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From the top down and the bottom up: the contemporary practice and choice of midwifery in Louisiana

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FROM THE TOP DOWN AND THE BOTTOM UP:
THE CONTEMPORARY PRACTICE AND CHOICE OF
MIDWIFERY IN LOUISIANA

A Thesis

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Master of Arts

in

The Department of Geography & Anthropology

by
Michelle M. Wydra
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This research examines the contemporary practice of midwifery in Louisiana, a state that very early on had progressive legislation, yet remains a tough place for a midwife to practice. What, then, are the social forces that affect the ability to practice midwifery in Louisiana? I try to answer that question by examining the narratives of midwives and their clients, and evaluating the options these women have access to in this state.

The narratives provide opportunities to observe the authoritarian knowledge of biomedicine in our society, and apply Foucault’s theory of power/knowledge. I describe that although Louisiana’s regulation of the practice was progressive when written, the regulation alone cannot guarantee access to midwifery. I also deconstruct the meaning of choice, a phenomenon that involves not merely the existence of alternatives, but real ways of accessing them equally. Efforts to employ midwives and have a home birth are often thwarted by biomedicine, law, private insurance, and Medicaid. Additionally, the social sanctions against midwifery clients can be painful. This research demonstrates that an out-of-hospital birth, while legal, is not easily available or practiced by women in Louisiana.

Using anthropological skills to understand the complexity of choice for midwives and their clients in Louisiana also offers me the opportunity to consider how the social forces shaping that choice might better work with midwifery. Working as an applied anthropologist provides the chance to engage in change with the community. Making this research available to women who consider this choice or have already struggled to make it is a first and crucial step in that engagement.
INTRODUCTION

Reproductive rights is a phrase loosely used and seldom intended to include the right to make choices about the nature of your pregnancy and birth. The contemporary feminist agenda has not shied away from the fight to choose not to be reproductive, but has been less visible in the struggle over choosing a birth plan. In fact, even as mainstream culture has begun to embrace pregnancy in the public sphere, it is still only tolerated in a tightly constructed way. An article in *The Wall Street Journal* (Stout 2005) about maternity photographers cited the “glamorization” of pregnancy due to recently pregnant celebrities such as Britney Spears. I found this amusing because I remember women I interviewed fuming about Ms. Spears scheduling a cesarean section for no apparent reason other than the convenience of it. However, Ms. Spears’ delivery does present one aspect of the reproductive choice dilemma: being able to schedule and deliver by cesarean section is reproductive choice to some women, casting those who champion a birth free of medical intervention as less glamorous.

I chose to examine the choice of midwifery, both the choice made by the midwife to undertake this practice, and the client’s choice for putting herself in a midwife’s care. Much has been written on the history of midwifery in the United States (Wertz and Wertz 1977), but my research is a picture of the current state of affairs in one local area. This work is not an inquiry into the safety of home birth in Louisiana; it has already been proven to be safe (Richard 2002). My questions were not about how we got here, but rather which questions this moment presented us with. For me, this research generated many inquiries into femininity, politics, social norms, and law. I was also forced to confront how socialized I am into the biomedical model of the body.
Initially, I planned to speak only with midwives. I felt that for this study I would not have time to work with both midwives and clients. A few other anthropologists suggested that I work with the clients as well, but again, I wanted to focus on the practice of midwifery. As I began speaking with Misty Richard (the consumer advocate on the Louisiana Advisory Committee on Midwifery) and the midwives, they made me understand that I could not do this research without also including the clients. Eventually I realized that I was still unconsciously approaching midwifery with a biomedical philosophy, which led me to assume that I could sieve out aspects of midwifery and “specialize” in what was of interest to me. What I was taught throughout this research was that midwifery does not allow for fragmenting the experience. Everything and everyone in a woman’s life is integrated into her pregnancy and birth experience. Some of the midwives with whom I spoke still became emotional when remembering clients, as over the course of the pregnancy a midwife typically becomes close with the client. The clients also provided another perspective of midwifery, and by taking into account both the midwife and the client I was able to understand the forces that influence choices for both of them.

I focused this research in Louisiana, because I was continually surprised by the inaccessibility to midwifery care in an area where I would have predicted the opposite. I often heard about other ways of healing in areas of the state that existed peacefully next to biomedicine, such as herbalists. In fact, people would tell me about seeing both a physician and an herbalist for care, and both practitioners would refer to each other. However, I did not find a thriving midwifery community. Historically, this was not always the case; in fact, Louisiana previously was strong in midwifery. Owens (1985)
pointed out that Louisiana midwifery was unique in that midwives here crossed all ethnic lines, and that it was the dominant birth practice in urban and rural areas. In fact, until 1963 there were more midwives listed in the Yellow Pages than are even licensed to practice in the state today (Owens 1985). Only one midwife recently listed herself in the Yellow Pages. The lack of any free standing birthing center in the state led me to think about the consequences for parents who did not want a hospital birth. Louisiana has a number of licensed practicing midwives totaling about five. What are the social forces that contribute to this phenomenon? Furthermore, what does the manifestation of those forces mean for parents in Louisiana who seek care outside of the biomedical model?

An ideal birth is a different construct for each individual. Ashford (1984) described the conditions by which a birth may not meet the woman’s ideal, such as when you need one more push to get the baby out and that effort is thwarted. Ideal births, especially those constructed by a woman’s wish to be in control of the experience, can be thwarted during an entire pregnancy by a lack of education, a practitioner’s enthusiasm to intervene, the trespass of a surgeon’s knife, or the vacancy of a supportive social network. Louisiana provides an interesting case study in birth, legislation, consumerism, health, community and politics. For while Louisiana’s midwives agree that the state’s legislation of midwifery continues to be on par with, if not above, the rest of the country, the lack of midwives and an alternative birth community remains inexplicable.

The question which hangs in the air throughout this research is: if you build it will they come? In other words, if there were accessible midwives and education about the practice would more women choose midwifery? The prevalent idea among all the participants in my research was that education and activism would strengthen the
midwifery community. This case was demonstrated recently in the state of Virginia, where midwives and home birth advocates have spent the last few years lobbying for a licensure for their direct-entry midwives (Craven 2005). There were many setbacks, and a hostile medical community to fight. As Craven chronicled the legislative battle, she demonstrated how legislators and doctors used the power of authoritative knowledge, “birth as a medical event,” to try and swing the vote (2005:199). They also wielded that power to attempt to characterize home birth mothers as negligent and ignorant. Nonetheless, the licensure legislation was signed by Governor Warner in March 2005 (Citizens for Midwifery 2006a). Notable though is the fact that not only did the advocacy take years in the face of repeated failures and personal attacks on the advocates themselves, but the effort also took state-wide organizing. Citizens for Midwifery (2006a), a national non-profit advocacy group, lists ten different advocacy groups throughout Virginia specifically devoted to natural birth. Virginia’s non-nurse midwife numbers are estimated to be a few dozen (Jenkins 2005).

Louisiana shares with Virginia a medical community hostile to midwifery. However unlike Virginia, Louisiana currently has no midwifery consumer advocacy group, and only a small association of about five licensed midwives. The title for this thesis, “From the Top Down and the Bottom Up,” came out of a conversation with Janet, now a retired midwife who worked in the 1980s for Louisiana’s regulation of direct-entry midwives. She commented that midwives are created by the community. They need to be supported by the state and the medical establishment, but they also need to be supported by people who want and believe in this choice. This research intends to examine how the choice to pursue a midwife-attended birth is constructed through the
support or antagonism of those on “top,” and the advocacy or apathy of those on the “bottom.” This effort is not to predict the future, but rather an attempt to understand the confluence of factors that have intersected in this situation.

However, the future is of concern. My goal as an applied researcher is for this work to educate people about a community, and hopefully provide midwifery supporters with an advocacy tool. Doughty defined the applied anthropologist as “one who would utilize research-derived knowledge to promote human well-being” (2005:303). Included in the idea of well-being is the comprehension of the wide spectrum of women and their partners. This spectrum, while broad and diverse, is bound by the intent to make good choices for their bodies and their families. Serving in applied work answers Doughty’s call to “avoid retreating into abstract activities and not engaging these challenges in the context of our disciplinary knowledge and skills” (2005:304).

Engaging in the challenge also means that we do not shy away from policy or providing “expertise” (Doughty 2005). Working within an area so closely tied to legislation, I am aware that I have the opportunity also to become an advocate. At a recent conference I introduced myself to someone and mentioned my research topic. The other scholar replied, “So you’re a birth activist?” I paused, unsure of how to answer. Somehow claiming activism did not seem objective enough for a researcher, but ultimately I said, “Yes, I am.” I would be foolish to believe that as a woman in this culture I did not have a vested interest in the proliferation of reproductive choice. For me, this research is the beginning of my activism in the birth community.
Overview of Midwifery

When I disclose my research about midwives with academics and others, I get a range of reactions, but typically I hear, “They still have those?” Yes, midwives still exist. However, I understand their confusion, as the current picture of midwifery in the U.S. is anything but clear. Health care, and anything it may broadly encompass, is regarded in our country as a “state’s right,” meaning that each state may create its own definition of a practitioner and its own licensure process with little federal intervention. Another typical reaction I get is, “I guess they work with poor and rural people.” Obstetricians I have interviewed have given that response as well, when asked under which circumstances they might sanction midwifery. However, my research shows that there are women of different backgrounds in Louisiana who seek out or practice midwifery.

The Midwives Alliance of North America’s (2006) website lists the following definition of a midwife, accepted by most national and international health and obstetrics associations:

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counseling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family
planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service. [Midwives Alliance of North America 2006]

In the U.S. midwives are not legal in every state, but in many states they are not necessarily illegal either. According to Citizens for Midwifery (2006b), thirty states have no law, licensure, or permit which regulates the practice. In ten of those states the practice is prohibited, and in some of the remaining twenty the legal status hinges on an interpretation of another statute. In states where the legal status is dependent on another statute, a law not written for midwives is used to determine whether or not midwifery can be legally practiced. However, in a state where there is nothing regulating or prohibiting midwifery, attempting to practice as a midwife can result in arrest for practicing medicine without a license. Janet, a retired Louisiana midwife, described what happened when she moved to Connecticut:

I believed at the time that I was going up there for an unrestricted or less restricted practice. That was fine with me to fly under the radar. I got up there and it just couldn’t happen. I did four births the first two years, after meeting with everybody, and came down here my first summer back. I went home to find that four of the midwives had been arrested and were being prosecuted for practicing medicine without a license. I had been under the impression that I would practice less legally [with less regulation of her practice] because there wasn’t a statute, but it turned out that even if there was no statute that they were still under the same thing. And having been through it so long here it didn’t interest me. I don’t want to practice illegally. I don’t want to lose my home, my family.

Of the twenty remaining states with some sort of regulation, in only half of them can Medicaid, which is overseen by each individual state, reimburse for midwifery services. Louisiana’s Medicaid does not reimburse the licensed midwives. Figuring out which type of midwife one has the option to employ or to be trained as has become a game of alphabet soup among the acronyms CNM, CPM, DEM, and LM. Each type of
midwife has separate credentials and not all credentials are licensed in every state. A Certified Nurse-Midwife (CNM), holds a nursing degree and has pursued additional training and licensure as a midwife. The CNM is governed by the American College of Nurse-Midwives. There are practicing CNMs in Louisiana, although I did not include them in my research. They are licensed in Louisiana by the State Board of Nursing. A Certified Professional Midwife (CPM), is a credential awarded by the North American Registry of Midwives (NARM). This type of midwife has completed tests on her knowledge and skills, and works within the Midwives Model of Care (see Appendix A), usually in out-of-hospital settings. The Direct-Entry Midwife (DEM) is someone who does not need to have a formal institutional education, but rather is self taught or taught through a midwifery program. However, most DEMs pursue lengthy apprenticeships with an established midwife who typically does homebirths. This midwife also espouses the Midwives Model of Care. Licensed Midwife (LM) is a term used within a state or jurisdiction. Also, midwives who practice outside of regulation are referred to as “lay midwives.” Lay midwife is also often used to refer to “granny midwives,” who are typically older, African-American women who practice within a specific community. In Louisiana, lay and granny midwives are reportedly found in small communities or fervent religious centers. I was not able to find anyone who knew lay or granny midwives still practicing, although the tradition may or may not still be strong in communities that are generally inaccessible to outside visitors.

The midwives with whom I worked are all licensed DEMs. The actual Louisiana legislation refers to them as “licensed midwife practitioner,” which is abbreviated as LM. They all have different styles in their practice, some clinical, some more intuitive. Some
might wear scrubs, others everyday casual clothing. An interesting trend among almost all the midwives with whom I spoke was an understanding of the body within the context of a religious belief. Janet, a retired LM, described her view of the body as:

> Self containment, personally I think we have a very wise and giving Creator. I believe in intelligent design, that there are just things that we are not going to know about. I believe that very little needs to be added to it. If you let the body do what it’s supposed to do without quantifying everything about it, it will fulfill its purpose. I don’t know when we got so afraid. I don’t think there’s a reason to be.

Marie, a practicing LM, espoused a similar view:

> The Bible says that we are fearfully and wonderfully made and I certainly agree with that. I think that pretty much sums it up. The body is just an amazing machine if you will, organism is more accurate. It is built to sustain life for a long period of time with a lot of bombardment. The stresses that we live under today and the quality food that we eat, it’s amazing that any of us are functional.

During my interview with Dara, an LM, she also alluded to believing in the Bible.

Also trained as a Naturopathic doctor, she described the body holistically:

> [How do you view the body?]

> Definitely as working as a whole. Seeing all the parts being interconnected. If I’m treating a digestion I’m treating the whole body. I don’t compartmentalize, and with birth I see the body as having wisdom. If you provide the right elements, you provide what’s needed if there is deficiency and the body will balance itself out. If you take away, there’s certain things that need to be taken away, the body will balance itself out. It’s in a working balance and that’s how I feel it was designed.

Most of the midwives admit to saying silent prayers during birth, although they do not preach their faith in their practices. In fact, the women who seek out their services are comprised of almost every type of American women of which you could think. Faith, a senior apprentice, described her clients as, “Very intelligent. They know their bodies.
They are very confident in their bodies. They are concerned about nutrition. They want a natural birth. Some of them are anti-doctor.”

Marie, a current LM, characterized the diversity of her clientele as:

Pretty broad. It tends to go by areas. My clients down there [south of her residence] are a mix between Christians, Jew, Atheist, pagan, and lesbian. Up here [where she lives] I would say predominantly Christian, although there’s a smattering of a little bit of everybody. Predominantly white, middle class. I have very few African-American clients. Actually I have a young woman who has approached me for an apprenticeship who is African-American. I am very excited and encouraging her to pursue it because that’s a section of our culture that could really benefit from midwifery care. I think it’s going to be hard to open up that area without being one of their own.

The greater majority are pretty well educated. Now as far as their formal education, it varies a good bit. I would say the majority of my clients have had some form of college education. Some have Master’s degrees and a few PhDs. Numerous chiropractors, several doctors, dentists.

As diverse as Marie’s clientele has been, she does mention the lack of African-American midwives and clients. This does not mean that African-American women are not seeking out midwifery, but for one reason or another, they have not sought out the licensed midwives in Louisiana.

Janet, a retired LM, reflected with emotion on the women she has worked with in almost 400 births:

Let me paint the picture of the person who does come to me. They tend to be very autonomous, they tend to take a lot of responsibility for their family, they tend to be extremely informed, and the bulk of my clientele is informing me on some level. I’m not saying that we’re ill informed; I’m just saying they tell us about things that we hadn’t thought about or something they read lately. They tend to be very politically savvy; both ends of the spectrum, not necessarily ultra liberal, and some very conservative people as well are very much into family and individual rights. If you don’t want to get with the program [nutrition and prenatal care], I don’t take you. If I had to break it down, I would say a third of my clientele is feminist, a third is mainstream but very articulate, motivated and intellectual, and a third is hippies or neoconservative Christians.
I might cry telling you how much these people have brought to me. From every walk of life and each one is a gift to me. I miss it so much. It’s not for the faint of heart and not for the weak. Wonderful women, very self-possessed, and the interesting thing — do you know the new wave of femininity that is much less aggressive, not manipulative, and has a very strong sense of self that is accommodating to the ones in their life? Instead of being oppositional with their mate and neglectful of children, they tend to be this all encompassing woman. Very loving and a lot to give. Unlike the old days that seemed to be the eager hippies or all Christian. Now a little more yuppie too. They’re less likely to say “I’m not asking him. I don’t care what he thinks.” I never hear that anymore.

I found the midwives and clients with whom I spoke to be of diverse backgrounds and belief systems. They include people who never left Louisiana, and those who recently moved to the state. Religious affiliations ranged from fervently Christian, to a converted Jew, to a long practicing Buddhist. Politically, some women professed to be conservatives and others claimed to be liberals. Some participants described themselves as “New Agey” and others felt they were pretty typical middle class. Their education levels ranged from graduate degrees to high school degrees. Some mothers returned to work outside the home after their births, some did not. A few women felt strongly about identifying themselves as feminists, and others would not consider themselves feminists. One of the most profound realizations for me as a self-identified feminist researcher was how incredibly different these women were, yet they were united in their willingness to battle uphill for the choices they wanted in their pregnancies and birth. These choices transcended politics, religion, education, and even feminism.

**Louisiana’s Licensure**

Louisiana has regulations of midwifery that are specific to this state. DEMs are allowed, and LM is the credential used. LMs are overseen by the Louisiana Advisory
Committee on Midwifery, which reports to the State Board of Medical Examiners. According to the Midwife Practitioners Act (1985), the Committee is composed of seven unpaid members who are appointed by the Governor, confirmed by the Senate, and who regularly report to the State Board of Medical Examiners. Per the legislation, one member is a physician who is selected by the State Board from a list of physicians submitted from the Committee to the State Board of Medical Examiners. A second member, per the legislation, is a registered nurse or a CNM selected from a list of nurses submitted to the State Board of Nursing. The remaining members are selected by the Louisiana Midwives Association and per the statute include a pediatrician, three midwives, and a citizen who has been a consumer of midwifery services.

According to the Midwife Practitioners Act, all LMs in Louisiana must be at least 21 years old, a citizen (or lawful resident), and be CPR certified. Beyond that there are academic and clinical requirements. Students must apply for an apprentice license, which allows them to practice under the supervision of a licensed midwife, a CNM, or a physician. A senior apprentice midwife may take on his or her own clients, and does not require direct supervision. Coursework must be completed in human anatomy, human physiology, biology, psychology, nutrition, and theory of pregnancy and childbirth, and may be completed at any accredited college, university, or midwifery school. The clinical requirements involve a certain number of supervised prenatal visits, births, and postpartum visits. In order to be licensed as an LM, a student must take a written exam, which is the NARM exam for CPMs, and a practical exam. The amount of time each midwife needs to achieve licensure varies. Faith, a senior apprentice in Louisiana, is happy with her current status, and is in no rush to attain her full LM licensure. Marie,
who currently practices as an LM, admitted that she needed about ten years to fully
license due to having her own children during that time.

Under the current regulations, the scope of midwifery practice is defined as:

The licensed midwife may provide care to low risk patients determined by
physician evaluation and examination to be essentially normal for
pregnancy and childbirth. Such care includes prenatal supervision and
counseling; preparation for childbirth; and supervision and care during
labor and delivery and care of the mother and the newborn in the
immediate postpartum period if progress meets criteria generally accepted
as normal as defined by the board. [Midwife Practitioners Act, Statute
3244:1985]

By law, a licensed midwife must practice with a physician back-up and the planned
delivery site must be within a 50 mile radius of physician care. A physician must agree
to supervise the midwife, although the physician does not need to attend births or care
visits. Clients must see an obstetrician twice during their pregnancy: one initial visit to
ensure their low risk status and a second visit near week 36 to check for any
complications that may have developed. The client may see any licensed obstetrician, the
doctor does not need to be the midwife’s back-up. However, the issue of physician back-
up is significant for Louisiana’s midwives; all of the midwives with whom I spoke
identified the physician back-up as a primary reason for so few midwives practicing in
Louisiana. The issue is not that midwives do not want to work with physicians, but rather
that physicians refuse to back midwives. Part of the issue may be philosophical, as
practicing LM Dara noted:

It’s really difficult. There’s no real motivation on their end. Unless
they’re overloaded or something, I’m not sure what the motivation would
be to put themselves in that position. Unless they were doing it from their
heart. You don’t find that many physicians that are willing to do that. It
hasn’t been good at all. In this area, I haven’t found anybody at all willing
to do the backing. I’ve had doctors open to see the patient, they have two
required visits, but then they tell the patient, I wash my hands clean of
your birth. They’re very rude. But the problem is too that when doctors have that philosophy of treatment, they get run out. They get shut down by their peers, or the community hospitals, or whatever. There are all kinds of risks for them. One, for taking on these people they’re not seeing on a continual basis as their patients, and so, they really have to put their trust in the midwife more than anything else. You have to have someone who gets the philosophy of natural childbirth and at the same time wants to be doing high risk childbirth. I haven’t found a lot of doctors who are in that place, who have that vision.

It’s a big problem. To be written into the laws, you have to have this, but then there’s nothing in the law that says it will be provided.

Dara is not alone in lamenting the need for physicians who believe that not all pregnancies are pathological, but are willing to practice high risk obstetrics; every midwife I talked to spent much time describing the lack of physicians to back them.

Marie, a practicing LM, lamented the loss of physicians who were supportive:

Our biggest problem is getting doctors to back us. We don’t really have a problem so much with getting the two required visits, and that’s all that is required of our clients, is two visits by the doctor, but for a doctor to actually say, call me if you have a problem? It means in reality that he will be on call for you and be there when you call and you can get him and not just get whomever is in the practice – that’s the big problem. You’ll have a practice of anywhere from two to ten and there will be one or two that are supportive and the rest of them are not. What happens is that they will quietly see your clients and if they’re on call and you need to come in, then that’s fine. But what happens is when you do have a transport, the other doctors find out about it – oh, there’s a midwife involved. They’ll usually come down with both feet on the one that was cooperative. The next time you send a client in to him it’s like, “Oh we don’t do that.” So I couldn’t tell you how many times that has happened. It’s very frustrating and you know, there are a lot of good doctors out there who believe that pregnancy and birth are normal functions of life and should not be a medical function. But their hands are tied.

Janet, a retired LM, clearly articulated the dilemma in which doctors find themselves, and how sometimes a home birth mother can be construed as irresponsible when she is merely trying to comply with the law:
What happens, and I totally understand this, I say to the client, you’re my client, and you come to me for seven months of your pregnancy and we find out that you’re twins. Well, first, twins are outlawed in the legislation. Secondly, most people consider them more risky. Risk is not something you want to invite to a home birth. You want to keep the risk minimal. So I don’t have a back-up, a written plan, anybody to turn to, I have to say find yourself a doctor. So you go find a doctor and they say how many months are you and you say seven, and they say goodbye.

In midwifery, and in the medical community, a person who is concerned and wants a good birth is going to seek, and you hear this as a buzzword, “early prenatal care.” You get screening mechanisms, and for some people that is it - but for some people eating well and taking care of yourself is a lot more helpful. Still, if you want to tell your practitioner that you’re irresponsible, show up at seven months. It says something very bad about you.

So this doctor is looking at a case, and he doesn’t want my records. They don’t want the midwifery records, they mean nothing. So he’s left with a patient with no records, no ultrasound, no prenatal, nothing. This much risk is now this much increased risk. And it’s not fair. I’ve been there myself and there are too many unknowns in a perfect scenario for what this baby is doing and what this mom’s body is doing. You have no time to build a relationship with the client to get to know her, time for her to get to know you. It’s not fair. You’re asking the doctor to increase his risk, possible cut down on the amount of payment he’s going to get, and he feels really put upon.

Recently, the Louisiana Midwives Association has been debating revisions to the regulation that would eliminate the physician back-up. However, that solution is not easy either. All the midwives with whom I spoke desire a relationship with physicians that can be a dialogue which results in the best care each woman needs, whatever their assessed risk. Janet explained:

Why is there a back-up? If you were to remain my client and you have an emergency in the birth process, they [the obstetricians] need to have a record on you, they need to know what blood type you are, what size I expect the baby to be, they need to know something about you and something about the way I do my work so they know what they’re going to get. It’s a horrible situation and it’s a catch-22 because they’re liable for anything that happens under my care. So I’m asking them to take the risk of the delivery, now it’s high risk and that’s why I’m walking in -
plus anything I might have done. Now I know I’m not causing anything at home, but how does he know that? So he’s agreed to take the call, stay up all night, he already has a sick person, and possible a sick baby, and then say “sure, I’ll take the blame for whatever she did at home. And anything I don’t know about that client.” So in this case whether he’s agreed to be a back-up or it’s an emergency situation where he’s never seen us, in a place where doctors, I don’t feel sorry for them, they’ve done this to themselves – but they’re already in a place where they can’t get insurance and – not that they need to get richer but they don’t need to pay more for malpractice insurance. So I think we’re looking at socialized medicine down the road, because of all these problems. There does need to be back-up. And anybody’s that’s worked outside of it, and I have, will tell you that it’s a very scary place for everybody involved.

Dara, currently a practicing LM, described the lengths she would go to in order to continue to offer midwifery to women:

In the ideal, there would be doctors who would be totally willing to be there for you if there was a complication. You do feel better. You definitely have to find the right doctor who gets it. You have doctors who are risking everyone out, when the women don’t need to be risked out. You’re always leery. We just end up documenting, this physician won’t work with us, this physician won’t work with us… what are you going to do? It comes down to does this girl have an option of having a baby the way she wants? I choose that she does. I tend to go to the grayer laws of the land. I feel it’s a strong calling and I want to provide this. If I was in Alabama [where home birth is illegal] and stuck there, I would be like this is a service to have someone there, whether it’s against the law or not. I’m not a law breaker, but I don’t believe in that.

Second, the classification of a patient as low risk is debated by many, as Dara alluded to in the above quote. Under the current regulations (Licensed Midwives – Rules, Chapter 5361:1991), nineteen conditions are listed that constitute high risk pregnancies, including multiple gestations, age of the mother, drug addictions, and conditions such as diabetes or hypertension. Although most midwives agree that some pregnancies have risk factors too high for home birth, many believe that biomedicine assigns risk in a manner that does not consider the normal variation in pregnancy and birth from one woman to another. Janet, a retired LM, commented on this by saying:
What happens, as a practitioner, they rope you in to you want to be legal, you don’t want to be outside the lines. But you don’t quite know how it works. If we’re going to be responsible there’s got to be a backup and you have to be able to get to a hospital, then you have to do it this way. You know, subsection E, title B, number 1. They basically have you roped in to their form of practice and you don’t have a lot of leeway. So that the beauty of midwifery, which was trusting that this mother and her baby knew how to complete this process 99% of the time, and only 1-2% of the time you need a hospital and a doctor. Well they have you down to about 40-60% by the time this client has been laboring too long, this woman is overdue, this woman pushed too long, this woman her water broke first…. I personally wasn’t out there trying to see how many babies I could kill by pushing the envelope, but I had a very safe practice and rarely was I within the bounds. What I personally did was to explain to the parents the risks either way. I can tell you what the law says to do, and what I’m supposed to do, but I can’t make the decision for you. I would have to say that I have a 95% rate at home [successful home births], and 5% were sections. Five percent, maybe 6% or 7% [needed a transport].

Janet felt that this idea of medical risk and removing control and trust from the mother resulted in the following dangerous situation for clients:

As a mom, I think what happens to a lot of women is they say, I want to have my baby at home but I don’t want to get you in trouble. So they start to stack their numbers. They start to alter their due date or their period date. Or maybe they won’t tell you the whole truth about whether or not they’re smoking. They should be able to tell you. Little things that in some way can affect how the birth comes out but they feel regulated into specific behavior.

Frequently, clients told me about lies they told to their midwives or doctors in order to achieve the goal of their ideal birth, or in order to avoid medical intervention they felt would be administered to them against their will, particularly cesarean section. Often this entailed lying about their due date by altering what they knew about the date of conception, lying about when their water broke, or staying at home until the last possible minute.

These women realize that medicine and law are attempting to regulate their bodies in a specific way. Pregnant women fear that if they do not say what doctors want to hear,
they will be forced into interventions they do not want. In Melissa’s birth story, we see how a client and a midwife who deliver in a hospital might team up to try and avoid protocols they feel are unfair:

I never saw an obstetrician in the hospital, but when she [the CNM] has a patient in the hospital she continually updates an obstetrician to tell them who has come in and tries to give them updates in case that obstetrician is needed, so that he, he or she, is aware of the situation. The obstetrician that was sort of following my case, he wanted me on pitocin from the minute I was in the hospital and he knew my water broke. I think she didn’t tell him how long ago my water had broken because she thought he would really freak out if she told him exactly how long it was. She was sort of, not that he could do anything to me, not that he could barge in and order me to do something, but she was continually reassuring him that everything was okay, this is what we were going to do.

Generally, when approaching their health, most people tend to strive to be compliant. Sometimes they feel that by being “good patients” with their doctors or midwives they might get the best outcome of care, even if that means lying about their condition to meet that goal (Fisher 1986). Clients realize how far many midwives would consider going to help them achieve their ideal birth, and so they might lie to create less pressure on the midwife to practice outside of the regulations, or hospital protocols. Unfortunately, even if such a client is able to deliver safely at home, withholding information creates a less safe situation for midwives, doctors, and mothers. While regulating midwifery has many advantages, regulating sometimes creates a situation where a woman feels compelled to convey an image of her pregnancy and health that reflects the regulated ideal instead of the actual situation so that she appears compliant.
The Debate to Regulate

Regulation of midwifery carries many pros and cons, all of which at the time of proposed regulation created a debate within the midwifery community that is still alive today. In the early 1980s the Louisiana midwifery community organized to lobby for regulation. Abby, a retired LM midwife who helped write the current regulation, told me she felt that regulation gave the clients some assurances. Janet, a retired LM, who also helped write the legislation, described the experience of working with an unskilled and deceitful woman who turned her into a supporter of regulation:

I did a couple births with her and it was very clear she didn’t know anything. Turned out that she was a drug addict, trying to get money. She could see that there was money to be made off of people. The last few babies, after everyone figured out that she was troubled they just were scrambling for someone to help and I did two or three of her deliveries. Unfortunately or fortunately, I’m not sure, the experience with that lady made me more pro-regulation because if that’s what’s going to happen when we have no regulation.

In the late 1970s, Marie, a current LM, was just thinking about becoming a midwife, and she recalled the situation in Louisiana:

I had found out about some certified nurse midwives that were practicing here and had called them to ask them about being a midwife. At that time, it was probably about ’78, what I didn’t realize found out later was that the state had just, I don’t know how you put it, that they had suspended or kind of put on hold licensing midwives. Because for quite a number of years, I think they were still under the State Board of Medical Examiners. Either that or just the Health Department would certify midwives. No, it was, even at that point, the State Board of Medical Examiners would offer a test and you could become a licensed midwife. It was a 100 question test that had absolutely nothing to do with midwifery and everything to do with nursing. And if you passed the test, poof! – You were a midwife. There was no clinical component required, and for a long time no one had presented or applied to take the test. And then a midwife down in the New Orleans area offered a class and started teaching other midwives and all of the sudden there were like six or seven apprentices presenting to the State Board to take the test and it was like – wait a minute! We thought we got rid of this. We didn’t think we had to deal with this anymore. They did
let them take the test and then it was after that - it apparently threw flags up and somebody said we need to think about this. So they stopped even offering the test for several years. And it wasn’t until 1984, I think that the law went through, our current law, and it took them another two years. It took them another two years and took a lot of prodding from then Governor Edwards. The ace in the hole was that his mother, Miss Lillian, was a midwife. So the women at that time went to him, a couple of them had some political connections and had his ear, and asked him to help. And he did.

The midwives, and the consumer base they rallied at the time, were deliberate in the regulations they wrote. They did not just want to be legal, they wanted a regulated status that meant something. Just being legal was not any better to the midwives than taking the 100 question test previously offered in order to be licensed. The goal of the regulation was to guarantee clients and physicians a minimum amount of education and clinical experience by the midwives. This regulation made the midwifery license dependent upon practicing midwifery under supervision. Janet remembered:

    We passed our legislation in ’84. In 1983 we had the opportunity to pass legislation that made us just legal, not regulated but just legal. And that was way ahead of its time, especially for something anti-medical and it just wasn’t going to happen. But the following year we just jumped right in and got legislation that was landmark legislation, but no one could see 20 years down the road that it would legislate you into underground practice. I think we’ve had about 25-30 licensed midwives and over the years no more than 8 had any type of practice. And that speaks for itself. And the state could probably use 50-70 and keep them busy, for people who are uninsured, underinsured, or that want it.

Abby, a retired LM originally trained as a nurse, also recalled the fight between the Board of Nursing and the Board of Medical Examiners over who would oversee the midwifery regulation and licensure. The Board of Nursing was adamant that it should govern, since it already credentialed the CNMs. However, the LM regulation was written to allow for direct-entry midwives, eliminating the need for a nursing degree, and the Board of Medical Examiners prevailed.
Janet’s above quote in reference to practicing “underground,” may seem to convey a feeling of desperation in the midwifery community. However, all the midwives I interviewed, including Janet, felt that the legislation was one of the best in the country. Abby felt that the licensing could be even tougher, with more emphasis on the midwifery clinical skills. Faith, a senior apprentice, was thankful to have a direct-entry option, as she would not want to practice within a strong medical model. Marie said, “For the most part I think it’s [regulation] effective and our requirements are achievable.” She added:

I think we’re up there among the better [states]. We can practice, we’re legal, we have an attainable law. Like I said, there are some sticking points on the rules and regs, and the doctor back-up issue is a bear. My biggest complaint about that is I’ve paid all my dues, I’ve paid my fees, I continue to pay, yet I’m still treated like a criminal in some aspects. You almost feel like you have to sneak around a bit to get things done. I don’t like that at all.

The midwives generally feel that they have effectively regulated themselves all along in order to guarantee a standard level of education and experience to offer their clients, as well as physicians and legislators. Additionally, they were proactive about regulation. Regardless of that effort, they feel that they are still treated by some citizens and medical staff as if they are ignorant and malicious. Despite twenty years of standing legislation, a comparatively long record, medical and lay opinions towards midwives have not progressed with the regulatory effort. In the following chapters I explore the possible cause of the mindset, and the ways in which midwifery is still not considered a viable choice for most mothers in the state.
METHODOLOGY

When I began this research I was unsure of what the Louisiana midwifery community was and where I would find it. However, I did not imagine that finding midwives or clients would be difficult. In fact, this search took a few months, because I could not find any midwives or anyone who had tried to work with one. I was lucky to find a contact for the Louisiana Midwives Association (LMA), Misty Richard, who currently serves as the consumer advocate on the Louisiana Advisory Committee on Midwifery. I had decided to interview both midwives and clients, and through her I was able to send a call out for help from clients and midwives who might be interested in speaking with me about their experiences. I identified that I was a graduate student at Louisiana State University (LSU), and that my purpose was to learn and be educated about the forces that allowed or restricted women’s choices in their pregnancy and birth. The response was immediate. Women emailed and called me who really wanted to tell not just their story, but explain why these choices were important to them. When I met with each of them, they expressed their shock and optimism that someone, anyone, was interested in this. To me, their response showed how strongly they felt that society judged their choices to be wrong, unimportant, or marginal. Ms. Richard was also able to connect me with some of the midwives active in the LMA, and some of those midwives gave me additional contacts.

For this research, I formally interviewed twelve women in Louisiana, seven clients, and five midwives. Two of the midwives were retired, and had helped develop the initial regulation. Two of the midwives were fully licensed and currently practicing, and one was a senior apprentice. Initially, I was a little disappointed with interviewing so
few women, and there were others who had contacted me, but scheduling was often
difficult due to their children, jobs, and spouses. Some interviews were at the
participants’ homes, others were at a public place such as a coffee shop, and occasionally
we were only able to manage a phone interview. Also, the region was hit with hurricanes
Katrina and Rita, and many possible participants were displaced. Scheduling interviews
after those events became almost impossible. However, as the following chapters
demonstrate, there are in fact only a few practicing midwives in the state, and not many
women in Louisiana who seek this option. According to the LMA, there are fewer than
ten practicing midwives in the state, and of those who are not apprentices, the number is
five or less. I made multiple attempts to contact those licensed midwives with whom I
had not spoken, but I did not receive any response.

Thanks to the T. Harry Williams Center for Oral History at LSU, I had the
equipment to record most of the interviews. Most interviews lasted about 3 – 4 hours,
and so I indexed each interview, and then transcribed them myself. I had lists of
questions for clients (see Appendix B) and for midwives (see Appendix C), although the
interviews were informal. I use the word “interview” in Czarniawska’s (2004:47)
definition as “two persons seeking knowledge and understanding in a common
conversational endeavor.” I encouraged each participant to take me through her birth
experiences in her own speed and style. I then followed up with questions. Informed
consent was obtained for each interview, when possible in writing (see Appendix D). If
an interview was over the phone, I read the same consent form to them and asked the
participants for their verbal consent. One of the conditions of this research is the
confidentiality and anonymity of the people involved. Often health information and
intimate details of their lives were shared with me, and I have remained the only person with access to that information. All tapes were coded, and any names on the tape have been erased. All names have been changed for this document, and place names (cities and hospitals) have been omitted to ensure anonymity.

The quotes included in this document are excerpts of the larger transcripts of each interview. My analysis of the transcripts was at the content level. Spoken units are indicated by commas, semicolons, periods, or even ellipses in the case of an unfinished or interrupted sentence. I did leave some disfluency, but generally slightly edited the quotations based on my contextual knowledge in order to make them easier to read while still providing the actual language used by each woman.

Like many of the clients with whom I spoke, I experienced the incredible frustration of trying to find midwives who were not constrained to a hospital. Online searches led only to the many requests for help that went unanswered because no one had answers for those women in this state. Quite often the midwives and clients I met would suggest readings or websites to me, and I quickly followed up on those suggestions. In fact, often women turned the microphone on me, so to speak. Sometimes, when we were nearing the end of an interview, they would ask if I would answer some of their questions. Not only did this convey that they were genuinely interested in me and my motivations for meeting them, but also that they were comfortable claiming authority where they felt they needed or should have it. Often these questions were about anthropology or LSU, and how my research was of interest to either. Sometimes they asked personal questions about my life and my family or health. If we met in their home I often met their children and partners, sometimes the young children liked to “help” with
my equipment. Breastfeeding during an interview was not unusual. I sought to mold myself to their space, observing and listening. Often we started our introductions with handshakes and formal introductions, yet at the end there would almost always be hugs, and occasionally tears. When discussing the power structure of the interview, Czarniawska (2004:48) notes that the interviewee is exchanging his or her knowledge for the researcher’s “respectful and interested attention.” I found this to be true. I was grateful to the midwives and parents in my research that opened up to me, but all of them professed to be grateful that anyone would want to hear their story or understand their choices.
THE NARRATIVE EXPERIENCE

Ethics

Before this research began, I obtained Institutional Review Board (IRB) approval, and submitted revisions and updates as necessary. Although I do believe in the need for ethical overview, I also felt the weight of confirming informed consent and conforming to institutional policy for this research project, since such regulation is something that many of my participants spent much of their lives defying. Women had agreed to tell me about the most emotional, and for some of them traumatic event of their lives, but before they began I had to ask them to sign a form. I was concerned that this formal consent even hurt my rapport with my participants, although they professed to understand I had to do this because of being a researcher. However, the issue of formal consent continued to bother me. After all, one of the most frequent complaints of women who seek care outside of biomedicine is that no one within biomedicine will touch you until you sign every form. I would not even talk to them about those experiences until they also signed my form. Additionally, the midwives with whom I spoke are committed to a high standard of informed consent, albeit of a different kind, with their clients. For the midwives, informed consent means that you educate a woman as much as you can, present her with options, and allow her to make choices. Janet, a retired LM, commented on choosing the clients with whom she worked:

I would never approach it from how to be inclusive. Inclusive on education, yes, but then the person has to make their own decision about what they’re going to do with that education. I find that we don’t want to be responsible for what we choose. So those people that are like that, I don’t want them. I’m afraid of them. When they joke about lawsuits on their first visit, get out of here. That’s not funny. I’m not going to lose what my kids have because you don’t want to be responsible for the
choice you make. I believe firmly in informed consent. I give tons of information out.

Marie, a current LM, also espoused a strong belief about informed consent, and shared it with the medical community:

I’ve spoken to medical students at Tulane and LSU, always a fun thing. I love to do that because I can hit some of my soapbox issues, and my biggest one with them is informed consent. Contrary to popular belief, informed consent is not here – sign this piece of paper. It’s education. Physician means teacher. The last time I did that, about two years ago, there was a large contingency from the LSU Nursing School. And they were very supportive.

I felt a lot of pressure to “do right by them,” and tried to educate the people I talked to about my research instead of merely asking permission. I realized that while I may have initially approached midwifery from a biomedical mindset, I now approached my own research from a midwife’s model. I felt that educating the participants in my project about my research was more important than merely obtaining a signed consent form, although I still used the consent form. Perhaps in future IRB applications when continuing with this work I may apply to waive the consent form.

**Inducing Narratives**

A crucial part of each interview with a participant was her birth story. Often I would not even have my tape recorder turned on yet and she was already describing her labor! These stories are highly tellable in the sense that they narrate an event occurred outside of the status quo, and there was something complicating it that in the end was positively or negatively resolved (Czarniawska 2004). These narratives are “reportable” because they relate something that is worth telling because it does not happen every day (Linde 1993:8). These narratives are also worth telling as demonstrated by points of
evaluation within the narratives (Labov 1972:367). Different types of authority are evaluated with regard to what a woman privileges as knowledge about her pregnancy and who is offering that knowledge.

A reportable event that happens to us is a cause for much reflection and often the need to talk about it. For Labov, evaluation is diffused across the structure of the narrative, and often is focused on some sort of “complicating action” (1972:369). The action in that choice was different for each woman, but all shared a conflict surrounding the choice they tried to make about their birth experience and gave them a reason to want to tell me this story. In Jaclyn’s case, she was battling Medicaid rules and false information given to her by her obstetrician as a way, she felt, of controlling her. Melissa’s story is one of being left with only the choice of a hospital. While she had a positive experience with her CNM, after the birth she suffered at the hand of hospital protocols. Hope wrestled with understanding her insurance options, and making multiple attempts at resisting affordable biomedical solutions, holding to the financially impossible dream of a home birth. Tara’s story demonstrated her quest for knowledge about her body and her children, while medical authority found her ignorant.

Birth stories can be considered as narratives in Czarniaska’s sense that “stories do not lie around – they are fabricated, circulated and contradicted” (2004:45). Furthermore, Cerniawska added “it could be said that stories are produced (concocted, fabricated), sold (told, circulated), and consumed (listened to, read, interpreted) – often all in the same performance” (2004:45). Although most women have their birth stories well rehearsed from telling them so many times, I was told by more than one woman that I was the first person who asked about the importance of their choices and the difficulties they
encountered in making them. Thus in their interview with me, a woman may have told this story for the first time this way, with the intention of defending her choices to me, and then the process of my consumption as a researcher began.

While much has been written about the power relationship between the anthropologist and consultant (e.g. Hampshire et al. 2005), my position as “researcher” was not perceived or treated as authoritarian. Something obvious early on was that these women were eager to learn and to question; they had trained themselves not to take anyone’s knowledge at face value. Often, after mentioning a condition or method, they would ask what I knew about it. This may have occurred in part because many of the women knew that I had not experienced pregnancy or birth. For example, after Melissa mentioned that her baby was turned posterior instead of anterior, she asked “You know what that means?” Women would also ask me about other interviews, or about the experiences of other women with whom I had talked. An example is after Hope told me about the criticism her mother received for allowing her daughter to have a home birth, she asked me “And have you heard much of that?” I interpreted these questions in part as curiosity, and in part as a way of gauging their experiences against other midwifery clients. I believe that because there is no strong midwifery birth network in Louisiana, a lot of these women are unaware of how normal or abnormal their experiences were for a midwife-attended birth, and they are anxious to find out. To them, I was an informant.

Narratives are “social units,” which depend on an interaction between people (Linde 1993:4). Narratives also have certain “social demands,” which are expectations a listener has so that the story makes sense (Linde 1993:7). An example is chronology. In this culture, we remember events based on our notions of time and order. This is obvious
in birth narratives, where a woman will typically start off with when she became pregnant, how she found her midwife or doctor, and then the birth. The retelling of the birth event itself often begins with “when my water broke,” and although the chronology may be interrupted by other details, the story still tends to follow contractions through to pushing and then to seeing their baby. This structure of retelling is interesting because it demonstrates not only our dependence on chronology, but how socialized we are into the normal progress of pregnancy and birth. Stories are told in almost stages, similar to the way that birth is described through biomedicine (Martin 1987).

Narratives also serve as a “social resource for creating and maintaining” the self (Linde 1993:98). Often the reportability of a narrative’s event is related to moral character. For my research, I sought out women who did not subscribe to a biomedical birth. In other words, something in their character allowed them to make a choice, and that is why I have heard their stories. Also, just as many stories often have a moral, many stories are told to demonstrate a moral self, which is one aspect of Labov’s (1972) evaluation. We want “a good self, and a self that is perceived to be good by others” (Linde 1993:122). Narratives allow us to mold ourselves a certain way based on events that (usually) have actually happened, and then we take the opportunity to share those moments. In the sharing we hope to demonstrate what should or should not happen. Maybe we made a good choice, maybe we were not able to make what we thought was the best choice for some reason. Regardless of the outcome, the narrative allows us to show that we are moral people. Women asked to speak with me who were not able to have a midwife or a home birth, because they wanted to tell me why they could not make the choice they felt was best for their family.
Clients automatically tended to start their narratives with their first birth (if they had multiple births), and take me through that event with a positive tone. They often focused on what was joyful to them about the event. After they told me about the birth, they would then elaborate on the difficulties they faced, or the saddest moments of the experience. Often I would be surprised after hearing such a joyful story to then hear all the negative details that were sometimes then revealed. Ashford noted that even a happy and healthy birth can be sad, if a woman is unable to accomplish the unique “psychological ‘task’” she sets for herself (1984:xii). The separation of the happy and the sad aspects of birth is part of the process Davis-Floyd described as “compartmentalization” (1992:241). The woman has privileged the positive experiences of her birth (i.e., feeling the head crown) and put towards the back of her mind the moments when she needed to fight for her birth (pleading not to have pitocin or painkillers). Sometimes we needed additional thoughtful questions on my end in order to bring to the surface some of the more disconcerting details. My intention was not to focus the birth narratives on the negative aspects of a woman’s birth, but rather to be comprehensive in understanding their choice and the positive and negative experiences that resulted from it.

The midwives told me their birth narratives a little differently. Typically narrated chronologically from the beginning of their midwifery training to the present, they wove their own births into their stories as midwives. Also, they did not just add the births of their children, but often told me stories about their own children attending births or birth education classes with them. Sometimes details would slip in of births from other
women with whom they are close, and often those birth experiences had an effect on their
decision to practice midwifery. Marie’s story demonstrated this:

It started with the birth of my second niece in the mid-1970s. She was
born over there [at a local hospital] and I went to see my sister-in-law and
niece in the hospital. I can remember standing there, looking in that
nursery window and counting over 20 babies in there. And this is just the
newborn nursery, this is not intermediate or NICU. There were over 20
babies in there and you could count on one hand with fingers left over the
babies that did not have forceps marks or bruises or cuts on their heads. It
just made such a negative impact on me standing there seeing all these
babies, and just gut level knew something was not right. These babies
need to be with their mothers, why are they institutionalized from birth?
And then realizing all these bruises and red marks, all this on their heads
was from the mothers having huge episiotomies and them being pulled out
with forceps. Even as young as I was, not considered yet my own children
at that time, I wasn’t married yet, it really hit home that something’s
wrong with the program and needs to be fixed.

One of the most identifiable trends in both the midwife and client narratives was
the use of the words “lucky,” “empower,” and “pioneer.” Clients themselves did not
reflexively use the word “pioneer,” although a few midwives did. I thought this usage
was interesting because the status of “pioneer” was not used for those choosing this
practice, but rather it was reserved for those practicing. Clients who wanted a natural
birth and were able to have that used “lucky” to describe that achievement. Often it was
used in a context such as Melissa’s description of her 79 hour labor: “It turned out to be a
vaginal delivery which was lucky because if I would have had an obstetrician it would
have been a c-section.” The word “empower” was also used in different contexts. One
was to relay a sense of achievement in knowing your body so well that you could get
through labor without medication. Jaclyn described the birth of her first child as
empowering, because “with each contraction I cried with joy because then I knew I could
do it.” Tara chose a different context for the word in describing her experience with
midwives: “It was so empowering to be around people who didn’t condescend to you because you were pregnant.” Both clients and midwives demonstrated through the language they used to describe their experiences how firmly they believe that pregnancy is not a time of fragility and weakness, but rather of strength and opportunity for empowerment. However, their language also reflected their awareness that this view is marginal, and those who practice midwifery continue to blaze a new frontier of care.
AUTHORITATIVE KNOWLEDGE

Understanding Authoritative Knowledge

Authoritative knowledge is a complex construct, one where many cultural factors intersect. Jordan (1997) noted that authority is not about what is right, but what “counts.” Realizing which type of knowledge a community devalues is as revealing as knowing the system they do choose to privilege. This analysis involves reflection into our own culture and the vision to see the practices that continue to lie on the periphery. In the U.S., biomedicine is privileged. American medicine is an institution whose gaze falls on both those who voluntary seek it and those who attempt disobedience. Biomedicine also works in tandem with another social institution, the law.

Authoritative knowledge in biomedicine can be approached from Foucault’s idea of power/knowledge (Allen 1999). Allen described this expression as a “reciprocal, mutually reinforcing relation between the circulation of specialist knowledge and the government of conduct” (1999:70-71). This circulating knowledge can be witnessed in obstetrics by observing that women cannot pursue the science of their body and their own knowledge of the body. That knowledge is produced for them, not by them. Intuitive knowledge is devalued in exchange for science.

The social power that biomedicine has gained, however, is not a definitive conclusion. Rather, Allen (1999) suggested thinking about power/knowledge as a form of currency. Printed money is really only worth the paper on which it is printed, until as a society we award it symbolic value. Printed money is also exclusive. By putting money on paper, we do not allow anything else to qualify as currency. We have eliminated our options for other forms of money. Similarly, by awarding biomedicine
“currency” status with regard to pregnancy and birth, we have abandoned other options and can no longer imagine them as real or even better.

Davis-Floyd reminded us that anthropological reflection on the American medical system is important because that system serves as “American society’s microcosm – the condensed world in which our society’s deepest beliefs, greatest triumphs, and grossest inadequacies stand out” (1992:48). In conjunction with American medicine is technology, which according to Davis-Floyd is “embedded in and created out of its dominant belief system” (1992:46). As Americans, we generally feel that technology exists only to better our lives. Modern obstetrics started to become dominant over midwifery concurrent with the Industrial Revolution and the enduring vision of the Cartesian idea of the body as machine (Martin 1987). Male dominance in society at that time provided for the “male body as the prototype of this machine” (Davis-Floyd 1992:51). As Davis-Floyd (1992) concluded, female bodies became a deviation from the male prototype, and obstetrics became a field that focused on developing technology to correct them.

Martin (1987) demonstrated how dominant obstetrics has become in the way our society conceptualizes pregnancy and birth. The body as machine is prominent in the term “labor,” which is what a woman must work through to produce a baby. Since the obstetrical literature classifies the uterus as an “involuntary” muscle, the uterus is really the machine and not the woman. Thus the doctor focuses on the mode of production, and not the woman herself. Also, the end product is a baby, an outcome that is unrelated to the woman’s experience. The technological ideal is so pervasive through our society and
our medicine that it has affected the way we talk about pregnancy, and certainly the way obstetrics is practiced.

Murphy-Lawless also interpreted obstetrics from Foucault’s perspective as a science that has “closed off our agency, [and] dragged us with it into an altogether different space” (1998:10). The attempt to strip away agency has convinced women that science has methodology and answers that they could not achieve without it. Women are encouraged to let science take care of their bodies, to hand over control of their pregnancy. Fisher noted from her interviews with women, “Patients believed that the doctors had information and skills that they lacked; they believed, therefore, that the doctors should be the ones making the medical decisions” [emphasis in original] (1986:6). This new paradigm allows for no alternate outcomes, only those expected by science. However, when an expected outcome is not achieved, science is not at fault, the woman is. Even women who distance themselves from the biomedical model tell birth narratives with moments of success and failure. Science has assigned certain norms to pregnancy and birth, and most women never imagine questioning how those norms are established (Murphy-Lawless 1998). In fact, compliant patients do not see themselves in a position to challenge or re-establish norms. From Fisher’s fieldwork in reproductive health clinics she wrote, “These doctors often argued that a little knowledge was a dangerous thing. Questioning, they said, weakened the doctor-patient relationship” (1986:6). Twenty years later, women are telling me the same thing. These narratives contain moments of Labov’s evaluation of the types of authority in their pregnancies and the knowledge that each tries to provide.
In addition to norms, obstetrics also defines risk, which decides for a woman what her options are. The list is long for what legally disqualifies a woman from midwifery care. While the midwives with whom I talked agree that risk should be kept away from home birth, current regulations are so strict that many women cannot legally choose it. Obstetrics has co-opted technology to provide for the safest birth possible, and the decision of a woman to turn her back on that perceived security is grave. First, it may be illegal. Second, socially she will encounter pressure, disdain, shock, and horror.

However, the nature of power/knowledge allows for dissent and subversion. Power/knowledge is not so much a circle as a network, with two levels (Oksala 2005). The overall level has power “by virtue of its stable, shared and sedimented meanings” (Oksala 2005:108). Composing the other level are the people who are acted on by the institution with power. For the institution to remain powerful, the people being acted on by that power must also exercise that power. A woman is socially sanctioned for choosing a midwife because social, legal, and financial institutions recognize and exercise the overall power of biomedicine. However, a woman is able to make a marginalized choice because she has agency; in other words she can allow her body to be a site of resistance or acceptance of the dominant system. By not exercising the hegemonic power, she weakens it.

If a person’s agency alone can weaken the power, how does it initially come to dominate? Foucault thought of the human body as a sort of *tabula rasa*, onto which culture wrote (Oksala 2005). People do not exist autonomously from their society and their cultural norms. Often people find it shocking and unimaginable to question cultural norms and expectations, especially sources that allegedly exist for their best interest.
Thus our agency acts to increase the strength of the hegemony rather than subtract from it.

Biomedicine in the U. S. has achieved the power/knowledge status of “institution.” An institution can be framed by many definitions. In this case, biomedicine not only clutches the authoritative knowledge, but also creates and validates what knowledge is and is not. As a dominant belief system, biomedicine constructs and reinforces the norms surrounding it, which serves to “indoctrinate future citizens” (Rich 1976). Rich explained the limits of this indoctrination for women by not only stating that “patriarchal thought has limited female biology to its own narrow specifications” (1976:39), but also by pointing out that the patriarchal institution was “never conceived as a means of releasing the energies of women into the mainstream of culture” (1976:14). Her point regarding the conception of the patriarchy is well taken. In this case, literally from birth, a person “is claimed for the institution” (Davis-Floyd 1992:81). Davis-Floyd’s work demonstrated how hospital protocols in prepping a woman for birth served in a ritualistic way to ensure “effective socialization of its citizens” (1992:75). Davis-Floyd further wrote that, “Society and its institutions cannot exist unless women give birth, yet the birthing woman in the hospital is shown not that she gives life, but that the institution does” [emphasis in original] (1992:95). The women that I interviewed echoed this sentiment.

Biomedicine is not the only institution in American lives that affects pregnancy and birth choices. A recurring theme throughout my interviews was that of the economic market. Every woman brought up consumer demand, or consumer advocacy. In the U.S., there is no doubt that access to insurance coverage is limited by the ability to secure
employment benefits, and paying out of pocket is expensive. Additionally, Medicaid, the
government program to help low income individuals have access to health care, does not
cover the services of midwives or home birth in Louisiana. Women felt that money,
whether in the sense of currency or insurance, severely limited their choices. Many felt
that through their efforts as consumers they might be able to change that. Not only has
birth been industrialized by mechanistic mindsets and language, but it is strongly
capitalistic as well. Pregnancy and birth truly interface with the strongest elements of our
society: medicine, technology, and capitalism.

Legally Birathed

Pregnancy and birth force us to confront our idea of citizenship and family in our
country. Daniels (1993) wrote that the family is a historical and social unit, whose
organization becomes part of the political order. In America as in many other countries,
being born in that country (or to parents of that citizenship) is the only qualifier for
citizenship. However, birth is also the beginning of indoctrination into that society. For
many Americans, the ideal of a successful American citizen is someone who will become
technologically savvy, embrace the capitalistic model, and work to protect both. The
prominent presence of these forces in American birth is not surprising. Marie’s prior
comment about babies being institutionalized from birth is evidence. Davis-Floyd (1992)
reminded us that birth also serves as a rite of passage for parents, a reminder of how to
raise ideal citizens and patients. Many hospitals still whisk the baby away right after
birth to “check” him or her (Davis-Floyd 1992). This action demonstrates an institutional
claiming of babies, by the institution okaying a child before the parents even see him or her (Davis-Floyd 1992).

Not only is a birth in American culture controlled by an institution, but pregnancy itself has become an entire legal field. Rothman (2000) noted that obstetricians have long called on the law to regulate pregnant women’s behavior. Recent trends in fetal rights legislation and at the opposite end the right to die, have forced Americans to examine their spirituality and the rationalism of the law in defining a person. Schroedel (2000) observed that in the last twenty years two-thirds of states have prosecuted women for “fetal abuse” – something that is not a crime in any state’s statutes. The decision to prosecute is based on a judge allowing another statute to be interpreted in a way that includes the protection of a fetus. The right to practice midwifery is similarly left to the device of legal interpretation, with district attorneys and judges interpreting statutes in a way that allows them to prosecute pregnant women and midwives.

A founding principle of our nation is the responsibility of the state to protect its citizens. Interpreting a fetus as a citizen is a problem when that infringes on the privacy rights of another group of citizens – women. Daniels (1993:53) poignantly wrote that, “When we tolerate even a single case of forced medical treatment for a pregnant woman - simply because she is pregnant – we affirm an entirely different standard of citizenship for women than for men.” Not only is a woman’s right to self-sovereignty in conflict with the state’s interests, but midwives, whose practice encourages self-sovereignty where safe, also become enemies of the state.

The idea of the patriarchy is pervasive in U.S. law and medicine. “Patriarchy” is given many definitions; here I use Rothman’s (2000) idea of paternity at the center of our
social relationships. The patriarchy is about what women and motherhood mean in relation to the state and men and paternity, not fatherhood (Rothman 2000). The patriarchy depends on reproduction, yet ultimately women’s bodies are responsible for pregnancy and birth. Thus women become renters instead of owners of their bodies, and the space is really only leased to them until a fetus occupies it. At that point the state asserts its right to protection over its citizenry. Women who resent this feel that they own their body and their baby because they are the ones who endure pregnancy and labor. However, this “sweat equity” remains unvalued in American society (Rothman 2000:73-74). Rather, technology and institutionally produced knowledge are valued, and thus obstetrics and the law become close bedfellows while midwifery is categorized as an unsafe threat.

“I Know My Body Best”: Challenging Biomedical Knowledge

For all the knowledge that biomedicine produces, the women with whom I spoke felt that medical professionals did a poor job of education. Abby, a retired midwife after 1,009 births, said that when women handed their power over to doctors they then forgot that they were ever empowered to begin with. She added that “it became normal not to have an education.” The midwives characterized their clientele as generally knowing their bodies very well, and the clients’ narratives reflected anger and frustration when they encountered medical personnel who assumed they were ignorant.

Jaclyn, who does not have the option of a home birth because she is on Medicaid, felt that “obstetricians don’t let you trust your instincts.” During her first birth, in a hospital with the only CNM who accepted Medicaid, Jaclyn proposed trying different
positions to help with her labor. She was told by the obstetrician that her ideas “were bad because then they couldn’t monitor the baby.” After the baby was born, Jaclyn tried to refuse the silver nitrate drops for her baby but was told that this treatment was legally required. Later she found out that she could waive use of the silver nitrate. Additionally, with the births of her first two sons, she “got bad information” about circumcision. She was told that without it the boys would contract sexually transmitted diseases. Later when she did her own research, she found this information was not accurate. She expressed frustration with finding reliable information, which she has learned she cannot expect to get from the medical establishment. She was upset with herself because she did not know the laws well enough at the time of her first two births to challenge the obstetrician.

Tara’s narrative was full of the many ways that she and her husband subverted hospital protocols at the birth and after. She summarized their approach to education as:

My husband and I both felt like there is nothing more important than having the responsibility and custody of another human life. We felt like it was our responsibility, our duty, to find every shred of information we could. And frankly we were appalled to find so few people that shared that idea. The way that the medical establishment in this country has grown and has developed, we just as a culture take it for granted that they know what’s best and that if the doctor says it should be done this way then it should. That’s not to say that there aren’t some wonderful and insightful and intuitive doctors out there, but I’ve been in my body for 33 years and I know how my body works. There is no doctor in the world, no matter how many times I’ve seen him, who can better know how my body works than I do. We felt the same way about our children. We’re not militant anti-vaccination people, but we don’t believe you should do something just because a doctor says to do it. I think if you’ve done your homework and made the decisions that are right for your family, then you’ve done right by your children. I find it reprehensible to say, okay, that’s what the doctor says. I can’t imagine taking that huge a task and not giving it a second thought. Yeah people have kids every day, maybe if a few took a little more of an active role, maybe we would not have the world we have now, maybe things would be a little better.
The above excerpt from Tara’s narrative is filled with different points of Labov’s evaluation of authority. First, she mentions her husband feels the same way, which leverages her authority, because someone else feels the same way. By not doing something just because a doctor recommends it, she evaluates medical authority, which she later rejects in favor of her own research and decisions. By using “we” (“we’re not militant ant-vaccination” “we don’t feel like there’s any single physician”), she again leverages her authority to not only include her husband, but her whole family. She positions her family unit and its right to decide over what the medical establishment tells her to decide. Whenever Tara encountered any problems in her pregnancy or after, she thoroughly researched the topic and did not shy away from discussing it with the doctors or nurses she saw. However, instead of a dialogue, the encounters were often hostile. She remembered an occasion when she needed an anti-depressant while breastfeeding and the doctor would not prescribe it for her. She found research which stated that the anti-depressant was safe while breastfeeding, and when she shared this information with the doctor, he still would not write the prescription. Finally, Tara got her pediatrician to write a letter stating that the levels of the anti-depressant were not high enough in the breast milk to cause concern, and the doctor wrote the prescription. Tara also recalled a particularly painful night at a local hospital that had an enduring effect on the staff as well:

We ran into a lot of resistance, and still do. [The baby] ran a fever one night and it was a fairly high fever. We went to the ER because they had a pediatric ER and I knew if my kid was really sick I wanted a facility that had the best medical treatment possible. The doctor came in and said, “Has he been vaccinated yet?” I said, “No, we wait in our family to do that.” “Well, why would you do that?” I said, “I have a whole list of reasons that I would love to discuss with you at a later date but right now I
would really like to figure out what’s wrong with my son.” She said, “Well, and in the meantime if he’s exposed to [tape unclear] he will die.” I said, “Doctor, when was the last time you saw a case of diphtheria or [tape unclear]?” She kind of recoiled, like how could I possibly know that, because she clearly thought I was stupid, that I hadn’t done any homework at all, and that I was some idiot who thought shots were bad. She said, “I saw that about three weeks ago.” I said, “Oh, that’s weird because I keep tabs on the CDC website to make sure that there are no outbreaks in my area and I hadn’t seen that.” “Well, maybe you should look again,” she said. I told her that I would. And off she went. She comes back and tells me they need to take some blood from my son, and with my older son every time he got a needle of any sort, or when anything was done to him that could be painful I breastfed because there are studies and studies and studies that show that breastfeeding is preferred for newborns or young children. The second best option would be letting them suck on a pacifier. I said, “I’d like to breastfeed him while you do that and I can get in whatever position you need me in. I’ll make sure his limbs are available to you; I’ll contort myself as needed.” She said, “Absolutely not.” And I said, “Why not?” She said, “If he gets a mouthful of milk and cries he’ll inhale and aspirate.” I was so angry and distraught that my child has to experience even a little more pain than he would have had. I couldn’t even think clearly. I said, “Haven’t you read the studies?” She said, “I’ve never heard of any studies.” I said, “Are you a pediatrician?” She said, “Of course I am.” “Then how could you not have seen this?” She said, “I don’t know where you got it but I would sure like to see it.” I said, “Oh you will.” She said, “You can ask the nurse.” Then I hear her go into the hall and say to the nurse, “That crazy mother in room whatever thinks she can breastfeed while her baby gets blood drawn. Would you please disabuse her of that notion?”

So she [the doctor] had given her order. I said, “I heard what she said, is there any way?” “I’m sorry we can’t.” I had to sit there and listen to him scream. The doctor never showed back up. The nurse [a second nurse] who discharged us came in and I recognized him because a while ago I came in with the other boy because he had a little abscess. While they drained it I breastfed. He said, “I know you! You’re the lady who breastfed while we did the toe!” I said, “Would you please tell Dr. L about that?” He said, “Oh, you had Dr. L? She doesn’t have the best bedside manner but she’s a really good doctor.” I told him what happened and he said, “You’re kidding!” He said, “I have to tell you, I’ve never seen anybody do that but I sure have recommended it to people. Dr. C hadn’t seen it either but she has also recommended it. We team up and we recommend it to any woman that comes in with a baby.” He said, “I’ve never seen a baby react that well to something I know was painful.”
I called the administrator at the hospital and left a message. She called me and said she’d never heard of the study either, but she gave me her word, and I got copies and sent it to her and Dr. L. She promised me that she would set up a seminar for everyone in NICU, PICU, and pediatric ER so that they would know and would allow people to use it.

Tara again uses “we” again to increase her authority; the whole family may believe in choices that other see as marginal, but the family makes the decision together. Tara directly challenges medical authority by asking the doctor “Are you a pediatrician?” The use of direct quotations in this narrative is fascinating, and serves as an evaluative point in itself. Tara does not tell us what happened during this encounter as much as she tells us exactly (according to her memory) what everyone said. She is not making this up, this is what they said. She is using the doctor’s own words to show how ignorant she is about the breastfeeding study, and she uses the discharge nurse’s words to demonstrate that there are medical professionals who support her choice.

As with many women with whom I spoke, Tara does not forsake medicine. When there is a sickness involved, she believes that medical care is needed and she will seek it. However, she arrives armed with an arsenal of self education. She checks the CDC website, she searches for journal articles, and she keeps up with current developments. She is seeking someone who wants to treat her children, but also who recognizes the effort that she has taken to learn and be accountable. Instead, time and time again, she is assumed to be ignorant or crazy.

Hope contracted viral meningitis during her first pregnancy, an experience which further cemented her belief in avoiding medicine when possible. She also encountered professionals who she did not believe were acting in her or her baby’s best interest:

I was in the hospital a week. I’ve never been in a hospital and I was pregnant. And it was really interesting, they wanted to give me so much
stuff. I knew I was pregnant. At first I wouldn’t even take the morphine or I tried to take it as little as possible, but I don’t know if you know, but it’s the most horrible headache in your neck and your back and everything. I told the nurse that I was pregnant and I was trying to take as little as possible and she said, “You can’t do that, your body will never be able to heal.” I don’t know. I was just trying to keep everything down to nothing.

On another note, you learn after you have a disease like that, that doctors don’t know what they’re doing. They just threw a lot of antibiotics at me and they gave me steroids. Can you imagine giving steroids to a pregnant woman? It just seems dangerous. I got better. But they wanted to get me an MRI. I said, “I’m pregnant, you know that right? Can you review your orders?” You know you never really talk to the doctor. He reviewed it and ordered it again, and I was lying down. I didn’t realize that they put something in your veins. Ok, I just told you I’m pregnant, and there has been no research on pregnant people, but it’s your bloodstream. I can deduce this. Finally my husband, I wouldn’t have done it any way, but it’s hard to do that when you’re sick and you’re drugged. I think I would have just started crying. But my husband had to say, “Look would you have your wife do it?” The guy, it’s so political in hospitals these days, he said no. But he hated answering that question. It was like then why is mine?

Hope is telling this story to challenge the medical authority. She signals us to pay attention by saying “it was really interesting.” However, she is confused between her own knowledge which tells her that ingesting medicine while pregnant is harmful, and the nurse’s knowledge that Hope will not be able to heal without taking the medication. She says, “I don’t know.” She tries to find a compromise between the two types of knowledge by taking as little medication as possible. However, she and her husband later privileged their own knowledge about the possible harmful effects of the MRI. Hope felt that she was a victim of medicine’s ignorant attempt to try to control her condition. She had not done the research that Tara had done, but Hope conveyed that she felt that she is a smart person and could figure out that something which goes into your bloodstream may reach the baby. Without any evidence from the doctor that this procedure was safe for pregnant women, she and her husband would not proceed.

However, the idea that women are already efficient organisms is the source of their empowerment in birth. Tara articulated this as:

> It was so empowering to know so early on that I could handle this, that my body was already set and built to do this. It’s been this way since humans first entered the planet. And it was so nice. I used to watch A Baby Story all the time. I don’t know why because it was torture. But I’d watch it almost every day, and I ended up screaming at the television because the doctor, every single time the doctor would come in, male or female it doesn’t matter, and say all right, “Let’s have this baby!” And I just want to grab him and shake him and say, “It’s not let’s! You’re not doing anything!”

Jaclyn described “being on top of the world” because she knew that she could give birth to her baby with just herself and her husband. She knew she could do it, and felt “empowered” by her experience. Hope expressed her anger at the marginalization of midwifery:

> I think the midwives today have to be the pioneers. And the fact that you have to say that word just makes you cringe, because, hello?! This is how it started before you guys in the white coats built your buildings that you decided to call a school and train some people. Before all that, this is how we did it. So it is interesting that you have to call them pioneers.

Interesting enough, when I asked midwives about what they considered a successful birth to be, they all mentioned empowerment. Naturally a healthy baby and mother were of highest priority, but then they talked about helping the mother accomplish her goals during the birth. Faith, a senior apprentice, aimed to help the clients achieve whatever
type of birth they wanted and hoped that it “[made] them more confident in themselves.”

Dara, a current LM, described a successful birth as:

> A perfect birth, which I’ve had a lot of. Basically everything goes without complications or there are complications and you handle them right there and they’re taken care of. The mother is well supported and she feels in the end, she feels like it’s the best experience of her life because it is! It’s a huge event in her life that should be very intense but a very spiritual and happy event. For her to feel like that was the best for her and her baby. To feel like that was the best choice. And that’s most of the births that I do. It’s very gratifying work. It’s intense, but in a good way. Usually I’m pretty bonded with these moms because of what we go through.

Marie, a current LM, described a successful birth as:

> One in which the mother feels safe and secure in her choice of where she delivers, and with whom she delivers. And she feels like the outcome is satisfactory to her. Now you know, that leaves a broad open idea. My personal idea is a home birth with midwives and your family around you. But that’s my successful birth. But somebody else’s successful chosen birth could be a section. I don’t sanctify that, I have a hard time justifying that, but thank God all of us have the right to choose. I don’t promote the idea that we should be able to choose a section on demand, I don’t agree with that. I think that that is wrong education and that is something that needs to be educated out the realm of availability. I don’t think they are being educated on the flip side of it, what it’s actually doing to their body, to their baby. But you know, to the individual who chooses that way to go and is happy with the outcome, that is a successful birth.

A retired midwife, Janet’s interpretation was intriguing, because she articulated that success means a lot of things, but in no way should a birth be conveyed as a failure:

> Mom is happy and the baby’s happy and everybody’s healthy. I try really hard, honestly in the early years natural birth was the goal with no epidural, no drugs, and you got everything on your list of 32 items. But you know, over the years, especially first time moms, sweetie, you’re having a baby. You can’t fail at this. It’s like driving to the other end of the driveway – you could take a tree out on the way, but getting to the end of the driveway was your goal. So just because you went to the hospital and had a section, that’s what it took. I mean I saw how hard you tried. That’s not the problem. It’s not that you didn’t fight hard enough. So I try, especially with first time moms, to go into it with an open attitude. I know that you can do what it takes to get this baby out. A successful birth is where mom still feels like a human after it’s over. She still has some respect for her mate. I personally hate walking away from a birth where
they weren’t happy. The only time you’ll ever see that is when they expect it pain-free. And it’s not. It’s just very difficult.

Resisting biomedical recommendations can have serious consequences. Although Tara’s story was traumatic, other women and midwives have told me stories where authorities have threatened to take a baby away from his or her parents. Melissa’s narrative included an example of a serious consequence for making these marginalized choices:

We had a random pediatrician who didn’t know us, who didn’t know anything about what we had wanted. Well, she got really upset that we weren’t doing all those things, and umh, was really very rude and unpleasant to us. And I had, and my husband, had just gone through this really long labor, and we have this perfect little baby and she was – I don’t know. At one point she came in and she kind of roughly took him from me and started examining him and I didn’t know what she was doing or why.

And all of the nurses that kept coming in and out were talking to me, and I was upset. And they said, “This pediatrician is impossible to work with, don’t let her bother you, she just is upset because you’re not doing everything her way.” In retrospect, if I have another baby and if I were in that same situation, I would just take him and leave.

I was just so happy that the baby was born. Within two or three hours of his birth I had gotten up, taken a shower, put my clothes on, I was fine. Now I would just take him and go home because now I know better. But at the time, I thought, is something really wrong with him? Apparently there’s a state law about the PKU test. If you don’t do it in the hospital you get reported to Child Protective Services. So somebody from CPS had to come in and talk to us. That was just a nightmare.

Marie, who is currently practicing as a LM, told me about the tense situation that can come up when you need to transport a client or her baby to a hospital. Often, even if the birth is uncomplicated and the baby is healthy, the mother may need care. Midwives are regulated and trained to seek medical care immediately if they even suspect something is abnormal. However, when they exercise this, they are often met with hostility. The midwife needs to get to the closest hospital, but that may not be where the physician backing her is on staff, or if the back-up is not on call the midwife will need to work with
whoever meets her in the emergency room. Marie commented on her interactions with hospitals and transports:

Generally I would rate it very good. Even on transports where we went in unassigned, thank God there have been exceedingly few. But I had one just recently with a retained placenta. With this situation we had to go to the closest hospital and I chose to transport by ambulance because she’d lost blood. When the ambulance driver said which hospital do you want to go to and I mentioned the closest hospital, she rolled her eyes and said, “They’re not going to like you.” I said, “They will have to get over it.” But I said, “Why that one in particular?” She said, “We’ve picked up women before who have gone in unassigned and the doctors give them a really hard time.”

I have my little prayer that I say anytime we have to transport: God, keep the assholes away and give us the best you got. And He’s never let me down.

I have heard horror stories from other midwives who have had to transport after the birth and wanted to leave the baby at home [with a partner or relative] and the EMTs have insisted the baby had to come with the mother. When they [midwives] said, “No, no we just need to take the mother, we’ve not taking the baby,” they [EMTs] call the police. I’ve heard that more than once.

Although these women are doing nothing illegal, they are treated like criminals nonetheless. Social agencies and police are called. Midwives and clients can suffer verbal abuse. If ever there was a question about the consequences for choosing a system of care outside of biomedicine, these narratives have illustrated the answer. These women, consciously or not, intentionally or not, have created a model for birth that becomes an act of political resistance. Midwives and their clients are challenging the “best” and “safest” way of giving birth and raising children. These women dare to imagine that they are able to accomplish something without technology and biomedicine, and arguably they are even better and safer without them. However, in Louisiana, midwives and those who seek them must be willing to support the choice on their own.
WILL YOU PAY FOR THIS?

Women Navigate Financial and Regulatory Institutions

The U.S. health care system is not equally accessible to Americans who want to custom tailor their care to their own beliefs about the body. Certainly citizens, doctors, and politicians talk about health care in an egalitarian way, but the narratives in this research demonstrate another phenomenon. Health care is for those who play by the rules. One does not choose care so much as one agrees to it. Many women, upon hearing about my research, chose to contact me to tell me about how they could not have a home birth with a midwife despite that being their ideal birth experience. Often the bottom line was that the insurance or Medicaid would not pay. Medicaid in Louisiana does not reimburse for home birth, and there are few CNMs who accept it. Most of the midwives in Louisiana charge about $3,000 for care, which includes all prenatal and postpartum care, as well as the birth. The woman or couple must assemble and pay for their own birth kit, which are the supplies the midwife and parents will need at the birth. Insurance policies can be grey on the coverage of midwifery services, and so many parents simply must come up with the $3,000 themselves.

Often this issue is compounded by when a woman finds out she is pregnant. Abril, a woman who is planning to start having children with her husband in the next two years, has started searching for a midwife already, although so far there is none practicing in her area. She is hoping to save enough money, but she will still need insurance to pay for some of her care. She hopes her insurance will cover midwifery services when she becomes pregnant. Jaclyn had private insurance without maternity coverage, because she had an IUD. However, the IUD failed, and she was shocked to find herself pregnant.
She was forced to enroll in Medicaid for prenatal care, and could only find one CNM in her area that accepted it. However, this dashed her hopes of “the birth I’ve always dreamed of” at home. Moreover, Jaclyn was pregnant again at the time I spoke with her. Her first son is now 5 years old, and he wanted to see the baby born. However, because of the hospital regulations, she must find someone who will agree to chaperone him at the hospital. In her words, “the law has very limited options for me.” She felt that these regulations would not be an issue if she and her husband made enough money to pay cash to the midwives, but that goal is not attainable given their income.

Melissa ended up having her birth in the hospital with a CNM. She was adamant about documenting her struggle with her insurance company:

When I got pregnant and we found [her CNM] I called my insurance to ask if it would be covered. I wish, I should have brought that for you. I kept notes over about two months of making phone calls to the insurance and talking to one person who didn’t know, and then they would connect me to somebody else. I would talk to a bunch of different people and then they promoted my question further and further up the chain through all the people, and all I wanted to know was will you pay for this if this is what I choose? And nobody could ever tell me. Finally they said send in a pre-cert document. We have to pass that through our procedures and then if it’s pre-certified maybe it will get paid for.

So I did that, and I got this letter back that said your medical care is pre-certified. However, this is no guarantee. So after he was born and everything got filed they ended up paying for the hospital room and the charges that came just from the hospital, but not the midwife’s bill. And then we tried to argue it a little bit, but I was just too tired at that point. I didn’t know what else to do, so we just ended up paying for that ourselves. But the thing that’s not right about it, or not even smart is that my medical costs were way lower than most people, because I had good pain management and didn’t need an epidural – that’s like a $1000, and because I ended up not needing it, I didn’t even see an anesthesiologist. If I’ had the c-section I’m sure that is thousands of dollars. I also didn’t take a number of tests when I was pregnant that are pretty standard. I did have one ultrasound, but other than that…. So all these things would have saved the insurance company money.
Many women assumed that their private insurance would pay for a midwife. Melissa was even led to believe it might be, but in the end she had to pay for the CNM’s services. The matter of fiscal responsibility is in other narratives as well. In all cases these women have declined pain relief or prenatal testing because of their own research and desire to avoid any unnecessary intervention. However, they feel that an additional benefit to their choices is the money saved. The irony though, is that in many cases the individual paying a midwife spends more of her own money on a less expensive birth than she would for an insurance covered medical birth. The insurance will pay for doctors, nurses, and equipment, but insurance will not cover a midwife’s services. A low risk birth with a midwife at home costs substantially less money than a hospital birth with an obstetrician. Even a birth in a hospital with a CNM costs much less than an obstetrician attended birth, but private insurers typically do not reimburse for the CNM’s services either. The parents then must pay the entire sum. Hospital births with an obstetrician, covered by insurance or Medicaid, will often either cost very little to the person or not more than their deductible. However, to the insurance or the state government, the at-cost price is much higher. While using a midwife results in a less expensive birth, parents will pay more money because they will be responsible for the entire sum of the birth. If those parents chose an obstetrician, the birth itself will be more expensive, but the parents would not be paying the entire sum themselves.

The situation is further complicated when during the pregnancy the family moves to a different state and switches employers, as was Hope’s case. She described what happened, particularly with COBRA (Consolidated Omnibus Budget Reconciliation Act), which is a federal program intended to enhance insurance portability:
Here I did have insurance, but it was a smaller company, about 150 employees and I went to COBRA. I thought I had coverage and in September I pulled up the 50 page contract that says what’s covered and what’s not. Well, two things happened. I decided I was going to do COBRA, and I read a lot of the pages and I missed some things. There were so many issues with the insurance. First [insurance company “A”] pulled out of Louisiana. [Insurance company “A”] was pretty good in some ways. So with this smaller company and their plan, if I was outside of Texas I had no coverage. Or you pay a huge deductible. That’s fine if I was still working there. Once I went on COBRA, if I left and went out of state, I was moving to something better I guess. I said, “I moved to Louisiana with my husband,” and they said, “Well, that was voluntary.” I was like well, I didn’t want to have the child by myself. And my husband was here. It was really upsetting how the insurance does that. It’s not like I worked for this company two to three months, I worked for them a couple of years. So I was looking at paying a whole new deductible because the baby was born in January. Then they said we have some rollover so anything you spend in October, November, and December will be counted towards your deductible. Well, that’s pretty magnanimous, but considering that in your pregnancy most of your testing is done in the first three months and the last three months, my pregnancy doesn’t help me at all. It was a very difficult time for us because we were like, oh my gosh, are we going to get a break?

What always blows my mind is that the insurance companies pay less for a cheaper birth than they do for the expensive one and they give you so much grief.

Hope became pregnant with her second child in Louisiana, and this time had private insurance. This insurance, however, did not give her much more choice about paying for her intended home birth:

I found out that home births were excluded, and this was after four phone calls crying telling people I’m a week from my due date and you guys won’t tell me if I have coverage. This was literally one of my last weeks of pregnancy. And that’s when you really improvise – we’re just going to have a healthy baby.

With the pregnancy, the only reason, it’s just the benevolence of my midwife. I think I paid her only [part of the fee] and my baby is six months old. That’s really hard. I know his [Hope’s husband] business will pick up and I’ll pay it off, but the thing is, if I didn’t have the opportunity of a person who said “You know what?” And this is what she said to me, “I’m here to bring babies into the world.” I know because I
cried to her two or three times. I said “Dara, I just don’t have it. I just don’t.” I said, “But look I know this is the contract but I don’t want to come to my first appointment and my second appointment and then act like this is a surprise to me. Oh, look! I can’t do that. I’m not here to waste my time or yours.” She said, “Look, I’m here to make a baby come here. I know you’ll do what you can.” Honestly, if she hadn’t said that my baby would have been born at [the local hospital]. I might have tried to have it home, but you don’t know.

Hope expressed remorse about not being able to pay her midwife on time. She also knew that the midwife had her own children and could not afford health care at all for her family. Working full time midwives doing home births can manage usually one to two births per month, and with a fee of $2,000 to $3,000 for each birth their income can range anywhere from $24,000 to $72,000, which depends, of course, on if they get paid from all their clients. These women have no billing clerks, and their expenses include transportation for all their visits, and keeping their supplies and equipment updated and stocked. They do not carry malpractice insurance, and in fact until recently there was no company to even offer it to home birth midwives. However, none of the midwives felt they could manage to pay the malpractice premiums. Although the malpractice rate among midwives nationally is low, and no one told me about anyone in Louisiana ever being sued for malpractice, in the back of their minds they know that if someone decided to sue them it would be the end of their livelihood.

A woman’s pregnancy absorbs everything in her life, including employment and insurance, and the birth narratives revealed this. Tara interjected the following into the story of her second birth:

With our second child, my husband was laid off shortly after September 11. He’s a pilot, and the company that I worked with did internet research and our funding was pulled on September 10. So we both lost our jobs within the span of a month, and we had this brand new baby and a new house, and we were up to our eyeballs in debt. We started a business with
our unemployment money, and invited my brother to come and work with us. He embezzled a bunch of money and the company went down the tubes after three years. We were just pretty destitute. We lost the house, we did bankruptcy and all that. We decided to go ahead and come back to Louisiana because my husband’s family was here and my family of origin had been here.

I got pregnant right before we left. I was really excited but terrified because we had no jobs, no insurance. I was so wiped out emotionally. The idea of trying to find a hospital that I could go to was just awful. And so we went and signed me up for Medicaid, which was wonderful because they cover all the prenatal care. But there was not a single midwife on the list. So I did a search myself. I went on the internet and found anyone I could and said, “Do you know anyone, lay midwife or otherwise in Louisiana?” After bouncing around I finally found Marie, and she doesn’t take Medicaid, but we thought because my husband was supposed to get another flying job, we thought we could afford the price of the home birth. It became clear about three months before my due date that that wasn’t going to happen.

Tara assumed that midwives would be on the Medicaid list, and that the program might pay for home birth. Choosing home birth was an obvious choice to Tara, and she did not even consider that Medicaid would not cover that choice. Tara continued through her pregnancy hoping for a home birth, yet soon before her due date realized that this would not happen for her. Her story continued with how she felt coerced by the Medicaid system:

Sometimes with Medicaid they refer to [a prenatal program] which is affiliated with [local hospital “A”]. The way that they conduct their little seminars is that they herd a bunch of women in and they basically tell you if you don’t sign up with [this hospital “A”] right now, you’re going to have your baby at [a charity hospital]. So you need to hurry up and do this, this. I did that because it was better than [a charity hospital]. I was terrified. I was absolutely terrified and I found out eventually that [hospital “C”] accepts Medicaid. So we’ll go there, I just have to find a doctor. One night I was watching television and there was this advertisement for a doctor that accepts Medicaid and has a nurse-midwife.

In Tara’s situation, Medicaid women were pressured to commit to the hospital which hosted the “education” program. Already Tara was distraught by not being able to afford
a home birth, and suddenly her other choices were curtailed. Although the relationship with her CNM was “disconnected,” she felt lucky during her birth to have a supportive nurse assigned to her.

Women who needed to enroll in Medicaid often felt lied to or coerced into a biomedical model that was not supported by their own research. Additionally, women felt as though they were continually treated as ignorant, even though they may have already given birth and parented. Hope said, “We actually did qualify for Medicaid or CHIP [“Children’s Health Insurance Program,” a program which provides expanded Medicaid coverage for children], and I know that I will only get it this year. But I won’t take it because I don’t want to vaccinate.” Not only would Medicaid not have reimbursed for Hope’s home birth, but it would have forced her to vaccinate her children at a time that she did not feel was safe for them. The insurance she had with COBRA continued to “harass” her as well:

They said you didn’t sign up for Mommies To Be. Some asinine, silly program. I’ve had a child before. I don’t need you to tell me, did you go take your glucose test? Which, by the way, I didn’t have. I didn’t feel it was necessary. Mommies To Be was basically one of those information things. That just really bothered me. Why the heck do you have to have my mailing address to send me stuff I already know and you waste paper and kill the planet…. Anyway, it’s like if you do all these things we might help you but if you skip a step…. Hope felt that her knowledge as a woman and a mother was completely devalued in the eyes of the state, the hospital, and the insurance company. Where she needed the help she could not receive it because she did not make an “approved” choice. Any aspect of the behavior of pregnant women left out of the law is quickly covered by either Medicaid or insurance companies. The law and insurance regulations conspire in a multi-lateral
effort to regulate the behavior of women and newborn children into productive and complaint patients and citizens.

Lobbying for Medicaid reimbursement for home birth seems like a possibility to widen the options for women, but the reality is that the midwives cannot operate that way. The structure of the situation presents a dilemma. While midwives agree that every woman should have the option of a home birth, midwives cannot file the paperwork and follow up on payments from the state. Marie, a midwife, does not accept Medicaid and Faith, a senior apprentice, said she never would. Faith pointed out that she does too few births (maybe ten a year), and the fee is always discounted. When practitioners enter into a contract with Medicaid or a private insurance company, they negotiate payment terms. The payment is not based on the cost of the service, but rather the payment a practitioner is willing to accept in order to gain access to a large network of patients. The practicing midwives with whom I spoke are all booked, in fact they are turning clients away because they cannot handle the demand. They do not need to access a large network of clients, although they would like women to know there are options to medical births. However, just because they are booked does not mean they can afford to discount their rates. Even with a full workload, these midwives cannot afford to purchase insurance for their own families, and they have trouble making ends meet sometimes. Waiting six months for a payment is not an option for them. However, paying up front is not an option for many clients trying to manage this type of birth. What then, really, is the choice left for either?
I introduced this research by contemplating the words “reproductive choice.” I now refine that to processing how choice is constructed for women in Louisiana who want to pursue a midwife-attended birth or practice midwifery. Lopez conceptualized an “ideology of choice” which “is based on the assumption that people have options, that we live in a ‘free’ society and have infinite alternatives from which to choose” (1997:160). Lopez (1997) argued that ideally, as individual social agents, we should be able to envision our choices, and then voluntarily choose from among them. However, Lopez added that “choices are primed by larger institutional structures and ideological messages” (1997:160). Lopez (1997) concluded that the existence of alternatives does not constitute choice; choice only exists when we consider the perceptions or knowledge women have about those alternatives. Louisiana’s women find themselves in this situation. Ideally, there are choices available for different kinds of birth. Practically, that choice does not exist for most of them.

The state’s regulations for midwives look good on paper, but in practice midwives do not have a lot of choice in their ability to practice in this state. In addition to the insurance issues discussed, this is also due to the much voiced issue of physician back-up. However, the legal requirement of back-up is not itself the problem; the problem is the inability to secure back-up. Physicians choose not to support midwives in this state, and those physicians who support midwifery risk persecution as great as that the midwives themselves face. This negative attitude towards midwives was observed by women who tried to find midwives through their obstetricians. Melissa described the beginning of her search for a midwife: “I started, first I called, I had seen a GYN in town and I called and
asked if they recommended any midwives and they acted like I was nuts on the phone.”
Marie, a current LM, even commented about the questions midwives get from the State
Board of Medical Examiners being ridiculous. On one occasion she recalled a physician
asking what midwives do when there is a medical emergency, to which someone
answered “We go to the hospital!” Marie said, “They didn’t even know that we did that.”

The back-up issue also restricts how midwives may practice in this state. A few
of the midwives would like to open a free-standing birthing center, which would provide
another out-of-hospital birth option. However, the center would have to be backed by
physicians. For a physician this would mean being legally liable for every birth in the
center, where there would be no surgical facility. This is a great amount of potential risk
for doctors to consider. However, as some of the practicing midwives get older, they
would like to do more births with less travel. They are all still committed to home births,
but a birth center is an option in which clients have expressed interest, but is not
available.

In addition to a lack of education about midwifery within the medical community
and despite their continually hostile attitude, Dara, a current LM, made a strong point
about needing to find a physician who believes in high risk and low risk birth. You need
to find someone who wants to do high risk births, but does not generalize the philosophy
to all births. In other words, midwives would like to work with a physician who does not
see pregnancy as pathological, and considers high risk the exception and not the rule.
Otherwise, the required physician back-up serves only to suppress the midwifery practice
in Louisiana. With so few midwives, a woman who wants a midwife-attended birth must
be lucky on more than one account. She must be living within an hour’s drive of a
midwife. Currently, Abril has no choice because she does not have a midwife close enough. Her pregnancy must be timed so that if there is midwife in the area, that midwife has the time to fit Abril into her practice. Hope described this situation:

I called La Leche League and they mentioned Marie. I couldn’t reach her or something. Then I just went online and that’s how I caught up with Misty Richard I think. She referred me back to the same person. That’s when I realized – oh my gosh, there really aren’t that many around here. Marie had too many births in that time period. I mean how could she not? If you’re the only book in town! She referred me to Dara, and she was fine because even though she was an hour away it’s an easy drive and she was okay with it. I was really nervous because you can’t tell me no. I was so nervous she was going to say I’m booked up too. I never even thought that it would be so hard, that there would be so few.

Multiple clients reminded me of how fervent they were on their initial contacts with their midwives, to the point of demanding that they be accepted as clients. The midwives, with the exception of Dara, do not advertise, and are not listed on any national birth activist website. Without more midwives in the state they would only be advertising to turn women away. The women who do reach them have already fought a battle to arrive at that point. Next they must sometimes battle to be accepted as a client. Many women at this point may be risked out, meaning that they have a condition that Louisiana’s regulation considers too high risk for a midwife-attended birth. Midwives disagree about how much risk is safe for home birth; however, most seem to agree that twins are safe at home as are some atypical presentations, although the regulations prohibit midwives from accepting any of those clients. Some midwives will practice outside of the regulations and some will not. Usually the situation is that a woman is risked out of a midwife-attended birth, and although the client understands the law, she begs the midwife to help her anyway. The midwife is then faced with a difficult choice.
At this point, if a woman has been accepted as a client, she must also be able to pay the cash herself. A woman who does not have the cash has no options. Medicaid in Louisiana will not pay for her choice. Her insurance will not reimburse her. Not only is there is financial cost though, there is also a personal cost.

Authoritative knowledge retains control by popular sanction. Women who make the marginalized choice of a home birth face strong disapproval by their family, friends, co-workers, and complete strangers. All the women with whom I spoke described scenarios where they were chastised for their choice, and many times were told, “Don’t you know your baby could die!” The ultimate insult thrown on these women was that they are such poor mothers for rejecting the best that medicine can offer that they actually put their babies’ lives at risk. A number of comments made to these women, and those who supported them, show just how much their behavior put other people outside of their comfort zone.

Kara, a woman who was planning a home birth until Hurricane Katrina hit, was shocked when she evacuated to another state and found a visible and supportive midwifery community. Melissa felt that her midwife attended birth in Louisiana was acceptable to people here because it was still in a hospital:

I do think that women who have had good experiences with midwives should talk about it. Actually I haven’t had a single friend who said “I’ll do that next time.” But I’ve gotten more positive reactions to people than I might have thought. Nobody said, “Oh, but that’s so dangerous.” I think because when you say, but it’s in a hospital, that puts to rest a lot of fears that people have. People think it’s very irresponsible not to give birth in a hospital. They think you’re endangering the child and that maybe they should call Child Protective Services. I was kind of the opposite. I thought the closer I got to the hospital the more something might go wrong. I just felt sort of lucky that I escaped anything bad. I wasn’t ever really worried that anything would happen. I kept thinking maybe if I just stay home a little longer maybe he’ll be born right here in the kitchen.
And people say, “Oh, I gave birth in the car on the way there and it was terrible.” I’d say, “Oh, I wish I’d just given birth in the car.”

For those women who have worked with midwives, Melissa’s point about needing to tell people the truth about their experiences was a strong motivation for these women to share their narratives with me. The “reportability” in a narrative like Melissa’s, among other issues, is that although you still might have to fight multiple institutions to get there, the fight is worth the result of having the birth you want. She felt that there was still a mysticism surrounding midwife-attended births, and by being honest with their experiences they might work towards changing perceptions and opening up this choice.

Hope talked about the pressure she felt at her job:

I said peer pressure, but the point is if I would have said I think I’m going to have the baby natural, they would have said, are you crazy? Or - do you know what can happen? When I started working there I was breastfeeding my six month old. So that was a little different I think. I was just always “that girl.” I remember getting really offended by what some people would say.

She continued as she talked about supportive relatives and friends:

It’s amazing because your friends and family who do support you, they get the same thing. My mom would call me almost in tears about something so hateful that someone would say to her about me wanting to have my baby at home.

These people are just my friends! They’re just excited about a baby, why are you doing this to them? I feel that people, whatever you do, they feel judged by your actions. Which is so silly because you’re not me and I’m not you. But instead it’s she’s trying to have it at home and I didn’t do it that way. I did it the best way.

These experiences led her to lie to many people about her home birth:

It just got to the point where people would say, “Oh my God, your baby could die.” And they say those words, oh my God, your baby could die. And have a good afternoon to you too! It’s right here, it hears you. Scott [her husband] and I very strongly believe that who a baby is, is very affected by the experiences of the mother while pregnant.
When Janet was a young mother attending La Leche League meetings, she brought up her home birth, which elicited a strong response. She contemplated that experience:

I think they’re jealous. I hate to say it, but I really think they are. The woman jumped up and said we need you to know that La Leche League does not support or condone – what was that about? It turned out that she had always wanted a home birth but could never have one for different reasons. I really felt like that’s what it was about. It was a way for her to separate herself, off the record. Some people have enough guts to do it and some don’t. It doesn’t make you a bad person, but you have to know you can do it in your gut. A lot of people are very ignorant and they don’t want to know. They don’t want to bother to find out, so they have to assume that you’re wrong and they’re right.

The hostility to which Janet, Hope, and other women have been subjected to is a weapon in what Peskowitz (2005) had termed the “Mommy Wars.” Peskowitz wrote that this hostility occurs because as mothers “we are isolated, defensive, guilt stricken, and tired. Instead of encouraging us to band together, voice concern, and work for change, the Mommy Wars prompt us to judge and undermine mothers who live their lives differently” (2005:22). As American parents we do not construct choice as a right to the alternative which we would never choose, but rather the right to the alternative we believe is right. The women with whom I spoke were conflicted about trying to promote midwifery and low intervention births, while not attacking the women who have made the choice to have a medical birth. They struggle with how to make their natural birth choice more supported without appearing to disapprove of other types of births.

Peskowitz wrote about the Mommy Wars in a way that summarized how choices are constructed by institutions and not individuals:

Women do envy and dislike each other (as do men) for various reasons. Envy is endemic in our society, and our society seems particularly mean spirited these days. We are encouraged to express nastiness instead of yielding to the better and more empathetic instincts. When I ask whether
real women have Mommy Wars, it’s not because I think we’re all saintly. I’m attempting to separate our true instincts from the images public culture and media create for us, images that we sometimes adopt as our own, images that take our diverse and complex experiences and sculpt them into something more singular but which ignore the more humane and community-building parts of our lives. The most widely available images of motherhood are not positive reflections of mothers’ existence – in fact, they are often poisonous. [emphasis in original] [2005:22]

A fascinating undertone in the quote above is the suppression of intuitive knowledge in exchange for the authoritarian knowledge. I personally found how pervasive that model was when I described my research into midwifery, and was continually asked “What do they do if there’s a problem!?” One day I realized that a “natural” birth is not even expected anymore, people assume that complications will arise in birth. Unfortunately, many of those people are not educated about how many of the medical interventions actually cause the “problems.” Instead of embracing the diversity of our experiences as mothers, we attempt to squeeze them into a category of “good motherhood,” which is not created by us, but rather for us. That category is created by the institutions that are interested in compliant patients, obedient citizens, and strong capitalists and consumers. That category is fed when women make those decisions which distrust their own knowledge and intuition about their bodies and privilege technology.

The river also flows the other way, meaning that many of the women with whom I spoke felt that they were better than average mothers who did not invest themselves in all the research and reading natural mothers did. Better mothers question doctors. Abril told me that she was thinking of training as a midwife “because you know these women care for their children. They care more.” Abril is an example of the view of the “better” mother as the one who questions and rejects the biomedical model, and who devalues the mainstream way of birth and parenting. What results is two categories: those who accept
the biomedical model, and those who do not. Those categories are not constructed equally; they are weighted as good enough and better. In Bobel’s study of natural mothering, she claimed that although these mothers may be “turned off” by mainstream parenting, they are “turned on” by an equally powerful ideology which privileges nature (2002:106). Their agency is not truly independent, but guided by a different type of knowledge system, the authority of nature.

I do not think that a lot of women in my study would disagree with that statement. I think many of them are aware that they also privilege a way of knowing, and that it guides their decisions. However, I think they construct choice as the ability to opt for another way of knowing. Turner (2002) reflected on her own midwife-attended births and questioned how culturally constructed her non-medical births were. Her conclusion was that “birth is less an issue of natural and more one of informed choice” (Turner 2002:665). I want to add though that no women with whom I spoke would take away any woman’s choice. However, promoting your choice as equal to other choices is difficult without pointing out the shortcomings of the alternatives. The largest shortcoming they attributed to the biomedical model is the lack of education and the overabundance of fear and ignorance. Women who seek births outside of the biomedical model are seeking a dialogue about knowledge, not an ultimatum of care they feel doctors give them. They want a relationship with their practitioner that allows them to question recommendations and discuss choices. Abril said “I really want to have the child at home. My friends have had hospital births. I don’t think they know they can have it at home.” Kara said that, “We have been taught to fear our bodies” which led us to “giving up on this idea about birth in our home.”
Although midwives do practice an alternative view of pregnancy and birth, they are nonetheless wedged between two types of authoritative knowledge, biomedical and natural. Additionally, the reality of their situation in Louisiana is that they are governed by biomedicine. They must rationally argue with the state and the Board of Medical Examiners for fair regulation. Davis-Floyd wrote that, “It is one thing to proudly hold a countercultural space in which women can make alternative choices, and it is another to watch their clients suffer the effects of negative stereotyping” (2004:218). A midwife’s knowledge must be demonstrated on biomedical terms, and in this sense the practice remains marginalized in Louisiana, and elsewhere. Janet, a retired midwife, commented on balancing the biomedical interaction and the tradition of midwifery:

When I took these courses I hated the idea. I know what I know, and I was already trained. I don’t want to hear about Mendel’s stuff that he did. But really you sound like you’re anti-the folk art as it were and the folk medicine in midwifery. However, to make yourself able to rub elbows with people who are going to talk over your head… it should not be the case that they talk over your head. You should be able to say I know exactly where that bone is and exactly what you’re talking about. After taking them [courses] I felt they were well-rounded. Midwives should be able to know what any nurse knows, basically. Most states have some meshing with nursing. My goal personally was to know almost everything a doctor knows about the normalcy and how pregnancy runs, and only use what you have to use.

Wouldn’t it be helpful if we could change the dialogue on a policy level because we’re in that dialogue? Instead of the people on the periphery that don’t know what’s going on, that never stepped inside the machine, that don’t have a clue about the terminology or where health care’s fitted… we’re not at the table. We need to be at the table. I believe that we need to get at that table and still practice.

The midwives with whom I talked typically shied away from politics, claiming that they became midwives to help birth families, not get into a fight with doctors and legislators. However, as Janet pointed out, they have a choice to be “at the table” or not. They can
help to “legitimize” their position in the state or they can be “talked over.” Ultimately, not just midwifery suffers by disengaging with the politics of birth, but women lose autonomy. Abby chronicled how hard feminists and midwives worked a generation ago, only to have today’s young women take legal midwifery for granted. She was hopeful that the midwifery cause for which the former generation lobbied could be passed on to a new generation of activists.

Currently in Louisiana, every midwife with whom I talked or heard about seemed to have a different style. Some were described as more clinical, some as more spiritual, and some as strongly homeopathic. The situation would seem that even with regulations, midwives who attend home birth can still practice their philosophy of childbirth or accommodate that of the mother. Ideally, women would be able to talk to different midwives and find the one best suited for both of them, as was the case of Kara when she evacuated to Texas. She could not believe the variety of midwives to choose from, and the fact that these midwives were not overbooked. The reality is that finding any midwife in Louisiana is a challenge, and seeking out a particular practice is unimaginable. Under the best of circumstances you may have a choice of using a midwife, but you cannot choose what kind.

Any choice of midwifery in the future, according to both midwives and clients, hinges on education and consumer advocacy. Interestingly, the consumerism that is so often shunned by natural mothers is the very phenomenon viewed in a savior’s light (Bobel 2002). For all that natural birth rejects a market and capitalistic model, the very fate of choosing an alternative hangs on supply and demand market forces. Midwives would like to see a school in the state to help attract and retain new midwives. They
would also like to see a strong consumer advocacy effort, in order to cement a midwifery community in Louisiana.

A repeated theme was that midwives should be welcomed “to the table” because they provide high quality care at a low cost. Upon reflection of this theme, I was reminded of Harrison’s article on Jamaica’s female workers, where she wrote that female labor “has been politically, legally, and culturally constructed to be cheap and expendable” (1997:457). She continued to write of the “patriarchal assumptions [that] ‘natural’ women’s tasks [require] no special skill, training, or compensation; that jobs defined as skilled belong to men, who deserve to be remunerated” (Harrison 1997:457). The parallels to midwifery could not be stronger. Since midwives approach birth with as little intervention as possible and center birth on the woman, the practice is viewed as unskilled and ‘natural’ to women. Therefore in the eyes of the patriarchy it cannot be respectable. However, obstetrics involves much intervention, technology, and skill, and portrays a more paternal, child focused idea of birth – this the patriarchy rewards. Midwifery advocates, who with the best of intentions, champion midwives as “cheap” good care, may inadvertently contribute to continued marginalization. However, the choice remains for midwives, how mainstream do they become in order to gain greater acceptance and respectability for themselves and their clients? The choice of how to approach the table will no doubt be debated among the midwives, but eager consumer advocates should be included in this conversation.
WE HAVE DAUGHTERS

When I asked Janet about the future of midwifery, she replied, “We have daughters.” What she meant was that women who experience and embrace midwifery have daughters in whom they instill this idea of birth. These daughters then pick up the fight, ensuring the preservation of the practice for their daughters and sons. A fight seems to be in the future for midwifery in Louisiana. Recently revised legislation was submitted by the midwives to end the mandatory physician backing. They are waiting for a response. Nonetheless, Marie was among those who remain optimistic:

I really think the future is very bright. It’s really wherever we want to take it. What kind of emphasis, wherever we take it. That’s why I have been so adamantly involved in LMA [Louisiana Midwives Alliance]. That’s why I push myself to be involved in any political thing going on, because I want to be a part of directing that in the right areas. My line of thinking is to preserve home birth midwifery and the integrity of true midwifery. Not to funnel it into nurse-midwifery. Not to say that nurse-midwifery is bad but to preserve the integrity of true midwifery in the aspect that is truly an art and not a science. And maintain the availability of home birth.

When considering the marginal position of midwifery in Louisiana, Hope saw many factors at play, but also remained optimistic:

I think that it’s a combination of law, I don’t know how you separate these great big insurance companies with the law. Because it’s kind of like which comes first, the chicken or the egg? Because it is the businesses and professionals that moves what happens in the laws. So I guess you would say there are a lot of people who are perking up interest but then they get shut down because they can’t afford it or they don’t have the support or whatever. It’s that circle though, if you don’t say anything and make it happen…. I think we are starting to make it happen, more women coming here who want to have a home birth.

Hope made an interesting point that more women are coming here that want a home birth, not that women already here want a home birth. Dara, the only practicing midwife to
come from another state, was still surprised that none of her clients has ever had a home birth. Do women in Louisiana not want home birth?

This question is crucial because, as Janet said, midwives are created by the community. Melissa saw this question as large with no easy answer, “I think as long as we have this overall atmosphere or idea in our culture that birth and pregnancy and really everything else is medical, then I don’t think you’ll move past that very easily.” Tara saw the need for education to offer an alternative to that attitude, although she too saw the difficulty:

I think ultimately just educating people. I don’t know how to establish that because it’s been a hundred years that we’ve been taught as a society that medicine’s right and that medicine knows better than our own bodies how to do things like have babies.

The problem with huge education campaigns is getting people to pay attention to them. They’re so comfortable with the status quo. I think each person has to come to a point when they’re ready to consider other things.

I was surprised that many women were frank in believing that Louisiana was just a different state, “backward” in some ways and comfortable with ignorance. Jaclyn said she felt that “Louisiana takes the backseat on the natural way” and “is slow on getting things on the natural way.” Regarding this idea, Marie added, “It takes education to break those bonds. It takes educating people out of what they’ve been educated into. They do have choices.” Dara articulated the difficulty in attracting midwives:

We’re a highly persecuted race, anyway. So no matter which state you’re in, you’re going to be persecuted. I just think that, number one why are you going to be in Louisiana unless you were born and raised here? In this profession, it’s a hard place for people who are minded naturally to just want to come to. If I was just going on that alone, it’d be like, why do I want to go there? It’s the toxic waste dump of the Mississippi. There are just so many things that go against that grain that I think a lot of midwives are like no way. And then when they get into the politics of the
licensing and basically it’s run by the medical board and the whole doctor thing, and the climate of trying to find that…. I think that people feel it’s a place not conducive to practicing. If you go to Mississippi and there’s not a whole lot of regulation, you go to Oregon and there’s not a whole lot of regulation, midwives feel better practicing in those types of environments. And the people, they end up having a large population of people who want that in those areas too. I don’t know which came first, the people or the midwives.

Dara then added, “I am making converts to this philosophy.”

I introduced this research by recognizing myself as an applied researcher. The goal of my research is to provide materials, education, and advocacy to promote choices in pregnancy care and alternatives to medical births. I believe that Louisiana has the potential to be a place of conversion. In many areas of the state you can see herbalists practicing next to doctors, and one referring patients to the other. Already the state has not only a legal status for direct-entry midwives, but a licensure and regulation process as well. The biggest battle remains making room for another idea about birth within the Louisiana medical community. The viability of midwifery as a practice in Louisiana hinges on support from physicians. While it is easy to blame physicians for not backing midwives, even the midwives recognize that Louisiana can be a difficult place for physicians to practice in as well. Louisiana needs to be a safe place for all practitioners in order to offer choices to women.

Additionally, the midwifery community must make itself visible. I believe that social support for this choice will not come as long as finding information about it remains difficult. Since most women mentioned turning first to the internet for answers, a website for Louisiana’s midwives and their supporters would be helpful. Also, advocates must manipulate the health care market to satisfy their demand, although this should be a joint effort with the midwives. As I have demonstrated, the most convenient
alternatives for clients, such as insurance coverage, may not be realistic options for midwives. To preserve the integrity of the midwifery tradition, advocacy must also center on real choices in care, not just cheaper care.

Kara brought up a silver living to the dark clouds left behind by hurricanes Katrina and Rita. She hoped that people who had to evacuate the state will return with new ideas from the places they have been and choose to share that with their communities in Louisiana. As these women have daughters and sons, hopefully they will choose to share and network the birth community, not just to make the choice a realistic logistical one, but a socially acceptable one as well.
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The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes.

The Midwives Model of Care includes:

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

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

[Citizens for Midwifery 2006c]
APPENDIX B
INTERVIEW QUESTIONS FOR CLIENTS

1. If I ask you to describe yourself professionally, personally, ethnically – what would you say?

2. How many pregnancies have you had? At what ages?

3. Have you lived in Louisiana for all your pregnancies?

4. Before becoming pregnant, any major health/fertility problems?

5. Did you plan your pregnancy? Any special circumstances in your life at this time?

6. Describe your approach to your pregnancy. Did you immediately seek out a midwife or did you want a doctor, or not want either? Did anyone make or influence these decisions with you?

7. Describe how you found your midwife.

8. What was the initial interaction like?

9. Did you experience any frustrations in your approach to your pregnancy? Anywhere you felt denied information, freedom, etc? What could or should change in that process? Or what is good about the process?

10. Describe your pregnancy. Emotions, behavior changes, progression of pregnancy, etc. How well do you feel you knew your body and baby during this time? How well do you feel your midwife/doctor knew your body?

11. How did you become educated about pregnancy and birth? Did you want more or less? From whom and where? How or did you use this knowledge with your own intuition?

12. Who provided support during your pregnancy? Husband/partner, relatives, friends, etc.

13. Describe your prenatal visits. Did you see an OB/GYN at all? What did you talk about with your midwife?

14. How did you know your were in labor? Was anyone with you?

15. Describe your labor. What do you remember seeing, hearing, smelling, feeling? Who was with you? Any feelings of intuition about your labor?
16. What happened after the delivery? How did you feel? Physically and emotionally? What was your midwife doing at this time?

17. Describe your postpartum visits. How many? What happened? What did you talk about with your midwife?

18. How did you pay for your midwife?

19. Overall, what are your thoughts about giving birth in Louisiana? How do you feel laws regarding birth are written here? Would you choose another state if you could?

20. Do you know of any birth activist groups? Would you be interested in being part of one if it existed?
APPENDIX C
INTERVIEW QUESTIONS FOR MIDWIVES

1. Are you currently practicing as a midwife? If not, how long did you practice?

2. Do you practice in a rural or urban setting?

3. Do you have children? Describe your birth(s).

4. At what age did you decide to become a midwife?

5. When in your life do you decide to become a midwife? Were there any special circumstances surrounding that decision?

6. Describe your motivation to practice midwifery? Why does it appeal to you? How long do you anticipate practicing?

7. Describe your midwifery training. How long was it? How was knowledge obtained? (via books, lectures, observation, etc.)

8. Tell me about the steps involved in obtaining a license to practice. How was the exam paid for? What type of information did you need to know for it? Did you feel it was a good and fair measure of your ability to practice?

9. Tell me about the women you have worked with. Are there women who are more likely to seek our midwives than others? How do you decide whether to accept a client or not?

10. How would you describe the interactions you’ve had with hospitals and/or obstetricians? Have you found an OB willing to back you? Have you had good/fair/poor experiences with transports?

11. If you could write your ideal midwifery guidelines, ignoring all past/current limitations, how would it read? What would be added or omitted?

12. How would you summarize your view of the body as a midwife?

13. Walk me through a prenatal examination. What about the body will we observe? What will those observations tell us?

14. Describe your primary goal in interacting with a client. What are the means you use to reach that goal?

15. How do you prepare your clients for birth?

16. Can you describe to me how you explain the process of birth to a client?
17. How would you describe your role in the birth event?

18. Describe the birth to me. Besides who is present, who giving instruction, who is receiving instruction? What do you smell and hear?

19. In your opinion as a midwife, what is a successful birth?

20. What type of care needs to be given to a mother and infant after birth?

21. Do you feel that the midwife in Louisiana has the same role as midwives practicing in other states?

22. Could you comment on what you think the future of midwifery in Louisiana will look like? Is that what you feel it should look like?
APPENDIX D
CONSENT FORM

1. Study Title: An Oral History of Changing Practices of Midwifery in Louisiana

2. Performance Site: Louisiana State University and Agricultural and Mechanical College

3. Investigators: The following investigators are available for questions about this study, M-F, 8:00 a.m. - 4:30 p.m.

   Michelle Wydra 578-5942

4. Purpose of the Study: The purpose of this research project is to identify and record how midwives practice in Louisiana, and how the practice has changed in the region since regulation.

5. Subject Inclusion: Midwives who are currently practicing in Louisiana or are retired.

6. Number of subjects: 30

7. Study Procedures: The study will be conducted as an oral interview. A tape recorder will be present, and participants will be asked questions regarding their practice as a midwife in Louisiana.

8. Benefits: This is the first study of Louisiana’s midwives in two decades, and I hope insight will be gained into their role as a healer.

9. Risks: There is minimal risk in this study. If participants are uncomfortable with any questions, they may skip them. Additionally, all tapes and records will be kept confidential by remaining in a locked area with only the principal investigator having access.

10. Right to Refuse: Subjects may choose not to participate or to withdraw from the study at any time.

11. Privacy: Results of the study may be published, but no names or identifying information will be included in the publication. Subject identity will remain confidential unless disclosure is required by law.

12. Signatures:

   The study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to the investigators. If I have questions about subjects' rights or other concerns, I can contact Robert C. Mathews, Institutional Review Board, (225) 578-8692. I agree to participate in the study described above and acknowledge the investigator's obligation to provide me with a signed copy of this consent form.

   Signature of Subject ____________________________ Date ____________________

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VITA

Michelle M. Wydra attended Freedom High School in Bethlehem, Pennsylvania, during which time she also attended the Pennsylvania Governor’s School for Excellence for Health Care. In 2002, she was graduated from the University of Pittsburgh with a Bachelor of Arts in anthropology, a minor in history, and certificates in the following: Conceptual Foundations of Medicine, Latin American Studies, and Russian & East European Studies. She spent the 2000 summer studying in Cuba at the University of Havana, and the 2001 summer studying in Bratislava at Comenius University. After two years of work as a non-profit event planner and also as a translator, she chose to begin graduate study at Louisiana State University. She earned a Master of Arts in anthropology in 2006. In addition to midwifery, her interests include feminist identity, activism, food, community, and tourism. She has presented her research on culinary tourism in New Orleans at the 2005 meeting of the American Anthropological Association and on midwifery at the 2006 meeting of the Society for Applied Anthropology. She hopes to continue researching with an applied focus.