floyd 2006; Rothman 1982; Davis-Floyd 2002). Three of the OBs interviewed for my study commented on the benefits of the midwifery model of care and the safety of home birth for low-risk women. I follow the suggestions put forth by Vedam et al. (2009) who advocate for theoretical and clinical education on out-of-hospital births in professional health curricula for maternity care providers as a way to increase "the overall favorability toward planned home birth" (280). Likewise, they point to the way that incorporating home birth curricula and clinical experiences into the core requirements for medical education could facilitate greater collaboration among medical and midwifery practitioners: "Interdisciplinary education about planned home birth could lead to 'best practice' guidelines around collaboration in maternity care and remove significant barriers to practice" (280). I argue that it is important for DEMs to be trained in obstetrical complications and emergencies so that they are skilled to recognize such conditions in their clients. Likewise, mandatory licensure in the state of Oregon may exist as a compromise some unlicensed DEMs are not willing to take, but it may help bridge the gap between providers and assist in facilitating more collaborative

relations. Medical staff interviewed in this study expressed concern over the variation in DEMs' skills and training and therefore, mandatory credentialing and licensure may be a necessary compromise in order to diminish confusion regarding DEMs' education and practices.

Contributions to the Literature

My data offer a vantage point which counters the assumptions made by Johnson and Davis-Floyd (2006). They argue that home-to-hospital transports are particularly problematic for DEMs and their clients in states where midwifery remains illegal or alegal due to the lack of structural guidelines governing conduct. Johnson and Davis-Floyd are particularly interested in what factors facilitate mandorla transports in those states where direct-entry midwifery is illegal or remains legislatively unsanctioned. It is their belief that in such contexts, "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" (2006, p. 472). However, my data reveal that interactions between DEMs, OBs, nurses, and mothers are complicated regardless of the legal status of direct-entry midwifery. For instance my study takes place in the state of Oregon where midwifery is legal and there is a considerable population of both midwives and consumers who seek out the care of direct-entry midwifery services and home birth. The data that I collected indicate that even though Oregon has some of the most progressive laws surrounding midwifery and home birth in the nation, the relations between home birth midwives and

the medical community are not always characterized by “smooth articulations” (Davis-Floyd, 2003; Johnson & Davis-Floyd, 2006).

My data reveal that even in a state where midwifery is legal and licensure is voluntary, structural guidelines surrounding conduct and practice for DEMs and medical personnel during a transport remain absent for both midwives, their clients, and the medical personnel on staff at the hospital when a transport takes place. What my data illustrate is that midwives and their clients are not able to predict how they will be received upon arrival at the hospital because practitioner attitudes and behaviors are so variable. This is not to say that Johnson and Davis-Floyd (2006) are wrong, but my findings suggest that the legal status of direct-entry midwifery and home birth in a state does not necessarily result in smoother interactions between DEMs and medical staff during hospital transports. The legal status of direct-entry midwifery in a state does not change the way in which DEMs are positioned within the context of the hospital institution. For even in states like Oregon where DEMs legally practice and enjoy a degree of protection from the law, once in the hospital context they do not possess authority as practitioners in the eyes of the medical institution and as such they do not formally possess hospital privileges. It is this disjuncture between their status as legal, autonomous care providers outside the hospital context and their status as merely labor support once in the hospital context that DEMs must grapple with during home-to-hospital transports. The ways in which this disjuncture is reconciled are evidenced in the various strategies DEMs employ in order to continue providing care to their clients and advocating for their clients’ needs and interests which typically involves a degree of negotiation with medical staff during the transport situation.

The dominance of the medical model and the professional hegemony of the obstetric profession are maintained and reinforced by a neoliberal influenced healthcare system where the needs of the market and institutions supersede the needs of women and their babies (Hough, 2006; Goodman, 2007). The state converges with the free market economy in maintaining the obstetric hegemony and dominance over U.S. maternity care by constructing medical professionals as the experts in pregnancy and birth and by legitimizing medical education as a source of authoritative knowledge (Jordan, 1993; Goodman, 2007; Hough, 2006). However, biomedical hegemony, neoliberal healthcare policy, and the medicalization of pregnancy and birth do not go unchallenged. The experiences presented in this dissertation illustrate the ways in which mothers, DEMs, nurses, and OBs exerted agency as they negotiated, collaborated, and interacted during home-to-hospital transports.

In light of structural constraints, many of the midwives I have interviewed have been successful at subverting the obstetrical hierarchy and institutional protocols associated with the local hospitals and have strived to, and some have been quite successful at, establishing smooth articulations with hospital staff. These smooth articulations have a lasting effect as well and are not just a product of the transport in that moment but rather these positive relations carry on and are maintained after a transport has occurred. In my research, some of the OBs and many of the nurses were critical of the obstetric dominated maternity care system. Two of the OBs interviewed openly expressed the superiority of the midwifery model of care due to the better outcomes and fewer interventions in comparison to the medical model. My data indicate that smooth articulations and mandorla transports are something that are developed over time in micro

level interactions with particular midwives and particular doctors and nursing staff. They subvert existing hospital protocols and dominant ideologies surrounding birth as they strive to "orchestrate the normal". Subversive practices on the part of the DEMs I interviewed often take place in partnership with particular medical personnel who tend to be more home birth and/or midwife friendly. This tremendous amount of work on the part of many of the DEMs and many members of the hospital staff to go beyond the divisions and conflicts and find a place of reconciliation improves the transport experience for all involved.

Implications for Home-to-Hospital Transports

Throughout this dissertation, my intention has been to illustrate how the perspectives and behaviors of individual care providers, although personal, are not merely individual. Rather, individual perspectives and behaviors were shaped by their jobs, by the model of care they practice according to, and by the way that their jobs situated them differently in relation to the broader maternity care system and in relation to the hospital context. Thus, there was a degree of variation in how participants experienced home-to-hospital transport. The lived experiences of mothers who transported illustrate how the interaction between their DEMs and medical staff had the potential to render a transport experience positive or negative, ultimately resulting in a continuum of transport experiences. At times participants reported a collision between practitioners of the two models. According to other women's lived experiences, transport entailed a situation where DEMs and medical staff reconciled ideological differences and the models of care overlapped in such a way that the interaction between DEMs and medical staff was characterized by smooth articulations (Davis-Floyd, 2003; Johnson &

Davis-Floyd, 2006). This often involved impression management for DEMs and medical staff wherein DEMs reported displaying their medical knowledge and terminology through detailed charting and records as well as displaying a professional demeanor through dress and discourse. For medical staff interacting with DEMs and their clients during transport impressions were often managed in ways that involved medical staff becoming more personal and less removed from their patients and the birth process. Nurses dimmed lights, OBs used gentler voices, and OBs incorporated and acknowledged DEMs suggestions and information regarding their clients' care.

An interesting finding from this research is that there was a willingness on the part of practitioners of both models of care to improve home-to-hospital transport. For care providers interviewed, work plays an important role when it comes to transport and being able to do one's job according to their work and professional obligations was important. Transports were not necessarily always a crisis or caused medical staff to shift into a crisis mentality, but, rather, transport for DEMs, nurses, and OBs often meant that it was not going to be business as usual. Transport had a particularly influential effect on all groups. Most DEMs, mothers, nurses, and OBs found it necessary to enter into a space, void of institutional guidelines and protocols, where they had to negotiate, on some level, in order to provide quality care to women and their babies. Individual actors had to create their own way of doing, making their own guidelines and protocols for a given situation depending on the need at hand. These individual-level actions were often informed by colleagues, professional socialization, and other work-related obligations.

Marginalization and Power

This dissertation is about marginalization and simultaneously it is about the power dynamics present when marginalized practitioners interface and interact with practitioners of the dominant medical model. This dissertation provides a glimpse into the way that marginalized groups DEMs, challenge the power of biomedicine and how powerful groups, such as OBs, at times acknowledge and work alongside marginalized groups during home-to-hospital transports. Conversely, this dissertation reveals the ways OBs, as members of a hegemonic profession in the U.S., exert discretionary power in ways that dominate and continue to marginalize the midwifery model of care, its consumers, and its practitioners within the hospital context. The structure of U.S. healthcare positions the medical model and the midwifery model as opposites and the professionalization of medicine in U.S. society has had the effect of marginalizing the practice of midwifery and the midwifery model of care. As Goodman (2007) suggests, marginalization, "has to do with the social, political, and personal construction of boundaries, deciding who controls and maintains these boundaries, and who is permitted inside. The marginalization of professions occurs via a process of social closure where dominant groups or stakeholders have power and control over market conditions that protect their interests from competitors" (p. 612). This dissertation has documented some of the effects consumers and care providers face when midwifery and medicine are not integrated.

Many of the direct-entry midwives interviewed spoke about the importance of establishing relationships with medical personnel, in particular OBs, as a way to facilitate better communication and care for their clients should the need to transfer care or

transport to a hospital arise. DEMs argued that negotiating with medical staff often involved them upholding knowledge of the medical world, a burden that marginalized groups must often endure wherein they are often in situations where they must have an understanding of the dominant system. Many of the DEMs interviewed embodied the notion of the "postmodern midwife" as defined by Davis-Floyd et al. (2001). Building upon Davis-Floyd et al. (2001) view of the postmodern midwife, this study of home-to-hospital transport is particularly situated to examine how DEMs are involved in resisting the medical system while simultaneously managing their impressions so as they appear to be in compliance with biomedicine and its practitioners during a transport as a strategy to continue providing midwifery care to their clients within the hospital. DEMs were often compelled to simultaneously resist and acquiesce to medical staff and biomedicine during a transport since DEMs are not viewed as valid care providers by the hospital institution, or by many of those who practice according to the medical model of care.

The findings from this research suggest that we might incorporate the term "postmodern obstetrician" to refer to those OBs who acknowledge the effectiveness of the midwifery model of care and support midwives in their community by openly offering consultation and continuity of care during home-to-hospital transports. Several of the OBs interviewed were involved in establishing collaborative partnerships with DEMs and working to bridge the gap between direct-entry midwifery and medicine so that women could experience continuity of care and ease of transition from home to hospital.

This study of home-to-hospital transport reaffirms existing research (MacDorman et al. 2010; van Teijlingen et al. 2009; Davis-Floyd, 2006) documenting the

demographics of women who plan home births with direct-entry midwives. Examining the phenomenon of home-to-hospital transport we see that marginalized practitioners (DEMs) are serving predominantly advantaged women. Overwhelmingly, the women who participated in this study were white, middle class, college educated, and married. Thus, the experiences documented in this dissertation pertain to a select group of women in the United States. This is a trend throughout the country, wherein women whose class and racial status accord them with the privilege to make the decision to seek out alternatives to hospital-based births and birth attendants other than obstetricians. It must be noted that women who plan home births with DEMs find birthing at home, natural childbirth, and hiring a direct-entry midwife to be culturally valuable and empowering. What must be gleaned from this research is that not *all* women may find birthing at home with a midwife to be empowering or even desirable. It is elitist to assume that midwifery care and home birth would automatically be sought after by all women regardless of their racial/ethnic background and social class location if midwifery were mainstreamed into the U.S. healthcare system. Therefore, this dissertation tells the story of a very small percentage and select group of women in the U.S. who, by virtue of their white racial status, and class status as middle class Americans, are able to exercise greater freedom of choice regarding their reproductive health. This is not to say that women of other social locations are not able to exercise choice, but that not all women find value in home birth and the care of direct-entry midwives.

The findings from Fraser's (1995) research indicate that African Americans did not necessarily view the decline of midwifery in the U.S. as a negative consequence of biological hegemony. Fraser found that the central issue facing African American

women and families in the south during the mid-twentieth century, was not about resisting the medicalization of pregnancy and birth, but, rather, their focus was on the inclusion in a healthcare system they had historically been excluded from and ignored by. According to Fraser:

> I, for example, saw and knew the erasure of the traditional midwives to be a tragedy of immense proportions because of the racist and faulty assumptions that guided the southern health-care establishment's campaign against them. By contrast, elder African American residents of Green River spoke about the benefits of reproductive progress and of the health-care equity that had come with increasing access to hospitals and obstetric technologies…reproductive change signaled a symbolic, if not fully realized inclusion in the field of vision of a health-care bureaucracy that had until then largely ignored the health needs of African-Americans. If this inclusion meant giving up the much valued midwife, it could also lead to being part of the public in 'public health'. Our own enthusiasm for the recuperation of the midwifery arts should not obscure the race and class issues that led African-Americans to welcome modern bodies and modern minds even at the expense of the traditional values and knowledge that they had so respected and valued (1995: 56-70.

The ways in which identities of class, race, and gender intersect among the women who transported that are represented here suggests that their socio-economic class status intersects with their white racial status granting them the economic wherewithal to seek out the resources and cultural knowledge regarding home birth with a DEM. Although the average cost of hiring a home birth midwife is nearly one third less than a non-interventive hospital-based birth with an obstetrician (Johnson & Daviss, 2005), many insurance policies do not cover DEMs' services and therefore some clients must pay out of pocket for their care. This study of transport reveals the ways in which race, class, and gender intersect and affect the degree of choice and value that women have and attribute to home birth and direct-entry midwifery. The findings from this dissertation indicate that, at times, particular DEMs, OBs, and nurses were able to establish

collaborative partnerships in order to provide the best care for mothers and their babies. However, we must ask is it enough for only a handful of DEMs, a handful of medical staff, and, ultimately, a handful of mothers to have these positive transport experiences? Further studies of home-to-hospital transport may benefit from ascertaining whether or not white, middle class, college educated women are more likely to assert their interests, desires, and their right to choose, and exercise their authority in the hospital than women from less advantaged backgrounds who plan home births and transport. The United States is steeped in the ideology of individualism and the belief in an individual's freedom of choice. But, choice is rooted in and harnessed to one's location in the hierarchies of race, class, and gender. Currently, in the structure of contemporary maternity care in the United States, those who continue to be offered choice in terms of birth and birth location tend to be white, middle class, college educated women.

This study of home-to-hospital transport reveals the dynamics of class, race, and gender. It is primarily white, middle class, college educated women who plan home births and thus, it is typically this select group of women who transports and may possess a greater degree of social capital with which to navigate the hospital bureaucracy. Therefore, the social location of many women who transport plays a role in their ability to retain decision-making power within the hospital institution. It is problematic that the model of care that has numerous research studies backing it as the most effective and safe in terms of benefits to mother and babies is primarily accessed by a select group of women from advantaged backgrounds. This finding speaks to the racial and class disparities in the United States' national healthcare system. With 48 million people uninsured in the U.S. (vanTeijlingen et al. 2009; Goodman, 2007), various women may

have difficulty securing any prenatal care at all let alone being able to make the choice to birth at home. It is a systemic problem, one which emanates from neoliberal economic policies and ideologies that suggest market forces will remedy social inequities and social problems such as income inequality and poverty.

Implications for U.S. Maternity Care

The U.S. healthcare system exists within a market-based economy that is characterized by competition over resources, power, and status among professionals (Goodman, 2007). The United States is unique in relation to other high-income countries in that the U.S. lacks a state-controlled health care policy which results in unequal access to healthcare and healthcare services. Unlike other high income countries in the U.S. the midwifery and medical models of care are not integrated and midwifery remains on the periphery of the maternity care system. Despite the exorbitant costs per capita spent by the U.S. on healthcare, indicators of maternal and infant health pale in comparison to other high income countries that provide universal healthcare and the majority of births are attended by midwives. For instance, in 2004, the United States spent 1.9 trillion dollars on healthcare (OECD, 2005) while the U.S. currently ranks 41st in maternal deaths of all high-income nations and 32nd out of 33rd for infant mortality (Cheyney, 2010). The reality that pregnancy and childbirth are constructed as medical events is evidenced in the way that 99% of births occur in hospitals and 91% are attended by physicians despite the fact that the American Public Health Association and the World Health Organization assert that 70-80% of all births are normal and low-risk (Goodman, 2007; Martin et al. 2006; Wagner 2006; World Health Organization, 1996).

Rather than guaranteeing its citizens healthcare coverage, the U.S. profit-oriented healthcare system relies on the free market to provide healthcare[20]. Consequently, such a model results in disparities along racial, class, and gender lines when it comes to being able to afford and thus access healthcare. Neoliberalism is at the crux of U.S. social policies and undergirds U.S. social institutions. Under neoliberalism state policies that support and bolster market forces are often implemented as a way to protect powerful economic interests and wealth (Goode & Maskovsky, 2001; Goodman, 2007). Implementing neoliberal-oriented policies for programs designed to meet basic human rights and needs (healthcare, food, and shelter) have not been effective or successful in producing positive outcomes. Consider welfare restructuring. Neoliberal efforts aimed at reducing welfare caseloads by putting people to work in the low-wage labor market while simultaneously curtailing essential safety nets for families such as state-funded healthcare and public assistance as they move from welfare to work have not been effective in removing people from poverty (Goode & Maskovsky, 2001). The same results can be found in the maternity care system where leaving healthcare provision to market forces does not translate into improved maternal and infant mortality rates. Under a profit-oriented healthcare system, economic wealth of powerful groups, such as the obstetric hegemony, and the needs of institutions tend to win out in the end, rather than adhering to what policies and types of maternity care are best for mothers and their babies.

If we truly want to move midwifery from the margins to the center of U.S maternity care, I adhere to the already loud cry for healthcare reform and the equitable

[20] The exceptions here are Medicare and Medicaid, the U.S., federally-funded health insurance programs that help offset healthcare costs for the elderly and the poor.

distribution of resources which suggests we must first address the glaring inequities that continue to leave out women who cannot afford healthcare. Unraveling the racial and class injustices that have so long excluded many women of color and poor women from accessing medical care and being included in public healthcare policy is a hefty task. Even if women of color and poor women were given accurate information regarding midwifery care and alternatives to hospital-based births (arguably, some women may already have it), it is uncertain whether or not they would choose it. Further developing and incorporating midwives and the midwifery model of care into the U.S. maternity care system, thus reversing the trend whereby 91 percent of births are attended by OBs (Goodman, 2007; Wagner, 2006), may indeed be the first step in improving maternal and newborn outcomes while saving millions of dollars in healthcare expenditures.

In a recent article van Teijlingen et al. (2009) argue that U.S. "exceptionalism" is a useful concept with which to examine maternity care in America. Applying the concept of exceptionalism captures the way that the U.S. is the only high-income country that has not had "an influential social democratic or communist party in the twentieth century" (van Teijlingen et al., 2009, p. 2.1) and how the dominant ideology of individualism encompasses society-wide support for equal rights, but "these values do not provide a foothold for a shared responsibility for the social welfare of all" (van Teijlingen et al., 2009, p. 2.1). The authors argue that the U.S. maternity care system differs significantly from other high-income countries due to these political developments coupled with dominant cultural values. According to van Teijlingen et al. (2009, p. 7.1):

> The dominant cultural values held by the US populace have had a decisive influence on the way care during pregnancy and birth is organised. There is a noticeable lack of support for a publicly-funded health care system, which is

> central to the notion of exceptionalism in the US system. Yet at the same time these general cultural values interact with one each other and the socio-economic environment. Thus, the kind and quality of maternity care available to certain groups of US women (and not others) is influenced by historical developments, the portrayal of childbirth in the mass media, the way in which both the health care system and the accompanying health insurance system is organised, the risk of litigation experienced by obstetricians, and by inter-professional conflict rather than collaboration.

In some ways, Oregon serves as the exception to U.S. exceptionalism due to its progressive state laws surrounding direct-entry midwifery and home birth, the availability of a publicly-funded health insurance program that assists low-income individuals, consumer demand for direct-entry midwifery services and home birth, and the collaborative efforts on the part of some OBs and some DEMs to further integrate and establish dialogue between direct-entry midwifery and biomedicine. Despite these regional qualities that render Oregon unique, the legal status of direct-entry midwifery in Oregon does not automatically translate into the hospital institution or medical community recognizing and acknowledging DEMs as valid practitioners during a transport. Studying transport in Oregon, a state where laws surrounding midwifery are relatively progressive, in comparison to other states, offers insight into the way that the lack of institutional protocols governing conduct continues to render the collision between the medical model and midwifery model during a transport a possibility. This dissertation suggests that we can be assured, however, that instances of collaboration do occur among particular OBs, nurses, and DEMs as they make local-level efforts at transcending the home/hospital divide to ensure quality care for women who plan home births and transport.

APPENDIX A

SAMPLE TRANSPORT FORM AND CONSENT FORM USED BY DIRECT-ENTRY MIDWIVES

Emergency Transport

Our belief is that every woman has the right to choose where and with whom she has her baby. However, we must abide by the state of Oregon regulations, which restrict our practice in number of ways. Should your pregnancy fall outside the realm of our practice guidelines at any point, we will do our best to help you make alternative plans for the remainder of your pregnancy and birth.

All births, regardless of the setting (hospital, birth center, or home), carry a certain degree of risk. Even with low risk pregnancies and births, complications can arise. There are certain risk factors that would necessitate a hospital transport which were listed on the Risk Factors consent form that you signed on (date) _________ .

In the event that an emergency arises and transport is necessary we will do our best to help plan a strategy for back up care for mother and baby to local emergency facilities. Parker Hospital and Rosemont are the two hospitals located in the area. If an emergency transport occurs in an area not near the above facilities we will transport to the closest available emergency care facility.

The ideal of obstetric and pediatric back-up care has not yet been realized in this area. However, the Emergency Medical Treatment and Labor Act (EMTALA) mandates hospitals may not refuse emergency treatment to pregnant women, women in labor, or her newborn baby. Should a transport occur, you will not know which physician will care for you or your baby until we get to the hospital. We cannot guarantee what type of reception you will receive from the hospital staff or physicians, although most of the time we have received a positive reception.

In the event of either a complication of at my own discretion, if we determine the well-being of mother and/or baby is at risk, we will recommend transport to the hospital that we feel will best be able to meet your needs. Transferring to the hospital in labor can be disappointing and scary. We will remain available to you at all times, helping you understand everything that will be happening and serving as an advocate for both you and your baby.

Please be advised that we expect the cooperation of mother, partner, and any family members present if transport becomes necessary. If transport is refused, we may be forced to call an ambulance to stabilize mother and/or baby. Upon arrival of the ambulance, we will turn care of mother and baby over to the paramedics.

Transport may take place in personal vehicle or by ambulance depending on the nature of the complication. This information is also listed on the consent form that you signed on (date) ________ . If a transport occurs emergency delivery supplies and equipment provisions will be carried in the vehicle.

Our main goal is a safe birth for you and your baby.

Notes regarding client questions and discussion of this form and emergency transport:

Client name: ____

Client signature: ____ Date: ____________

Consent Form

I (We) plan to give birth at ____ with a midwife in attendance.

We believe that birth is a natural and generally safe process. We have, however, discussed with our midwife some of the fetal monitoring devices, forceps, vacuum extractors, blood plasma, and quick access to a cesarean section. We are fully aware that in the event of a serious complication it will require additional time to transport and receive such care. Consequently, in the event of a serious complication there may be additional risk to the baby or mother. We are aware that the midwives have medical equipment and medications such as Doppler for monitoring baby's heart, oxygen, ambu for resuscitation of the infant, hemorrhagic meds, IV fluids, local anesthesia, and suture equipment for suturing tears.

During prenatal care, if the need arises to refer my care to a clinical specialist I will be provided with the appropriate referrals. During labor, if complications arise requiring hospital transport, what we do will depend on the nature of the complication. My midwife will either call a doctor or midwife with hospital privileges to transfer care, or we will go directly to the hospital and transfer care to the obstetrician on call. If the transport is not an emergency then we usually contact a physician or midwife and transport to the hospital in clients' and/or midwife's car. If there is an emergency the standard procedure is to call 911 for an ambulance, and then to call the hospital labor and delivery unit to advise them of the problem and that we are on our way. The hospital staff will take over my care when I arrive. A midwife will come to interact with the hospital staff, and act as support person and advocate for me.

I understand that my midwife cannot carry the weight of making every baby and every birth perfect. I stand by whatever choices I make on where to birth and I stand by the midwife I have chosen to guide me through this most important time in our lives.

I have been informed that the midwives do not carry malpractice insurance. I make the choice to birth at ______________________________ with a midwife believing that it is a reasonable and responsible decision for the birth of my baby.

Client Signature(s)

____

Date: _______________________

APPENDIX B

INTERVIEW PROTOCOLS

Interview Protocol for Women who have had a Hospital Transport

Background

Tell me a little bit about yourself. Where did you grow up?

How old are you?

How long have you lived here in town?

Tell me about your education.

Tell me about your decision to have a home birth.

Tell me about your decision to have a direct-entry midwife provide your care.

How did you come to this decision?

How did other people (your family or friends) react to your decision to have a home birth?

Experience with transport

Did your midwife ever discuss the possibility of hospital transport while you were receiving prenatal care? [If yes, tell me about this. If no, why do you think this is?]

Did you feel adequately prepared when you had to transport to the hospital? Why or why not?

Before you went into labor had you thought about the possibility of transporting? How did you feel about it then? How did you feel when the possibility of transport was first raised? [When it was decided you would go? On the way? At different points during the birth? Afterwards?]

When was your baby born?

Where was your baby born?

Tell me about your labor. How did it start? How did it go?

Describe the events that led to the transport. [Probe here for: Who determined that a transport was necessary? What did they do? Was the hospital called? Was there any consultation with an ob/gyn or other medical staff? If yes, describe this consultation.

Tell me about your transport. [Probe here for: What were the reasons for the transport? How did you feel about having to transport? How about others present, how did they feel?

What hospital did you transport to? How did you get there?

Describe the medical personnel who were present when you arrived. [What were they like? What did they do? What medical personnel were present later?]

How were you treated by medical personnel?

Tell me about who was present.

Was the birth different than you expected?

Was your midwife (and assistants?) present during the birth? If so, describe what role they played.

Tell me about the interaction between your midwifery team and the medical personnel. How would you describe the interaction between your midwife and the doctors and nurses?

In your view, did the interaction (or lack thereof) between your midwife and medical personnel affect your birth experience?

Has your transport experience changed your view of the medical establishment?

Has your transport experience changed your view of the practice of direct-entry midwifery?

Has your transport experience changed your view of home birth?

How do you feel about your birth experience now?

Did you get what you needed during the transport?

Is there anything you would change about the transport? Describe.

Did you do anything after the birth to process the transport?

Looking to the future

How might hospital transports be improved?

If you became pregnant again, what kind of care would you seek out? Why? Describe. If you were to seek out midwifery care again would you choose the same midwife? Why or why not?

How do you imagine the birth?

Is there anything else you would like to add?

Interview Protocol for Medical Personnel

Background

What is your title?

Tell me about your education.

When did you decide you wanted to be a ob/gyn [labor and delivery nurse, certified nurse midwife (CNM)]?

Tell me about your training. In your medical training did you ever learn or discuss anything about home births? About direct-entry midwifery? If so, describe what you were taught. If not, why do you think this is? [Probe for diversity of experiences: Did you ever hear any different perspective? From where?]

Philosophy of care

Describe the work that ob/gyns do. [Describe the work that labor and delivery nurses do.]

Describe a typical day at work.

Describe what you do during a birth.

Describe a typical birth. From your perspective, what is it like for the mother? The baby? The dad? Others who are present?

What do you enjoy most about your work?

Tell me about any aspects of your work that you would like to change.

Hospital Transport

In general, what do you think of home birth? What do you think of midwives? (DEMs and CNMs)?

Tell me about your experiences with hospital transport for women who planned to have a home birth. [Probe here for: How often do you witness a transport? Are you typically on call when a transport occurs? How often do you participate in a transport? Tell me about the main reasons for hospital transport. What kinds of things are women transported for?]

Describe a typical hospital transport you have been a part of. Describe a transport you remember the most. [Are most transports are like the one you describe? and if not, how do they differ? Are there different kinds of transports? How would you describe them?]

Have transports changed your view of the practice of direct-entry midwifery? How so? How did you view direct-entry midwifery before you experienced a transport? How do you view the practice of direct-entry midwifery after experiencing a transport?

Have transports changed your view of home births? How so? How did you view home births before you experienced a transport? How do you view home births after experiencing a transport?

What is a transport like for you as an ob/gyn? [labor and delivery nurse? What's it like for the mother? (father, infant, midwifery care team)]

How do you think direct-entry midwives see ob/gyns? Medical personnel? Hospitals?

Physician and Midwife Collaboration

When a home to hospital transport occurs, what is the interaction like between you and the midwife? [Probe for: What is the interaction like for the mother, other medical personnel? Have you had any interactions that were really different from that?]

When misunderstandings occur, what is usually the culprit?

Do you think it is different from the interaction in regular hospital births? How? Why?

Have you had better or worse experience with transports? Tell me about some of those.

Describe your relationship with direct-entry midwives in the community. Are there any midwives you have had particularly good experiences with? Bad experiences? What makes the experience better or worse for you? Do you have any interactions with them outside of transport situations?

Have you ever offered back-up (either formally or informally) to a direct-entry midwife? [If yes, tell me about this. How did you start doing this? How often have you done this? If no, describe the reasons why.]

How often do you offer consultation with a midwife? Under what circumstances? What typically happens – how does the consult work? Are you happy with how it works? What would make it better?

What do obstetricians and medical staff need from midwives upon a transport? [How often do they get what they need? What factors matter in whether they get what they need?]

How important is it for a home birth midwife to have a relationship with medical personnel? Why?

In your view, is it important for direct-entry midwives and medical personnel to have an open dialogue or open communication? [Probe here for: Have you ever had an experience when this has occurred?] Describe the experience.

Describe any changes you would like to see in regard to hospital transport for intended home births. Are these changes really possible? What gets in the way? What would have to happen for the changes to occur?

Interview Protocol for Direct-entry midwives

Background

Tell me a little bit about yourself. Where did you grow up?

How old are you?

How long have you lived here in town?

Tell me about your education

How and when did you decide that you wanted to be a midwife? Tell me a little about this process.

How long have you practiced midwifery?

Are you a licensed midwife? Why or why not? Describe the process of licensure.

Are you a certified professional midwife (CPM) ? Why or why not? What does this credential (CPM) mean? What does the credential (CPM) mean to you?

How much do you charge for your services? Describe how clients pay for your services. Are you reimbursed by insurance companies?

Do you tell your clients about the possibility of transport?

<u>Relationships with other midwives</u>

Not all midwives are alike, what are some of the differences in style and procedure that you see?

In your view, are there differences among home birth midwives? If so, describe these differences. Are there any stories or situations you can think of that really demonstrate those differences? If no, why do you think there are no differences?

Tell me a little about your relationships with other home birth midwives.

Have you ever had any problems with other midwives? If yes: What kinds? How did the problem start? Is it still going on? If no: Do you think there are tensions or problems between other midwives? What kinds?

<u>Midwifery Care</u>

Describe the work that midwives do.

Tell me about nutrition for the mother.

How do you view pregnancy?

<u>Midwifery Care</u>

Describe the work that midwives do.

How do you view pregnancy?

How do you view birth?

Describe what you do during a birth.

Describe a typical home birth. From your perspective, what is it like for the mother? The baby? The dad? Others who are present? What is it like for you?

Tell me about any changes your practice has experienced.

Have you ever practiced with other midwives? How was that?

Have you ever had any students? How many are there? What did/do they do?

How do you think midwifery has changed since you started practicing?

Hospital Transport

Tell me about your experiences with hospital transport. [Probe for: How often do you have to transport? What kinds of things do you transport for? How do you prepare for a transport? How do you choose which hospital to transport to? Which do you prefer and why?

Describe a hospital transport you have been a part of. [Tell me about a typical transport, or the one she remembers most. Tell me about your most recent transport. Are most transports like the one you describe? If not, how do they differ]

Have transports changed your view of the mainstream medical establishment? How did you view the medical establishment before you experienced a transport? How do you view the medical establishment after experiencing a transport?

What is a transport like a midwife? What's it like for the mother? What is it like for others present?

How do you usually feel when a transport happens?

Physician Collaboration

Describe your relationship with the medical establishment.

Do you have physician backup? (if yes: have you always had the same backup? How did you come to have it? How long has the current situation been in place? If no: Have you ever had physician backup? Would you like to have it? What's keeping you from having it?]

How often do you consult with a back-up physician? Under what circumstances? What typically happens – how does the back-up work? Are you happy with how it works? What would make it better?

How important is it for a home birth midwife to have a relationship with medical personnel? Why?

In your view, why do some physicians offer back-up? Why do some physicians refuse to back-up?

What do midwives need from obstetricians and medical staff upon a transport? [How often do they get what they need? What factors matter in whether they get what they need? And, do you want to ask what medical staff needs from midwives?]

Tell me about how you have been treated during transports? After transports? What's the range of experiences? Tell me about what factors make a difference?

What impact has this treatment had for your? For the mothers? For the babies? For others present at the birth?

Public Perceptions

From your perspective, how do you think the general public views direct-entry midwives?

How do you think the general public views home birth?

Where do you think these ideas come from?

Is there anything you would like to change about the public's perception of midwives?

Is there anything you would like to change about the public's perception of home birth?

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