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## Pushing for New Options in Childbirth: A Case Study in Contemporary Integrative Midwifery

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PUSHING FOR NEW OPTIONS IN CHILDBIRTH:  
A CASE STUDY IN CONTEMPORARY INTEGRATIVE MIDWIFERY

By

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A dissertation submitted in partial fulfillment of the requirements for the

Doctor of Philosophy -- Sociology

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May 2015

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is approved in partial fulfillment of the requirements for the degree of

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May 2015

## **ABSTRACT**

Pushing For New Options in Childbirth:  
A Case Study of Contemporary Integrative Midwifery

By:

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Dr. Barbara G. Brents, Examination Committee Chair  
Professor of Sociology  
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In this study, I investigate the concept of “integrative midwifery” in a major metropolitan area in the Southwest United States. Specifically, I look at a group of midwives, doulas, and other birthworkers who have organized into a collective business entity to provide services to pregnant and birthing women. Stemming from a perception that the medical model of maternity care is broken in this country, these practitioners seek to offer alternatives. I draw upon literature regarding complementary and alternative medicine (CAM) which shows that market conditions have created a situation in which alternatives to medical modes of care have become increasingly popular, and many consumers are choosing to use both models simultaneously. While CAM integration is an increasingly documented trend in medicine, few studies have examined the ways in which midwifery is integrating with medical institutions. This study explores the ways that these birthworkers appear to be seeking integration with the medical model which illustrates a larger picture of midwifery as a social movement. Based on a multi-method case study of this alternative birthwork collective, I examine how this group positions itself on a continuum from midwifery to the medical model of maternity care. I further

examine how these workers negotiate that space using boundaries to distinguish themselves from others. I employ the notion of collective identity to understand how these workers validate and sustain their movement participation, and also project an image to the public that reflects their willingness to integrate these normally disparate models.

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## **DEDICATION**

This dissertation is dedicated to the memory of my darling grandmother:

Margery Jane Weaver

Thank you, Nana. Without you, I never could have achieved my dreams.

I love you.

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## CHAPTER ONE: INTRODUCTION

In the 1970's, the women's movement in health inspired women to usurp the control of their physicians in order to become experts on their own healthcare (Ehrenreich and English 1973; Rich 1976; Wertz and Wertz 1986; Benoit 1991; Rushing 1993). This movement empowered women, as informed healthcare consumers, to understand and customize their own childbearing experiences. With a focus on women-centered-care, BY women, FOR women, midwifery was a key player in this social movement. Since that time, and due to the success of these and other consumer movements in health, market conditions have changed. Today, almost every hospital has birthing suites, in which women can labor and subsequently "room-in" with their babies until they go home (Wertz and Wertz 1986). Not only has maternity care come to incorporate many of the elements of the women's health movement, but complementary and alternative medicine (CAM) practices like acupuncture, chiropractic, vitamin therapy, nutrition, and massage have been incorporated to varying degrees into mainstream medical practices (Schacter et al. 1993; Borkan et al. 1994; Baer et al. 1998; Shuval et al. 2002; Goldner 2004; Mizrachi et al. 2005).

Research today is showing that the simultaneous usage of medical and CAM (Hedley 1992; Shuval et al. 2002; Gaffney and Smith 2004; Adams 2006; Tournaire and Theau-Yonneau 2007; Harris et al. 2012), is a pertinent and growing trend in society. Research finds that physicians of the medical model express a "cautious approval" toward CAM therapies for their patients. Rather than expressing a belief in or an acceptance of these therapies, the physicians view them as having a placebo effect, and

allow their patients to “believe in” CAM provided the treatments do no harm (Mizrachi et al. 2005).

Other studies examine how CAM is working within medical institutions, for example, Goldner (2004) finds that when CAM practitioners are able to gain entry into the medicalized space, they are able to reshape these institutions using legitimate channels. On the other hand, Hall et al. (2012) have very different findings. In their study of twenty five midwives who use CAM within the hospital setting, these scholars found that the presence of CAM does very little to change the status quo in these settings.

Shuval and her colleagues (1999) studied the studies the accommodation of CAM practitioners within medicalized spaces and found that while some are accepted, there is still a great deal of monitoring and control on the part of the medical model. These researchers liken this very conditional acceptance to a “Bear Hug” in which the large and powerful “arms” of the medical model encompass CAM, but are still very much in control.

Further, research shows that pregnant women, in particular, commonly utilize CAM services (Hall, Griffiths, and McKenna 2011; Steel et al. 2012), in conjunction with their obstetrical care and express a belief that CAM therapies offer a safe alternative to pharmaceuticals (Holst et al. 2009). Steel and her colleagues (2012) find that midwives are more likely to refer their patients to CAM therapies than obstetricians. Adams and colleagues (2006) attribute this trend to the similarity in orientation between the midwifery model and CAM, in particular that both favor a team-like or collaborative approach to care as opposed to the authoritative tone of the medical model. While CAM

integration is an increasingly documented trend in medicine, few studies have examined the ways in which midwifery is integrating with medical institutions.

Exploring the ways in which midwifery may or may not be seeking integration with the medical model of childbirth illustrates a larger picture of alternative medicine as a social movement. Accordingly, this study examines the current state of midwifery as a social movement, and how it has evolved since its reemergence in the 1970's as a part of the women's movement in health. Furthermore, this study sheds light on the possible future direction of complementary and alternative medicine, of maternity care, and also of midwifery. In this study, I focus on a business organization of birthworkers<sup>1</sup> called The Stork House (TSH). This organization provides pregnancy, birthing, and parenting resources and services to their community including midwifery and doula care, childbirth education, and lactation counseling, alongside a host of classes and workshops on related topics. The individuals who work within this organization refer to themselves as "*affiliates*" and are independent contractors with the business. They describe their mode of treatment as a *Midwifery Model* or as *Women Centered Care*, and differentiate their form of care from that of the *Medical Model*, which many of these respondents find to be patriarchal and condescending. Thus, I find that their practice of birthwork is a sort of response to, or possibly even a resistance of the medical model of maternity care in the United States. Due to their resistance of an established, authoritarian structure in society,

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<sup>1</sup> In this study, I am using the term "*birthworker*" to denote those who work in service to pregnant, birthing, and postpartum women. This term is meant to encompass occupations such as midwife, doula, childbirth educator, and lactation counselor.

I frame these workers as a social movement in their own right, despite the fact that their resistance occurs within the context of a for-profit business entity.

While these workers commonly speak critically about the maternity care in society, the TSH organization actually seeks to build alliances with medical providers and locations in their local *birthing community*<sup>2</sup>. By their own public definition, these alliances are seen to provide clientele with an abundance of choices and options for their care; however, I suspect that there is more to this practice. I also examine the other possible motivations these practitioners may have for integrating with the medical model such as legitimizing their marginalized status and/or matters of financial success.

*The ultimate purpose of this dissertation is to answer the following questions:*

1. How does TSH position themselves IN, AROUND, and AGAINST the mainstream medical model of maternity care?
2. How does TSH position themselves IN, AROUND, and AGAINST the midwifery model of maternity care?
3. How do they negotiate this position as individuals and as an organization?

To address these research questions, I conducted a multi-method case study of the CAM organization, TSH. As a part of this study, I utilized the method of semi-structured, informal, and open-ended interviews that operate more like a “guided conversation”

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<sup>2</sup> For the purposes of this paper, the term “birthing community” is used to represent individuals and institutions commonly understood to assist women in giving birth to their children. For example, in addition to birthworkers, physicians, nurses, along with hospitals and their managerial staffs are all components of the birthing community.

(Lofland and Lofland 1995), in order to better understand the subjective worldview (Charmaz 2002) of my respondents. In all, I interviewed twenty four birthworkers.

Another component of my study is ethnographic in nature as I served as a participant observer in order to glean more information about these practitioners and their interactions with one another. Because of my previous experiences, not only as a researcher of birthwork, but also as a birthworker myself, I was able to gain entry into many different classes, meetings, and events. Guided by these interviews and observations, I examine how this CAM related social movement in birth positions themselves on the continuum between the midwifery and the medical models of maternity care. Specifically, I want to understand how these birthworkers reconcile their holistic orientation with marketing their services to a clientele that wish to simultaneously incorporate these with medically modeled techniques. While these workers have been marginalized by mainstream cultural beliefs and hegemonic views of the medical model, today there is a changing medical landscape in which consumers are looking for alternatives to mainstream medical models. I seek to understand how these birthworkers are negotiating both their resistance to mainstream models and their desire to create a more legitimate public image for their work.

In this study I compare and contrast three models of maternity care: the midwifery model, the medical model, and CAM. The Midwifery Model of Care as we see it in our society today has developed as a result of several social movements of the past: 1. the women's health movement, and 2. the consumer movement in health. The main tenets of this model of care draw from the claims of these previous movements. For example, the midwifery model draws upon the women's health movement in that practitioners seek to

empower their patients to seek out information for themselves (Ehrenreich and English 1973; Rich 1976; Wertz and Wertz 1986; Benoit 1991; Rushing 1993). In their preference of informed patients, midwives and related alternative birthworkers tend to spend more time with their clients explaining and providing references to self-study materials (Bylund 2005; McCourt 2006). Instead of lording over their clients, the midwifery model of care prefers a team approach, where the practitioner is just one part of the decision making process, and sees treatment plans as matters of shared responsibility (Gaffney and Smith 2004; Adams 2006; Tournaire and Theau-Yonneau 2007).

The Medical Model of Care as applied to pregnancy and childbirth draws its mainstream popularity from a legacy of authority enjoyed by medical practitioners in our society for over 150 years. Within this model, physicians are dominant over their patients and have exclusive access to information, treatments, technologies, and institutions (Starr 1982; Quirke and Gaudilliere 2008). Physicians in this powerful position can be seen as agents of social control as they hold this unrestricted access over patients who must obey their directives or possibly risk losing their practitioner (Zola 1972; Segall and Roberts 1980; West 1984; Wu and Perlman 1988). The concept of exclusive information control and authority over one's patients positions the medical model of care at odds with the midwifery model's informed patient and team approach to care.

Another difference in perspective toward the task of caring for the maternal body between the midwifery and the medical models of care is that of the naturalness versus the riskiness of pregnancy and birth. Physicians are trained to seek out any pathology that may be present in the pregnant body, so much so that they are ineffectual when observing

a healthy natural process such as childbirth (Kapsalis 1997). Midwives and other alternative birthworkers, on the other hand, see pregnancy as a natural, normal, and safe rather than a risky part of the cycle of life. The larger issue at work here is a boundary or jurisdictional dispute, or the medicalization of childbirth (Conrad 2007). This dispute marks an historical shift from midwife to physician, home to hospital as the proper practitioner and place for the task of giving birth. This transition is an important part of this study, as it creates a contested boundary in maternal care.

I argue that TSH birthworkers are practitioners of CAM as both respond to consumer calls for returning to nature, focusing on spirituality as well as physical health, and feeling skeptical about pharmaceutical treatments and the authority of the medical model. Sharing many views in common with the midwifery model of care, CAM is attractive to the agentic patient who wishes to educate him/herself, and to participate in formulating and carrying out their own treatments (Gaffney and Smith 2004; Adams et al. 2006; Tournaire and Theau-Yonneau 2007). Many CAM patients utilize CAM services alongside traditional medical services, and some medical providers have cautiously accepted their local CAM practitioners (Gaffney and Smith 2004; Tournaire and Theau-Yonneau 2007). TSH has created some important inroads with medical practitioners in their area, which may be seen as a business tactic, and raises important questions about the level of collegiality and the boundaries between these practitioners whose philosophies are potentially often at odds.

While midwifery is not typically considered a modality of CAM, I characterize the midwifery of TSH as CAM in this study. In order to clarify this thought, I make three distinctions to the practice of midwifery: Traditional, Medical, and Integrative.



Traditional midwifery, or “hands-off” midwifery, is an approach that sees the role of the midwife as very much a background role. Here, midwives are present to witness a birth, and the best births occur with no intervention whatsoever. These midwives refer to the “natural-ness” of the birth experience and espouse essentialist views about women’s intuition – meaning that women’s bodies intuitively “know” how to give birth and are capable of doing so on their own without guidance from outside parties. Traditional midwives express extreme disdain for the medical model of childbirth.

Medical midwifery in this study refers to a form of midwifery that is constructed in the halls of academia with practitioners first securing a bachelors degree in nursing, the Registered Nurse, or R.N. From that point, the credentialed nurse will seek experience on the labor and delivery room floor at hospital and go on to pursue more education in the form of graduate nursing studies. The culmination of this schooling will result in the credential of CNM, or Certified Nurse Midwife, whose resultant work will be performed as an independent deliverer of babies in a hospital setting under the direct supervision of an OB.

In this study, I will show that TSH midwives do not fit into either category, and instead, I refer to them as “integrative midwives.” I position these practitioners as occupying a “third” space between the medical and the traditional models of maternity care in our society. I chose the word *integrative* as the organization, TSH, seeks to *combine* elements of the midwifery model with elements of the medical model. For example, the integrative midwives at TSH have established strong connections with two OB’s in their area to provide backup medical services for their clients. They also include techniques and products of the medical model such as IV’s, pharmaceuticals, and oxygen

masks into their model of patient care. At the same time, these integrative midwives preserve some aspects of traditional midwifery into their practice such as homebirth, waterbirth, and empowerment of patients to seek their own information and participate in their own care, which is reminiscent of the women's movement in health, and as such corresponds with traditional midwifery.

My study is informed by and extends the literature on CAM in a number of important ways. The simultaneous usage of medical and CAM (Hedley 1992; Shuval et al. 2002; Gaffney and Smith 2004; Adams 2006; Tournaire and Theau-Yonneau 2007; Harris et al. 2012), is a pertinent and growing trend in society today. In my study, I extend upon this research by examining how TSH attempts to integrate their organization with that of the medical model in order to answer these consumer calls for simultaneous use of both of these models.

Mizrachi et al. (2005) find that physicians of the medical model, on occasion, express a "cautious approval" toward CAM therapies for their patients. Rather than expressing a belief in or an acceptance of these therapies, the physicians view them as having a placebo effect, and allow their patients to "believe in" CAM provided the treatments do no harm. In this study, I extend upon this literature by interviewing two obstetricians who have collaborated with the TSH Integrative Midwives as back up physicians. In these interviews, I ask questions designed to reveal the nature of the relationships between these providers and TSH to see if these physicians share the reluctance of accepting CAM that Mizrachi's (2005) physicians do. Further, through these interviews, I am able to examine the specific details that govern these physicians' acceptance or rejection of simultaneous CAM and obstetrical maternity care.

## **Chapter Outlines**

Chapter one examines a brief history of the women's health movement and how this has led to a call for women to take control of their own healthcare. Here, I detail the questions that guide my research and provide a basic overview of related literature. Furthermore, this chapter outlines the three models of midwifery I examine in this study: traditional, hands-off midwifery, medical, hospital-based midwifery, and a new form of midwifery which incorporates elements of both of the aforementioned forms which I entitle "Integrative Midwifery."

Chapter two provides an extensive discussion on the background and historical context of western maternity care, and examines the practices and roles of practitioners of this care, both medical and non medical. Furthermore, this chapter examines CAM as a sort of resistance or reaction to the unchecked authority of medical practitioners in our society while shedding light on the ways that consumers gain power through active participation in health related social movements. This chapter ends with an examination of care work and how TSH affiliates may be affected by the long standing gendered nature of this work.

Chapter three details the data collection process and sample criteria and demographics for the study. Furthermore, this chapter examples the qualitative mixed-method design I have utilized, comprised of both interviews and participant observations. I also state my reasoning for choosing TSH and detail the types of events I participated in as a researcher in the study.

In chapter four, I give a background of the history of previous birthwork organizations in the city where TSH exists. I discuss how the TSH organization

developed and detail their changes in location, the services they offer to their clients, and their organizational structure.

In chapter five, I portray TSH as a social movement, and as such, utilize the notion of collective identity, specifically that which is shared among members, to analyze the philosophies that sustain their participation in the movement. For example, I examine the notion of a “sisterhood,” a familial analogy used by TSH affiliates to describe the relationships they foster inside of their group. Furthermore, this chapter examines some of the expectations for affiliate participation in the group.

Chapter six continues to build upon the notion of collective identity, but here, I apply this notion to the identity these workers wish to project to others. A very important component of the externally projected collective identity of this group is that of “informed choice.” These workers seek to project an image of being non-judgmental to portray that they welcome all sorts of women making all sorts of choices. This practice attempts to mainstream midwifery, making it more accessible to mainstream clientele.

Chapter seven the ways that TSH attempt to integrate into the medical model. Here, I examine the ways that these practitioners negotiate their place on the midwifery/medical continuum by drawing boundaries to define who and what they are, and are not. For example, this chapter details the ways that these practitioners differentiate themselves from more traditional, hands-off midwives by including elements of medical practice and building relationships with medical institutions and practitioners.

In chapter eight, I examine the resistance of TSH toward the medical model. Here, I examine practices that cause them to fall closer to the midwifery model on the midwifery/medical continuum of maternal care. For example, I look at the ways they

negotiate the medical/midwifery conflicts between money and love, profit and activism. Taking a social movement perspective, I examine the way that these practitioners frame their dilemmas (Diagnostic framing), what they propose as solutions (Prognostic framing), and, based on this, how they continue to call for action and sustain their movement participation (Motivational framing).

In chapter nine, I explore the ways in which TSH affiliates struggle with the medical institutions utilizing the notion of diagnostic frames (Snow and Benford 2000). Here, I examine how affiliates focus their grievances against the medicalization of childbirth, against hospital policies, and against the unchecked authority of physicians. This chapter also provides counterpoints from my obstetrician respondents detailing their unique set of diagnostic frames.

My final chapter summarizes the primary findings of this study, specifically my answers to the research questions of how TSH positions themselves in, around, and against the mainstream medical model and the midwifery model, and how they negotiate this status. I also detail the implications of a new form of integrative midwifery for the future of CAM, the midwifery model, and the medical model of maternity care. This chapter concludes with a discussion on the limitations of my study and offers suggestions for future research.

## **CHAPTER TWO: LITERATURE REVIEW**

The present inquiry is informed by, and extends upon several distinct bodies of literature. Specifically, I am examining a small group of alternative practitioners of pregnancy and childbirth care (birthworkers) from a symbolic interactionist lens, informed by the sociology of medicine and reproduction, and characterized as a social movement resisting mainstream modes of such care in America, all through a gendered lens of feminist ideology and traditional notions about the roles that women fill in society.

### **Background and Historical Context**

Prior to the middle of the nineteenth century in The United States, childbirth was a social event (Wertz and Wertz 1986). Around the year 1850, U.S. medical schools started producing graduates who wished to claim as many jurisdictions for their profession as possible. One such jurisdiction was that of the midwife. In an attempt to do so, recently graduated medical doctors went out on a smear campaign against midwives, portraying them as dirty, unskilled, and immoral among other salacious assaults on their work and personal character.

This campaign against midwifery was largely successful, and by the early 1900's, it was seen as a statement of class and sophistication for a woman to give birth with the assistance of a medical doctor as opposed to a midwife. This practice has become stronger and stronger over the years since. Currently, it is estimated that 99% (CDC 2012) of American women give birth in the hospital setting, under the supervision and directive of a medical doctor.

Since the first printing of the influential women's health text, "Our Bodies, Ourselves (BWHC 1971)," it has become apparent that a growing constituency of women in The United States has become disenchanted with what they see as a paternalistic medical model. They argue that women must seek their own information about their bodies and share that information with other women. They argue that the mainstream medical model takes an omniscient view, wresting control over one's own body away from the individual. They see the medical model of women's health care as paternalistic, condescending, and dehumanizing.

Stemming from these notions, a constituent of women from across The United States has formed in order to advocate for a more fully informed, involved, and agentic patient. Out of this group has emerged an occupational group, birthworkers, who serve other women in addition to or as an alternative to the mainstream medical model of maternal care in the United States. Due to common and dearly held cultural perceptions of childbirth as extremely painful and inherently dangerous, the United States as a society largely sees the medical management of birth as most appropriate. Thus, birthworkers status as alternatives to the medical model places them in a marginalized or even radical position, making it difficult for them to do their work unchallenged by both medical professionals and family and friends of the pregnant/birthing woman who chooses their services.

Since the early twentieth century in the United States, obstetricians have largely been dominant in the care and delivery of pregnant women. Their authority over this practice was gained through their efforts at professionalization of their work, and also through a successful smear campaign against midwives as dirty and unskilled.

Additionally, as technology and science made advances in the medical area, popularity of the hospital grew in general, making physicians an important and desirable authority figure.

This study focuses on a particular organization in a major metropolitan area in the southwest United States, The Stork House (TSH). This organization is comprised of over 20 women, referred to as “*affiliates*”, who occupy various positions providing services related to pregnancy and childbirth. For example, two of the TSH affiliates in this study are midwives, or specialists who monitor a pregnancy, screening for risk factors, and in the absence of these, will deliver the child in the home of the mother when labor comes. Fourteen of the TSH affiliates in this study serve as doulas, or specialists who assist women throughout their pregnancies with information and planning for the birth event, and then assist in labor with physical and emotional comfort measures. One of midwives at TSH also serves as a monitrice, or an advanced doula, who also has some medical training. A monitrice can provide services such as taking blood pressure, checking for dilation, and listening to fetal heartbeats for a woman laboring at home, allowing her to stay home as long as possible before going to the hospital. Furthermore, a number of TSH affiliates are Childbirth Educators (CBE’s) who teach courses to women and their partners as they prepare for childbirth. TSH also provides lactation services to breastfeeding mothers through the assistance of the affiliates known as Certified Lactation Counselors (CLC). Affiliates’ participation in TSH is organized on an independent contractor basis, and there are many of their duties for which affiliates serve as volunteers. Although, TSH is officially defined as a business, this organization also



can be defined as a social movement due to their resistance against cultural hegemony and their will to create change in the social order.

In the following section, I will first give a description of the three main types of birthworker that I include in this study. These paragraphs will detail the job description for each occupation, and then provide a short overview of some of the major research conclusions concerning each. Although there are a few other distinct types of birthworker I include in the study, these paragraphs describe the work of the majority of my respondents.

### **Birthworkers in the Literature:**

#### ***Midwives***

A midwife is a woman who provides prenatal care and delivers babies. For this paper, I interviewed four midwives, two of whom work within The Stork House (TSH) and two who are independent. Interestingly, all of these women have, in their training, been an apprentice of one of the others. In this study, I focus on the lay midwife who is not a part of the medical model and does not deliver babies in the hospital.

There are a number of paths to become a midwife. Some midwives, Certified Nurse Midwives (CNM) serve as registered nurses first and then pursue an additional specialty in nurse-midwifery. Another form is the “lay midwife,” or more specifically, a Direct Entry Midwife (DEM), who learns their trade through an apprenticeship model, combined with correspondence or self study. Another designation of lay midwife is found in the Certified Professional Midwife (CPM), who also learns through self study, apprenticeship, and/or correspondence but further must pass an examination administered

by the North American Registry of Midwives (NARM). All four midwives who participated in this study are CPM's, although one of them has served as a CNM as well. CNM's commonly work in hospitals and birthing centers under the supervision of obstetricians and are legal to practice in all states, while DEM's and CPM's typically deliver babies at home, and are not legal to practice in all states.

Midwifery care serves an alternative to obstetrics and the medical management of pregnancy and birth (Davis-Floyd 1994). Many women are currently choosing the services of midwives over obstetricians as they feel that midwives favor a relationship of shared responsibility with their prenatal care over the mainstream model of a passive patient, dependent upon one's obstetrician (Ehrenreich and English 1973, Wertz and Wertz 1986, Zadoroznyj 2001). Furthermore, like other practitioners of Complementary and Alternative Medicine (CAM) studies have shown that midwives spend more time with their patients, conversing, informing, and explaining choices in maternity care (Bylund 2005; McCourt 2006). Midwives also tend to take great care in establishing boundaries which clearly demarcate their services from those of the medical model (Foley 2005). Meanwhile, however, due to the salience of medical discourse on childbirth, midwives and other birthworkers must become particularly well-versed in scientific and medical language as a part of their quest for legitimacy (Rushing 1993; Foley and Faircloth 2003,).

In this study, I examine the roles of midwives and more specifically, those belonging to the TSH organization, to see how they position themselves in, around, and against both the midwifery and the medical models of care. A part of this is done by examining their method of patient care to see how it compares with the shared

responsibility perspective as proposed by Erhenreich and English (1973), Wertz and Wertz (1986), and Zadoroznyj (2001) I also enquire as to their boundaries, like those so important to Foley's (2005) midwives, which they draw around themselves and their practice, to distinguish their form of care from that of others. In addition, I seek to build upon Foley's work by examining the boundaries in their relationships with other birthworkers to see if these are collegial or competitive. Furthermore, I will explore the extent to which these women have adopted medical discourse into their practice, as suggested by Rushing's (1993), and by Foley and Faircloth's (2003) works about the midwife's quest for legitimacy.

### *Doulas*

A doula is a woman who is trained to provide physical and emotional support to pregnant and birthing women. In this study, I have interviewed sixteen women trained as doulas, twelve of whom work as affiliates with TSH, one who is independent, and one who is no longer practicing. Furthermore, I have been trained and have worked as a doula myself in the past. Due to the fact that the majority of my respondents work in this role, and further because doulas serve in the capacity of bridging the gap between the medical and the midwifery models of care, doulas are a large focal point in this study.

Doulas usually begin their work with a woman during her pregnancy, at which point the doula will provide information to the mother about her body throughout the course of pregnancy and childbirth. Doulas are trained to understand the common issues that arise during pregnancy and to help mothers to navigate these. Further, doulas are typically well versed in hospital protocol and common interventions that a woman might expect during labor. Doulas help women to think about these items and construct an

individualized birthplan with the mother. During the labor, doulas attempt to empower women to ask for what they want. Doulas also commonly provide support to partners or spouses of the laboring women and help them to be involved in the birthing experience.

Doula work is a marginalized job which occupies a precarious space between alternative childbirth models and the medical birthing community. Doulas are often seen as an alternative to the technological management of birth, and as such are often placed in opposition to Western medicine (Foley and Faircloth 2003). According to Van Zandt and colleagues, “Doula care is a low-tech complementary intervention usually provided in a high-tech environment. (2005:159).” A doula provides information, translation of medical jargon, advocacy, comfort, and other assistance for women in childbirth (Morton 2002; Meltzer 2004; Block 2008).

Doulas often perform their work within hospitals, in the domain of physicians and nurses. Due to the recognized expertise of these individuals and institutions, the embedded hierarchy within the relationships between doulas and hospital staff explicitly shapes the nature of the professional and personal interactions between them. As laypersons, doulas have no inherent rights to be in the birth room, and are in all actuality guests of the patient (Block 2008). The doula’s ability to advocate for her clients relies in large part on her ability to gain the respect of the nurses and doctors in the hospital setting (Hodnett and Osborn 1989; Gilliland 1998). Thus, doula work is significant because it is inherently political and wrought with conflict.

Currently, due to cost constraints, clinical duties, staffing issues, and client overload, nurses are less able than ever to provide continuous one-on-one socio-emotional care to laboring women (Scott et al. 1999; Van Zandt 2005; Block

2008). While it is true that some hospital staff view the doula as an asset as she helps to perform many of their tasks and keeps the birthing family calm (Wertz and Wertz 1986; Gilliland 1998), many nurses may feel threatened by the doula and feel as though their territory has been invaded (Mainord 1997; Schwartz 2002; Adams and Bianchi 2004; Papagni and Buckner 2006). Accordingly, doulas are often treading on potentially hostile ground when entering the hospital and may expect to be ill received due to negative pre-conceived notions on part of the hospital staff. Doulas must present themselves in such a way as to prove themselves to be helpful associates and not derisive adversaries.

The role of the doula in the birthing room is markedly different from that of the doctor, midwife, or nurse. As opposed to performing medical care, a doula is focused on the social, emotional, and spiritual needs of the mother during the birthing process. In addition, doulas may act as intermediaries in communicating the mother's wishes to the hospital staff. This most important doula function, serving as advocate to their client (Campero 1998; Hodnett 2007; Block 2008), is also one of the most challenging in terms of social interactions as well as the balance of power.

In this conflictual role, a doula must act as an intermediary strategically advocating for her client's wishes while maintaining a positive impression with hospital staff (Meltzer 2004; Breedlove 2005). This can be a daunting task as many women who choose doula care also choose a less medicalized birth, placing doulas in a position contrary to that of hospital protocol. In these situations, the stakes are quite high for the doula who must cautiously act in concert with her client first, theoretically, while simultaneously acting to maximize her potential for repeated and positive interactions with the medical birthing community.

In this study, I examine the marginalized role of the doula in the potentially conflictual hospital setting. Building upon the work of Gilliland (1998), and Hodnett and Osborn (1989), I examine if/how the TSH doulas are able to gain respect in the hospital setting. Because of the established relationships and reputation of TSH with medical practitioners and spaces, I find the role of their doulas to be particularly unique. For example, I wish to discover whether hospital staff see TSH doulas as an asset (Wertz and Wertz 1986; Gilliland 1998) or as a threat (Mainord 1997; Schwartz 2002; Adams and Bianchi 2004; Papagni and Buckner 2006). In this study, I build upon the notion of advocacy as a doula's most challenging, yet most important role as stated by Block (2008), Campero et al. (1998), and Hodnett et al. (2007), and seek to discover the role of the established business relationships between TSH and the medical model in fostering these interactions.

### ***Childbirth Educators***

There are many types of childbirth education (CBE), from privately hired, trademarked styles such as The Bradley Method™, HypnoBirthing™, and Lamaze™ to more condensed, efficiently taught styles such as several hour workshops provided in hospitals to expecting parents. In this study, I interviewed four women who currently teach private childbirth education classes in connection with and at the physical location of TSH. Two of these women are teaching classes that they created themselves, while one teaches a national Christian-based course and the other teaches the international HypnoBirthing™ method.

Literature suggests that there are marked differences between private classes and those provided by hospitals. For example, one study of these two distinct camps of CBE

finds that hospital based CBE familiarizes patients with protocols and procedures to ensure awareness and compliance, while private CBE encourages self-advocacy, and decision making and participation from the patient (Sargent and Stark 1989). In this study, hospital educators stated that the hospital was in control the content of the class, and despite any misgivings these women had about the information presented, they taught it anyway in order to keep their job. While the hospital instructors saw their purpose as one of familiarizing parents with hospital policy, the private educators saw their classes as informing parents on options, promoting the asking of questions in the labor room, and increasing parental confidence.

A similar finding was presented by Armstrong (2000), who found that hospital-sponsored CBE serves institutional interests more so than serving the interests of the mothers and families who attend them. Meanwhile, however, these classes are presented to the public as being in the patients' best interests. Armstrong further traces the emergence of the out-of-hospital, private modalities of CBE as arising in response to a perceived over-medicalization of childbirth. These models surfaced in the 60's and 70's, alongside women's and consumerist movements in health seeking to stray from the immense authority of the medical model and its physicians, in order to put power of choice over one's health and body into the hands of the individual.

Despite the many options available to expectant mothers, recent research illustrates a decline in the number of women in attendance at CBE classes (Declercq et al. 2006). Most healthcare systems in The United States widely accept and even prescribe CBE as an important part of the pregnancy and childbirth experience. By becoming widely accepted, childbirth educators have been able to reach a larger number of women

and have a positive impact in their lives. However, when employed by hospitals, childbirth educators become less effective at promoting parental self-advocacy in favor of furthering institution-specific goals (League and Novelli 1994; Goings 1995; Sargent and Stark 1989; Armstrong 2000).

Because TSH CBE's are operating out of a holistically minded business while simultaneously serving many clients who will deliver in the hospital setting, I am interested in understanding how these women position themselves and their work on a continuum of medical to midwifery models of care. I wish to examine if these educators' philosophies are at odds with the medical model as suggested by Armstrong (2000), and if so, how they reconcile these with an organizational imperative to develop and maintain positive relationships with these practitioners.

### ***Complementary Roles***

At times there are feelings of animosity between doulas and nurses. This is due in part to differences in philosophy regarding the appropriate forms of care and intervention for laboring women. Because TSH seeks to develop harmonious relationships between its doulas and the members of the medical model with whom they often interact, it is important to consider the literature on complementary roles.

In the past, nurses were known for, and took pride in their bedside manner, while the current organization of healthcare leaves little to no time for that one-on-one care (Scott et al. 1999; Van Zandt 2005; Mizrahi, Shuval, and Gross 2005; Block 2008). Meanwhile, doulas, for example, are completely focused on providing that care. Some nurses may see this as a benefit (Wertz and Wertz 1986; Gilliland 1998), and some might feel threatened (Mainord 1997; Schwartz 2002; Gilliland 2002; Adams and Bianchi 2004;



Papagni and Buckner 2006), especially since the ideology behind the care of these two providers can be at odds.

As an alternative to these feelings of animosity, there is literature that shows positive results from collaboration between health and social care professions that contend that such efforts would make the best use of scarce resources, reduce overlapping duties, and better address the intricate needs of patients (Reeves 2000). For example, the roles of nurses and doulas are sometimes seen as complimentary to one another as the two could feasibly operate as co-members in the birthing team (Gilliland 2002; Adams and Bianchi 2004; Ballen and Fulcher 2006). Gilliland (2002) suggests that the knowledge each of these birthworkers brings to the labor and delivery room are in fact complimentary. For instance, the doula has the advantage of a developed relationship with the mother, and has insider knowledge about this woman's dreams and fears regarding her birthing experience. Meanwhile, the nurse has the advantage of knowing about the facility, its policies, and the particular behaviors and attitudes of the physician. By working together, armed with these bodies of knowledge, doulas and nurses can provide an optimal experience for the laboring woman.

In this study, I apply the ideas proposed by Gilliland (2002) regarding the possibly complimentary roles of nurses and doulas in the labor and delivery room to the philosophies and practices of TSH doulas. I ask questions of my doula respondents to determine the nature of their relationships within the hospital setting, and explore their techniques for building and maintaining these associations. I further investigate if/how TSH doulas use their relationships with medical staff to appeal to prospective clientele.

## **Complementary and Alternative Medicine**

While most research does not frame midwifery as a modality of complementary and alternative medicine, I position the TSH organization and its unique form of midwifery as CAM. By unique, I mean to say that TSH's midwifery straddles the fence between traditional midwifery and the medical model of maternity care. As a CAM organization, TSH brings a wide variety of services together to meet the needs of a particular group of consumers. Furthermore, because this organization offers so many classes, workshops, and services that are either complementary or even alternative to mainstream models of maternity care in the United States, I see this characterization to be appropriate. Doulas, herbalists, and massage therapists are commonly referred to in CAM literature, and are also a large part of TSH. Thus, it is imperative to review the literature on CAM as it plays a large role in this study.

This large body of literature examines alternative models of therapeutic care that are often placed in opposition to the dominant medical model in the United States today. A number of researchers in this area state that there is a lack of consensus in defining exactly what constitutes Complementary and Alternative Medicine (CAM) (Fadlon 2005; Frass et al. 2012). To combine a number of working definitions, one could say that CAM is a set of therapeutic practices that are offered as an alternative to conventional medicine (Mizrachi et al. 2005), that these practices exist outside of conventional medicine (Hall, Griffiths, and McKenna 2011, Tournaire and Theau-Yonneau 2007) due to the lack of proof of their effectiveness and/or safety (Su and Li 2011).

According to Fadlon, the terminology associated with CAM is a "charged issue (2005:1)" in both research and daily usage. She finds the word *complimentary* to be

problematic as it seems to refer to these practitioners as wishing to “join up” with the medical model who would, at the same time, seek to co-opt these therapies for their market value. Further, she finds the term *alternative* to describe a radical situation in which these practitioners see themselves as replacing the medical model due to its shortcomings. In her work, Fadlon chooses to replace CAM with NCM, or Non-Conventional Medicine, which she sees as a neutral way to describe these therapies that are not a part of Western science.

Cant and Sharma (1999) see alternative therapies as gaining popularity beginning in the 1970’s. Since then, these therapies have experienced immense growth in use and popularity, and the number of alternative practitioners is also growing expansively. Alternative treatments are being utilized by consumers more and more often (Launso 1989; Cant and Calnan 1991; Eisenberg et al. 1993; Fulder 1996; Vincent and Furnham 1996), and scholars predict that we should expect to see this trend continue in the coming years (Coulter and Willis 2007).

Literature on CAM suggests that the most typical client for these practitioners is a middle-aged female who is high in educational attainment and income (Adams et al. 2009; Hall, Griffiths, and McKenna 2011; Frass et al. 2012). These patients share some characteristics in common such as being active patients who wish to participate in their treatment (Gaffney and Smith 2004; Adams et al. 2006; Tournaire and Theau-Yonneau 2007), they also tend to be committed to environmental causes, spirituality, and a love of the foreign or exotic (Frass et al. 2012), and many patients use CAM simultaneously with medical models as they see fit (Gaffney and Smith 2004; Tournaire and Theau-Yonneau 2007).

Pregnant women are large consumers of CAM services (Hall, Griffiths, and McKenna 2011; Steel et al. 2012). Research finds that many pregnant women utilize CAM services alongside their medically modeled maternity care and believe that these therapies offer a safe alternative to pharmaceuticals (Holst et al. 2009). Research shows that the most common CAM modalities used during pregnancy include massage and chiropractic services, vitamin, mineral and herbal supplements, hydrotherapy; meaning laboring or even giving birth in water for pain relief, and also aromatherapy, yoga, and other relaxation techniques (Gaffney and Smith 2004; Tournaire and Theau-Yonneau 2007). Furthermore, Steel and her colleagues (2012) find that midwives are more likely to refer their patients to CAM therapies than obstetricians. This may be due in part to the fact that CAM shares a similar orientation toward client participation and empowerment with the midwifery model more so than the authoritative tone of physician care (Adams et al. 2006).

Some research argues that these increases in popularity may be due to the widespread disillusionment with the medical model of care (Mizrachi et al. 2005), although many patients use both models simultaneously, according to what they see as most fitting to their particular needs, and to supplement rather than replace traditional care (Hedley 1992; Shuval, Mizrachi, and Smetannikov 2002; Gaffney and Smith 2004; Harris et al. 2012).

There are numerous critiques of the medical model inherent in CAM, among them a critique of the incredibly high costs of medical care, the tight control over medical knowledge, the insistence on dominance of the medical professional over the patient, and the ignorance of social factors as causes of disease (McKee 1988; Lupton 2003).

Research shows that patients will utilize CAM for a diversity of reasons. For example, some patients choose CAM practitioners because they want to be more involved with their course of therapy (Tournaire and Theau-Yonneau 2007), which is a characteristic approach of these methods: building a healthcare “team” between practitioners and patients. Other patients use CAM for the purposes of illness prevention or health promotion, or because they see it to be more in line with their own personal philosophies (Harris et al. 2012). Still others use CAM because its philosophies are more in line with holism (Gaffney and Smith 2004), or because they see CAM as a way to restore control to themselves as patients instead of submitting to physician authority (Adams 2006; Adams et al. 2009).

The increase in use of alternative models is further evidenced by increase in regulation (Coulter and Willis 2007). In October of 1998, the National Institutes For Health established the National Center for Complementary and Integrative Health (NCCIH). The mission statement of this agency reads as follows: “*The mission of NCCIH is to define, through rigorous scientific investigation, the usefulness and safety of complementary and alternative medicine interventions and their roles in improving health and health care.*” (<https://nccih.nih.gov/about/ataglance>) The operating budget for NCCIH was \$123.8 Million in 2013, and the agency employs approximately 65 full time employees. The agency boasts a strong research agenda and opportunities for grants and funding. They do not refer the public to particular providers, nor do they endorse any corporate or other organizational interests.

There is some degree of cooptation of alternative methods within the medical profession (Baer et al. 1998; Shuval et al. 2002), although some members of the medical

model still refuse to accept these practitioners (Goldner 2004). When traditional medical providers do refer to CAM practitioners, which has become a more frequent trend (Schacter et al. 1993; Borkan et al. 1994), they express what Mizrachi and his colleagues (2005) refer to as “cautious approval” of these therapies. This equates to a non-committal endorsement from the medical model for alternative therapies which does not acknowledge them as useful, but more so of having a placebo effect, and allows patients to “believe in” these therapies providing they do no harm to the patient. For physicians, the effectiveness of CAM is about belief systems, and not about scientific facts or medical effectiveness. As popularity has increased, however, these methods and models are being included in medical schools teachings (Coulter and Willis 2007; Frass et al. 2012).

Shuval and her colleagues (2002) found that sometimes, alternative practitioners are able to gain entry to hospitals, though usually through informal rather than bureaucratic means. If alternative practitioners *are* included, they must cooperate with the overarching medical institution (Goldner 2004). Even when practitioners are able to practice within larger institution, they remain marginal as compared to other hospital staff, and this marginal status is reflected in a number of structural and symbolic ways (Shuval et al. 2002). For example, a study in Israel found that when medical model practitioners entered the room, CAM practitioners literally moved aside from the patient in an act of deference (Mizrachi et al. 2005). Some research claims that when CAM practitioners are able to gain incorporation into the medical model, they are able to reshape formal organizations using legitimate channels (Shuval et al. 2002; Goldner

2004). Meanwhile, Hall, Griffiths, and McKenna (2012) find that the availability of CAM does very little to change the status quo within the medical institution.

There are many arguments in favor of collaboration or integration between CAM and medical practitioners. A part of this stems from the fact that healthcare is now customer driven as a result of historical consumer movements in health. In their study, Mizrachi and his colleagues (2005) traced the entry of an alternative clinic into a hospital in Tel Aviv. They found that it was market factors that first urged this collaboration in 1991, and stated that hospitals that have similar clinics are aware of the growing demand for such collaborations. Facilities such as this use these collaborations to their advantage by advertising their presence in order to attract new patients.

While these collaborations between CAM and medical models of care can be useful to clientele, these unions have mixed results for the practitioners themselves. Shuval and her colleagues found a “dual process of simultaneous acceptance and marginalization (2002:1745)” for CAM practitioners in medical spaces. Here, the CAM practitioner trades some of their holistic orientation and also take a cut in pay for the benefits of working in a prestigious medical space. Meanwhile, she finds that the medical practitioners who collaborate with CAM practitioners lose some of their prestige as they interact with unsympathetic or even hostile non-believers amongst their colleagues (Shuval 2002). While many of their medical colleagues do not understand their CAM modalities, Mizrachi’s (2005) study found that physicians felt respectful and supportive of their CAM associates.

Alternative practitioners commonly use boundary work in comparing and contrasting themselves with the dominant and hegemonic medical institutions with which

they must work (Foley and Faircloth 2003; Foley 2005). Practitioners of alternative medicine commonly differentiate themselves from medical professionals in a number of ways. These lines of demarcation are a very important part of the identity creation and maintenance of alternative practitioners, as they forge a path for themselves into a sometimes hostile territory.

One way CAM differentiates itself from the medical model is by rejecting the Cartesian mind/body dichotomy (Scott 1999), instead arguing that a holistic approach is more appropriate. In fact, most CAM practitioners condemn the mainstream medical model for lack of holistic care and intrusive measures (Gevitz 1988). CAM practitioners claim to spend more time with their patients than do medical doctors, discussing all aspects of their patients' lives as opposed to simply discussing illness symptoms (Bakx 1991). These boundary demarcations build a different type of relationship with the patient, which is more likened to a "team" than the traditional physician/ patient relationship. In fact, CAM prefers an active/agentive patient who takes responsibility for their own care, unlike the passive and submissive patient preferred within functionalist medicine (Berliner and Salmon 1980; Fulder 1998; Lupton 2003).

Another boundary technique that is used by CAM practitioners is that of Isomorphism. This occurs when a marginalized entity seeks to gain legitimacy in an organization, and begins to emulate the practices and behaviors of those in power (Powell and DiMaggio 1983). According to Mizrachi and colleagues (2005), CAM practitioners seeking entry into medical settings will imitate the style of dress, the language, the furnishings and décor, and the practices of medical professionals. These researchers concede the irony of these situations is that by behaving isomorphically, the alternative



practitioner often contradicts the fundamental premises of their otherwise non-invasive, holistic, team-like approach to patients and their conditions.

There are a number of critiques in the literature on CAM as well, pointing towards an overstated nature of the boundary demarcations touted by the practitioners. For example, CAM practitioners (not unlike their medical model alternates) control access to information through the professionalization process, thereby reaffirming inequalities by lording over their patients (Scott 1999). In this critique, all things are not as equal in the practitioner/client relationship as they may have been made to seem.

Another critique stems from political economic theories and states that CAM offers no political critique, and ignores structural impediments (such as SES) to care (McKee 1988). It is commonly acknowledged that most health insurance providers do not fund nor reimburse for alternative treatments (Frass et al. 2012) thus, CAM relies upon private paying clients, and does very little to help those of lower socioeconomic classes. Lupton argues that alternative models may even be “more insidious because they overtly offer an alternative...while covertly legitimizing social inequality (2003:139).”

Further, some scholars argue that the growth and success of CAM is exaggerated or misrepresented in form. Saks (1994), for example, argues that there is insufficient evidence to show that CAM is as effective as practitioners claim in undermining the authority of the mainstream medical model. Similarly, Coulter and Willis (2007) claim that any decrease in the dominance and authority of the mainstream medical model is simply a product of societal changes such as the consumer movement in health and back-to-nature, “green” trends, and is not based upon the supremacy of CAM itself.

Regardless of their detractors, the popularity and usage of these models is deeply entrenched in the studied society. Still, while there is resistance from mainstream models of care, it seems that there may be enough adherents to CAM to preserve and possibly even further its momentum. In fact, some supporters are so enthusiastic as to make CAM a large part of their lives that many scholars claim that these models are turning into identity or new social movements associated with a healthy lifestyle consciousness (Goldstein 1999; Kelleher 2001; Goldner 2004).

The overarching question that I seek to answer guided by this literature is where TSH affiliates position themselves within complementary and alternative medicine. To be more specific, I examine which tenets of CAM are most salient in the TSH provision of maternity care. For example, being active patients who wish to participate in their treatment, (Gaffney and Smith 2004; Adams 2006; Tournaire and Theau-Yonneau 2007) or working with women who are committed to environmental causes, spirituality, and the love of things foreign or exotic (Frass et al. 2012). I am also interested in examining if TSH clients are exclusive to their unique form of CAM or if they typically utilize this simultaneously with medical models (Hedley 1992; Shuval et al. 2002; Gaffney and Smith 2004; Adams 2006; Tournaire and Theau-Yonneau 2007; Harris et al. 2012).

Furthermore, with my two physician respondents, I examine the degree of co-optation of alternative methods such as midwifery, doula care, herbalism, and massage therapy within their practice, and further, how they view TSH's form of CAM for their patients (Baer 1998, Shuval et al. 2002). I also seek to understand if these men, like the medical professionals in other studies, express cautious approval of CAM or view it as a

belief system, or perhaps even see it as having placebo effects (Mizrachi et al. 2005).

Since TSH has been accepted to some extent in the hospital setting through informal channels, I am interested in seeing how they cooperate with the overarching medical institutions as suggested by Goldner (2004). Here, I wish to explore if they are able to reshape formal organizations by using legitimate channels (Mizrachi and Smetannikov 2002; Goldner 2004), or if their presence does very little to change the status quo, and they remain marginalized (Hall et al. 2012).

A very important area for CAM practitioners of all sorts who work with medical model professionals is that of boundaries. For example, Foley's midwives (2005) use boundaries to compare and contrast themselves and their practice from those of the medical institutions with which they must work. Boundaries are a very important part of the identity of alternative practitioners, and in the study I seek to understand how TSH draws boundaries around themselves, the medical model, and also their clients. I also seek to understand the role of isomorphism and how it operates within TSH. Specifically, I wish to see if and how TSH imitates the medical model in order to gain legitimacy (Mizrachi et al. 2005).

### **Biomedicine and Physician Authority**

I will now turn to the pertinent literature on Biomedicine and Physician Authority as these concepts underpin the feelings of resistance of the birthworker movement. By examining the main beliefs of this strong, powerful, and ultimately successful system of care and the accepted authority of its practitioners, we can come to understand the

arguments that frame the resistance of birthworkers to this type of care. This is not to say that all birthworkers completely reject these practitioners or philosophies, but rather to state that there are issues here that many of these workers are taking a stand against, or at least wishing to question or modify.

According to Engle, the biomedical model has been reigning paradigm in medical science and practice since the 17th century (1992), and defines health as the absence of disease or pain. The biomedical model of care stems from the enlightenment philosophies of the elevation of scientific knowledge and sets the stage for the rise of doctors as an authoritative class. In this paradigm, it is the rightful place of the doctor to objectively diagnose health conditions without regard for the patient's subjective opinion or experience.

According to Davis-Floyd (1988), biomedical knowledge is based on "the principle of separation" - meaning that biomedicine presupposes the separateness of bodily and illness categories, and prefers to examine various phenomenon as detached. Biomedicine, unlike other healthcare philosophies such as the biopsychosocial model, sees the patient as separate from his or her environment and society, and further delineates between the mind and the body of the patient. Furthermore, biomedicine causes separation between the phases of treatment, alongside of jurisdictional separations in the form of specialization.

Paul Starr (1982) states the shift to biomedicine as the dominant form of care has been the catalyst for the professionalization and specialization of medicine and nursing. This shift occurred in the 19<sup>th</sup> century when significant linkages between laboratories and hospitals and the notion of public health developed due to new discoveries in

bacteriology, diagnosis, and treatment of diseases (Quirke and Gaudilliere 2008). Furthermore, the emphasis placed on diagnosis within biomedicine paved the way for the creation of the allied health professions, new scientific technological and pharmaceutical interventions, and new social forms such as the hospital, clinic, and private medical practice spaces. All of these specializations can be seen to encompass the Biomedical Technical Service Complex Incorporated, a dramatic shift in the organization and practice of contemporary biomedicine due to techno-scientific innovations (Clarke et al. 2003).

Within biomedicine, bodies are seen as analogous to machines, and the proper focus is one of screening and diagnosis by specialized practitioners. There is also an intensive focus on scientific information and the development and use of evermore sophisticated technology, which cause Davis-Floyd (1988) to describe biomedicine as the “technocratic model of medicine.” With the biomedical emphasis on pathology and aggressively technological treatments, its doctors are unfamiliar with healthy bodies. This creates a situation where doctors’ minds are trained to be vigilant to pathology, such that they are ineffectual when observing a natural and healthy process, such as childbirth, for example (Kapsalis 1997).

Gaines and Hahn (1985) characterize biomedicine as a socio-cultural system with a consistent and complex set of internal belief rules and practices. Many social scientists see these beliefs, rules, and practices to be focused around the notion of power in a Foucauldian sense. His notion of “biopower” (1973; 1977) informs such scholars in the sense that powerful people can remain in control by getting their subordinates to

internalize core disciplinary procedures. Once this is done properly, populations will control themselves based on the directives of those known to have power.

In biomedicalized society, medical professionals have a great deal of power. They occupy a space of respected authority. In general, most people respect the expertise of their doctors and, to some extent, will follow their recommendations. Medical professionals are said to have social control in the sense that they control access to technologies, medications, and institutions of health. Furthermore, medical social control extends to expanding definitions of what is relevant to the practice of medicine, and absolute and unquestioned access to taboo subjects and areas of the body (Zola 1972).

The sociohistoric context of the physician's dominance is rather recent, in fact. In the 18th and 19th centuries doctors were not regarded as professionals – "every man his own doctor" was one of the slogans of the time (Ehrenreich and English 1973). However, by the 1900s, medical doctors had virtually dominated the health care field. As the first medical school graduates began to practice specialties such as obstetrics in the mid 1800's in America, they dominated midwives who had been practicing since the beginning of the development of The United States (Wertz and Wertz 1986). This is but one area in which the authority of medicine dominated previous ways of caring for the body and its functions.

The role of "doctor" was the epitome of a professional in Goode's (1960) research on such lofty occupations. Professions stand apart and indeed above other types of work as they are seen as more respectable and important. This professional dominance enjoyed by physicians is one in which they are licensed, yet self-regulating (Wolinsky 1993) and free of lay evaluation. While there is a general recognition among doctors that honest

errors do exist in medical practice, and that all physicians make them (Bosk 1979), the legislation of a profession is shaped by the professionals themselves, in this case, with the peer review.

Friedson (1970) argues that the dominance of the the physician's profession comes from the extensive control of medical profession over laws, practice, financing, autonomy, and prestige of its own members. This dominance is maintained by the notion that many members of the public are convinced of the authority of the physician, in some cases, even respecting this authority more than religion or law (Zola 1972). This is one way in which physicians are agents of social control, dictating and deciphering the norms of health and illness for their host population.

Another area in which physicians hold control over their patients is found in their ability to control information. For example, some doctors think of their patients as medically ignorant and unable to understand the cause of their disease (Segall and Roberts 1980). Others do not discuss their rationale with their patients (Wu and Perlman 1988), and in fact may become irritated when patients press for more information on diagnoses or prognoses (West 1984). In fact, other studies have shown that some physicians control interactions through dominance in language, using such devices as interruption and diminutive speech (Todd 1981; West 1984) Further, the maintenance of tight controls over medical jargon and information serves as a protective device in managing medical mistakes (Millman 1976). All of these controls are subsiding; however, as the information revolution places medical knowledge more at the hands of consumers than ever before (Hardey 1999).

There are other areas, too, where physicians are losing their omniscient professional power over the people, and especially in recent times, with rise of the agentic patient. For example, patients can and often do choose which doctors they see and then go on to discuss these choices with others, leading to a situation in which there are lay controls over the profession (Friedson 1960). And, furthermore, instead of quietly staying in an uncomfortable relationship with one's doctor, as a result of the consumerist movements in health, many patients will terminate their relationship with their current physician and shop for a new one (Hayes-Bautista 1976), instead looking for a relationship with trust, satisfaction, and participation in decision-making (Stepanikova et al. 2006).

According to Light (1991), there are a number of related institutions within society which serve to balance unchecked power of medical model such as governmental interference, alternative providers, consumer advocacy groups, and corporate purchasers and sellers. These "countervailing powers" all exist in a constant power struggle with medical profession (Hafferty and Light 1995), such that there is no longer complete control of physicians (Light 2000). All of these outside influences have a collectively immense impact on the autonomy and power of the medical model more generally.

Ritzer and Walczak (1988) use the term "deprofessionalization of physicians" to refer to the loss of complete autonomy and control over one's clients. Literature suggests that increased consumerism is an important factor in this shift (Haug 1973). For example, patients are increasingly well-informed, assertive, and taking initiative with their own healthcare, due in part to an ever deepening loss of confidence in the medical profession. These agentic patients seeking second opinions and/or more in depth knowledge of



his/her own conditions serves to reduce the monopoly over medical knowledge and therefore physician autonomy.

A final aspect in the loss of physician autonomy is found in the corporatization of medicine expressed in the aforementioned Biomedical Technical Service Complex Incorporated (Clarke et al. 2003), or dramatic changes in medical care in the United States coming out of the 1980's. In order to run the institution of medicine in a more business-like fashion, cutting costs and enhancing the bottom line, Health Maintenance Organizations (HMO's) took corporate control over medicine (Light and Levine 1988).

Under this reorganization, many physicians are being employed by new medical industrial complexes, and as a result, their practice is no longer under their complete control and autonomy (Kletke et al. 1996). Within these systems, physicians are constrained by official guidelines set forth by the HMO as to which types of testing, referrals, or other types of treatments are appropriate. According to MacArthur and Moore (1997), this loss of physician autonomy creates a threat to the quality of medical care as a practitioner's ethics become compromised for commercial interest.

Ehrenreich and Ehrenreich (1971) designated the term "Medical Industrial Complex" to denote the now multi-billion dollar industry surrounding medicine in the U.S. This complex involves the labor specialization within and expansion of corporate ownership and control over healthcare provision. These and other political economy researchers are critical of for-profit medical system (Navarro 1976; Wohl 1984), and argue that the stated agendas of medicine – research, healing, education, etc... have taken a backseat to the real purpose: business. In this for-profit system, only those who have

capital/financial security/insurance will be served, and the rest must scramble to find health care.

The critiques of the political economic literature regard these theories as too negative and as ignoring the benefits of capitalist modes of production on human health. For example, capitalist medical systems have created improvements in sanitation and better contraceptive offerings. Further, Turner (1995) argues that the nationalized systems in socialist societies aren't that much (if at all) better in terms of their overall health status. Thus, critics find it short sighted to pin health problems and issues entirely on capitalism.

In this study, I spoke with two obstetricians alongside the alternative birthworkers that practice in the same geographic area. I am interested in understanding the role of biopower (Foucault 1973; 1977) in birth and birthwork in terms of the subordination of TSH affiliates and/or their clients in relation to these medical practitioners with whom they frequently interact. I also seek to uncover whether or not TSH affiliates are agents of de-professionalization (Ritzer and Walczak 1988). In particular, I seek to understand if TSH affiliates may reduce the medical monopoly over knowledge and physician authority, and if so, what mechanisms they might use to do so. For example, applying the logic of Hardey (1999), I seek to answer the question of whether the referrals to websites given by TSH affiliates to their clients have the effect of negating the informational authority of physicians. Further, building on the ideas purposed by Haug (1973), I seek to understand how, if at all, TSH empowers of clients to act as consumers of healthcare by carefully selecting providers and locations. Finally, I seek to understand how the fields of midwifery and birthwork are impacted by the Biomedical Technical Service Complex

Incorporated (Clarke et al. 2003), and if so, how this might impact the political economic critiques that medicine is more about money making than best medical practice.

### **Gendered Division of Labor in Healthcare**

While medical authorities enjoy a great deal of power and prestige, these are not allocated in an equal manner. Literature suggests that there is a gendered division of labor within healthcare which is something that affects midwives and birthworkers, primarily female, and cast in traditional female roles in their occupations. For example, as has historically been the case, midwives are hired into the home as women have long been to care for those in need. Furthermore, midwifery is commonly referred to as woman-centered-care, and as such, it is useful to the purposes of this study to understand the gendered nature of healthcare provision in the community studied. There is institutional sexism present in occupations within healthcare such that women are concentrated into lower paying, less prestigious jobs. Furthermore, women are seen as appropriate caregivers, and typically are seen in supportive roles to male professionals, who have greater autonomy and make more money. This has not historically been the case, however, and when we look to the history of health occupations, we see a definite gendered shift in power dynamics, and specifically when looking at the provision of healthcare for women.

In colonial times, women provided most healthcare (Starr 1982), and nursing has historically been seen as a woman's duty (Reverby 2001). In fact, Florence Nightingale, a social reformer and founder of the occupation of nursing herself stated, "every woman is a nurse" (Nightingale 2008, originally published in 1860). In her view, like that of many

cultural feminists, women are “born” nurses, as an intrinsic value or trait. Whether professed or natural born, women as nurses, widows or spinsters, domestic servants, etc. would be hired by a family to take care of the sick in the home for pay without certification (Reverby 2001).

These women typically learned their trade through an apprenticeship model from other women (Reverby 2001). Further, several hospitals established nursing programs in order to have an abundance of student nurses at the ready. These hospital nursing schools typically had neither instructors, nor libraries, but rather “taught” the young women on the hospital floor while working long, unpaid shifts (Reverby 1987). In addition, these women, and the profession of nursing were unlicensed until the 1920’s. In order to gain greater treatment and favor within the hospital setting, nurses forged alliances with male physicians and administrators (Reverby 1987).

Literature suggests that there are gendered differences in healthcare provision in terms of practitioner reporting and also patient perceptions. For example, Lorber (1984) found that when male doctors assess their accomplishments, they speak of their technical skills and treatment choices. In the same study, the female doctors stress their patient relationships, using words such as “help” and “care.”

In terms of patient perceptions, female physicians are perceived as more empathetic and egalitarian in their relationships with patients and more mindful of patient concerns and psychosocial issues than their male counterparts (Martin, Arnold, and Parker 1988). Furthermore, patients feel more of a partnership with female doctors, which is most likely due to a difference in communication style (Cooper-Patrick et al. 1999).

In this study, I seek to understand the gendered healthcare provided by women for women. I am interested in understanding whether or not TSH affiliates see themselves as natural nurses as suggested by Nightingale (1860), and view their work as a naturally feminine duty (Reverby 2001). I am also interested in understanding the nature and purposes of the alliances the women from TSH forge with the male obstetricians in this study, and whether these can be likened unto alliances early nurses forged with physicians in order to gain favor in the hospital setting (Reverby 1987).

Furthermore, drawing upon the research on patient perceptions of gendered care, I examine the differences in the care provided by the men and women in this study in terms of emphasis on technical skills or helping patients (Lorber 1984), and also the role of communication (Cooper-Patrick et al. 1999), empathy, equality, and partnership (Martin et al. 1988) in the narratives of each. Finally, I am interested in building upon this literature by determining whether female birthworkers must adopt stereotypically male medical model roles in order to gain more success in their caring work.

### **Social Construction of Illness**

Another thing to consider when looking into the background of the midwifery and birthwork models is the social construction of illness. One way to see this phenomenon is through the historical shift from home to hospital birth. Another is in the language applied to childbirth, which I will refer to as a “risk discourse,” or a language that frames pregnancy and childbirth as inherently risky and thus in need of medical expertise. This research is informed by the literature on social constructionism in that childbirth has been successfully socially constructed as an illness.

Drawing on the work of Spector and Kitsuse (1977), social problems are defined by individuals who make assertions of grievance, or claims relating to a certain condition. In the social construction of illness, it does not matter if there is a real condition; the focus is on the social definition. Social constructionism in general is a reaction to positivist worldview that saw social problems as real entities; instead, this work seeks to understand the meaning making of everyday interaction.

Critics, however, would look at the degree of reality in phenomena to determine if the problem is objectively real or if it is created by societal definitions. For example, Best (1989) distinguishes between *contextual* and *strict* constructionism. Contextual constructionism pays attention to the actual condition, while strict constructionism deals only with the claims made not the condition itself.

Social constructionism is also informed by the work of Foucault in “Madness and Civilization” (1966) as a postmodern critique of positivism. Instead of focusing on institutions and social actors, we must deconstruct language and symbols to show the creation of such knowledge. Without this deconstruction, researchers are placing a false reliance on existing structures.

From the structuralist perspective, however, these existing structures are very important and must be examined in order to better understand the process of social construction. From this view, we must break social constructionism down into component parts (Brown 1995). For example, researchers need to examine how medical practitioners develop their knowledge, and how the professional socialization of medical practitioners might lead to the social construction of medical knowledge. This approach focuses on the origin of professional beliefs and diagnoses within the medical model.

Symbolic Interactionists have a close relationship with social construction as it directly relates to the overarching tenets of the paradigm. Within this framework, humans derive meanings through their interactions with others in the social world. These meanings are not fixed, but rather fluid, and grow and change as we continue to interact and interpret them through lived experience.

Thus, the symbolic interaction paradigm encourages researchers to examine how we deal with our own, and other people's illness within a society which largely accepts medical knowledge as explanatory. Furthermore, we must examine the difference between the lay experience of illness and professional definitions, as these two groups understand illnesses differently (Freidson 1970, Conrad and Schneider 1981).

Laypeople are often central to the discovery of diseases, and, in particular, conflictual diseases in which lay discovery conflicts with medical and other authorities. Illnesses that are non-conflictual are only occasionally discovered by laypeople. However, lay discoveries are less likely to succeed on their own, but rather need professionals and institutions for successful claims making. Sometimes, social movements are needed to propel this action (Brown 1995). In addition, conflicted socially constructed illnesses have boundaries that are in dispute such that different institutions and organizations fight over a given phenomenon as being within their jurisdiction. These boundary disputes can lead directly into the medicalization of a condition, in which the medical side of the dispute gains jurisdiction.

In this study, I seek to understand how TSH deals with the fact that birth has been socially constructed as a dangerous and potentially pathological condition. Drawing upon the work of Best (1989), I seek to examine where TSH affiliates stand in terms of strict

vs. contextual constructionism. By this I mean to ask how they resolve the differences between the notions pregnancy being a dangerous condition with the medical and cultural portrayals of this danger. Furthermore, this study draws upon the symbolic interactionist belief that these meanings are fluid. Here, I draw upon Friedson (1970) and Conrad and Schneider (1981) as I question whether TSH is seeking to change the socially constructed definitions of birth as lay versus professional people. Alternately, I draw upon Brown (1995) who stated that social movements are often needed to change social definitions of illness when I frame TSH or birthwork more generally as a movement with such a goal. Finally, I find the notion of boundary disputes to be a very important focus of this paper in that I seek to understand what if any boundary disputes exist between TSH and the medical model in terms of the social construction of pregnancy and childbirth.

### *De/Medicalization of Childbirth*

When there are boundary disputes about a conflictual illness such as pregnancy and childbirth, there are a number of outcomes. One of these may be that the condition is deemed a true pathology, disease, or illness, at which point the sufferer/afflicted person would be sent to the medical model professionals for diagnosis and treatment. This situation, medicalization, is an important outcome of the social construction of illness, and applies greatly in this study as pregnancy is often described as the quintessentially medicalized bodily phenomenon.

Medicalization occurs when non-medical phenomenon come to be socially constructed as illnesses or disorders, the cure for which is seen to be available only through medical professionals. The notion of medicalization came to be used in the social sciences in the 1970s, and was usually used as a critique although medicalization



could be viewed in a neutral way. Over the years, cultural understandings of childbirth have become redefined in medical terms, so much so that medical sociologists say that childbirth is the quintessential example of medicalization (Conrad 2007).

Science, in this case, medicine, has replaced religion in U.S society as a dominant mode of thought and a trusted means of knowledge (Zola 1972). For example, fertility used to be seen as a spiritual or goddess-like quality of women, thus falling squarely within the province of religion. Now, however, infertility has been medicalized, and as such, falls within the domain of medicine (Rothman 1989).

The literature on medicalization views medical diagnoses as social constructions (Schneider 1985). Within this literature all knowledge is relative... so in a sense, as Conrad points out, social constructionism is also relative (1992). Initial studies of medicalization analyzed the medicalization of deviance, and, in particular, examined the conditions of hyperactivity (Conrad 1976), mental illness (Scull 1975; Szasz 1997), and alcoholism (Schneider 1978) as conditions which were once seen as social issues, but came to be known as medical issues.

Medicalization occurs in both deviant behavior and natural processes. Issues and conditions that have been seen as deviant in the past, now fall within the medical domain after a successful process of medicalization. For example, in the cases of obesity and/or anorexia, bodily states have come to be seen as being in need of medical intervention. With these instances, there may often be boundary disputes as well, between medical and psychological practitioners. Further, natural processes of the body have also come to be medicalized. In addition to childbirth, a social process which has come to be seen in medical terms, we can also see the medicalization of premenstrual syndrome, menopause,

and even aging. All of these natural processes of the body are now major cash cows for the medical industry to a large extent.

Medicalization can be seen as occupying various levels, as identified by Conrad (2007). At the conceptual level, a given problem utilizes medical vocabulary in a definitional sense, but is not treated by medical authorities. At the institutional level, an organization develops a medical approach to treat a specific problem, but most work is provided by nonmedical personnel. And finally, at the interactional level, physicians are directly involved in the guidance and or treatment of a given problem.

Sometimes, although a phenomenon is defined as a disease, the medical profession is only marginally involved. Just because a given phenomenon is medicalized does not mean that it does not deserve to be. Using this framework, diagnoses could be *discoveries* instead of *inventions*. Medicalization is not necessarily false, and in these cases, it is imperative for the researcher to examine the social processes involved in the construction of medical knowledge.

When attempting to understand the process of medicalization, it is useful to examine the participation of various interests. For example, exploring the *degree* to which the medical profession is involved in the process. This would involve examining what types of claims the practitioners are making, possibly in the professional journals, reports, and even in their participation in organizations related to the medicalized phenomenon.

It is not just medical experts that lay claim to medicalizing a given issue or condition, either. Lay interests can also work to define a condition or problem in medical terms. For example, women have, at times throughout history, embraced medical

technologies in childbearing. During the early 1900's, women of privilege traveled overseas to hospitals offering "Twilight Sleep," a cocktail of drugs, in particular morphine, scopolamine, and chloroform. The notion of Twilight Sleep was developed in Germany and then brought overseas in response to consumer demands for the medicalization of childbirth stateside (Wertz and Wertz 1986).

Medicalization can be observed in terms of degrees rather than as an either/or situation. For example, childbirth and death are *fully medicalized* while menopause and drug addiction are *only partially medicalized*. Spousal abuse and sex addiction are *only minimally medicalized* despite some efforts to define these problems in more medical terms.

There are definite factors impacting the degree of medicalization of a given problem. Among these are the support of the medical profession, and the availability of medical treatment options. Furthermore, a condition may be medicalized to a lesser extent if there are competing definitions that might define the condition in a non-medical way, or, furthermore, by the price and availability of the treatment options.

In terms of the range of medicalization, it seems that there are certain populations that are more likely to be affected. One of these is the aged population, as we see daily in the mainstream media; an increasingly large number of issues related to aging are becoming defined as medical issues. Another is women. As Conrad says, "... it is abundantly clear that woman's natural life processes (especially concerning reproduction) are much more likely to be medicalized than men's... (1992:222)."

A final note about medicalization: on occasion, there are conditions or issues that were once defined in medical terms and are no longer deemed appropriate to be placed

under medical jurisdiction. For these issues, we can say that “demedicalization” has occurred, as these conditions or issues are turned to other hands seen as more capable of care. For example, homosexuality can be seen as a de-medicalized phenomenon in American society which came to pass when the American Psychiatric Association voted to no longer to define homosexuality as a mental illness in the DSM-III (Conrad 1992). When a condition is “demedicalized,” the treatment is deferred back to the affected party, and an increased importance is placed on self care. Technological advances such as the do-it-yourself pregnancy test can lead to demedicalization, as does the popularity and increase in use of Complementary and Alternative Medicine (CAM) practitioners in place of traditional physicians (Fox 1977; Strong 1979).

In this study, I am interested in understanding where TSH would position pregnancy on a continuum of the medicalization. Specifically, I wish to expound upon the work of Conrad (2007) when he speaks about the levels of medicalization. For example, I would like to know if TSH affiliates see pregnancy on a conceptual level of medicalization, in which the language used is medical, but the treatments are not. Or, if perhaps they see it on an institutional level in which they, as lay people, are the appropriate care providers, but are guided by medical approach, or if perhaps they feel that pregnant women are best served by medical authorities. Further, drawing on the historical descriptions of Wertz and Wertz (1986), I am interested to see if/how TSH affiliates work with women who agree with or press for the medicalization of birth. Finally, I am interested in examining the role, if any, of TSH in the demedicalization of childbirth, for example to understand if they serve as CAM practitioners who usurp medical authority as suggested by Fox (1977) and Strong (1979).

## **Social Movements in Health**

In this study, I characterize these birthworkers as a social movement in health. These workers are emulating, or at least compare greatly to a prior health-related social movement in health, that of the women's health movement from the 1970s. This movement encouraged women to attain and share women's health information and to get to 'know their bodies.' Further, this movement pressed for societal changes lifting of restrictions on women's reproductive choices in order to liberate us from fear, passivity, and alienation from our bodies (Rich 1976).

Like CAM practitioners, the women's health movement of the 1970s encouraged an agentic patient who took responsibility for their own healthcare, only in this case, women saw doctors (primarily male) as adversaries who lord control over their health. This also reflects back to the concept of physician authority and social control. In the seminal text for this movement, "Our Bodies, Ourselves" (BWHC 1973), women were encouraged to move toward a holistic model of care and away from the medical model, which was seen as patriarchal and condescending (Wertz and Wertz 1986; Benoit 1991). This wresting away of control was seen as one way to overcome boundaries that exist between women and the patriarchal medical model (Ehrenreich and English 1973; Rich 1976; Wertz and Wertz 1986; Benoit 1991; Rushing 1993).

The women's health movement is one of many social movements initiated by concerns over health related issues. Historically, we have seen several types of health related social movements. Brown and Zavestoski (2004) categorize these movements into three groups: those concerned with access to or provision of health care, those that address specific diseases, and also those focused on health inequalities based on variables

such as race, class, gender, and/or sexual orientation. For example, there are social movements in health focused on topics as diverse as medical marijuana, physician assisted suicide, HIV/AIDS, breast cancer, environmental or occupational illnesses, and also the role of the consumer in progressively more and more capitalist medical markets.

As previously mentioned, the CAM movement is gaining great popularity (Cant and Calnan 1991; Cant and Sharma 1999; Mizrachi et al. 2005; Adams et al. 2009; Hall et al. 2011; Su and Li 2011; Frass et al. 2012; Harris et al. 2012) with no sign of decreasing use in the future (Coulter and Willis 2007). The recent surge in popularity of such groups is often attributed to a growing empowerment in which citizens feel a right and authority to influence or even demand certain changes in health care policies. (Shuval 1999; Brown and Zvestoski 2004; Adams 2006). Further, Scambler and Kelleher argue that this empowerment in fact creates a “culture of challenge (2006:221)” that has in the past, and will continue to perpetrate fundamental changes looking forward.

In this study, I seek to understand where and how TSH fits within a network of social movements related to health issues. I seek to understand how TSH employs the philosophies from previous health related social movements to their advantage. As all social movements employ tactics, I wish to ascertain what tactics TSH utilizes to create change, and further, I seek to understand what kinds of changes they wish to create. Drawing on the literature related to CAM related social movements that seek to empower patients to demand changes in health care policies and procedures (Shuval 1999; Brown and Zvestoski 2004; Adams 2006), I wish to explore whether TSH has similar goals and thus presents an example of what Scambler and Kelleher term, “A Culture of Challenge (2006:221).”

### ***History: The US Women's Health and Consumer Movements***

The birthworker movement I examine in this study stems from a number of historical groups, specifically U.S. women's health, consumerist, and natural childbirth movements of the 1960's and 70's. The keystone book of the women's health movement, Our Bodies, Ourselves, opens the chapter on childbirth by stating,

*We want to understand our childbearing experience. We literally have been kept in the dark about what we can expect physically and emotionally when we conceive and give birth to our children (1971:157).*

The women's health movement of the 1970's encouraged women to attain and share women's health information, to take back control of and responsibility for their own healthcare, to get to 'know their bodies,' and to overcome boundaries that exist between women and the patriarchal medical model (Ehrenreich and English 1973; Rich 1976; Wertz and Wertz 1986; Benoit 1991; Rushing 1993) During this time, feminist health movements encouraged a move toward a holistic model of care and away from the medical model as a central one in women's quest to take their body back from the patriarchal institution of medicine (Wertz and Wertz 1986; Benoit 1991). It was argued that only through the lifting of restrictions on women's reproductive choices might women come to know true liberation from fear, passivity, and alienation from their bodies (Rich 1976).

Midwives, doulas, and childbirth educators advocate for birthing women and are seen as a means of wresting control over women's bodies away from the medical model and placing it back in the hands of women. Since their reappearance in the 1980's doulas, for example, have been increasingly present in American birthing rooms, and

women with doula support are emerging from their birthing experiences filled with positive memories and a sense of accomplishment (Gilliland 1998; Papagni and Buckner 2006; Block 2008). In this study, I draw upon commonalities in philosophy between TSH and the women's health movement and consumer movements in health.

### ***Collective Identity and Birthworkers***

This study examines the way that collective identity among birthworkers serves as a prerequisite to their participation in a new social movement of birth. One important aspect of social movements is to create and sustain a sense in members of belonging to the group. This takes the form of collective identity, which is a shared definition of a group that includes what it means to belong, what types of resistance they face, what their opportunities are, what types of actions they are willing to take, and what their ultimate goals are. These identities are formulated, negotiated, and changed when necessary by active group members. I draw upon this literature in this study of the TSH social movement.

McAdam sees collective identity as a "requisite for the emergence of all social movements (2004:227)." Parekh states that collective identity "...facilitates the emergence of a new social subject with a distinct perspective (2008:34)." The language here involves a benefit to the individual through solidarity and empowerment within the group. Meanwhile, Taylor and Whittier argue that collective identity is "...constructed, activated, and sustained only through interaction and social movement communities..." and further state that collective identity "is an emergent socially constructed property that cannot be reduced simply to subjective individual attitudes (1995:172)." Accordingly, Melucci speculates that "... Collective identity as a process refers...to a network of active



relationships between the actors, who interact, communicate, influence each other, negotiate, and make decisions (1995:45) ." Herein rests a contrast between social psychology and sociology on the nature of collective identity and the role of the individual social movement participant.

This identity usually involves some sort of sense of a lack of civil, political, economic or other rights but also a quest for respect and public legitimacy or recognition for a marginalized identity (Parekh 2008). In this case, I am applying the concept of collective identity to the lack of rights perceived by these birthworkers in terms of the women they serve. For example, these workers feel that women are routinely denied their rights in a medical childbearing setting, manifesting in a lack of presented options and a condescension or even degradation on the part of the medical staff. By formulating a collective identity, they create a rallying call for themselves and mothers and their families to be recognized as intelligent, thoughtful beings, capable of understanding options and making choices for their own care.

There are a number of ways that collective identity can be viewed. Negatively, collective identity invokes language of liberation implying that the group wants to be freed from the dominant power. Positively, collective identity invokes the language of pride, basically inferring that liberation from oppression is not sufficient – the group publically displays their pride in membership (Parekh 2008). In this study, I seek to understand whether TSH affiliates are using collective identity in an attempt to be liberated from dominant power – in this case the medical model, or if their sense of collective identity is more focused on a sense of pride in their membership.

In this study, I apply the definitions for collective identity as defined by Taylor and Whittier (1992) and Melucci (1995) to the TSH organization. I examine the ways that their collective identity is constructed, activated, and sustained by affiliates as they interact, influencing one another and making group decisions. I further examine how TSH may employ their collective identity as a tool to garner respect and public legitimacy for their marginalized identity as alternative practitioners (Parekh 2008).

Collective identity is not without its dangers, and some of the shortcomings of collective identity include creating false dichotomies between groups, dismissing nonconformists and dissenters as victims of false consciousness, and creating intolerance and self-righteousness. According to Parekh, "...the politics of identity becomes the politics of conflict, frowning on all attempts to stress commonalities, exaggerating minor differences, and even engineering conflicts where none exist (2008:36)." In this study, I examine these detriments of collective identity in looking at the nature of relationships between TSH, other birthworkers and members of the medical model.

### ***Internal and External Collective Identity***

There are a number of important dimensions to collective identity that play into the study at hand. Melucci states that "Collective identity as a process can be analytically divided and seen from internal and external points of view. This separation of two sides is obviously a way of describing what should be seen as a basically unified process. Collective identity contains an unresolved and unresolvable tension between the definition a movement gives of itself and the recognition granted to it by the rest of society (1995:48)." In addition, Poletta and Jasper discuss the way that collective identity contains two parts: that which the group feels among themselves, and the identity they

present to others (Poletta and Jasper 2001). Thus, we see that in addition to an articulated internal identity, groups have not only an external identity that they wish to project to others, but also that which others grant unto the group. Here we see dimensions of internal versus external, and perception versus performance.

In this study, I will examine the way that TSH birthworkers see themselves internally in concert with their colleagues as they build their movement and their business. Furthermore, I am able to describe, in the words of my respondents, the way that TSH birthworkers attempt to foster a specific sentiment in the thoughts of the public, or their external collective identity. With certain respondents from outside of TSH, I am able, to some extent, to see the external identity that is perceived by others outside of TSH.

### ***Boundaries and Collective Identity***

Boundary demarcation and maintenance are also important parts of collective identity. These lines drawn can help to illustrate who falls within and who falls outside of the group border. Melucci states that collective identity “establishes the limits of the actor with respect to its social environment (1995:49)...” while Taylor and Whittier show how boundary setting rituals and institutions that separate challengers from those in power can strengthen internal solidarity (Taylor and Whittier 1992). In this study, I examine the way that TSH affiliates establish boundaries to distinguish between themselves, other birthworkers, and practitioners of the medical model. I provide examples of what they believe they are, and behaviors, practices, and attitudes which they purposefully distance themselves from.

### *New Social Movements*

In this study, I characterize TSH and birthwork more generally as a new social movement. The concept of a *new* social movement has brought about changes in the ways that researchers think about the nature of a movement. In his article on the current state of social movement studies, Richard Flacks (2004) explains that there are great changes in the way movements are being studied. The previous focus on rational goals, strategies, political opportunities, threats, and resources has shifted to one centered around communities and networks that serve a function of shaping the societies in which they exist. As opposed to previous eras, new social movements operate largely outside of the polity. We can't necessarily look at them solely by their strategies, because many new social movements prefer to raise public awareness and create "...new consciousness and identity rather than objectifiable goods (2004:137)."

Also, new social movement theorists place great importance on the notion of *culture* in social movements as contrasted to politics, economy, and other structural components, as mentioned above. Fine states that some social movements are explicitly cultural in that they seek not only to change some aspect of the political or economic order, but also the cultural perspectives of society (Fine 1995). According to McAdam the cultural turn in the study of social movements has had the effect of redirecting attention to a number of facets of social movement study – specifically "...the importance of collective identity in struggle...the role of emotion and collective action...and framing and other meaning making processes...(2004:225)" as central components of movement mobilization. Goodwin and Jasper state that while strategic effort is important to the mobilization of any group, researchers must not neglect to

examine the way that cultural traditions, common knowledge, material artifacts, rituals, identity, discourse, and speech shape framing processes in ways that may be unrecognized by social actors (Goodwin and Jasper 1999). Furthermore, Poletta and Jasper find that “Collective identities are expressed in cultural materials – names, narratives, symbols, verbal styles, rituals, clothing and so on...(2001:285).”

This shifting focus in social movement study also involves study of mobilizing emotions in the life of a given movement. Melucci claims that there is always an emotional investment in collective identity, as it is this element that helps to create a sense of unity and solidarity (Melucci 1995). Further, Goodwin and Jasper state that collective identity and injustice frames have powerful emotional and psychological dimensions, which are not always fully conscious to the movement actor. In fact, they argue that much of the power of collective identity and collective action frames stem from the heightened levels of emotion involved in movement participation (Goodwin and Jasper 1999).

In my study, I explore how these birthworkers construct a positive image of their work in the public eye and raise awareness among (potentially) pregnant women of birthing alternatives, and also inquire as to their thoughts and/or strategies on changing existing political structures. In this way, I explore the theme of new social movements and their focus on community based change and consciousness raising. I examine the role of cultural traditions, such as how cultural views of motherhood and the nature of women shape the collective identity of birthworkers. I will also examine the ways that birthworkers seek to transform cultural attitudes surrounding childbirth using a variety of cultural artifacts, symbols, and narratives. Furthermore, I examine the narratives of

birthworkers to better understand their meanings for movement participation. Finally, I examine the role of emotions in the mobilization of this movement, as childbirth is an emotional event for many women and my sample contains many women who have experienced childbirth themselves. I wish to understand the role of emotions in these women's mobilization. In these examples, I find my study to be unique as this social movement also functions as a business, and as such, the goals are somewhat different than they would be without a profit motive.

### ***Framing***

This study presents frames as narrative accounts of the ways that birthworkers make sense of the system of the medicalization of childbirth in our culture. I wish to explore the meaning making of these women as they attempt to work within and around this system in order to best achieve what they define as positive birth experiences with and for their clients. For the purposes of this paper, I am defining the framing task as Johnston who states that "...frames are problem-solving schemata, stored in memory, for the interpretive task of making sense of presenting situations. They are based on past experiences of what worked in given situations, and on cultural templates of appropriate behavior (1995:217)." And further, as Fine argues "that the process of exemplifying a frame occurs through the stories that members share, to the collective bundle of narratives that are treated as relevant to the movement ideology (1995:134)." Thus, I explore the narratives of TSH affiliates to learn how they collectively frame their problems and challenges to movement participation, and also how they frame the solutions to these dilemmas.

The stories told by these practitioners can be sorted into one of three categories as defined by Fine: horror stories, war stories, and happy ending stories. Horror stories justify one's involvement in the movement. They produce sympathy; intensifying emotion and angering participants, leading to a motivation to create change. War stories detail harsh experiences that group members have had within the context of their participation in the movement. These may include hostile responses from counter movements. War stories are effective in processing events and incorporating them into the ideology of the group. Finally, happy ending stories are those in which the speaker processes their benefits of participating in the movement or changes that have occurred as a result.

Snow and Benford find that successful social movements employ master frames which are then used by subsequent movements in a cyclical fashion (Snow and Benford 1992). Master Frames are those frames "...whose generality applies to multiple constituencies (Buechler 199)...". In this study, I refer to master frames emerging from the women's (and women's health) movement, such as a "feminist ethic of care" which calls for an end to bureaucratic decision making, for example, and a "patriarchal medical model" which birthworkers see as employing a bureaucratic structure, making personal decisions for birthing women. In these instances, birthworkers aspire to create a situation of fully informed consent, and encourage their client to make her own decisions or facilitate such that their client can make decisions with her partner. I also include frames stemming from various waves of feminist movements throughout history and how each of these has framed the task of childbearing and raising, for example the cultural feminist conception of women as intuitive and intrinsic mothers and nurturers.

According to Benford and Snow, "collective action frames are constructed in part as movement adherents negotiate a shared understanding of some problematic condition or situation they define as in need of change...(2000:615)" They define three components of this concept as diagnostic framing , which focuses blame or responsibility, prognostic framing, which involves the articulation of a proposed solution to the problem, and motivational framing which provides a call to arms or rationale for engaging in ameliorative collective action. In addition, injustice frames serve to mobilize groups for collective protest or rebellion, and are generated by those who find a particular authority to be unjust. Also related are boundary and adversarial framing which "...delineate the boundaries between 'good' and 'evil' and construct movement protagonist and antagonist (2000:616)." Finally, Benford and Snow explain that a framing dispute can occur within a movement when there is disagreement between members.

This study has been informed by all of these framing schemas. For example, I explore the nature the horror, war, and happy ending stories told by TSH affiliates in order to better understand how they frame their involvement, their harsh experiences within the movement, and ultimately how they frame the benefits of their participation. I am very interested in when and how they invoke the master frames from the women's and consumer movements in health. Furthermore, I draw upon the work of Benford and Snow (1992), I look at how TSH affiliates negotiate shared understandings through the use of diagnostic, prognostic and motivational framing.



## **Master Frames from Feminist Movements:**

In the sections that follow, I detail the literature regarding childbirth and motherhood from two feminist perspectives: Liberal and Cultural Feminism. In this study, I draw upon these bodies of literature as I believe that they are most salient in informing midwifery today. In particular, I explore in my study the ways that these philosophies aid in the formation of the collective identity of TSH, and also how they are employed in the master frames of the birthwork social movement. More generally, these ideas are an important part of the way the United States as a society views pregnancy, childbirth, and motherhood.

### ***Liberal Feminism***

Liberal Feminist literature states that even in childbirth, inequalities between the sexes are present (BWHBC 1971; Wertz and Wertz 1986; Jagger 1988). Women no longer have primary control over their laboring bodies. Again, returning to the concept of the body/mind dualism and its often-sexist outcomes, the male/scientific medical model has complicated the natural course of pregnancy and childbirth. This technology is a booming business, accruing capital hand over fist, and likewise, “men who are considered to be knowledgeable experts gain increasing control over the lives of so called ignorant women (Jagger 188).” For evidence of this claim, Jagger points to the incredible rise in cesarean section rates over the years. Even today, this concept can be located in this National Vital Statistics Report entitled “Trends in cesarean rates for first births and repeat cesarean rates for low-risk women: United States, 1990–2003.” According to this study, “Cesarean rates for low-risk women having a first birth, and repeat cesarean rates, increased between 1996 and 2003 to the highest rates ever reported for low-risk women

in the United States (Mannacker 2005).” Year after year, these rates continue to climb in The United States with no relief in sight (Block 2008).

Liberal feminist, Betty Friedan (1963) writes about the inequalities between the sexes in terms of childbirth: “For, of course, the natural childbirth-breastfeeding movement Margaret Mead helped inspire was not at all a return to primitive earth-mother maternity. It appealed to the independent, educated, spirited American woman – and to her counterparts in western Europe and Russia – because it enabled her to experience childbirth not as a mindless female animal, an object manipulated by the obstetrician, but as a whole person, able to control her own body and her aware mind (Friedan 147).” In this comment, Friedan illustrates that women are ready and willing to regain control over their bodies and to take the inequality out of the birthing process, to be empowered rather than controlled by men in the western medical model.

In my study, I examine whether or not TSH affiliates take a liberal feminist view and find issue with the medical model’s control over women’s bodies. I also examine how these practitioners view the equality between the sexes in the provision of maternity care. Furthermore, I seek to understand the role of liberal feminist arguments in the master frames that inform this social movement in women’s health.

### ***Cultural Feminism***

Midwifery is informed by cultural feminism as it sees birthing and childrearing as being a special endowment that should be cherished, celebrated, and liberating to women. Instead of focusing on the ways to equalize the differences between men and women in society, cultural feminists prefer a celebration of traits that they consider to be uniquely feminine. This includes traits such as “the non-rational, the intuitive, and the

often collective side of life (Donovan 1988:31).” Their political motivation is to liberate women from patriarchy, instead valuing matriarchy, or a women’s culture that is separate from men’s culture. This matriarchal society would place importance on stereotypically female qualities such as nurturance, the giving of care, and the settling of differences in order to create peace among societies.

Sara Ruddick conveys cultural feminist sentiment in her article entitled *Maternal Thinking*. In this piece, Ruddick explains that there is a particular way of thinking which when practiced by women has great potential for changing societies. This is maternal thinking, which stems from the experience of motherhood either as daughters experience their mothers, or as women experience their jobs as mothers. As Ruddick describes it, maternal thinking is natural and compelling; it fosters “a sense of maternal competence...pleasure in reproductive powers.... [and] a love, which for most mothers is as intense, confusing, ambivalent, and poignantly sweet as they will experience (1995:344).” Ruddick goes on to state that she is convinced that there are many female traditions and practices that spawn specific frameworks of “womanly thinking (1995:346),” which is consistent with the cultural feminist ideal of crediting and celebrating women’s unique ways of knowing.

Ruddick does not deny that maternal thinking could possibly exist for men, but certainly states that it is acquired differently for women. She states, “It is because we are *daughters* that we receive early maternal love with special attention to its implications for our bodies, our passions, and our ambitions (1995:346).” She does not explicitly state nor does she deny that maternal thinking is a genetic feature of women, but does believe that the woman’s biological makeup might “foster certain features of maternal practice,

sensibility, and thought (1995:346).” She feels that many features of maternal thinking are universal to women as a gender, and are both invariant and unchangeable. These features cause women to have certain characteristic errors, certain intellectual capacities, and certain interests that are hers solely due to her acquisition of or innate qualities of maternal thinking.

Cultural feminism is critiqued as being essentialist, or for its implication that there are universal truths that are constant for all women. It is directly opposed with other schools of feminist thought such as liberal feminism that attempt to lessen the divide between women and men. Although other difference feminisms such as radical feminism agree that women are not like men, they seek to balance the inequalities between the sexes rather than to separate them. This school of feminist thought begs the question of whether or not cultural feminism liberates women from their oppression or whether it perhaps deepens the subjugation of women by reifying negative stereotypes under the guise of celebrating them.

In my study, I wish to examine how TSH affiliates perceive cultural feminist notions such as nurturance, care-giving, and female collectives. I also wish to explore in which areas of their work TSH practitioners employ cultural feminism if at all. Further, I seek to understand the role of cultural feminist philosophies in the master frames that inform this social movement in women’s health.

### **Women’s Paid Work**

In whatever way birthworkers frame their conceptions of motherhood, these women all feel strongly enough about these feminine issues to work in marginalized

occupations which go against the grain of what is normal and mainstream in maternal care in the United States. These women also do this work for little to no pay, and sacrifice their own motherhood time with their children to attend to their clients. In the following sections, I will turn to the literature that illustrates these larger concepts of women's work both paid and unpaid. Within this literature, I also examine care work as a distinction within traditionally female work in the United States.

The notion of separate spheres has long been at the heart of academic inquiry and understanding of the gendered division of labor. For example, Talcott Parsons (1955) wrote about the family as a functional unit in society comprised of a monogamous, heterosexual male and female. For Parsons, each one has a proper role that dictates their behavior, which is assumed to be innate unless there is a dysfunction. For example, Parson's men assume instrumental roles: things related to setting goals, accomplishing tasks, and leadership, while females assume expressive roles: socialization of children, emotional support, and reducing interpersonal tensions. Some feminists critique these functionalist ideals (Ferree 1990; 2010) while others reproduce them (Chodorow 1978; Gilligan 1982).

The separate spheres ideology refers to a cultural belief in which men's appropriate place is seen as the public sphere while women are seen to be properly suited for the private sphere. The public sphere, or the marketplace, is characterized by low moral standards and a lack of propriety. It is a tough place, a dog-eat-dog world of competition and antagonism. The private sphere, or the home, on the other hand, is a safe haven, clean, comfortable, and serene. Many cultural feminists who celebrate what they see as innate qualities of women: moral guardians, nurturers, care givers, peacemakers,

etc... celebrate the notion of separate spheres. According to this view, the rough, tough, cutthroat marketplace is no place for a soft spoken, sweet, nurturing woman.

Hartman argues that as women, our position in the labor market is determined and regulated by the structures of capitalism and patriarchy (Hartmann 1979). Thus, women are commonly represented in the capitalist marketplace occupying roles that correspond directly to those that we have typically occupied in the home. The separate spheres ideology forms the basis of this strongly gendered division of labor, but not all feminists and other researchers accept it as a valid principle. In fact, many argue that we must look much more deeply at the many complexities that exist when speaking of women's work. In this study, my respondents are publically employed in traditionally female private sphere roles as nurturers, peace keepers, and caregivers. With Hartman's ideas (1979) and also these critiques in mind, I examine the complexities TSH affiliates experience as they go about performing their work.

Ferree (1990; 2010) argues very strongly against functionalist research perspectives within the social sciences as these pertain to separate spheres. She argues that we must move beyond separate spheres to truly understand the nature of gendered divisions of labor today. Ferree states (1990) that the ideology of separate spheres was greatly overstated historically and points to numerous examples of women's wage contributions in very early eras. These very important contributions seem to have been ignored in favor of this gendered ideology. Ferree argues that by turning a blind eye to women's wage contributions to the family, society furthers women's subjugation. Instead, Ferree argues that the task of contemporary gendered family and work research is to avoid being swayed by the separate spheres ideology, and to examine more closely

the “variation in women’s economic contributions across time, place, class, race, and culture (Ferree 1990: 872).”

While it is important to examine these nuances in women’s wage earnings, empirical research still shows that women’s traditional role as caregivers in the home seems to directly correspond to women’s paid roles as givers of care in the marketplace (Hartman 1979; Dalley 1988), and also that these jobs pay less on average than jobs that do not involve care giving (Kilbourne et al. 1994; England 2005). One way to explore some of the reasons why care work pays less and is belittled is to read Zelizer’s text, *The Purchase of Intimacy* (2005). As a society, we continue to create and maintain artificial boundaries between care/love and money, as there is a concern that these are incompatible. It seems as though combining the two will tarnish both in an irreparable and socially damaging way. In theory, it is objectionable if not impossible to pay for love, but Zelizer argues against this instead pressing for a “connected lives” approach in which people and legal systems find fair and effective ways to combine love and money in socially beneficial ways. According to Zelizer we are all experienced in finding these intersections, and rather than these elements being contradictory, they are in fact complementary things: love and money.

Nancy Folbre takes this idea further in her text, *The Invisible Heart* (2001), in which she argues for a new economic system with caring at the center in place of the invisible hand of supply and demand ala capitalism. In her text she focuses on the pay penalties for care-giving work, and points to its unseen, unnoticed nature in our current system. She discusses the “care-deficit” in which good quality, reliable care is becoming harder and harder to find in a market system in which the only thing that matters is lowest

price. She argues that the patriarchal, gendered division of labor in which women are seen as naturally suited to caring work serves to drive down the value of this labor. She also outlines a few common arguments in favor of paying care workers less; one, that children (as an example of recipients of care) are a public good and thus, caring for them is an honor of the highest sort, far more important than any monetary compensation one might receive for the work, and two, that care workers receive intrinsic benefits of beneficence in place of high wages.

In this study, I explore if TSH and its affiliates reproduce (Chodorow 1978; Gilligan 1982) functionalist ideas about instrumental and expressive roles (Parsons 1955) or critique them (Ferree 1990; 2010). I am curious to ascertain where TSH is located in the ideology of separate spheres, and wish to apply Ferree's analysis in fleshing out the complexities of birthwork to see its distinctions between public/private, paid/unpaid women's work. Further, the work of Zelizer and Folbre are important in this study in terms of the dilemma of love and money, and the price of care. In particular, I wish to apply Zelizer's "Connected Lives" approach (2005) to see if/how TSH affiliates have found a way to combine love and money in social beneficial ways. I also wish to apply Folbre's (2001) work on the care deficit and pay penalties for care work to see if these women rely upon the benefits of beneficence more so than an adequate paycheck for their services.

### ***Care Work***

Care work is work that is provided to ensure the well being and best outcomes for others. Some examples of this type of work are housekeeping, teaching, childcare, eldercare, health care, and care of the sick or needy. The respondents in this study also



perform care work as doulas, midwives, lactation counselors, massage therapists, herbalists, Reiki practitioners, and childbirth educators. Sometimes care work involves monetary compensation, sometimes it does not. Women in the public sphere are often clustered into care giving occupations, which we can attribute to cultural beliefs about women as the appropriate people to provide care. Men, on the other hand, have been found to see care work as physically challenging and tend to be apprehensive about seeking this type of employment (Isaksen 2002).

Some research on care work argues that women who undertake caring roles do so because these roles are meaningful and fulfilling to them (Baker 1976; Gilligan 1982.). Indeed, some providers find care work to be emotionally and spiritually satisfying as it can allow for a positive feeling of making a difference in someone else's life. In her text on women's historic roles as caregivers, Abel (2000) examines primary sources such as memoirs and letters from 1850-1940. In these documents, Abel finds that carework has been seen as a source of pride, and emotional and spiritual strength for women throughout the ages. More recently, researchers find that relationships of trust and connectedness can emerge in care work between clients and providers, giving meaning and satisfaction to the practitioner (Sharma 1992; Shildrick and Price 1998). Meanwhile, other care providers may find their tasks to be unsatisfying, and emotionally demanding as there are inequalities present in which recipients needs are primary and providers secondary (Wharton 2009).

Abel (2000) argues that the nature of medical care giving has changed as physicians worked to expand their authority through the devaluation of women's care. In her secondary analysis of the historical accounts of female care workers she finds care

work to have represented a sort of resistance against the patriarchal medical model. As male doctors entered the mainstream, they campaigned to override and undermine women's traditional roles as caregivers, but, according to these accounts, women found ways to resist the medical model and preserve their traditional ways of healing and caring for their own. I am interested in seeing if/how TSH affiliates compare with these workers and understanding if they see their care giving roles as a sort of resistance against the medical model.

Gordon (1991) argues that it is the capitalist marketplace that has devalued the caring professions by creating tighter regulations, budget concerns, and loss of worker autonomy. In her study, she spoke with over 100 women about their work in caring professions. Gordon argues that feminist projects encouraging women to enter male dominated professions, while useful and good, must not sacrifice care and kindness, which she sees as female work traits. Further, she states that currently, in order for women in medicine to make more money, they must embrace technology, abandon caring aspects of their work, and move toward (male dominated), more technological fields within the medical profession (Gordon 1991).

In Abel's work (2000), caregivers of the past have attempted to maintain their autonomy by serving as silent patient advocates and selectively following advice from authorities. The features of care giving that are often most rewarding to providers are often the very aspects that authorities seek to limit. For example, holding someone's hand, rubbing their shoulders, and spending time getting to know ones charges may be the perfectly appropriate (and even rewarding) thing to do in the caregiver's mind, but these are not the aspects of care that turn profits (Misra 2003).

Some research finds that care workers are likely to have at least two care giving roles to fill as the majority of paid caring work is performed by women in addition to their other, unpaid caring duties (Lewis and Meredith 1988). This dual role of paid and unpaid worker presents problems for the care givers family, and in particular those of color or lower SES, and numerous studies find that the worker's own children and loved ones often go without care in the private sphere whilst she is out working in the public sphere for pay (Harrington et al. 2001; Hondagneu-Sotelo 2001; Wolkowitz 2006). Similarly, I explore the personal lives of TSH affiliates with children to see how they reconcile their often competing roles as dual care givers.

In this study, I wish to draw upon the care work literature in a number of ways, applying these ideas to TSH affiliates to see how they experience their caring work. For example, I wish to understand if TSH affiliates can add to the theories of Baker (1976) and Gilligan (1982) in that they see their caring roles as meaningful and fulfilling despite the low level of pay. I wonder if TSH affiliates further reconcile this low pay like Abel's (2000) caregivers do in that they find their work to be a source of pride, emotional, and spiritual strength more so than simply as a paycheck. Further, I explore TSH's work in terms of the relationships that they build with their clientele to see if these relationships give a sense of meaning to these practitioners' lives that are seen as a fair trade off in lieu of higher pay. Finally, I wish to draw upon the notion set forth by Gordon (1991) to see if TSH affiliates see their future success to be contingent upon abandoning some of the caring aspects of their work in favor of embracing technology in order to gain legitimacy and higher compensation.

## **CHAPTER THREE: RESEARCH METHODS**

To address my research questions regarding the current trends and future of midwifery and birthwork, I conducted a multi-method case study of one alternative birthwork collective, The Stork House (TSH). This organization provides many maternity care related services, classes, and workshops to their community of childbearing women. TSH is situated in a major metropolitan area in the U.S. Southwest.

### **Choosing TSH**

I chose to focus on TSH for a number of reasons. TSH as an organization is a prime candidate for this study as they have developed a number of important relationships with medical practitioners in their community. There is a great deal of literature focusing on the philosophical divide between midwifery and medical models of care. Considering that this divide is a large part of my research interests, I feel fortunate to have found a receptive organization which has already undertaken the project of bridging these divides. In particular, I wish to know how this organization positions themselves in, around, and against the mainstream medical model of care, and furthermore, the midwifery model of care. With this information, I intend to make a statement about the current trends in and the future of midwifery and birthwork.

Second, I chose to study TSH is because I find their collective structure to be unique in that they offer many different types of pregnancy, birthing, and parenting resources all under one roof. Further, I think it is compelling that they are able to present a unified front meanwhile having anywhere from twenty to thirty different practitioners

on board with undoubtedly different personal philosophies and experiences to bring to the table. Furthermore, for the nearly ten years that I have been studying birthwork in this area, TSH has always hosted events concerning birthwork at their various physical locations, and as such I see them as key players in the provision of alternative maternal care in their community.

Finally, I had an established relationship with the founder and director of TSH, Jane, who has interviewed with me in the past and has been active in her local birth community for nine years. Jane has always been very welcoming to me, and has allowed me access to meetings, workshops, classes, and other events at no charge. She has also, on several occasions, given me tasks to complete as a volunteer within her organization, showing me that she trusts my confidentiality and judgment.

I have used a combination of strategies to locate the birthworkers who have the criteria necessary to be included in this study. I myself have been a participant in the subject birthwork community intermittently, for the past eight years. I have been formally trained as a doula, have attended HypnoBirthing™, and other types of in-depth childbirth classes, counseled and referred pregnant women, and attended multiple births, both home and hospital, medicated and non-medicated. Through these experiences I have come to know a number of birthworkers who were interested in being included in the study. The business collective, TSH, has played a large role in locating participants for this study. The founder and director of this group, midwife Jane, has referred many of her colleagues to me, and has also used the Facebook page for those affiliated with TSH to get the word out about this study. I have used a snowball sample method through my respondents to

gain referrals to any other birthworkers in their community that I did not locate through other means.

## **Methods**

### ***Interviews***

I specifically focused this study on the narratives of eighteen birthworkers. For example, fourteen of my respondents are doulas, four are childbirth educators (CBE's), two are midwives, and two are lactation consultants. Many of these women fill multiple roles within the organization as well with multiple trainings and certifications. Three of my respondents have never been affiliated with this organization, while three others were previously affiliated, though they are not any longer. These interviews from outside of TSH serve to give some external context to the organization and its affiliates.

In all, I interviewed twenty four birthworkers. Twenty two of the respondents are Caucasian women, and two are Caucasian males. All of my respondents are married, and all but two have children. My respondents' ages range from eighteen to fifty four, with the mean age being thirty five. The salary range is quite varied, with four respondents reporting no income, and three respondents reporting six figure salaries. Five of my respondents report having less than one year of birthwork experience, and two of my respondents have over twenty years of related work experience.

I began conducting my interviews with my respondents on February 25th, 2014, and conducted my final interview on February 27th, 2015. Jane, director and founder of TSH was both my first and my last interview. Over the one-year period, I interviewed a total of twenty four individuals. At the time I began interviewing, TSH listed twenty three

affiliates on their website, eighteen of whom were included in the study, thus I spoke with approximately seventy eight percent of their affiliates. The shortest interview lasted fifty minutes, and the longest lasted two and a half hours, with most interviews lasting around one hour and a half.

My interviews were conducted in respondents' homes or personal offices, at the TSH facility, at the hospital physicians' lounge, in an obstetrician's office, at various coffee houses, and in a private office on the university campus. Each interview was audio recorded with informed consent. I used a combination of my own transcription, and the services of a paid transcriptionist. Each birthworker in this study was promised confidentiality, thus I have changed the names of all of my respondents. Also, names of any locations or other providers have been changed as well. All birthworkers in this study have agreed to be contacted at a later date should a follow up interview be desirable.

These interviews utilize a qualitative format with semi-structured, informal, and open-ended interviews that operate more like a "guided conversation" (Lofland and Lofland 1995) with respondents. In depth interviews are an excellent tool for locating knowledge about areas about which the participant has extensive experience, and provide insight into their subjective worldview (Charmaz 2002). Interview questions (see Appendix A for interview schedule) were designed to ascertain how these workers view their work, their community, and their colleagues, and to solicit further understandings about alternatives to mainstream, aka medicalized, childbirth in this community. I asked my respondents questions designed to uncover motivations, relationships, boundaries, alliances, client profiles, business marketing strategies and the like amongst

birthworkers. For the purposes of this study, I asked these birthworkers to focus on their experiences within this community specifically when answering my questions.

### *Ethnography*

I also used the ethnographic method of participant observation to glean more information about these practitioners and their interactions with one another and their clients. Because of my previous experiences, not only as a researcher of birthwork, but also as a birthworker myself, I was able to gain entry into many different classes, meetings, and events. For example, I have attended the monthly Meet-And-Greets at TSH. In the monthly TSH Meet-And-Greet, many of the affiliates are present, ready to meet with expecting parents who have come to learn more about TSH's offerings. At Meet-And-Greets, two or three birthworkers give a talk about issues related to pregnancy and childbirth such as caring for a newborn, staying calm during labor, and herbal remedies for common pregnancy concerns. After their presentations, guests are free to tour the premises and meet and visit with the affiliates.

In addition, I have been invited to assist in several events involving this organization. At one point, I served on a committee to organize a women's health fair, where women could go to get information not only about pregnancy, but also other health topics such as yoga for stress relief and herbal medication. In this role, I worked as a secretary of sorts, taking meeting notes which I then typed up and emailed to other committee members. I also assisted in brainstorming sessions about the organization of this event and contributed suggestions and commentary in planning meetings. This health fair has yet to occur.



On another occasion, I was asked to give tours to expectant women at the grand opening of the TSH birthing center, named The Stork House Birth Center, which was opened by Jane in a home near to the office space that TSH occupied at the time. On that occasion, I was able to meet with many perspective clients and listen to their stories about their interest in hiring a midwife for their birth. I was also able to make contact with many birthworkers both TSH affiliated and independent.

In another participant/observer experience, I was invited to attend an annual birthworkers meeting at The Stork House Birth Center where Jane gave awards to members of the birthwork community and facilitated introductions between many women. At that meeting, I was asked to speak about my project, and as a result, made many contacts. Generally, this meeting had a fun and casual overtone, in fact, hula dancers were hired to come in and give the attendees dance lessons. At this event, there were many different practitioners from different orientations and specialties, as well as TSH affiliates and independent workers. Here, I noted a remarkable number of tensions between the workers in this unique observational opportunity.

I attended a number of workshops at TSH such as the water birth workshop where an African American (the only African American TSH affiliate) woman taught about the benefits of water birth to a small group of very obviously pregnant women. This woman owns her own birth tub company in addition to being a TSH affiliate in the form of a certified lactation consultant. Staying true to the affiliates, TSH specifically recommends her tubs to those women looking for a rental, but also allows other companies to place their business cards on the rack in the TSH store front. In this workshop, attendees watched videos of water births, heard statistics about the safety of water birth, and

learned from first hand stories about reasons why a woman might choose this method. There were also two tubs in the classroom that evening, which served as learning devices throughout the lecture. After the lecture, we were able to get into the (dry) tubs to see how they felt, and also to ask questions of the instructor.

I attended the grand opening/annual mother's day picnic at the brand new storefront space opened by TSH. This event brought together many families who had previously partaken in the services offered by TSH, as well as all sorts of practitioners from inside and outside of this organization. I was able to have an introductory discussion with one of the TSH midwives' backup physicians, Dr. Adams I also talked to a number of the TSH practitioners, and a few community partners such as a chiropractor and a children's psychologist who take referrals from TSH. Both of these practitioners served as sponsors for the event, contributing funds to buy food and prizes in exchange for the ability to place their advertising banners on tables and park gazebos at the event. At this event, there was a ribbon cutting ceremony, water play and face painting for the kids, and food and ice cream for all attendees. In addition, there were a number of workshops in the store front throughout the day such as herbal first aid, baby wearing, and a presentation on labyrinths.

A very interesting and enlightening opportunity came in the form of a city-wide meeting for all types of birthworkers regarding the impending licensure of Certified Professional Midwife (CPM). In this meeting, I was able to observe the interactions between all ranks of midwife from very medical Certified Nurse Midwives (CNM's) who work in the hospital to Direct Entry Midwives (DEM's) who deliver babies at home and are primarily focused on woman's intuition in childbirth. I observed many tensions in

between these practitioners and also was able to hear the varied concerns of these women as our state grows closer to mandating some sort of licensure for DEM's and CPM's.

### **Sample Details and Demographics**

In the next paragraphs, I will detail the basic information given to me by my respondents about their income and education level as well as my own impressions based on our interview time together. As previously mentioned, all of my respondents are married, and all self report as Caucasian. Only five of the birthworkers in this study list themselves as the primary breadwinner within their home. Thus the vast majority are supported by male spouses. Of all of my respondents, seventeen are currently affiliated with TSH, twelve of whom were also previous clients of the business, and in particular, home birth clients of Jane, the director, founder, and one of two TSH midwives. It is compelling to note that previous clientele provide a consistent source of new birthworkers for the organization. Two of my respondents were previously affiliated with TSH; one of these women was fired from the organization, while the other left to pursue more lucrative CAM related work.

While twenty four respondents is an arguably small sample, it is appropriate in this qualitative study as I am not seeking superficial data from a quantity of cases, but rather am seeking to become intimately acquainted with each specific case providing depth in place of breadth (Hammersley 1989). Additionally, in searching for birthworkers to interview, I chose to focus primarily on a business collective of women who are engaged in multiple aspects of birth work. I included others such as independent midwives, obstetricians, and previous affiliates of this business collective who were

willing to participate in the study to add context and to situate the collective amongst other interested parties in the subject area.

### **Data Analysis**

In this study, I have used a grounded theory approach to data analysis, which is appropriate for use with in-depth interviews (Charmaz 2002). This inductive method does not seek to identify causal or correlational relationships between variables; instead seeking to tell a collective story and provide a comprehensive snapshot of the participants' lived experience (Hammersley 1989; Charmaz 2002) In contrast to other types of research with pre-defined hypotheses, this method requires a continuous reconstruction of hypotheses during the course of the research (Hammersley 1989). As a result of this continuous reconstruction, this method produces an explanatory and descriptive theory that is grounded in the data (Corbin and Strauss 1990).

As I transcribed, or had each interview transcribed into text form, I was also looking for sensitizing concepts to emerge from the data. These themes and concepts are used in grounded theory methods in order to alert the researcher of ideas to pursue and sensitize themselves toward asking certain questions as the data collection process proceeds (Charmaz 2006). Some of these concepts stemmed from the research questions and relate to the types of conflictual interactions the doula experience while working in the hospital setting. At first, I saw the doula's role as being heavily restricted by medical staff directives, making hospital births completely conflictual for these birthworkers. As the interview process continued, however, I found that these practitioners were actually finding ways to work around these directives through their participation with TSH and by

utilizing the integrative relationships that this organization has built. Latent patterns also emerged concerning the intricate ways that birthworkers work with the medical model, and the roundabout ways that these particular workers distance themselves from other birthworkers in their area.

In grounded theory methods, initial codes become more focused as the coding process progressed (Charmaz 2006). For example, my initial codes entitled “hospital interactions” and “disempowering experiences” became one focused code “medical power/hierarchy.” In addition, another category, “dilemmas” was broken down into three more focused segments based of the type of problem, “work/family balance,” “medical interactions,” or “legal.”

In grounded theory analysis, researchers are encouraged to write memos, or personal notes recording interview happenings, patterns, question success or failure, and comparisons and connections in the data. In my memos, I noted some rather helpful and interesting things about the nature of my interviews. For example, I noted that because of my status as a previous birthworker, some people I spoke with took for granted that I shared the same views as they did. In these interviews, I encountered many “you know?” comments and had to solicit more information. In addition, many birthworkers I spoke with did not seem to understand the word “grievances” in my questions. These memos helped me to structure the subsequent interviews differently. For example, I included an introduction in order to address the fact that while I have also served as a birthworker, I needed them to think of me as a researcher during this interview, and although I may understand a term or scenario, I need them to articulate their speech as though I do not. Additionally, in the questions containing the word “grievances,” I added the words

“issues,” “tensions,” and “clashes.” This method, known as theoretical sampling, allows for increased focus on concepts that emerge and further development of theory as I proceeded with each interview in succession (Hammersley 1989; Charmaz 2002).

## CHAPTER FOUR: HISTORY AND ORGANIZATION OF THE STORK HOUSE

The metropolitan area that The Stork House (TSH) serves, a city with two million residents, has challenges both to its provision of medicalized health care as well as provision of alternative medical care. Its dramatic population growth over the last 30 years, the effects of the 2007 housing crisis and economic downturn, and the resulting transient population, has strained a wide range of infrastructure, including medical care. In 2002, the American College of Obstetrics and Gynecology (ACOG) named this state as one of nine “hot states” in which sharp increases in malpractice insurance premiums caused many doctors, including obstetricians (OB) to move elsewhere (<http://usatoday30.usatoday.com/news/health/healthcare/2002-07-01-malpractice.htm>). In 2014 the state was ranked among the top ten worst states in the nation to have a baby. (<http://wallethub.com/edu/best-and-worst-states-to-have-a-baby/6513/>).

It is in this context that alternative birth services have struggled in the city. Respondent birthworkers argue that the problem has been two fold. First, there is a lack of options for birthing women--the city has no midwife-staffed birthing centers and is short on associated services from the midwifery model of care such as birthing tubs and intermittent monitoring. Donna, a long time midwife who has worked both as a Certified Nurse Midwife in a hospital setting and with her own practice, and recently opened a home birth practice summarizes the perspective of most alternative birthworkers in this town,

*[natural childbirth] is not a trend that's going away. Especially in [this city]. There's no birthing center. You do a home birth or the hospital. I've*

*worked in Kentucky, Ohio, and California. There's choices there. Tubs in most of the rooms, you can walk around with monitoring. There's just not those options here in [our city]. --Donna*

Second, there are few systems of support for birth workers themselves.

In the following sections, I will discuss birth and development of TSH, one of a very few organizations that have arisen in the area to address these needs. I first examine other attempts in the city to provide alternative birth care for women and their families and to provide support for care providers. I will then move on to describe the establishment, organization, and purpose(s) of TSH, which is currently the only organization of its sort in their city.

### **Alternative Collectives in the Study Region 1990-2009**

Prior to the establishment of TSH, there were two fledgling birthworker organizations that served as precursors to the development of TSH. Both were collectives for alternative birthworkers, designed to help networking for practitioners, and to provide outreach and visibility to prospective clientele.

The first of these was The Birth Helpers (TBH), which was created in 1997 by a doula in an attempt to create a community for birthworkers. The idea behind this organization was to create awareness of what a doula was and to form a community of women of like mind. An email I received from a TBH meeting dated March 9, 2010 stated its mission:

*TBH is a nonprofit, grassroots organization that exists to 1. Act as a resource for expectant parents in southern Nevada to access independent*



*childbirth educator's birth and postpartum Doula's breast-feeding specialist and cesarean prevention advocates as well as help them locate other birth and parenting needs. 2. Act as a support group and networking body for aspiring and practicing birth professionals*

There was no central location for TBH, and there was a small fee to be listed on the TBH website. Meetings were held in leased spaces. TBH was rather haphazardly organized, using email to connect birthworkers, but their meetings were frequently cancelled or rescheduled. The organization appeared to fold shortly after the founder moved out of town around 2010, however, Jane, the director of TSH stated recently that when the TBH founder left town, “[TBH] was handed over to me, and I just eventually combined it into TSH.”

Another group, the Birth Buddies (BB), appeared in the city a few years after TBH formed. BB was founded in 2002 by a midwife. According to their website, “*The idea of Birth Buddies was to bring together professionals associated with the birthing year that also believed in informed consent and informed choice.*” At its peak, BB had thirty five members including midwives, doulas, childbirth educators, chiropractors, lactation consultants, massage therapists, essential oil specialists, and birth photographers. Birth Buddies charged \$100 for a birthworker to list her business on their website. This agency sponsored events where pregnant women could go to free seminars to learn about pregnancy related topics in presentations given by birthworkers. There was never a central location for BB. Monthly meetings were held at community centers just as TBH did before them. During these meetings, several birthworkers would speak about pregnancy, childbirth, and neonatal topics. Other birthworkers were present,

handing out their flyers and business cards to pregnant women and mothers from the area who attended for free. These meetings also had the effect of increasing contact between birthworkers and their potential clientele.

Perhaps as a result of the economic downturn that hit the area around that time, both TBH and BB folded between 2008 and 2010. Two organizations emerged out of the void left by these. These two groups reflected an ideological divide that was beginning to solidify at that time in the alternative birth community. One group was TSH, who reflected an ideal similar to BB around “informed choice” as I will discuss below. The other was a group of midwives, childbirth educators, and doulas in town who called themselves “Manger Mommas” and catered exclusively to home birth clientele. This group represented the more radical homebirth-only group of midwives. Manger Mommas was only willing to accept healthy and low risk women as clients so as to minimize the potential of a hospital transport. They focused on the power of women’s intuition in childbirth and saw mothering as an innate quality of women. For Manger Mommas, the best birth was one with no intervention whatsoever, and in their philosophy, midwives are more witnesses to childbirth than deliverers of babies. Due to their apparent disdain for the medical model, Manger Mommas was not affiliated with any physicians in the city. Furthermore, it was stated to me years ago by the founder of TBH that the director and midwife of this organization did not reveal herself as a midwife should she need to transport clients to the hospital. Instead, she would claim to be the doula for the family, keeping her midwifery business safe from medical and/or legal inquiry.

The Manger Mommas website expressed strong sentiments in favor of second amendment rights, and unabashedly advertised their fundamentalist Christian orientation.

This group espoused on their website anti-government sentiments in terms of regulation of birth practitioners. Manger Mommas website spoke of their intention to pray at one's birth, and sent away those who did not wish to participate in this practice. They did not reveal their exact denomination on their website, but were very straightforward about being Christian:

**Our faith** – *We all are both Christian, followers of our Lord, Jesus Christ, and married, and we are all very happy to let our husbands be the heads of our families. We will never ask you or anyone else to share our beliefs or conform to our standard, but we also do not apologize or work particularly hard to be politically correct or to use “inclusive” language.*

Over the years, I have heard many birthworkers and mothers reference this groups in terms of their “extreme” views. This group folded in 2014; however, many of the midwives in this collective continue to practice independently in the area.

### ***A Birthwork ‘Community’?***

The ideological divide among birthworkers in the area has remained. Birthworkers themselves are conflicted about this. Best articulated by one ex-affiliate of TSH:

*So the birth community in [the city] is small, incestuous, and snarky. It is really striking. I don't help that situation for sure because I am opinionated, but we are very competitive with each other and we really shouldn't be and really don't need to be. –Kathleen*

At a meeting I attended which included approximately 20-25 midwives and student midwives, some TSH, and some independent, I observed specific factions

amongst birthworkers. In a large room, chairs were placed all along the four walls. Just by observing where the women sat, and who they associated with, and even further, who they did not associate with, it was clear that these women do not see themselves as one big happy family. There are very different philosophies toward birth and the medical model. After attending this meeting, the notion of “snarky-ness” mentioned in this passage by Kathleen became clear. These women agree on very little, which was obvious as they voiced their differing opinions at the meeting.

### **The Stork House History**

The Stork House is the brainchild of Jane, midwife and founder. TSH is a one-of-a-kind model of alternative birth care in their metropolitan city, which offers midwifery and doula services, lactation counseling, massage therapy for pregnant women, and a plethora of classes and workshops on pregnancy, childbirth, and parenting topics. TSH’s creation established a collective umbrella for birthworkers, and provided a one-stop-shop location to address a variety of needs for pregnant women and to educate women on non-medical options for childbirth, including providing a space for consults, interviews, a boutique, and a meeting space for groups like Child Birth Educators (CBE) . When I first met Jane in 2007, she was working as a doula while training to be a midwife. As a fledgling doula myself, I had just joined the Birth Buddies (BB). I met Jane through that network. Her doula business seemed to be one of the more successful businesses in town, and many of the birthworkers I met at these meetings spoke of the business model she used as a doula as one to emulate. Jane was a recent import to the area from a very family centered community in Utah. Echoing my own sentiments and those of just about

every other birthworker I met at the time, Jane was shocked and dismayed by the lack of supportive services available to pregnant and childbearing women. Enough so that shortly after Birth Buddies folded in 2008, she was moved to start her own network for pregnancy/birth/parenting.

At the time of my introduction to Jane, she was in the process renting space in an industrial office complex to remedy the deficiency of social support by creating a space to build supportive relationships. After the demise of Birth Buddies and TBH, Jane decided to form an organization both to reach out to prospective doula clients in the community and to create a space for birthworkers in the community to come together. The offices located within the complex had four private specific office rooms, a lobby, and a great room. The rooms were sublet to midwives and doulas, and a great room was used to teach independent childbirth education classes, and to hold meetings and support groups.

In interviews she seemed motivated by a number of factors. Jane's vision was very much influenced by her desire to reject the traditional "homebirth only" model and walk a line in-between a medical model and a midwifery model. She was motivated by the idea of giving clients an "informed choice," a model designed to educate and provide services to the market of women who were as yet ambivalent about the traditional midwife model. Her business model reflected what she and many of her affiliates refer to as "the best of both worlds." First I discuss how she set up her initial organization. Then I discuss how she and her affiliates talk about the organizational choices that created the business.

### *Initial Development of TSH—A Central Location*

Having a specific location is similar to the practice of physicians, and as such may be more familiar to women seeking care. This TSH facility functioned like a medical clinic in many respects, several of the office spaces had examinations tables for use during prenatal visits, and there were medical implements such as fetal heart rate dopplers, and anatomical models and posters for client consultations. This structure has a similar appeal to the medical model and as such can make midwifery services more familiar and accessible to clients and their families. At that time, other midwives in the area were providing prenatal visits in the home of the client, a common practice in the midwifery model of care.

Jane framed her intentions in opening TSH more in terms of convenience for clients and practitioners than in terms of a similarity with the medical model of care. In her mind, a central location would remedy the driving that would inevitably occur in her large city as doulas interviewed with prospective clients and conducted prenatal meetings with new clients. Furthermore, she thought that a central location would provide more convenience for clients who could access all sorts of pregnancy related information and service under one roof. In the following passage, Jane describes the way TSH began for her:

*... a bunch of us were doing doula work and we were having to drive to all the clients homes and I thought well, wouldn't it be so great, if there was a space that somebody could come, and get childbirth education, and doulas, and midwives, and so we did, we signed a lease and open the doors, and it's just gotten really big. -Jane*

### ***Initial Development of TSH—Support Group For Birthworkers***

Jane also sought to create an emotional and occupational support group for birthworkers through the TSH organization. In interviews TSH birthworkers talked frequently about this side of the organization, as I will discuss in more detail in Chapter 5: Sisterhood – TSH’s Integrative Midwifery as Internal Collective Identity. They feel as though they have a team of women with whom they share many philosophies and experiences in common. They likened their collegial relationships to a “sisterhood” of women upon whom they could call at any hour of the day or night to decompress after a bad experience. The collective also provides them practical support from their colleagues such as babysitting for one another, covering for one another at a particularly long birth, and for sharing information resources on pregnancy and labor.

Another goal Jane had in organizing birthworkers was to create some consistency in the pricing structure. Here, Winnie describes the beginning aspirations of TSH:

*I’ve heard it told that there was kind of a separate way of working in town that everyone’s rates were different, there wasn’t really a system or a group backing system even or a place to debrief and that Jane and a couple of others were talking about, let’s gets us together as a group so we can support each other and back each other and that unify what we are charging so that there is not this feeling of undercutting each other so there is a way of kind of looking to create community, so that’s my understanding. -Winnie*

### ***Initial Development – Informed Choice***

The overarching principle of TSH is “informed choice,” a goal Jane and affiliates describe as neutrality toward the midwifery or medical models. TSH clients theoretically are free to lean in the direction of the medical model in that clients may choose to give birth with medical directives, or clients can eschew medical assistance and choose a home birth with midwife instead.

In occupying this middle ground, Jane states that she is not a home birth advocate; instead, that she is an advocate for informed choice. The notion of informed consent is a key component of the philosophies of TSH. In using the term “informed choice,” Jane and other TSH affiliates are describing a situation in which a pregnant woman understands all of the various options she has for her care, from both the medical and the midwifery models of care. Many birthworkers contrast the notion of informed choice with the medical model of care in which women are treated with a one-size-fits all approach and are administered various interventions without understanding what they are, why they are being administered, or what alternatives exist. For TSH affiliates, education is key, and whether attending a class at TSH or hiring one of the doulas, clients will be given a plethora of information about their options such that they can make choices armed with knowledge. Thus, informed choice is aligned with the midwifery model of care, and especially as it draws from the master frame of the women’s consumer movements in health from the 1970’s of the self-educated and agentic patient who takes charge of her own care.

Instead of rejecting the medical model of care completely, TSH attempts to position themselves more neutrally, providing services for all pregnant women from all



philosophical backgrounds. Rather than insisting that all women should give birth at home, midwife Jane states that, “...if a woman feels safest in the hospital, that’s where she should be...” Her statement represents a larger foundational goal of TSH, that of linking the often seemingly opposite worlds of midwifery and obstetrics.

This idea of catering to a wide variety of childbirth choices was key to Jane’s vision, and was echoed by all of the TSH affiliates I interviewed. Despite the fact that Jane is a home birth midwife, her business does not exclusively cater to that population. There are many services at TSH that could be of use to pregnant women who are under the care of an obstetrician and who plan to deliver at the hospital. For example, these women could attend TSH childbirth education, prenatal fitness classes, breastfeeding workshops, newborn care classes, birth story sharing circles, attachment parenting classes, baby wearing and cloth diapering classes, circumcision and vaccination classes, and of course they could hire a TSH doula and/or Certified Lactation Counselor (CLC).

So, while Jane’s midwifery business is only of use for the homebirth client, TSH is not. This arrangement places TSH in a unique position in their area as the business casts a wide net in attracting clients, some of whom may be more medically minded. This is a business advantage that no other midwifery-modeled group in the city has. One previous group, Birth Buddies, offered a wide variety of practitioners, but only on a referral basis, not in a cohesive business structure of affiliated workers.

As a part of bridging the gap between obstetrics and midwifery models of care, Jane has developed and maintains relationships with medical practitioners. In this way TSH is able to combine the best of both worlds, so to speak. One of the challenges of midwifery stems from the cultural discourse of childbirth as inherently dangerous.

Women considering giving birth at home with the assistance of a midwife may face criticism from their families and friends – something along the lines of “what will you do if something bad happens and you need a doctor?” One part of gaining clientele as a midwife involves having a system in place to combat the “what-if” concerns regarding home birth. Through the relationships Jane has built with obstetricians, TSH enjoys a broadened appeal. These relationships are an important part of the middle ground orientation of TSH.

One key area where this middle ground is articulated is in describing TSH’s approach to the question of transport – cases when a homebirth client must be transported to the hospital. Here, TSH has distinguished themselves from some other midwives in the area. Many independent midwives are reluctant to transport to a hospital for fear of reprisal from medical staff. As TSH affiliate, Rosie, explains:

*...what [non TSH] midwives had been doing previously was when they were going to transport...What they would do is drop the woman off at the hospital and they wouldn’t have charts and they wouldn’t have records, and so the hospital didn’t like midwives...*

A number of TSH affiliates explained to me that some independent midwives had been turned in to authorities for practicing medicine without a license by the doctors who had received their patients in hospital transport cases. Because this is one of the few states without licensure for CPM’s, the risks are great, and it is technically illegal for this type of midwife to practice in the state. The problem for the midwifery model here is that by dropping women off at the hospital in various states of distress, midwives anger

hospital workers and medical practitioners and further the divide between medical and alternative care.

Jane has worked hard to build relationships with medical providers in her city to contrast the TSH approach with traditional midwifery. Jane and her affiliates detailed in their interviews that when a transport happens, they do not see it as a failure, but simply as a change of venue. The midwives of TSH not only accompany their clients to the hospital in cases of transport, but also bring detailed digital charts of all vital and other statistics revealed during prenatal visits with these women. As Bridgette explains, the linkage of these often conflicting ideologies is a very important and unique aspect of TSH:

*I think the goal originally was to kind of create...a bridge way between the homebirth and hospital birth communities and to offer options.*

Many of my respondents stated that there are some midwives who are resistant to developing such relationships with medical providers due to a lack of trust and /or understanding. We can trace this distrust between medical and midwifery practitioners back to the women's health movements of the 1970's, where midwifery/feminist model proponents saw medical practitioners as paternalistic know-it-all types who treated women in a condescending fashion and disregarded women's abilities to make choices about their own bodies. The result is the same now; without a bridging of the gap between holism and medicine, pregnant and childbearing women lose options.

### ***Changes in TSH Since Inception***

Liz, who serves as the General Manager of TSH, explained that the organization has gone through a number of iterations on the path to where they are now. She stated,

*“Our first evolution is that we were going to be literally a referral center. Just like “Birth Buddies” Here, she is referring to the original office space, and went on to explain that the location quickly turned into one in which “...people could not just have appointments [with clients] but teach childbirth classes....”* After these classes were established, and the internal office spaces were rented by doulas and midwives, the front portion of the space, a sort of lobby area, was rented out and converted into a boutique, The Stork House Baby Boutique, which sold cloth diapers, baby wearing wraps, breastfeeding bras and salves, amber teething necklaces, and other items related to midwifery and alternative models of care.

These developmental stages of TSH ultimately led them from a referral based business, a concept similar to the model of the defunct Birth Buddies and TBH, into a sort of one-stop-shop, which is described further by midwife Julie:

*We wanted to be able to offer everything in one place. Midwives, doulas, lactation, classes, parenting classes and being holistic and having all of the things that we have here. We started out having yoga and different classes ... it was nice being able to have people come in and say “I can do everything here. I don’t have to look for anyone else.”*

In addition to the services listed above, TSH has also housed, at various points in time, chiropractors, Reiki practitioners, massage therapists, herbalists, and a wide variety of support groups and classes. Jane’s main objective behind providing so many different kinds of care to pregnant and childbearing women is to be inclusive of women and families from all walks of life. As one TSH affiliate, Tessa, describes, Jane felt the need to provide options for all, not just for those who chose homebirth:

*[Jane] felt the need of being just a support place for moms no matter what their choices... other than just, “we only support you if you want a home birth.” [TSH isn’t] just for a home birther; they are 1% of the population of the expecting moms, how about the other 99%? They don’t want to birth at home and they want to birth in the hospital. I think that is how TSH was created... saying, “Now, we can help the other 99% of women. We are not only here for the 1%.” – Tessa*

Over the years, TSH has changed its business model to appeal to a wider range of potential clients. The organization has moved twice since the original office space was rented. Donna explained that with the many workshops and classes as well as an expanding client base, more women found out about TSH’s offerings. The organization outgrew the initial office space and moved elsewhere. Independent midwife, Donna, who was Jane’s mentor and also a tenant in the original location, explains the move:

*[TSH has] grown a lot bigger now. We [midwives] looked for office space together and 2008 is when we moved. We outgrew the space and were bursting at the seams. All the students [doulas and midwives] had office space here, childbirth classes...and there really wasn’t enough space, so [TSH] moved down the road, and now they’re down on Central Avenue.*

#### *The Stork House Birth Center*

At the beginning of this study, TSH had recently made its first move out of the originally founded space. In a move toward the midwifery model of care, Jane rented a three bedroom residential property and converted it into a birthing center of sorts, with a midwifery office and consultation space, a great room for classes and meetings, a full

kitchen, landscaped yard, and two birthing rooms, one with a water birth tub. This location was off of the busier roads in town in a quiet residential neighborhood with older, custom ranch homes. This version of TSH was named, “The Stork House Birth Center.” The original goal for the Stork House Birth Center was to rent the space to women for a home-like delivery with their midwives. The property, being the first and only birthing center ever to be opened in the town, was available for rent to all midwives and their clientele.

An independent midwife and previous affiliate of TSH, Kelley, explained what Jane had envisioned for this project:

*Jane had been talking for a couple of years of starting a birth center. I loved the idea. This was an option for women who don't feel home birth or hospital is right. Also, women who come from out-of-town. Who come in from Palmyra, Evansdale...So to have it house-based instead of a hotel... I even liked the idea of sharing calls.*

Many respondents in this study, both TSH affiliates and non-affiliates suggested that a city of their size was in desperate need of a birthing center to provide care to healthy, low risk mothers. The Stork House Birth Center was different from the common model of birthing centers in the US in that it had no medical credentials; no medical equipment, no obstetrical supervision, and no official plan in place to transport. The goal of The Stork House Birth Center was to be an in-between space, somewhere that wasn't home *or* hospital, but many respondents suggested that it wasn't enough of either one. According to numerous respondents, The Stork House Birth Center wasn't medical model enough to provide the safety nets that women were looking for in mid-level care,

nor was it midwifery model “home” enough for women who were truly seeking a hospital alternative. It would seem that this would be one of the risks of being in the middle of the road when there are two very dichotomous paths to walk on either side. At the end of the day, The Stork House Birth Center was simply a stand-in for a woman’s own home, and respondents suggest that it why it was underutilized and ultimately closed down.

According to TSH general manager, Liz:

*We tried it for about a year, and the people that decided to [birth there] weren’t those that were terribly motivated. They didn’t necessarily want a home birth...I don’t know. It wasn’t an easy middle to be in. There were a lot of transfers for epidurals. It was kind of...people who wanted a home birth wanted a home birth, and others wanted the hospital.*

Basically, it seems from these interviews that The Stork House Birth Center failed to find its niche. Independent midwife, Donna, stated,

*...the transport rate [from the Stork House Birth Center] was very high...almost 50%. Just mom saying, "I want to [leave The Stork House Birth Center and] go to the hospital." Jane’s conclusion of why that was was that women just weren’t committed.*

Jane stated to me that the demand was much less than originally anticipated. The respondents in this study agreed that the birthing center concept never really took off. My respondents also stated that there were issues with zoning and licensure of the space, and the consumer demand for a birthing center birth was simply not enough to justify maintaining the space. After about a year, the birthing rooms were repurposed, and the Stork House Birth Center/Birthing Center concept was retired. From that point forward,

this location was used in much the same fashion as the original TSH office space: to see TSH clients for prenatal visits, and to host support groups and teach workshops and classes.

Eventually, the owners of the property put the home up for sale after a death in their family. As a result, Jane decided to purchase the Stork House Birth Center, and use it as her primary residence since she had made many improvements on the property as a lessee. At that point Jane abandoned the midwifery model ideal of running a birthing center and moved more toward a market-based strategy by opening a new shopping plaza store front instead.

### **The Stork House Today**

In May of 2014, just in time for mother's day, TSH moved again, and made several major changes, all of which moved TSH toward the business model it has today – a consumer based retail boutique, that also offers a wide range of services for birthing moms, including alternative care. They moved to a more visible location in a shopping plaza style strip mall with access to a major thoroughfare, changed the funding structure of the organization, and made some administrative changes. I will discuss these changes in detail below. Supported by Jane's midwifery business, and constructed by hand by her husband, the new TSH location seems to be a huge point of pride for Jane and her entire team. In the following passage, Jane summarizes TSH's progression to where it is now, which she sees as a successful venture:

*I feel like we've changed! Yeah, I think over the years... We even tried going in different directions, we moved to [The Stork House Birth Center]*



*because we thought we wanted to run a birth center, and it just wasn't advantageous to do so, and it wasn't what the community needed at the time, so then we went flowing back to the retail end of it, and it is interesting -- I think right now we are where we all want to be, I love every member of my staff, I love what we're doing! Because there's nothing out there like us. –Jane*

In this statement, we see Jane summarizing the geographic history of TSH. The major component of the business today is its retail component. She states that the birthing center wasn't a success as much as she had thought it would be, as the demand for a location of this sort was lower than anticipated. She differentiates between the midwifery model of care in terms of the birthing center to a more consumer focused retail boutique where women can purchase items for their babies and families, attend a class or workshop, or join a support group.



Figure 4.1 Vitamins and Herbs. Photo taken by Kerie Ann Francis, February 27, 2015.



Figure 4.2 Essential Oils, Tinctures, and Herbs. Photo taken by Kerie Ann Francis, February 27, 2015.



Figure 4.3 The Stork House Services and Offerings. Photo taken by Kerie Ann Francis, February 27, 2015.



Figure 4.4 The Stork House Services and Offerings. Photo taken by Kerie Ann Francis, February 27, 2015.

I will now examine how the organization is structured. I will examine the services offered and current philosophy, then turn to the organization--who is in charge, who makes the major decisions, and a variety of job titles and descriptions within the organization. I will also examine how grievances are addressed, or not, according to my respondents.

### ***TSH Services and Offerings***

One of the original purposes of TSH was to eliminate the need for doulas to drive all over town to meet potential clients. This focus on practitioner needs has led to a business model that is now marketed to clients. TSH provides a one-stop shop for pregnant women. Pregnant woman can meet a variety of doulas under the same roof. TSH also offers other services at their location such as midwifery services, childbirth education, massage therapy, herbalism, and a small boutique with related merchandise.

Here, Anna describes the one-stop-shop known as The Stork House:

*It became a labor of love of bringing all these birth workers together, and it has expanded to do so many things. It includes midwives, doulas, lactation consultants, placenta encapsulationists, we have support groups, we have classes, we have birth education, as well as family education, we just have a plethora of resources, even within our group, as well as with out, where we have a lot of resources, and OB's we work with, and pediatricians we work with closely, to just really help families. To know their options, to get options, and to be supported alongside their family journeys. – Anna*



Figure 4.5 A Presentation on Labyrinths in the Great Room of The Stork House. Photo taken by Kerie Ann Francis, Saturday May 10, 2014. (Faces and names obscured to protect identities).



Figure 4.6 Baby Shoes at the Stork House Boutique. Photo taken by Kerie Ann Francis, February 27, 2015.



In all, there are two midwives, five Certified Lactation Counselors (CLCs), eleven doulas, at least five different modalities of childbirth education taught, three types of fitness classes, eight workshops, and six support groups.

*Services for Clients -- The Boutique*

In the current storefront of TSH, there is a large boutique/lobby area upon walking in the door. Here herbal supplements, vitamins, essential oils, loose herbs and teas, green cleaning compounds, and baby items such as amber teething necklaces and walking shoes can be purchased. There is a play area for young children to play in while their folks attend classes, groups, or workshops in the great room. There are two consultation rooms for private prenatal visits with midwives, one of which is also used for massage and Reiki. This location is more focused on retail sales.

*Services for Clients--Meet-And-Greet*

One strategy for reaching out to the community and providing information as well as attracting new clients is the Meet-and-Greet night. This informational event occurs monthly on the last Friday of every month, and is free to attend. According to Jaqueline,

*Two to three of our birth professionals will present information... valuable, valuable information on topics of pregnancy, birth, and postpartum, we will talk... Each month it is catered to different topics but surrounding those are the main bullet points of pregnancy, birth, and postpartum*

By hosting this free event, TSH can also attract potential clients. Many affiliates of TSH, even those who are not presenting that night, attend the Meet-and-Greet event, which serves their business interests as well. Whereas a doula would need to drive to a

potential client's home, the Meet-and-Greet allows her to meet a number of pregnant women and couples in one place. The convenience extends to the women and families as well, as Lilly explains:

*...all the doulas are in one place... instead of doing separate consultations...they can come and talk to several doulas at once.*

#### *Services for Clients -- Mom's Milk Club*

In addition to the Meet-and-Greet, TSH offers another important meeting to the community, the Mom's Milk Club, a free breastfeeding support group and discussion circle. This is a service very close to a traditional midwife model whose purpose is to create social space for mothers to share ideas and meet others. As noted, TSH has a stated goal of "improving breastfeeding success rates," and the Mom's Milk Club is a free offering toward that end. This circle was started by TSH midwife Julie in 2008 and is free to nursing mothers. The circle meets for four hours every Tuesday and is always staffed by a Certified Lactation Consultant (CLC), who is there to help mothers who arrive on a drop in basis by assessing their breastfeeding technique and answering any questions they might have. Additionally, at Mom's Milk Club, breastfeeding mothers get to meet one another, which further promotes the TSH purpose of creating community.

There is also a scale which can be used by mothers before and after feeding their babies to ascertain how much milk the child is receiving. TSH affiliate and CLC, Mimi, explained to me that these weigh-ins help mothers who are nervous that their child may not be receiving enough breast milk to see how much, exactly, the child is eating at a feeding. She explained that this fear of not producing enough milk is often the reason why breastfeeding mothers quit nursing. If a woman cannot make it in for Mom's Milk

Club, there is a rotating on-call schedule of CLC's available to do home or hospital visits, or to meet at the TSH office to help with any breastfeeding problems that might arise, however, there is a fee for these CLC consultations.

*Services for Clients -- CenteringPregnancy*

Another facet of TSH is its participation in CenteringPregnancy, a form of group prenatal care based on the philosophy of a national nonprofit organization; The Centering Healthcare Institute. TSH is one of a number of providers nationwide giving group prenatal care to promote healthy pregnancy, medicalized or not. This organization seeks to lower costs to our national healthcare system by improving outcomes for maternal and child health. They believe that a group care model actively engages patients to take charge of their own health, set goals, build knowledge, and support one's peers in doing the same. In TSH's state, this program is sponsored in part by March of Dimes, a nonprofit organization dedicated to improving child and maternal health. Jane explained that her facility was able to secure funding through the March of Dimes to establish a branch of CenteringPregnancy. Maureen, A TSH affiliate and facilitator for the CenteringPregnancy describes the program thusly:

*Centering pregnancy is the idea that a group of women who are all pregnant get together for more of a group prenatal appointment and it allows us to cover a bunch of topics and to let pregnant moms talk to each other and teach each other and to bounce ideas off of each other and then pregnancy isn't such an isolated event where you sit in a doctor's office and wait to be called in for your appointment and see your doctor or your*

*midwife and walk out having never been effected by anybody else in the room.*

Both the Centering Healthcare Institute and the March of Dimes, make claims to great benefits in infant and maternal health as a result of this program. Keeping in line with the philosophies of the women's health movement, CenteringPregnancy encourages and empowers women to take control of their own healthcare, and to share the information they learn with other women. Further, the format of group care connects pregnant women together and creates community, a major tenet of Jane vision for TSH. As Maureen further explains:

*...when they are in the group environment, we want to help them to relate to each other and to make connections in the community. It has really done that and sometimes people will form friendships and then after the baby is born they get together and they have play dates ...*

Thus, the CenteringPregnancy program has far reaching consequences toward the goals of TSH. It provides accessible care to women, a greater awareness of evidence based care, and a better understanding of a broad range of choices for women. Additionally, the idea of a group based program further bolsters the unwritten, but often discussed goal of TSH, that of community building, which was a very common topic to come up in the interviews with TSH affiliates.

#### *Services for Providers--The Midwifery Certification Program*

In January 2014, Jane began a new project, that of opening her own midwifery school. Rather than seeking accreditation from an existing midwifery school, Jane has created her own 28 month curriculum and is sharing teaching responsibilities with her

partner midwife and TSH director of lactation services, Julie. The current enrollment is thirty women, and because it is her first course offering, there is no charge to this group of students, save printing costs for handouts. In the following excerpt, Tessa describes her student experience in the program:

*We meet at TSH ... It is a large group and we do exercises and we study a lot at home... We have an online group...[Jane] comes up sometimes with questions about, "what would you do in this case." So we do case studies, it is really nice...we meet once or twice a month, last month we met every week and we always have a lot of books to read and we went through an entire book on anatomy and physiology ... we go into the class with everything ready and she takes questions, and will go over her experiences and teaches based on those.*

One of the requirements for a CPM program in addition to the class work is to find a two year apprenticeship under a preceptor. Jane has agreed to serve as preceptor for six of the thirty students. Not only do the students gain valuable experience, but in the course of apprenticeship, they volunteer their time, helping Jane to run her midwifery business. According to Tessa, this is an excellent method of practical learning:

*She also runs an apprenticeship program and I am now part of the apprentice group so I can attend prenatal and be on call. Each student is assigned one day a week to be on call to attend births. So we can assist births and have some of the hands-on experience. -Tessa*

## **Current Philosophy of TSH: Informed Choice**

The organizational philosophy TSH as stated on their website:

*The mission of [TSH] is to reduce unnecessary birth interventions, increase and promote normal, spontaneous labor and vaginal delivery, improve breastfeeding success rates, minimize mother-baby separations, and promote a healthy mother, baby and family attachment as well as support a woman's right to choose her care provider and location of birth. Through compassionate, accessible, and non-judgmental education and resources for both birth professionals and clients, TSH promotes greater awareness of evidenced-based care along with the broad range of choices available to birthing women. In this way, TSH strives to create a positive fiscal impact on our nation's health care system and, most importantly, restore dignity and joy to the birthing process.*

Inherent in the official TSH philosophy is a critique on the heavy handedness of mainstream maternity care, which can be seen in the statement about reducing unnecessary birth interventions and promoting spontaneous labor. In this way, TSH aligns itself more with the midwifery model of care which favors low intervention. Instead of insisting upon homebirth like the midwifery model would suggest, however, TSH supports women's right to choose their own care provider and location, meaning that women can still partake in the offerings of TSH even when they choose the medical model of care, for instance an obstetrical delivery in a hospital. While some midwives might look down upon a woman choosing a medical delivery, TSH tries to maintain its middle-of-the-road status by remaining non-judgmental of the choices women make

regarding their deliveries. TSH seeks to attract a larger client base by providing services that can be consumed by women choosing a more medical birth. For example, women who choose a hospital delivery can still partake in TSH's childbirth education classes, breastfeeding support, newborn care classes, and birth story circles.

Respondents in this study stated that many birthworkers are partial to homebirth, while TSH's goal is to stay impartial. Affiliates explained that the organization focuses on referring clientele to information in the form of websites, books, or handouts, all with the goal of providing nonbiased information to support truly informed choice. While Jane is a homebirth midwife, she has created her organization to tailor to the needs of all types of clients, home and hospital birthers. For Jane, the main purpose of this TSH is impartial education for all:

*We have women come in for childbirth education classes that are having the hospital delivery and they're just looking for support, lactation counselors, doulas, that doesn't have to be homebirth, because I'm not necessarily an advocate for homebirth...I think homebirth is great! But what I'm an advocate for is informed choice, and that's kind of what my platform is... Women, I think, deserve the right to make their own choices.*

Throughout the interview process, TSH affiliates spoke similarly about informed choice and impartiality. Clearly, Jane has established this platform with her affiliates. In order to make TSH true to its goal of promoting informed choice, there are many educational opportunities available to pregnant women to help them to receive the information needed to make their choices from a knowledgeable place.

## **The Organizational Structure of The Stork House**

In this section I will discuss how TSH is organized in terms of leadership, decision making, and promotion. The organizational model has both elements of the midwifery model as well as the medical model. The funding structure has a lot of inspiration from the midwifery model which is based on lots of volunteerism and ambivalence about for-profit care. At the same time, the organization appears in some ways paternalistic, Jane's vision and charisma is very strong.

### ***Funding of TSH***

The lion's share of the funding for the creation and operation of TSH has come from Jane midwifery business. As Liz recalls, though, this model was not sustainable in the long term for Jane, who is the primary breadwinner for her husband and six children:

*Jane just kind of said, "Listen, I can't continue to build the midwifery practice and TSH. Either I'm just going to be a midwife, or we're going to have to do something different with TSH..." » -Liz*

One of the stated goals from their business manager, Mimi, is to "get TSH on its own two feet as an entity where her midwife practice and services are contributing to that entity but not completely supporting that entity." Affiliates are hopeful to realize this goal now that they are in their new storefront space.

As I was interviewing for this study, many of the TSH affiliates discussed the most recent changes that were engineered to remove the entire financial burden for TSH off of Jane's back. This new pricing structure for the various practitioners of TSH was set by Jane and her directors. These fees were changed in anticipation moving into the new storefront location. New doulas affiliated with TSH must complete three free births



before moving on to the student doula rate. Student doulas must, for the first year, take all of their clients for \$350 apiece, while fully credentialed doulas charge \$650. For student and fully credentialed doulas, there is a referral fee of \$50 that is paid to TSH to cover a number of costs including advertising, legal services, rent for the storefront, and other materials.

For Janice and others, the financial benefits of belonging to TSH are worth any fees paid to the organization on a per client basis:

*There's a lot of benefits, The Stork House has a website, they do marketing, businesswise there's a lot of benefits. And then socially, there is a tribe of women, and then financially and businesswise they have the structure in place already to market. Now we're considered independent contractors at TSH, so they have a standard contract, they have a doula packet for us... That's helpful to me, rather than doing that all on my own, they have every month, the meet the doula, or networking night, I also teach childbirth education there.*

TSH affiliates provide free and reduced cost labor as well as a lot of volunteer time to this organization. Some of this is being “on-call” as midwifery students are required to apprentice with the two midwives with their clientele. These students also have a regular schedule of unpaid days in the store-front to be present to observe and participate in prenatal check-ins with clients, doing tasks like checking vital signs and processing paperwork.

Furthermore, there are three unpaid administrative positions within the organization. Specifically, Winnie, a doula and CBE serves as the director of childbirth

education, Liz, a doula and herbalist, is the general manager, but is also currently filling in as the director of the doula program, Julie, midwife, CLC, and monitrice, now serves as the director of lactation services. I spoke to the office manager, Mimi, who has the only paid position on the TSH payroll, about the concept of volunteerism. She explained to me the structure of administration:

*Liz is who manages the doulas so she is the point person for questions.*

*Winnie manages the childbirth education. And Julie manages lactation. So those are department managers.*

I went on to ask about the pay scale, “Are those paid positions?” to which she responded, “*No they’re not paid for that. They are paid for the services they provide but as far as the time for doing that no.*”

Kathleen, a previous affiliate of TSH states, “*No one works for TSH. Unless you are the office manager, she does work for TSH, but everyone who is a doula or a birth professional there is an affiliate.*” In other words, TSH relies almost entirely upon volunteer work. The only paid position is that of office manager, and all the others refer to themselves as independent contractors. Many of my respondents described their volunteer work as a passion, and only one affiliate in this study expressed any objection to not being paid. Jane was clear that she needs and expects each of her affiliates to volunteer some time in order to be a part of the organization, and states that this is not a place to get rich quick, so to speak:

*So if someone were to come here because they’re in it for the money, they’re not a good fit for TSH. So you’ve got to be in it because you want to improve birth outcomes for moms and babies in [the city]. –Jane*

### *Affiliation and Administrative Structure*

Jane's official title is president and founder of TSH, along with being a certified professional midwife (CPM). Aside from the three director positions, most birthworkers are associated with TSH as affiliates. Affiliates are independent contractors who contract with TSH, meaning to say that affiliates work under an agreement of terms specified by the umbrella company, TSH. They are essentially self-employed and are responsible to account for their own taxes. TSH provides a contract for their affiliates to sign which lays out the conditions of their affiliation; rules, procedures, and expectations. An interesting fact about the current affiliate structure of TSH is that most of these women have been previous clientele of the organization. For example, 12 out of 17 of the affiliated respondents were also previous clients of the business, and in particular, Jane's home birth clients.

TSH affiliates are required to be non-competitive. As Rosie explains it, part of this can be found in Jane's motto, *"there is a doula for everyone and there's a midwife for everyone. Everyone has a different personality and you should be with the one person that clicks and that's what was meant to be."* In order for women to find their meant-to-be birthworker, TSH affiliates are directed to encourage potential clients to interview multiple practitioners. As Rebecca explains, competition is explicitly not allowed:

*...at TSH it is made very clear that it is not a competition, and we refer out to each other, Jane encourages her clients to interview multiple doulas within TSH, even outside of TSH.*

The affiliates are allowed to give discounts at their own discretion, but are encouraged not to do so very often. There is no undercutting allowed, again barring

competition, as Lilly explains: “...we don’t undermine each other. There’s no, ‘well, I’ll do it for \$500...’ ... ‘well, I’ll do it for \$400...’. There’s none of that going on.”

In addition, discounts must not compete with student doula rates. As Janice explains:

*\$650 is the going rate, but a lot of the times if I have a client who is either a TSH or Jane’s client, I will offer a discount. For any financial hardship, I offer a discount but not as much...so \$350 is the rate for student doulas so I won’t go down that low because I don’t want to compete with our student doulas.*

Another change in the TSH organizational structure is the establishment of the three aforementioned administrative or “director” positions. Jane said she needed to hire these directors because, “they take more off of my plate, because there’s just too much for me to do.” While these directors oversee certain aspects of the organization, Jane has the ultimate authority as president. That authority involves her making the final operational and financial decisions about the business. Winnie has been with TSH for four years, and has achieved the title of director of childbirth education. By achieved, I mean to say that when the position of director of childbirth education was established, Winnie, as a CBE in excellent standing with a multiple year history with the organization was asked and accepted the position. Here, Winnie explains the decision making process of the organization:

*I guess if an opportunity comes up ... or there is something over there that maybe we should be involved in, then whoever notices it will bring it forward, and [Jane] calls the shots on that. Like, “yes that’s probably a*

*good thing for us to get involved in...” or, “we want our name on that...” or, “we don’t want our name on that.” [Jane] also will make decisions about who is doing what within the organization, basically. Her business is kind of separate, I think a lot of what happens is her business financially does end up melding into TSH, which ideally it won’t once we are in our new space. Financially, also she will make decisions about where we want to put funds and such.*

***Promotion: Tenure and Shared Vision***

In the interview process, I asked each respondent if they were interested in becoming a director, or occupying a leadership position if they did not hold one already. Many of the women stated that they were happy with their current position within the organization, citing a desire to spend more time with their young children as a reason to keep their TSH participation at an affiliate level instead of seeking promotion to administration. I further asked respondents if there was a process to getting promoted, and if so, whether or not they were familiar with that process. Most were not certain of how to gain promotion, but felt that women who had been with the organization for years were most likely to be promoted. Here, Schlyer states that those with the longest tenure would be promoted:

*[There is] a lot of turnover. For doulas, its surprisingly high, people don’t understand that the strenuousness of it, and if you tough it out for four or five years...surely they’ll ask you to be in charge of something.*

I spoke directly with Jane about how affiliates were/are chosen for promotion. She explained that directors have suggested certain people as candidates for promotion,

but stated that the most important quality for her directors is that of shared objectives.

These shared objectives are a very important part of the success of TSH, and in particular in how TSH achieves its goal of providing care to both medical and midwifery clientele.

Jane explains here how approaches promotion of affiliates:

*Those of us that are directors get together and meet, and one of us might propose somebody [being promoted]....How I chose the women to become directors was just based on their desire to take on that responsibility. And their helpfulness, and I think with TSH... even though I really appreciate everyone's philosophy in the community... TSH definitely has its own platform, and so finding women whose voices were similar to mine, not exactly like mine, but similar to mine, we respect women from all walks of life, we allow women to make their own choices, hospital birth works for some people, homebirth works for some people, I have to find people who are okay with that.*

Here we see that a key issue is acceptance, at some level, of the medical model for inclusion into the higher ranks of the organization. In order for Jane's organization to continue to provide integrative midwifery, she needs to be certain that her staff will fall roughly in line with her midway between the midwifery model and the medical model. Thus, when making decisions to allow certain affiliates power in the organization, she needs to be certain that they are true to her vision of respecting medical and alternative pregnancies and deliveries. Perhaps this explains the reason why the most tenured are the ones being promoted: Jane has time to see that they truly respect her vision for the organization.

### ***Decision Making Processes and Meetings***

I asked TSH affiliates if there were ever any disagreements within the organization, and if so, how these were handled. Most women in the organization said that disagreements were few and far between. They also said that since TSH affiliates are also friends, they felt comfortable going directly to the person with whom they disagreed and solving the dilemma together, directly at the source.

Due to the unpredictable nature of birthwork, respondents stated that it is difficult to gather all affiliates together under one roof on any sort of regular basis. Most of the respondents in this study explained that they felt as though they were included in the decision making process on an organizational level, although it was unclear exactly how they were included, or which decisions any of them contributed to making. Jane said that she often asks for feedback in the form of organizational meetings, through informal calls, and in one-on-one discussions, to consider the opinions and suggestions of her affiliates and directors. Nonetheless, most affiliates expressed that Jane is very approachable, and that they felt included in the process of decision making. As Anna states,

*...depending on what the decision is, what its importance is, and who really needs to be involved in that conversation, that's how the decisions are made. But it's never that one person makes all decisions.*

When disagreements are larger and require mediation, it is Jane who would be called upon. As the president, and the primary financial interest, or capital owner, as she was referred to by some affiliates, it seems normal that she be in charge of sorting

through troubles and finding appropriate solutions. That said, Jane was concerned that everyone felt included in solving dilemmas, but ultimately stated,

*If there's a disagreement amongst us, that happens, and we visit it, and generally just try to meeting on middle ground, I think they would all tell you that I'm the final say... Sometimes I get what I want even if others don't always agree with me [laughter] is that mean? [Laughter] – Jane*

Most affiliates of TSH sing the praises of Jane as the president. She fits the bill as a charismatic leader for her affiliates who detail her strengths and inspiring nature. She is celebrated almost unanimously by TSH affiliates a kind and fair person, thoughtful and generous, even to a fault. Most TSH affiliates felt that Jane was very accessible and that her door was open to all of them for comments, suggestions, and concerns. The only dissenter in terms of Jane's fair and thoughtfulness was Patricia, who states,

*I don't tell my grievances because I've had experiences with other people and Jane doesn't like that. She doesn't like when someone disagrees. She is very sensitive and easily offended.*

Patricia went on to discuss a time when she had an issue with the way the organization was run, and specifically her volunteer work within it. She discussed her issue with another affiliate who in turn discussed it with Jane. Patricia stated she received a nasty email from Jane regarding the hearsay through the grapevine about Patricia's grievance. She stated that Jane threatened to remove her from the organization. For Patricia, there is no safe place to discuss a disagreement, and so now, she keeps her mouth shut. Patricia is the only current affiliate to assert such a negative view of problem solving within the organization.



Most respondent's opinions on the process of settling grievances resemble Michelle's:

*I never feel like there is a hierarchy. I definitely feel like we are all on the same page. We all know Jane is in charge but there is never, "oh she is in charge..." it's never that way, and when we are all in a room she takes everyone's ideas and we collaborate everyone's things. There is never a higher up.*

In this example, we see a cooperative structure, where Jane is clearly in charge, yet willing to listen to all ideas before having the final say, which she admittedly does have. Most affiliates expressed a clear understanding that TSH is not only Jane's brainchild, but that she is the chief financial support for the business historically and currently, funding the rent, advertising dollars, stocking the boutique, furnishing the storefront, etc... While TSH is organized as a cooperative structure, the cooperation rests on a single vision: Jane's. Thus a disagreement with Jane could lead an affiliate to quickly become an outsider. Regardless, the majority of affiliates denied any misgivings about the operation of the business or the organizational structure.

## **CHAPTER FIVE: SISTERHOOD – TSH’S “INTEGRATIVE MIDWIFERY” AS INTERNAL COLLECTIVE IDENTITY**

A key insight into how The Stork House (TSH) affiliates negotiate this “informed consent” model of midwifery, - this “Integrative Midwifery” - is in how they talk about how they feel about themselves as a group, and what binds them together. In talking about their identity as alternative birthworkers, what elements of midwifery do they retain and what do they reject? This chapter will explore how TSH affiliates talk about the sense of internal “we-ness.” I found several key components to this aspect of the collective identity that sustains the organization. The most common language affiliates used in talking about themselves was as a ‘sisterhood.’ TSH affiliates feel like a family, specifically, some refer to one another as sisters, and all feel like they are part of a community. Another component of this community includes how they provide backup for one another physically and emotionally. Finally, they talk about the importance of mentoring for learning the knowledge they need to provide their services.

This sisterly, familial language has been an important component of the midwifery model, the women’s movement in health, and even feminism more generally. In this way, TSH define themselves in very similar ways to past midwifery/alternative health care movements. In addition, the TSH business model explicitly creates a ‘collective’ allowing workers to rely on each other for informal support for the unpredictable hours. This is not something common for medical or obstetric work, nor for many types of paid employment.

At the same time, they talk about knowledge in an interesting way. They value shared knowledge, experience, in ways very similar to the women’s health movement.

At the same time they voice unease with relying solely on word of mouth/hand me down knowledge.

It is important to note, however, that owner and founder, Jane, communicates a strong unifying vision. There are two important components. First, she has handpicked a group of likeminded practitioners, a large proportion of whom were her former homebirth clients, assuring they share important tenets of her vision for the organization. As we will see, if practitioners disagree, they are either asked to leave, or never asked to join. Second, Jane is in many ways a charismatic if not autocratic leader. As we have seen in the previous chapter, while Jane has organized somewhat of a democratic administrative structure, she exercises tight control over which independent contractors she hires and has instituted a fairly autocratic structure.

### **TSH Birthwork as a Lifestyle**

To a large extent, TSH affiliates began the expression of their ‘we-ness’ in ways that were very similar to a wide range of midwives and alternative birth workers. That the work is done out of passion, or love, that birthworkers are a certain “type” of person. Anna expressed this in her comment, “*you're kind of born a birth worker.*” Workers are typically very passionate care providers; the money one makes is not normally sufficient to provide for a family. Further, Anna went on to explain that people outside of birth work might find it to be gross to work around childbirth. She said that other people wonder why and how birthworkers handle being around the pain of childbirth on a regular basis without depression. She explained that not only do birthworkers not mind these uncommon job attributes, but in fact they, “*live for that stuff.*” In this way, Anna

distinguishes TSH affiliates from outsiders, or those who do not understand their passion for birthwork.

What makes affiliates of TSH different is the way they talk about the benefits of the collective organization of TSH. The lifestyle aspect of midwifery is extended to include a wide range of other women who many women described as families of affinity. They talked about how members help one another, whether it is emotional support or work related support. They take care of each others' children, and trade babysitting favors, care for each other when they are sick and because these women are often actively reproducing themselves, they help each other with their own pregnancy and postpartum care. These women talked about the lifestyle aspect as going the extra mile to help out their colleagues from this organization. Here, Anna describes the ways TSH affiliates work together:

*It is so rewarding to be able to work together, know each other, be there for one another, through highs, through lows, we're just a family. Whether it's in birth work, or whether it's in our own family lives, I've had my own TSH teams support me when I had mastitis, support me when I've had three children and my husband has to go back to work, and I was just having hard times, it really is a family.*

Many of the women said their work would not be possible without this close knit community that they have built or joined in TSH. In a real sense, then, being a TSH affiliate is not simply a job, it is a lifestyle, and is not a place for a person who does not want these intense sister-like connections with their co-workers. While a physician goes to work and then comes home and is able to keep these two spheres separate, TSH

affiliates are in constant contact and are always available to one another. In this study, numerous women refer to themselves as sisters, the group itself as a sisterhood. One key place this vision is communicated is through the doula training that Jane has instituted.

As Liz explains:

*One of our biggest points to our doula training is we believe very much in camaraderie... We call ourselves sister doulas. I know that may sound funny. But we forge really important friendships, and that's how we're able to deal with losses, hard scenarios, how we can guarantee backup care...that our children have somewhere safe to be when you're at a birth. When you don't have a group of women to work with, that's hard. You'd almost have to forge some other kind of friendship if you weren't working with TSH.*

In this example, Liz asserts that the concept of family, and more specifically sisterhood, is built directly into the training of TSH doulas. Here, there is an expectation that TSH doulas will forge close relationships with one another. In fact, for Bridgette, TSH's purpose involves the building of such strong alliances: "*part of the mission of TSH is creating a tribe, or a sisterhood, which really appeals to me.*" For her, this tribal, familial sisterhood is not only part of the mission, but is actually a magnet which attracted her to the group.

Taking this notion of sisterhood further, Bridgette also expresses some feminist sentiments about mutual support. Instead of competing with one another, and criticizing one another, TSH women seek to support one another. This is one facet of their sisterhood that gives them strength. According to Bridgette:

*I like sisterhood, I believe in strong women, and I want to be surrounded by strong women. I want to support them, I don't in any way buy into women tearing other women down, that's not my thing. [Jane is] pretty clear that that's not allowed. It's a very supportive group. –Bridgette*

Here, Bridgette proposes that strong women don't tear one another down, but rather support and build each other up. Many feminists argue a similar message, that women, marginalized in a patriarchal system, have so much working against them. Instead of competing with each other in that system, women, from a feminist perspective, must bind together to work toward the betterment of all women. In this example, we also learn that TSH is a business that builds this sentiment right into collective identity, and will actually not tolerate this type of behavior.

As Julie says, *“I could have never done this job without the support network here and the support of my family...I am lucky to be in the practice and be part of a community that if I had to call somebody I could.”*

### **Shared Vision and Support While Working In a Medical Environment**

Another aspect of their “sisterhood” is the social cohesion formed through a shared vision. As Winnie explains that as a businessperson, *“I'm more bound to trust a service person that I am looking for that is part of something established or a community ...”* In this comment, Winnie is saying that because TSH affiliates are so connected, they are able to present a united front to their potential clients as a well-established business. This, to Winnie, is one of many reasons for a birthworker to belong to TSH instead of working individually.

A key part of the vision of TSH is informed choice, and TSH birthworkers are required to remain neutral regardless of the result of their client's experience. That said, my interviewees were very partial to homebirths, and at least birthing experiences without unnecessary interventions. In the course of providing client care, they see things in the hospital setting which they find very destructive and unnecessary. At those times, the community they've built at TSH becomes very useful to them in terms of having someone to call for emotional support while encountering a hostile medicalized system:

*One of the biggest things I think of is emotional support since it is like we talked about; the work is so hard that we need that community amongst each other. It feels lonely if you, at times, you have been at a birth for 24 hours and now there's my sister doula and I can call her and talk to and say, "oh my God I'm melting down" so there is community for sure...*

–Winnie

Like Winnie, many TSH affiliates recounted similar experiences in which their personal convictions collide deeply with actions taken by the medical model. Two aspects of the TSH philosophy are at risk here, that of being non-judgmental toward clients and also that of supporting a woman's right to choose her care provider and location of birth. Because TSH birthworkers, and doulas in general, do not speak for their clients, they must hold their tongue when in the medical setting. My respondents, both in and outside of TSH explained that they repress such feelings, putting them on hold for later. TSH affiliates, however, have at their disposal a sisterhood of women who are willing and able to provide emotional support to one another in processing these events. For TSH affiliates when they can discuss their experience with other birthworkers. While

these women could speak about their feelings with a friend or their spouse, they choose to call upon other TSH affiliates because they share similar experiences and understand the complexities of birthwork. As General Manager Liz says, *“I talk to other workers that I can call and cry...They understand what’s going on...”*

## **Backup Services**

Another key element of their sense of “we-ness” is enhanced through the formal on-call system in which TSH affiliates always have some sort of backup.

Literature on doula work suggests that these birthworkers are likely to experience “burnout” which may eventually lead them to drop the role of doula altogether. One of the primary reasons cited as a difficulty of being a doula is the long hours and unpredictable schedule. According to Donna, the TSH business philosophy has advantages in this arena:

*What TSH does is prepare [doulas], that if you don’t have help and backup, you’re going to burn out. You can’t be on call 24/7 and you have to have time off. They have a call schedule set up. I think that they’re a little bit different. –Donna*

Thus, the TSH business practice of back up doulas spares their affiliates to some extent from the harsh schedule of the job.

One of the main challenges of this occupation is the unpredictable time commitment, and these supports allow for a much lighter burden for practitioners.

*...you have a support network and a backup system, you ...have mentors, and other people to help you in that aspect and that is a huge benefit to me*



*and that is part of the reason that I joined TSH. Knowing that for some reason if I had an emergency and couldn't be at a birth, there was going to be another very qualified doula to be there. –Julie*

Independent birthworkers may have a struggle on their hands should something come up in their private life simultaneous to their client going into labor. In Julie's example, she has a backup system to call upon in such a situation. Most importantly, as a member of TSH, Julie knows that not only would she have a backup, but that this person will be qualified and of like mind in terms of the TSH philosophy.

### **Exchanging Health Information and Mentoring**

The midwifery model and feminist health care movement value experience and shared knowledge in the same way that the medical model values physician authority. These are, for each model respectively, the supreme ways of knowing that inform their work and philosophies. Here, the affiliates of TSH are more similar to the midwifery and feminist health part of this continuum. They spoke a great deal about learning through experience and the benefits of being able to turn to a more experienced member of TSH for assistance. New TSH doulas are placed into the field to assist women in pregnancy and childbirth. By being affiliated with TSH, these women have a source of information and experience at their fingertips, just a phone call or text message away:

*...there's always communication, like "hey I've got this mom who was struggling with this... Has anyone ever dealt with this? How do you handle this? What is the best way to help her, what would you suggest," it's a community – Suzette*

On the other hand, they express some contradictions in how they weigh experience and intuition vs. formal medicalized knowledge. All TSH doulas are required to take a three day intensive workshop which affiliates purchase through Doulas of North America (DONA), alongside a number of mandatory assigned readings. TSH affiliates generally seem to be willing to admit when they don't know a bit of technical or medical information and frequently speak of deferring to another authority. Despite this, it is more common for these women to turn to someone else *inside* of the organization for guidance rather than authorities outside the organization. Many of these women cited this aspect of TSH as being a very important attribute of their community. In fact, TSH has a private Facebook group that is set up specifically for this purpose, which allows for such questions to be asked at any time, day or night.

While affiliates talk about the importance of information shared with the community, they seek more knowledge. When asked what needed to be improved about their training, many TSH doulas answered that they felt they needed more time with mentors. One doula who was dismissed from her affiliation with TSH expressed that she felt ill prepared for her first birth experience and detailed a rude wakeup call when initially placed in the field:

*I think what gets lost in the translation, if you will, in this birthwork business, is mentorship and the need for experience. I did not have any mentors with me on the first birth that I went to and it was a terrifying experience. You walk into a room and you see those parents...a look of relief washes over their faces, and all the all of a sudden reality hits you.*

*'They're looking at me to help them, and I have no idea what I am doing.'*

*–Kathleen*

Here, Kathleen describes a situation in which she is expected to go from student to expert with what she felt was inadequate preparation. Many doulas shared similar concerns, that they are expected to be the expert in birthing situations, but often encounter things within the labor and delivery context that are unfamiliar to them. According to Melissa, *“Experience is the best thing. You're just not gonna see it all in a year or two years. So time and experience...”* Because TSH has so many different types of practitioners with multiple levels of experience, there is always someone to call upon.

*I love the ability to have that mentorship. The ability to have someone to give feedback. The ability to have someone to go to to ask questions, we're a family there. I just couldn't imagine before TSH was around. Before that, it's very much that you would go to a training, meet these people, and then do it all on your own. Maybe you could join online support groups or something like that... But you don't have that connection, you don't really have someone who's been there, who can mentor you, and walk you through... walk in those footsteps previous to you. I love that aspect of it, I loved to be mentored. –Anna*

Both of TSH's most experienced and educated birthworkers, the two midwives, have also served as doulas, so they really understand the role the doula plays. Anna and countless others detail experiences of calling or texting the midwives on their way to births. This practice seems to be encouraged and expected, a sort of informal benefit of affiliating oneself with TSH instead of working independently. Some spoke of stepping

out into the hallways during hospital births and sending a text question to one of these women. And even those doulas with a decent amount of experience under their belts continue to make use of their TSH mentors. The availability of mentors is another thing that makes TSH attractive to birthworkers as opposed to working on their own. Mimi expressed a sentiment that that the mentorship at TSH is not only important for birthworkers themselves, but for their clients as well:

*I believe that we are all better with the knowledge of others. So like I said before I don't have the answers to everything and I know I don't. I know a lot of amazing women who have experienced so many amazing things in their lives that can contribute to my growth and my business and my clients and I think that's for me the biggest deal about being involved with a group of women that are like-minded and Have the same goals in mind and that's why I would choose to be associated with TSH as opposed to being on my own. –Mimi*

Literature on doulas states that this position is often a stepping stone on the path to midwifery. In the case of TSH, that is true, both of the TSH midwives were originally doulas. Jane has said on several occasions that a doula has a shelf life of seven years. It is clear that the internal community of TSH thrives when they have seasoned birthworkers to mentor the newly trained. The mentoring practice keeps birthworkers affiliated with TSH, where independently they may have burnt out and quit birthwork altogether.

This notion of being “like-minded” sustains affiliates of TSH. As we have seen, sisterhood, community, backup and support of both an emotional and a practical nature

are important attributes of TSH. All of these characteristics also help foster a strong sense of community.

### **Lack of Competition**

Independent doulas are ultimately businesses, and in the free market model of health care, competition among doulas is to be expected. Indeed, one might expect that given the number of doula's affiliated with TSH there might be competition for clients. But TSH affiliates are required to be non-competitive, which reflects the feminist ethic of care. And all but a few of affiliates are happy with this model.

Jane keeps the number of TSH affiliates small. That way, there is a variety of practitioners to choose from, but not so many that there isn't enough business to go around. By maintaining a small, dedicated group, TSH attempts to ensure the continued success of all affiliates, meanwhile maintaining and further building the sense of collectivity amongst their birthworkers:

*Jane has been pretty loyal to us...she wants to make sure that those of us that have been committed and have been there are thriving enough without letting in just way too many people ... not that we are enclosed in that that we don't welcome others, but I think that it is a loyal group and there have been times where none of us have been really that busy...*  
—Jaqueline

If affiliates felt that they were unable to get business through TSH, they would go elsewhere. I was unable to locate anyone within the group who felt that they had to struggle for clients. In fact, most respondents felt that there was plenty of business to go

around, and a number of women said that they were not currently taking any more clients. It seems that a large part of the collective identity of TSH rests on a sense of unity and connectivity of affiliates as opposed to undercutting and competition. Here, Suzette summarizes this climate of non-competitiveness at TSH:

*There's such a varied amount of availability, there's not a lot of fighting for clients. I think that's a big part of it, I'm trying to think of all the women I know, and everyone seems pretty connected...looking at the personalities, I don't think that's going to change. And I don't know if I just have rose-colored glasses, but it doesn't seem.... I don't think the structure is like that. It's like when you're a parent and you can either raise your children to fight for resources, or you can teach them that we're a team. I think TSH is more of a cohesive group. –Suzette*



Figure 5.1 Appealing to a Mainstream Clientele : Family Photo Wall of The Stork House. Photo taken by Kerie Ann Francis, Saturday May 10, 2015 (Faces and names obscured to protect identities)

In addition to being cohesive, TSH affiliates pride themselves on being an egalitarian group, and, as we have seen, they do not express approval for competitiveness. Part of their sense of community dictates that they not one-up each other. In our interview, Jane hesitated when discussing the power position she occupies within the group. The business belongs to Jane, and she has to lead, in her view, but she tries to do this with a velvet glove as opposed to an iron fist. Numerous affiliates referred to Jane's position of power, but justified it with mentions of her financial backing of the organization.

### **Maintaining Sisterhood—The Policing of Identity**

While all involved parties attempt to remain unified, conflict in a group of this size seems inevitable and I now turn to how this collective vision is maintained in the group. Here is where one can see the power of Jane's charismatic and perhaps authoritarian leadership. It is clear that Jane is in the driver's seat with regards to setting the tone of the organization and being the final authority within TSH.

I asked respondents if there was a process or policy in place to address grievances at TSH. Most looked at me perplexed, unable to answer that question. It seems that conflict resolution begins on an individual level, as Rosie says, "*there have been a few discussions, but it is more likely they'll talk it out...*" If affiliates cannot solve issues individually, the issue in question would be elevated to the level of the director, Jane, who describes the grievance process thusly:

*If there's a disagreement amongst us, that happens, and we visit it, and generally just try just meeting on middle ground, I think they would all tell*



*you that I'm the final say... Sometimes I get what I want even if others don't always agree with me [laughter] is that mean? [Laughter]*

In this example, we see Jane's hesitation in acknowledging her power position in the company. At the end of the day, however, she is the founder, capital owner, and director of the group, and as such, hers is the final say. Most TSH affiliates are agreeably acquiescent to Jane on important matters. Very few people, it seems, have ever left the group on bad terms, as Lilly states, *"In our group, we work together and if you don't, you're probably asked to leave."*

I pressed this issue further with the respondents, asking questions about whether or not anyone was ever dismissed as an affiliate. General Manager Liz explained the process of inclusion and exclusion of individuals from TSH. She detailed the collectivity created and fostered by TSH. Here, we see that being a member of TSH requires an understanding and an allegiance to the group rules:

*I think some people view TSH as cliquish. We have to be...how we've survived is if we have someone that doesn't work well for us, we don't work with them anymore. Some people don't want to work with rules. An establishment that has rules doesn't appeal to them...—Liz*

By rules, Liz is referring to a number of things that are either represented in the TSH philosophy or that were referred to by other TSH affiliates. For example, some of these rules are only doing things one has been trained to do, not giving medical advice, treating hospital staff with respect, and remaining neutral about birthing choices. I also wanted to know who would be the bearer of the bad news should anyone be let go from TSH, and if there was a procedure for termination of affiliation:

*[Question: who fires TSH affiliates and why?] It depends. Usually Jane. There's usually an obvious separation. I think there's a general attitude how we work here. We work so close together, and I think there's this automatic exclusion if you practice differently than that. It becomes clear. That's usually the people who say TSH is not a good fit. And we agree. Most of the time it's a mutual agreement. -Liz*

To corroborate these quotes from Liz, I found a connection between her comments and those of a woman, Kathleen, who had been dismissed from TSH. Both in her interview, and also in the interviews of others, it was revealed that the reason this woman dismissed was due to a lack of care in following the rules. The specific rules she broke were in regards to scope of practice, meaning only doing the things one has been trained and is certified to do. For example, in this case, Kathleen overstepped her scope of practice because she checked her client for cervical dilation, and doulas are not taught or certified to perform pelvic examinations. Furthermore, Kathleen was very vocal about her contempt for the fee structure of TSH:

*In 2012 Jane kicked me out. It was very public. Everything happens for a reason. I think it needed to happen, I don't think it needed to be as public as it was, but I think it needed to happen. I am very much "what you see is what you get" and you are always going to know where you stand with me. I don't blow smoke up your ass, and I am a little bulldog from the Bronx. I swear, and I always tell you where I stand, and probably with very colorful language. And I am a closer. I get really pissed off if I have a consult and I don't close. Jane doesn't run a business like that...obviously*

*we are now on good terms because we have all had stuff that we worked through, it comes back to me telling Jane that she needs to raise her doula rates. –Kathleen*

In this example, Kathleen clearly states that while she did not agree with the procedure of being dismissed, she was indeed ready to leave her affiliation with TSH behind. She is self admittedly argumentative in an organization that calls for cohesion. She further admits to actions of competitiveness in terms of being a “closer.” By this she means to say that when she has a consultation with a perspective client, she likes to “close the deal” or “make the sale,” rather than adhering to the adage “there’s a doula for every woman.” These infractions fly directly in the face of TSH’s clear rules of non-competition, and additionally, she states that she does not agree with the fee structure as set out by Jane.

Here, we substantiate Liz’s statement with Kathleen’s that when TSH rules are not followed, and an affiliate violates the general attitude expected, there becomes a need to separate, and in this case, it is a mutual feeling of separation.

## **CHAPTER SIX: INFORMED CHOICE AND EXTERNAL IDENTITY**

Poletta and Jasper discuss the way that collective identity contains two parts: that which the group feels among themselves, and the identity they present to others (Poletta and Jasper 2001). In the previous section we discussed how the group feels among themselves. In this section, I will examine the positive collective identity that The Stork House (TSH) presents to the potential clients – their local community of pregnant and childbearing women.

TSH positions itself as a Complementary and Alternative Medicine (CAM) form of maternity care which incorporates elements of both medical and midwifery models as a way of attracting more clients. However, negotiating this type of midwifery involves presenting themselves as “neutral,” professional, non-biased and allowing client choice, often in contrast to other midwives. At the same time most of the affiliates are themselves in favor of home births, and seek to use their educational opportunities with their clients to teach them about midwifery approaches.

In this chapter we will talk about how TSH birthworkers craft a positive identity to clients through the rhetoric of individualized care and free choice. TSH is a one stop shop for all things maternity related, creating a safe community space for mothers and babies, being moderate and non-biased, promoting informed choices, and being professional.

The official TSH philosophy is what they call, “informed choice,” the ability of a woman to freely choose her birth experience regardless of how medicalized or interventionist it might be. TSH’s philosophy rests on a critique on the heavy handedness

of mainstream maternity care and embracing a midwifery model of low intervention. However, TSH defines itself against traditional midwifery in important ways. TSH seeks to attract a larger, more mainstream client base by providing services that can be consumed by women choosing a more medical birth. Women who choose a hospital delivery can still partake in TSH's childbirth education classes, breastfeeding support, newborn care classes, and birth story circles. The rhetoric of free choice means that TSH is opposed to either midwifery or medical approaches that dictate to women which avenues of care to choose. This notion of free choice in healthcare fits well with contemporary changes in CAM in which many clients simultaneously utilize both CAM and the medical model according to their needs and personal philosophies.

This consumer model of care also involves offering to clients many types of maternity care under one roof. TSH models itself as a one-stop-shop for clients. While in many ways this model is like a medical clinic, there are a wide variety of alternative health offerings at that location, including midwifery services, doulas, childbirth education, chiropractic care, lactation consultants, placenta encapsulationists and a small boutique with related merchandise. Clients of TSH can customize their experience. Because there are so many options available, no two women need to have the same experience. As Maureen says, "*That is another way that TSH is unique is that you don't just sign up for a midwife and then you get a one size fits all package.*" There are two midwives, five CLCs, eleven doulas, at least five different modalities of childbirth education taught, three types of fitness classes, eight workshops, and six support groups. Thus, there are plenty of combinations of services and providers that a client can customize to meet their unique needs.

## **Not Just For Hippies Anymore -- Appealing to a Mainstream Clientele**

By offering so many options, TSH seeks to appeal to a larger audience of women than traditional midwifery. Respondents in this and previous studies have expressed that midwives, doulas, home and water births tend to be associated with images of hippies giving birth in Volkswagen Microbusses. In fact, birthworkers I have spoken with use terms like crunchy, granola, hippie, and nature mama to describe what they see as the mainstream cultural understanding of their position and work. TSH attempts to appeal to a larger audience by projecting an image toward the more moderate mother, as Suzette says, *“I think that the strength of TSH is that it’s very middle-of-the-road, that it is for average women, ... But it touches on that spiritual side, so you can go and you can be a soccer mom, and have a midwife, and there’s definitely a need for that.”*

Many women in this study point to the recent upsurge in mainstream media coverage of non-medicated, midwifery driven maternity care as a contributing factor in the popularity of midwifery amongst mainstream women. Some common examples cited by respondents are the film by Rikki Lake, “The Business of Being Born,” and the publicized use of midwifery, doulas, and water birth tubs by celebrities such as Kate Middleton, Jessica Alba, Beyoncé, and P!nk. With these common household names, it is not surprising that a more mainstream client is seeking out these services. It has, in some ways, become fashionable to have a midwife, doula, and/or water or home birth. TSH sees this as their advantage and seeks to appeal to this clientele:

*I have a very very wide range of women that come into the practice. We probably do get more of your mainstream clientele than some of the other agencies in town. But that is because my platform is ‘everybody deserves*

*to have a home birth,' whereas if you were to talk to other agencies they would say no no no, just that woman who's willing to be unassisted, which is just not my belief system. I believe every woman deserves that. I probably have a higher transport rate than some of the other midwives in town, because I am willing to take anybody on. So I have doctors and lawyers and stay-at-home moms...--Jane*

Thus TSH seeks to project an image to clients that doesn't disregard hippie mothers, but at the same time offers services that are more in line with what more moderate, mainstream American women have come to expect from childbirth. They project this image through fliers dropped off at doctors' offices, through the Meet-The-Doula nights at City General Hospital, and by paying for Google Sponsored Links such that TSH's page appears at the top of search result lists.

Both TSH midwives discussed some of their more mainstream medical model-like techniques that liken them to the medical model which may be more comfortable and familiar for many clients. For example, both TSH midwives carry oxygen to births in case of emergency, they carry pharmaceuticals such as pitocin to births in case of hemorrhage, and of course, are willing to attempt a home birth with any healthy woman who even vaguely wishes to attempt one. Many respondents stated that other midwives do not carry oxygen and pitocin to births as they see these as tools of the medical model, and thus see them as being unnecessary and antithetical to the midwifery model. Further, many midwives will only take the extremely healthy client on for homebirth, as they seek to maintain low transport rates. Thus, TSH projects a middle range of care which I call Integrative Midwifery, to potential clients who are on the fence in choosing between the

midwifery and the medical models of care. In this way, TSH is saying that they have the best of both worlds, delivered with care and safety:

*We've been trying to carve our niche somewhere in the middle. Sort of a bridge between the super crunchy granola to the super medicalized. Meet common sense and evidence. Somewhere in the middle. -Liz*

### **Non-Judgmental Care**

A part of appealing to the notion of free choice is to appear non-biased. In this, they craft their identity by very explicitly contrasting themselves with traditional midwifery. Many of these respondents have, themselves, experienced childbirth from both medical and midwifery perspectives. Many respondents detailed what they saw as sharp contrasts between these two models of care. Further, most, if not all TSH affiliates prefer non-medicated, home births with a midwife, but understand that this is not the general preference of their potential client base.

They described their techniques for remaining non-biased and presenting TSH in that way to the public. Affiliates took care to point out that a pregnant woman who wants a medicated birth in a hospital is not going to walk into a midwifery clinic and be treated dispassionately by the women working there. Thus they felt TSH must illustrate to the public that all sorts of women who desire all sorts of birthing experiences will find themselves welcome with this organization.

*...TSH's philosophy has always been "it's your birth, we are not going to tell you how to do it. You tell us how you want to do it and we will support*



*you in that, we will help guide you through that, and help you get the resources to have that birth, that looks right for you.” – Anna*

There are many dimensions to the non-biased attitude that TSH wishes to portray to their potential clientele. This image involves a sentiment of non-judgment, instead highlighting empowerment for all types of preferences in birth. They talk about TSH as a place where women receive individualized treatment, in accordance with their unique preferences. In the following example, Winnie uses analogies from historical events, as many social movement participants do, to explain the current external collective identity of TSH that is presented to the public. Here, she is responding to practitioners who look down upon women who do not choose a non-medicated home birth experience:

*This is the same thing that happened in the 70s with stay-at-home moms... Versus moms going to work. This is the same thing. This is all women hating women. And that is not empowerment. The mommy wars... It is all bogus. The platform I always stand on is that of individuality: that is what's right for one is not necessarily for another.—Winnie*

In this passage, Winnie is referring to the ongoing mommy wars between stay-at-home and working mothers. In such arguments, one side continually degrades the choices of the other. TSH affiliates strive not to engage in such arguments. The now defunct Manger Mommas midwifery organization took a public stance in favor of women remaining in the home. They have been described in this study as being “traditional midwifery.” Manger Mommas did little if anything to assist women who did not wish to give birth at home. TSH seeks to be different in this regard, and this difference once

again sets the organization in a mid position on this medical/midwifery continuum, Integrative Midwifery.

### **Just the Facts! The Struggle to Present Non Biased Information**

Another aspect of the collective identity presented by TSH to the public is that of non-biased information dissemination. TSH uses peer reviewed research to educate clients on birthing options. In some ways it is similar to the women's health movement, getting and sharing information about women's health with other women. That said, they do rely on scientific research.

Many affiliates spoke about the types of things their clients wanted information about, ranging from circumcision to vaccination to whether or not to co-sleep. Birthworkers find it most challenging when their clients ask them for their personal preferences with these items, and will usually attempt to steer the conversation away from their own practices. This is an area that presents a difficulty in presenting a non-biased collective identity to the public. Jane reveals her challenges with this:

*I taught the vaccine class for years and years, and I just stopped doing it because it too emotionally cumbersome for me. I very much am looking to teach a very nonbiased class, because I very much want couples to come to their own choices and decisions, but I am very biased about it, so I would leave feeling emotionally drained, and so I have the girl who owns the retail shop to teach them. – Jane*

In our private interview, Jane confesses to her anti-vaccine bias, but this is something she cannot allow the public to see. By teaching the vaccine class, she has the

responsibility to portray impartiality, instead presenting information both for and against vaccinating children. Remaining non-biased is an area where a number of affiliates expressed difficulty, especially in terms of clients asking them about their own personal practices. To deal with these challenges, Janice defers to available literature:

*Because we don't tell a client what to choose, we just provide them with information on any kind of choices that they have a question about. Trying to get them as much unbiased information as possible... I usually like to use peer review, which is nonbiased - Janice*

### **Informed Choice**

This practice of referring clients to information leads directly into one of TSH's predominant philosophies, that of *informed choice*. Most, if not all of TSH's affiliates critiqued the medical model of care as one in which women are subject to many techniques and interventions that they do not know about or understand. Indeed, this is one of the main critiques of the medical model originating from the feminist movements in health. The practice of liberally applying interventions to women's healthcare which are generally not understood by the patient is a major reason why modern medicine gets a critique as being patriarchal. An analogy for the father-knows-best approach, one in which it is not important or even appropriate to ask what or why, but rather to submit oneself to the experts.

Conversely, TSH wishes to portray an image of themselves as promoting understanding of all of one's options. In this model, a pregnant and childbearing woman must understand all of the options that are available to her in order to make a truly

informed choice. In this view, women without information are robbed of their agency to decide what the best choice in a given situation might be. Part of the TSH philosophy regarding informed choice is to help clients learn what all the possible choices are, to understand each one, to know its side effects, and to know about any potential alternatives for each:

*I do think that at TSH, we focus on choice; we focus on the mother, and her making those choices. We were talking recently at one of our meetings, it isn't the birth outcome that leads to satisfaction, it is the choices that the mother is allowed to make during the birth, you can find complete fulfillment with a C-section if you were given the ability, given the information, and given those choices along the way that led you to that. So it's not a push for natural birth, it's a push for women making choices about their body. -Suzette*

### **Professionalism**

A final, yet very important part of the external collective identity TSH wishes to portray to potential clients is that of professional standards. This is related to a component of CAM known as isomorphism – mimicking the profession of the doctor who is seen as a legitimate authority. TSH affiliates talk about a common misconception that midwifery care would coincide with archaic theories and practices. TSH seek to portray themselves as a highly professionalized group in order to gain the trust and respect of the consumer. Many CAM modalities are using dominant medical language, props, and behaviors in order to legitimate their work.

TSH displays their professionalism to the community in a number of ways. One of these is by maintaining the office and client files in a modern way, much like the medical model. Jane demonstrates TSH's professionalism meanwhile debunking some possible misconceptions of the public by stating, "*we have technology and online charting, so it's not like you walk into my office and it smells, or you're not sure if it's clean or it's not...*"

Another thing that helps to build and maintain the professional reputation of TSH is found in the relationships that have been built with medical providers in their area. By aligning themselves with medical professionals, TSH affiliates feel they can extend their appeal. In order to maintain these connections, TSH must be willing to defer to medical model as established authorities, which presents problems.

It is known by all affiliates that TSH has a close-knit relationship with two obstetricians and two hospitals. The obstetricians are on a first name basis with both of the TSH midwives, who have agreed to serve as backup physicians in the case of transport of a home birth client. These doctors are also on a first name basis with many of the TSH doulas with whom they share clients in common.

One hospital allows TSH to come on property and have a "meet the doula" night in their lobby for pregnant mothers. Gaining access to legitimated spaces is a very important part of the success of CAM practitioners of all modalities. It is compelling that a hospital would allow a private business to come in and present to hospital clientele. This event is an important part of the professional networking that is done by TSH. Jane has tried to get into other hospitals in town to offer a similar program, but has had no luck.

It is very important that these relationships are upheld, as they were notoriously hard to build, and are very important to providing TSH clients with the safest and most harmonious care. While the midwives have more personal relationships with the doctors, and are rarely on hospital grounds, doulas have more contact with medical practitioners, and as Donna states, *“The Stork House holds doulas to a different standard.”* Julie explains this expectation further:

*We have really worked hard to foster those relationships, and even our doulas, we let them know that they represent TSH, and so you do need to act a certain way, and you need to build a rapport with people, because number one, birth isn't about you, it is about your clients... You can be a compassionate, loving, kind, and humble person and still be a professional entity... We have a standard, and we have set a standard that we expect to be followed, and we get reports back from people and [we have] evaluations so we keep up on that. So there is a check and balance system...that is important to have.*

In this example, we see that it is not only important to portray professionalism to potential clients, but also to medical model practitioners and locations. Part of this is because there are many negative connotations to alternative birth work amongst medical practitioners. For example, there is a concern that doulas not give medical advice, which is something that TSH specifically prohibits: *“we do have a good reputation in town that we are not giving medical advice and we are not stepping on toes.”* Janice

In order to continue to enjoy the success that they have had in their area, TSH is going to need to continue to build upon and maintain a positive external collective

identity. This involves continuing to make inroads with medical practitioners and locations, and to continue to include a variety of services and offerings that will attract a larger client base. Without the backing of both medical practitioners and institutions, and an interested populous, TSH will surely face an uphill battle, and it is clear in their narratives that TSH affiliates understand their role in this task.

## **CHAPTER SEVEN: IDENTITY AS MEDICAL PRACTITIONERS**

A key component of negotiating their place on the midwifery/medical continuum is to define who they are not. While collective identity illustrates what makes this group cohesive, boundaries are the practices, behaviors, and attitudes that affiliates feel make them different from others. Part of this story involves the boundaries that allow one to fall within the group, and another part involves the boundaries that would cause a person to fall outside of the lines. In the following paragraphs, I will examine the boundaries creation and maintenance of the The Stork House (TSH) group.

While informed choice is central to what TSH presents to the community, affiliates still have very strong feelings against the medicalized model of maternity care. They struggle against both medical practitioners and clients who only understand a medicalized perspective. In this chapter we look at where birthworkers negotiate against the medical model, including against others who reject the medical model. Part of this task involves the boundaries as described by TSH affiliates, but I will also examine the boundaries from other birthworkers, specifically, the two physicians and four non-TSH birthworkers who interviewed for this study.

### ***Identity within Medical Institutions: Treading Softly, and Surviving Within the Hospital***

One of the ways that TSH affiliates are different from other birthworkers is in the way that they try to straddle the fence between the medical model and the more holistic, mainstream model. In this section I discuss the specific interactional boundaries used by TSH affiliates and midwives in deference to medical model.



While Certified Nurse Midwives (CNM's) are medical providers, clearly located within the jurisdiction of hospitals, doctors, and other medical professionals, Certified Professional Midwives (CPM's) have a very different story. In fact, there are many types of CPM, some of whom advocate for absolutely NO medical interference whatsoever in pregnancy, labor, and delivery. As the director of TSH, Jane attempts to bridge the great divide between CPM's and the mainstream medical models of maternal care in the area. She does this by maintaining close relationships with medical locations and practitioners, by offering a number of medical-model options to her clients such as bringing oxygen and pitocin to homebirths, and also by standing in favor of licensure of CPM's.

Research shows that doula's often get a bad rap from medical practitioners for overstepping their bounds, upstaging the medical professionals in the room, and being confrontational (Mainord 1997; Gilliland 2002; Schwartz 2002; Adams and Bianchi 2004; Papagni and Buckner 2006). TSH doula's, on the other hand are trained to cooperate and even defer to the doctors, nurses, and hospital protocol. In previous research (Francis 2008, unpublished master's thesis), I have documented the ways that doula's are able to assist their clients in a sort of "quiet resistance," in which opposing ideologies are only discussed privately, out of earshot of medical professionals. Jaqueline, a TSH affiliate, details a similar strategy when discussing the boundaries between TSH and the medical model:

*...with our doula's, we all try to be that happy medium area between the doctor and the nurse and the parents. We don't get in anybody's face, and I think that that is really important, and what Jane has worked for in the training. We are not going to sit there and be the bad guys, and fight the*

*battle with the nurses and the doctors. We're going to empower our clients to ask the right questions. Help them understand that this something that is being suggested to you in labor ...and that is what I teach in my class: if something is being suggested, take a couple of moments talk about it with each other and ask the questions.*

In this commentary, Jaqueline discusses the “happy medium,” a very literal boundary that TSH attempts to occupy with some success. Respondents in this study have all alluded to such boundaries that allow them to simultaneously educate women in alternative options and methods, meanwhile keeping within the good graces of medical practitioners and locations. The staunchly anti-medical position of many birthworkers creates an “us and them” situation in which they are less than welcome in medical settings. This difference in philosophy does a disservice to the birthworker’s career, but more importantly to the birthing woman’s experience, which could involve oppositional interactions between her birthworker and hospital staff. In training and maintaining birthworkers, TSH sets boundaries on their scope of practice and acceptable interactions:

*[TSH has] worked with the medical community. It's not us against them. I said anytime you have student doulas, send them to the hospital... We can meet in the middle. Jane has ejected some doulas that are too far out on the fringe...any midwives too. “Sorry, you're not a part of us anymore.”*

*—Dr. Adams*

In this quote, we see the boundaries of acceptability in the scope of practice for TSH affiliates. This sentiment was echoed throughout these interviews; that TSH doulas must abide by standards in regards to their level of respect and deference toward medical

staff. TSH has, in its eight years in the area, worked to establish alliances with medical practitioners and locations and greatly values these connections. Any TSH affiliate is expected to uphold and honor these relationships as they are seen as incredibly valuable to setting TSH apart from other birthworkers.

In fact, almost unanimously, TSH affiliates believe that their relationships with doctors and the medical model are one of their most important assets. Jane related to me that she has visited numerous doctor's offices, obstetrical, pediatric, and perinatal, as well as hospitals in the area in an attempt to build new relationships. She wishes to inform these practitioners and locations that TSH is different from other birthworkers in the area. As Rosie explains, *"doctors can see that she doesn't view herself as above them or anything like that, and some of the midwives do."*

Both of the physicians in this study portrayed TSH and director Jane as being professional, above board, and non-confrontational, while expressing disdain for some, though not all other birthworkers in the area. While Dr. Green does not approve of homebirth, he still refers clients to TSH for various services. Dr. Adams seemed to have an even closer bond with Jane, even calling her to consult on midwifery related questions, and attending TSH functions such as the annual mother's day picnic, and the grand opening of the new location. These connections not only set TSH apart from other birthworkers in the area, but also serve to increase name recognition amongst doctors and nurses. Here, Kelley describes TSH director Jane's ability to make her organization distinct:

*Jane, one of her biggest gifts as a person, is her ability to lead and encourage and build this group. But also supporting the community of [the*

*city]. Also, the name recognition is important. She has a lot of name recognition with relationships with hospitals and providers that make a difference.*

These distinct relationships between TSH and the medical model make the group more accessible to the mainstream woman who herself respects and wishes to cooperate with medical authorities in her pregnancy and birthing experiences. By upholding standards of professionalism and cooperation, TSH remains welcome in medical spaces. This is clearly an objective of complementary and alternative practitioners as the best way to legitimate one's alternative practice. According to Goldner (2004), Complementary and Alternative Medicine (CAM) practitioners can reshape formal organizations best when they are able to gain access to the inside track.

### ***Change Medicine from the Inside***

Part of what I will be arguing in the last chapter is that TSH is a social movement organization. Their goal is not only to integrate with medical model, but also using that foothold to make changes from the inside. As agents of change, TSH practitioners and other birthworkers seek to reform the medical mode of birth in America. For example, TSH practitioners would like to see changes in terms of things like the rigid adherence to Friedman's Curve, shifting from continuous to intermittent monitoring in healthy mothers, allowing women to be mobile and labor in whatever position feels the best to them, and allowing for water birth in hospital settings. Due to the unique set of relationships established by TSH, this group is in a more advantageous position than others in the area to create such changes. Winnie, a doula and director of the Childbirth Education Program at TSH explains the bottom up approach to social change from within

established organizations and how TSH's boundary setting has put them in a prime position to affect such changes:

*I mean some people in the birth world in town might describe it as elitist, but we are not elitist. I look at it as it is not elitist, it is a standard. If what you are trying to do is help women, and help them in the hospital, and that is the ultimate goal, how are you helping them by alienating the staff that they have chosen to do their birth? The way I look at it is that you have to work the system from inside, and if you can't get inside you can't work the system. There is no way you can work the system from outside. If you bang and yell at that door they are going to keep it locked, so the only way is through gentleness, and you don't benefit anybody if you get that door closed on you. So I feel that TSH's attempt at kind of clarifying how our doulas work, and how we are perceived in our community and all of that is something Jane and I very much see eye to eye on. It's very much the idea that you have to work it from the inside. – Winnie*

## **Identity as a MEDwife**

### ***The MEDwifery Model***

While there are many benefits to permeating the boundaries of the medical model, there is also a fair amount of backlash from other birthworkers in the area based on the medically oriented boundaries of TSH. One aspect of said backlash can be seen in a label in the form of a slang term that has been applied to Jane, midwife, founder and director of TSH. This label or slang term is based upon Jane's official title of "midwife" but since

her boundaries include medical knowledge and medically based practices, other birthworkers in the area derogatorily call her “MEDwife.” This hearsay was corroborated by many TSH affiliates, one obstetrician, and both independent midwives. TSH affiliate Anna gives some background on this insider/outsider boundary between midwives in the subject city:

*... it should be what makes you comfortable, it should be what makes you feel safe, yes, we advocate having a natural childbirth, yes we advocate wanting women to get back to their roots of how babies are brought into this world, but, we also want women to feel comfortable and supported whatever that looks like. Our midwives do what some don't do, they bring oxygen to births, and use it if necessary, they bring Pitocin in the event of hemorrhaging after the birth, they do bring some medical procedures into homebirths, which in our opinion, and in our values as TSH employees, is to save lives. To keep people... to be able to achieve those goals and still have things that can really help you continue to have a homebirth, and to continue to have a safe homebirth if necessary. So, those are the things that can be kind of unique about TSH that not all birth workers provide.*

Some of the resistance to midwives carrying oxygen, giving IV's, suturing, or using pitocin to combat hemorrhage comes from midwives who philosophically oppose any interventions. Many of my respondents referred to another school of thought on midwifery called Ancient Arts Midwifery Institute (AAMI) as being very anti-medical. Here we see a midwifery model of care that is more traditional, focused on believed essential characteristics of women as instinctual birthers. TSH defines themselves against

this extreme midwifery in favor of a more medicalized approach. As Bridgette explains, “[The AAMI] school of thought is that there should be no intervention in birth, whatsoever. Almost like as a midwife, you’re just there to witness a birth.” On the AAMI website, where students can enroll in a correspondence course in midwifery, the group self describes as “birth trusting, hands-off midwifery,” and further hints at a disdain for certification and licensure.

Both obstetricians were skeptical at best of the hands-off version of midwifery. Indeed, both doctors serve as hospital back-ups for TSH due to their willingness to include medical safety nets as much as is practical in a homebirth setting. Dr. Adams more so than Dr. Green felt that homebirth was a reasonably safe option for healthy women provided the midwives overseeing such births are aware of and willing to defer to medical perspectives on childbirth:

*Jane says, [TSH is] looked down upon in her community. [More traditional midwives] call them "med-wives." But they have people out there saying, "we're not doing an ultrasound. We've got to trust. We won't do anything medical." As far as things way out there, that's like driving without a seat belt. "Let's just trust our driving skills and instincts." Well, I'm sorry. When an accident happens, you're not going to be able to throw your seat belts on fast enough, or strap your kids in the back. You're going to go through the windshield. And more than likely from what I've seen, you're the bodies that we [doctors] can't do anything with. –Dr. Adams*

Here, we see Dr. Adams referring to the need for more medical knowledge and deference to medical authority for midwives in the quest to offer best practice for their clients.

***Against Traditional Midwifery – Medical Knowledge and Worst Case Scenarios***

At the time of the data collection for this study, there had been a case where a baby died in utero for a client under the care of a homebirth midwife. The incident was vaguely discussed by many of the respondents in this study, and even then in hushed tones and with great caution not to reveal the identity of the practitioner. Both doctors were aware of the case, and Dr. Adams was involved as the available doctor when the mother was admitted to the hospital. This event was discussed as a reason to integrate and defer to the medical model.

The news of this case has been widespread all over the internet by a particularly aggressive critic of midwifery, The Skeptical OB, who was discussed by a number of respondents in this study. On the Skeptical OB website, [www.theskepticalob.com](http://www.theskepticalob.com), a female retired obstetrician questions “*the received wisdom on natural childbirth and breastfeeding.*” Her approach is extremely critical of homebirthers in general, and on her website she commonly covers cases around the country in which babies or mothers who are under the care of a CPM have died or been injured. In the coverage of this particular case, The Skeptical OB calls out the midwife in question by name (not one of my respondents), meanwhile referring to Dr. Adams as “Dr. X.”, and describes him thusly “*he provides backup for many homebirth midwives their city.*”

The general consensus I received from the narratives of my respondents was that the midwife lacked in caution, instead focusing on the more traditional form of midwifery



that eschews medical diagnostics. By the time this woman was admitted to the hospital, there was little that could be done to save the life of the child. Dr. Adams worked on the baby and mother for nearly an hour, to no avail, the baby passed away. This is one instance in the area that has and will continue to occupy an almost folkloric status as it illustrates the dangers, fears about, and worst case scenario of a failed homebirth. Everyone with whom I spoke about this case seemed to be in agreement that this infant's death could have been avoided had the provider had more medical knowledge of and/or deference to the medical model of care. Thus, the case appears to rationalize further the importance of the "MEDwifery Model" for the continued success of the TSH organization.

### ***Against Midwifery and the Hospital Transport Issue***

Another time when different midwives have different philosophies involves the change of venue from a client's home to the hospital. Birthworkers refer to this practice as a "transport," which is done after a decision is made by the birth team. In such cases, it may be that the labor has been going on for a very long time, or has been particularly intense for the woman, at which point she decided that she would like pain medication that is administered only in the hospital setting. A transport can also occur at the suggestion of the midwife, when, in her professional opinion, a homebirth, for whatever reason, is no longer a safe option.

As previously discussed, TSH has a unique relationship with a number of physicians in the area, and when faced with a possible transport, TSH midwives will call upon these individuals for backup upon arrival at the hospital. According to a number of respondents, there are other midwives who do not have relationships with physicians like

these which serve to set TSH apart. Instead, respondents suggested that these midwives providers might encourage the woman to stay home in the case of needing pain medications, or simply transport to the nearest hospital and engage the care of the on-call physician.

One problem with transporting a homebirth client to the hospital without a backup physician on board and waiting is found in the type of treatment that woman is going to receive upon her arrival. A number of my respondents suggested that transport clients will be spoken down to, taunted, and shamed by hospital staff for having chosen a home birth and having ultimately failed to accomplish their goal. There is, it seems, a sort of condescending, "I told you so" attitude towards these mothers. Here, Certified Nurse Midwife (CNM) Donna describes the transport from her unique perspective as both a medical and an alternative practitioner:

*I've been on the receiving end, and you often feel like something's getting dumped on your doorstep, on the receiving end. There's often from the get-go a feeling of, "I don't trust you, I don't want to be here, and I'm only here because I have to be." If you start things out that way, it's not going to go well.*

Birthworkers in this study do not want their client to be treated in such a manner. In his interview, Dr. Green stated that this negative treatment of mothers is a major reason why he became involved in backing Jane for transport situations. He explained that he had witnessed nasty treatment toward homebirth transport patients on part of the on call doctor. He further stated that these occasions made him feel really bad, and so he

now accepts transport patients from Jane such that he can be sure the patient is treated with dignity.

I asked respondents in this study for more information about transport and the nuances therein. I was told that for other midwives, there are several important considerations at hand when dealing with a transport. One of these is a concern for legality on the part of the midwife, another is a concern with their own transport rates, and another is the treatment of homebirth clients without backup physicians, as we have just seen.

In terms of the legality issues, there is a fear amongst many homebirth midwives that they will be arrested or sued for practicing medicine without a license should something go wrong with their client's birth. This fear of being sued, and the contention that occurs upon arrival at the hospital has been enough to keep a number of midwives out of the hospital, instead attempting to keep clients at home. Some respondents in this study almost jokingly referred to the midwife just slowing down her car enough to kick patients out at the front door. All joking aside, there are some midwives who do not attend hospital transport births with their clients, which has ramifications in the long term, as Donna describes:

*It really is miserable ...when someone just shows up [at the hospital]. No midwife, no report, no records. It gives a terrible name to home birth midwifery. It gives the impression that you gave such bad care, you can't show your face. I think a lot of midwives believe they could really get into trouble. That someone at the hospital would report them to the health board. I think that's what keeps them from coming in.*

In Donna's comment we can see the dilemma for homebirth midwives. Those who do not accompany their clients into the hospital are, to some extent, able to avoid prosecution themselves, but at the same time, make things harder for their clients in the immediate, and harder for their occupation in the long run. Here, I refer to research on alternative practitioners who seek to be co-opted by the medical model and ultimately change the system from the inside out. In the bigger picture, as Donna stated, midwives refusing to transport, or to accompany their transport client are doing a huge disservice to the reputation of homebirth midwives.

TSH affiliates learn early on in their tenure with the organization that the behavior of dropping clients off at the hospital door is not tolerated. This violates the boundaries of the organization in terms of cooperation and deference to the medical model. Rosie explains with the following success story, "*[we] have reached out to hospitals and [Jane] has two doctors who back her. We have come in and we stay with the women when we transport, and we have all of their records that we can give them and all of these things. Now the hospitals are saying that it's not so bad.*" The success story related here claims that by following TSH protocol, affiliates are successfully creating change within the hospital setting in that they are increasing acceptance for their brand of care, meanwhile improving the labor experience of their clients by showing unconditional support and continuity of care.

### ***Midwife Transport Rates: Dirty Little Secrets?***

A final issue involving boundary differences between TSH and others can be found in the rates of transport. The transport issue is a difficult one because it is an important number that may attract future clients. Jane and Julie explained that they are

not concerned with their transport rates, and further state that low transport rates are not a selling point for them to use with their clients.

According to former TSH affiliate Kathleen, *“I think that that is something that the natural birth community doesn’t want to talk about. It is like a dirty little secret, and there are lots of midwives who won’t transport because they don’t want their transport rates behind.”* Here, we see a situation in which other midwives are concerned that when speaking with prospective clients, one bit of information that is being sought is that of their transport rate. By acquiring and comparing this information prospective clients may become concerned that under the care of a higher transport rate midwife, their chances of achieving a home birth may go down. Thus, these women may seek out midwives with a lower rate of transport.

The philosophies of TSH concerning transport set them further apart from these other midwives. One of these demarcating boundaries concerns the TSH belief that every woman deserves to *try* a home birth. A corresponding belief stems from the fact that TSH midwives are not concerned with their rates of transport. In fact, both TSH midwives suggested to me that their transport rates are amongst the highest in town. Furthermore, we must reflect back to the previously discussed notion that TSH midwives are different because of their physician relationships, which, in the case of transport, leads to a situation where TSH midwives are completely comfortable with transporting a client at the first indication of a problem. As TSH affiliate Suzette explains, these boundaries regarding transport are a large part of her participation: *“they’re not risk takers, and that makes me want to work with them.”*

Part of not being true to the TSH goal of providing a large variety of options to clients and simultaneously not being risk takers comes from being willing to have a high transport rate. A part of this rate is TSH's stated goal of offering an option to every woman to try a homebirth, all the while being armed and ready to transfer to medical authority without shame or judgment. Multiple respondents in this study used the term "train wreck" to discuss waiting too long to transport a laboring homebirth client to the hospital. TSH affiliate and general manager Liz summarizes the organizational boundaries regarding transport thusly:

*Some midwives in the area pride themselves on having a low transport rate, but I don't necessarily see that as a good thing. That's why we have a relationship with Dr. Adams. We don't bring in train wrecks...not this dire emergency every time. I think more doctors would back midwives if that wasn't always the scenario they see. It differs on the kind of clients these midwives accept too. Jane takes clients that others wouldn't handle. Jane might have a higher transport rate that probably wouldn't have a home birth with another midwife. Some midwives almost do it like an interview process. If they're a smoker or having twins, they don't accept them. If you have a low risk clientele, you're not going to have a high transport rate.*

The "train wreck" concept was discussed by many others in the study, including both obstetricians who expressed disdain for some of the other midwives in town who they perceive as not understanding or heeding warning signals in their client's behavior or physiology. In their view, TSH midwives are more knowledgeable than many others in

medical aspects, and trust the medical model enough to defer to them on potentially dangerous cases. Indeed, this quasi-medical stance serves to differentiate TSH from these others, as does their trust in the medical model as an authority in such cases.

### ***Against Manger Mommas***

As we have discussed, there was another organization that opened around the same time as TSH, Manger Mommas. These two organizations showed how the dichotomy between traditional, hands-off midwifery and the more medicalized, integrative midwifery erupted even as midwifery began to turn to a more consumer oriented model. Years ago, the Manger Mommas website (since updated, prior to closing) included information about the group's strong beliefs in the second amendment, Christianity, and patriarchal households. The midwives at Manger Mommas stated that that they, as a general rule, practice their religion at births in the form of praying aloud. They clearly stated on their site that if a client was uncomfortable with this practice, they should hire someone else.

My respondents had a number of things to say regarding the lines of demarcation between TSH and Manger Mommas. There were two overarching themes: perspectives on the medical model and the role of religion in childbirth. Although no one specifically referred to Manger Mommas midwives as being the women who call TSH midwife Jane a "med-wife," it seems that TSH and Manger Mommas are very different in terms of their boundaries involving medical involvement in practice:

*[Manger Mommas] are very against medical things, and they kind of get bugged if you want to have a relationship with the hospital, they really think that you should ... what I've heard anyway is that they are really*

*wanting you to stay home and think that [Jane] pushes medical stuff too far. – Rosie*

In this example, Rosie points out what many others explained as well, that Manger Mommas midwives not only cater to homebirth clients, but that they even express disdain for midwives who utilize tools of medicine in their homebirths. Liz further explains:

*I think Manger Mommas was just for home birth. To be honest, home-birthers don't really have problems knowing their options, stuff like that. We're trying to help people on a grand scale. If only 10% of births happen at home, we're trying to cater to the 90%. We cater to the hospital or any variances in there.*

Here, we see that not only does TSH separate itself from Manger Mommas in terms of medical practices, acceptance, and support, but also that they see this position as a part of a larger outreach to mainstream women. In fact, many TSH affiliates as well as the two independent midwives suggested that Manger Mommas focused solely on homebirth, did little to provide support for anything other than homebirth, and did not really even offer doulas for these clients. Meanwhile, TSH looks to provide some sort of care for all types of birthing experiences.

The other area in which TSH sees themselves as different from Manger Mommas is in their religious orientation. As previously mentioned, the previous Manger Mommas website spoke of their intention to pray at one's birth, and sent away those who did not wish to participate in this practice. They did not reveal their exact denomination on their website, but were very straightforward about being Christian:



*Our faith – We all are both Christian, followers of our Lord, Jesus Christ, and married, and we are all very happy to let our husbands be the heads of our families. We will never ask you or anyone else to share our beliefs or conform to our standard, but we also do not apologize or work particularly hard to be politically correct or to use “inclusive” language.*

Here, we see a very stark contrast in ideology between Manger Mommas and TSH. Manger Mommas puts their own religious philosophy before that of the client. They do not strive to meet clients on their own comfort level, but rather insist that clients conform to the philosophy of Manger Mommas. Conversely, TSH’s platform is one in which the organization seeks to reach out to as many different types of people as possible, including a diversity of races/ethnicities, economic statuses, sexual orientations, ages, religions, and other distinct practices.

Janice stated that Manger Mommas is not welcoming to certain groups if those groups violate the religious philosophy of their organization. She states, “*Manger Mommas is super religious. Won’t give care to lesbian couples. This came up recently when we had a couple come to us and asked us if we were willing to work with them. We said of course we do.*” Winnie adds to this comment by saying,:

*A lot of the people in TSH are really religious, either Christian or Mormon, you know strong religious beliefs, but that is not the premise or the philosophy on which we operate and we welcome everybody. Manger Mommas is very religious based, and unapologetically so, and it’s not a criticism of them it’s just the way it is. So there is a difference there, so I think there’s a bit of a limitation in terms of who they end up helping.*

In these statements, TSH is distinguishing themselves from what was the second largest alternative birthworker organization in the area, which has since gone out of business. Here we see TSH establishing their goal to serve a diversity of clientele regardless of their preference for home or hospital birth, and further, to make a safe place for a diversity of women, regardless of characteristics such as sexual orientation or distinct practices or identities. Another thing that makes TSH distinct can be found in their openness to all sorts of options in childbirth, and a belief that there is no one-size-fits-all approach to pregnancy and childbirth.

### ***Negotiating Conflicts among Midwives***

Regardless of their differences in practice and philosophy, one might assume that there are times at which midwives would stick together to stand up for their occupation and the women they serve. As I have come to understand it through the words of the founder and numerous affiliates, TSH was originally created to be a place where these unified moments could take place. It seemed logical to me that a marginalized occupation struggling to gain legitimacy would put their differences aside when reaching out to the public in order to present a united front that is stronger than any differences that may divide them. When I asked TSH affiliate Bridgette about this, she stated that that this was not always the case:

*I think that when Jane started TSH her goal was that everyone would get along. All the midwives in town will get along. And from what I understand, that's not how it is. There are definite groups.*

In one instance, I was invited to attend a meeting at TSH involving a very large number (approx. 25) midwives from around the area. As I observed the interactions in that space, I found that there were definitely tensions amongst them. This meeting was held to discuss the topic of CPM licensure in the state of Nevada, which most midwives feel is inevitable, but many do not want to see happen. Some midwives at the meeting expressed strong anti-government sentiments in the discussion while others seemed quite pleased with the prospective of licensure and simply wanted more information in order to best prepare for the coming regulations.

Despite all the differences of opinion, it was an impressive turn out with midwives from all walks; CNM, CPM, DEM, etc. TSH's facility was used for what Jane described to me as its original intended purpose. Jane, director and midwife for TSH states that she seeks to be a part of a bridging between perspectives amongst midwives and calls for more collaboration and support:

*I wouldn't say we're a supportive group of individuals, the [midwives in our state] kind of have a reputation for not getting along, there's no licensure so you have very wide extremes, philosophies, stuff like that, so, I think we would all support each other when push came to shove, but, were not all friends. I thought we could be, when I open TSH, I thought "oh my gosh, we all serve the same clientele," but that's not how it goes, but I do think when push comes to shove we would be [supportive of each other]. I would love to get along with all the midwives, and I respect everybody has a different philosophy, everybody works a little differently*

*and I think that's the beauty of midwifery, because I think it's silly that we keep assuming that people should practice the way we practice...*

Jane acknowledges the philosophical and practical differences between practitioners. Unlike some midwives in town, TSH seeks to embrace all clients' viewpoints, modalities, orientations, and choices of birthing practice, and would like to extend that openness not only to clients, but also to acknowledging and respecting the philosophical differences between birthworkers. Jane is concerned with bridging the gap between her own practice and others such that they may serve women and families better and continue to promote the occupation of midwifery. While her wish would be for practitioners to treat each other with kindness and respect, her ultimate focus is not on herself, but rather on the care provided to clients and on the united front that midwives portray to the public:

*... [another TSH affiliate] really helped me out a lot, I was confused as to why we all couldn't get along, and we couldn't all work together... And I said "I just don't feel like these women like me whenever we meet." And she said "they don't, get over it." [Laughter] and it was like, 'oh my gosh, they don't have to like me, that's okay, we don't all have to be best friends. If we have a united front when push comes to shove... its okay that they call me a "MEDWIFE" behind my back.' – Jane*

## **CHAPTER EIGHT: TSH AS SOCIAL MOVEMENT -- IN AND AGAINST FOR-PROFIT MEDICINE**

In this and the following chapter, I explore the ways in which The Stork House (TSH) affiliates express their activities as activism. I will examine several areas, other than those discussed in previous chapters, in which TSH affiliates identified as key areas for social change. In this chapter I look at the ways they negotiate the medical/midwifery conflicts between money and love, profit and activism. In the next chapter I will look more explicitly at how they struggle with medical institutions.

Taking a social movement perspective, I argue that there is great importance to the way that these practitioners frame their dilemmas (Diagnostic framing), what they propose as solutions (Prognostic framing), and, based on this, how they continue to call for action and sustain their movement participation (Motivational framing). Further, I employ Fine's (1995) notion of horror, war, and happy ending stories as I detail the narrative accounts of the experiences of these movement participants. These stories are very important as they serve to justify movement participation, help participants to process events, and provide the motivation to continue in an attempt to reap the benefits of the happy end when goals are reached and changes occur.

In these interviews, I asked respondents to tell me about the parts of their job that were difficult for them. Based on previous research, I highlighted a few issues in my questioning which have proven difficult for similarly situated Complementary and Alternative Medicine (CAM) practitioners. What emerged from this line of questioning were several structural impediments against which birthworkers struggle. I argue that these matters serve as structural impediments and it is against these that birthworkers

employ the resistance that ultimately qualifies them to be regarded as a social movement, fighting to create change.

One very important theme from the narratives of affiliates is how they negotiate the boundary between love and money. In the view of Zelizer (2005), this is an artificial cultural boundary, which many subscribe to in theory, but not in practice. All birthworkers grapple with the intersection of love and money in an attempt to reconcile these two, seemingly incompatible things. Those at TSH especially confront these issues in different ways as they struggle to craft their unique form of integrative midwifery in between the medical and traditional hand-off midwifery models.

### **Love or money? Working for Pay. Or Not.**

On the one hand, many workers in our society try and secure a position that pays the bills, at the same time as seek work that is personally satisfying; the birthworker instead secures a job that is personally satisfying. TSH affiliates define their identity, as discussed in previous chapters, as motivated by passion and against the for-profit, capitalist enterprise of modern medicine. Indeed, they, like anyone else, must find some way to pay the bills. How do the affiliates survive? All of the TSH affiliates in this study (other than the midwives) have a primary breadwinner at home who pays the bills. This allows them the luxury of defining a passion as payment -- passion to help women in what these practitioners see as the most natural and important rite of passage in a woman's life: childbirth. Calling upon notions of cultural feminism, and celebrating the uniquely feminine ability to give birth, Anna employs a master frame of the women's health movement, that of women-centered-care OF women, BY women:

*...we're charging to simulate what used to happen naturally for free. That was women coming together to support women having babies. This used to be a tribal thing. Women came together, the mothers, the grandmothers, all the women in the tribe would come together and bring a baby into this world. That's how women birthed. We were natural midwives, we were natural doulas, that's just what we did. And that's gone. And so now, to bring that back, we have to do it as a charged service. It's a weird demographic even for myself as a birth worker, to think of it that way, because even when I explain it that way I'm like "I wish I could just do this for free because that's how it should be." But that would involve everyone getting on board, and everyone being a doula, worldwide! For free! [Laughter] And so it's become a service that we pay for, and it's a beautiful service that we pay for, obviously! I love it, and I stand by it.*

*—Anna*

In this revealing comment, Anna employs the historical frame of women's social childbirth to validate the stance of the birthworker movement, that childbirth is not the domain of hospitals and doctors, but rather in cozy homes surrounded by female family and friends who, through their female intuition, knew how to guide one another through this important process. In one sense, this statement presents a critique of medicalization of childbirth, and a subsequent call to action to return to the old ways. In another sense, the statement, and also the action of charging for these services, is more likened unto the profit driven, capitalistic medical model of care.

Furthermore, in Anna's statement, we see issues in women's care work. Clearly, she sees, from a cultural feminist perspective, care as a central and innate component of womanhood. Many, if not all of the women in this study agree with this perspective. Like the sentiments found in Abel's (2000) examination of primary historical documents, the women in this modern birthwork movement see care work as a source of emotional and spiritual strength.

On the other hand, many of the birthworkers in this study are critical of their founder and director's practice of discounting services, or even giving them away for free. Indeed, as discussed in previous chapters, TSH affiliates do a lot of volunteering for the organization in the name of furthering the goals of the birthwork movement. Patricia states, "*I don't think Jane is a very good business person because she is too good of a person.*" TSH was recently reorganized oriented to generate more money for the organization. Working as independent contractors, TSH affiliates must pay a fee to the organization for each of their clients, but beyond that are free to discount their services as they see fit. In Colleen's view, the work is simply not lucrative enough to retain her position, regardless of spiritual or emotional rewards:

*At the end of the day what it came down to for me was, it was a bulk of time that I could not just commit to and financially for me having a business already it was not advantageous. It's not that the work is not rewarding it is just that for me where I was at it just didn't... wasn't advantageous.*

Colleen, unlike many other TSH affiliates has turned to profit over emotional/spiritual reward. She served as a TSH affiliate for a short time, and, finding the



financial rewards to be too low, quit work as a doula and returned to a more lucrative branch of CAM. Colleen built a Reiki business and self identifies as a business woman. Her Reiki business is very successful, and many TSH practitioners refer out to her as she is listed on the TSH website in the wellness category. She spoke highly of the organization, but left birthwork in TSH because the financial rewards are too low.

Other birthworkers in the study spoke highly of extra benefits they receive from their birthwork by participating in the TSH organization and do not mind the fees they pay.

### **Dilemmas of Profiting From Birthwork**

#### ***The Haves and the Have Nots: Bringing Midwifery to Impoverished Women***

In one of the critiques of CAM (McKee 1988), only those who can afford cash out of pocket can access these services, so in some ways, CAM, and by extension, Integrative Midwifery, just reifies the divide between the haves and the have-nots in the same way that the medical model does, if not more so, as they claim to be an alternative to such systems (Lupton 2003). This is where the passion comes in, and TSH defies the detractors of CAM from a political economic standpoint. In the following passage, we are able to witness the how birthworkers grapple with financial concerns on the part of the impoverished. Jane, who has been credited, to a fault, with a generous heart, explains her difficulty in turning anyone away for an inability to pay:

*...the woman that just left here interviewed with some homebirth midwives and she couldn't afford it, because she's on Medicaid and they live in a week by week place - so they legitimately have nothing... so since she has*

*Medicaid she went to one of the CNM's in the hospital because 'I thought that they would give me the care I was looking for and now I'm due next month, and I feel like I get the pat on the head.' She's looking for something different, so she weeps on my couch, and she has a girlfriend with her who says, "we're trying to raise money for her to have the birth that she wants," how could I possibly turn this woman away? How could I possibly not care for her? But I have to say I at least need the \$1600, so then she starts talking to me about the skills that she has, and the hours that she's willing to come work and donate to me. And I think, "how can I turn this woman away?" —Jane*

This is where TSH birthworkers run into trouble in reconciling their own financial needs with the need to serve women in what they see as a pivotal life event. These women seek solutions to this issue, and these solutions serve to motivate participants to continue on their quest to raise awareness of their work in providing alternatives to the mainstream obstetrical model of care. As their narratives suggest, workers try to find a number of ways to accommodate those who cannot afford care. Kelley's comment serves as a prognostic frame (Benford and Snow 2000) in this area, articulating a proposed solution, that of Medicaid:

*I feel midwifery should be forever. Not everyone can access this care for financial reasons, cultural reasons - whatever. But here in [the city], I would really appreciate it if we could take Medicaid. In other states, they can take Medicaid.*

Here, Kelley is stating that if birthworkers were seen as legitimate practitioners in the eyes of the state, then they could increase the number of women they serve without penalizing their own families financially. This prognostic frame has many repercussions for the birthworld as it leads to larger issues of legitimacy for the profession, which would allow for not only Medicaid, but also other forms of insurance coverage, and would also involve tort related issues such as malpractice claims, and furthermore, lead to a strong discussion about the licensure of area practitioners, which, at this time, is not regulated by the state.

In a similar prognostic frame, Rosie discusses insurance coverage for alternative birthing services:

*It would be great if insurance could cover us because then we could get more clientele and more women would be given the option because there are a lot people who would love a home birth but couldn't afford it and not just makes me really sad to hear that. That they wanted something and couldn't get it.*

TSH seeks to offer many classes and workshops for free or at a low charge in order to both extend birthing alternatives to all without regard for income level, and to increase awareness of their work in the public eye. One example is the free weekly Mom's Milk Club at TSH, where women can come in and have free access to a CLC to answer any questions they might have. This meeting serves to create community for these women as well, which is another stated goal and benefit of TSH. In this prognostic frame, Mimi, a CLC at TSH proposes a solution for women who cannot afford the \$50 fee for a lactation consultation:

*...if price is a question I always suggest that moms come to Mom's Milk Club. If it is something emergent that can't wait I do a phone consult and that doesn't require me to get a sitter and leave my family to go and see them. I will do a phone consult for free.—Mimi*

These prognostic frames articulate some solutions to the problems of finance inherent in the world of birthworkers. Some birthworkers seek to accommodate those in need by lending their own charity. Some see insurance as a solution, and others seek community based solutions such as the establishment of free, group workshops such as Mom's Milk Club. While prognostic frames propose solutions to movement participants problems, motivational frames compel movement participants to strive for these solutions in everyday life. Here, Kelley succinctly expresses a motivational frame that exists in the minds of many area birthworkers:

*...for me, having worked with low income women here volunteering my services, I really so whole heartedly believe that midwifery care is for everyone...not just those who can afford it... I guess I do say I do feel a higher calling to help those who need it. I feel a personal drive to help people where I can. Not that I'm a doormat, but a 'let's all come along' philosophy.*

This motivational frame represents what most TSH affiliates feel. The words “higher calling” and “personal drive to help” are most compelling. These relate directly back to the emotional and spiritual gains that many birthworkers take from their work, regardless of pay. These words also clearly illustrate the passion that I argue qualifies the activities of these women, and the organization of TSH as a social movement and not just

simply as a business. Seeing as how these women vow to take three births for free, three more at a reduced cost, and to dedicate quite a bit of their time back into the organization illustrates this point clearly.

***Fees Due and Payable: Justifying Charging Clients***

TSH affiliates articulate conflicted feelings about love and money, which is portrayed by our culture as a contradictory and forbidden union of unrelated things. They spent much time in interviews justifying charging for services, something very different than how they see the medical model. Thus, I believe as integrative may be, it is more like a social movement in this respect than a business.

*I really love what I do. I just have such a passion for it. It's so hard to even call it work sometimes. Because you just love it. The hard part about it is that you are taking money for it. You have to, you have to make a price for yourself, and be able to eat and live... One reason, why in my heart it's hard to take money for this is because I love it. Unfortunately, in our culture, it's weird to do something you love for an occupation. Which is so important. I advocate for everyone do what you love! Quit that job that makes you miserable, and do what you love. You can do it! –Anna*

In this excerpt, Anna explains her conflicted views on love and money. She echoes a sentiment that many birthworkers in this study hold, that of love for their work. In our society, it is hard to see love and money as compatible, but they are, and as Zelizer argues (2005) we all participate in this seemingly paradoxical intersection. Anna reifies this notion as some of the reward she receives comes from knowing the intrinsic value of her work. Critics would argue that this perspective continues to drive down the wages of

primarily female-based occupations such as care giving. While Anna encourages others to give up miserable jobs in favor of personally satisfying jobs, it is noteworthy that she is not the primary breadwinner in her home and has also referred to her income as supplementary. It is indeed a luxury that Anna was able to quit a job that she didn't enjoy for one that she feels passionately about.

In another related comment that resonates in many of these interviews, Bridgette states that she has a difficult time asking for money from her clientele. It is as though she has internalized the artificial divide between love and money. She like many others in the study wishes she did not have to charge for her work:

*...when I have had to address money with people, it's difficult for me. I know it's not just me... There is such an emotional and spiritual aspect of birth, it's hard to mix money and with that... It's kind of like, "let's get the money out of the way so we can just have a baby." I think a lot of this is that I would do this regardless if I could, but I can't financially devote so much time to something and not get paid, but I would.—Bridgette*

While Bridgette would like to work for free in assisting women in childbirth, practical considerations get in the way. One that she mentioned was her husband, the primary breadwinner for her home, who is not thrilled with the amount that she makes for her birthwork. According to Bridgette, “*my husband is very big on pointing out the balance...*” which Bridgette explains is actually an overdraw on her bank account. Many TSH affiliates in the study expressed similar sentiments from their husbands and significant others.

Birthworkers must learn to ask for money even though many see this as inappropriate with the task at hand. Prognostic frames enter into this dilemma to articulate reasons why fees are an important part of birthwork. Despite any financial hardship on the part of the client, area birthworkers identified two overarching reasons why payment must be received. One of these is burnout, the other mutual participation and interest in the service. Regarding the latter, TSH affiliate Rosie stated, *“If I could, I would do it for free, but then it is not special and they're not really wanting it. If they are not willing to put something forth, then it is not a value to them.”*

Many women in this study stated similar ideas about sacrifice that must be made on part of the client. In a horror story (Fine 1995) detailing a harsh experience with payments and equal participation, Donna recounts the reasons why she refuses to work for any less than her asking price. This, like other horror stories has a moral that effectively justifies birthworkers in requiring payment from clients. I asked Donna if she gave discounts or worked for free, and here is her response:

*I have in the past, but I've been burned. I've gone to parents' houses and they have a brand new car and a \$3,000 nursery, and I feel resentful. I don't want to bring that energy to my work. On the other hand, I've had students living in teeny tiny apartments, yet it's important enough to them; they never once asked for a discount. It's important to them to have this kind of birth and they pay for it. You get the same amount of me, so a sliding scale never made sense. But I know a lot of midwives that do. Really, what it is for me is an equal exchange of energy. I don't want to be the only person there committed.*

The second reason for requiring payment that is commonly cited by birthworkers is that of burnout. One of the side effects of unpaid or low paid carework is a sort of burnout in which care providers are no longer able to function effectively and give their charges the type of care that they need. Sometimes this burnout can lead to resignation from one's position. There are jokes amongst area birthworkers about the shelf life of a doula as seven years. I have heard this commentary at many birthwork events. Without decent pay, these effects are exacerbated:

*There's a lot of turnover in this. When you break down to the number of hours, especially if they're paying for child care, I think it's why there is such high turnover. – Kelley*

Clearly, there is a real dilemma of not being paid for work that a person does. In TSH organization, there is a high expectation for free labor to drive the organization. As Anna explains,

*...being a doula in general is not done for the money. [Laughter] it's definitely for the love of it. You start off by taking at least three births for free, at least if you work at TSH, so those are totally free. You're talking about your gas free, your childcare free... Not free to you, but you have to pay for it. As a student doula, which usually lasts somewhere around a year, you're only being paid \$250 per birth, so with that, often between gas, childcare, sometimes it's very minimal money in your pocket. We are moving up to \$600 as a certified doula, a graduated certified doula, it can be enough to help supplement bills, but it's rarely enough to be a sole income, a lot of birth workers end up doing several birth things... I'm*



*currently looking into becoming a placenta encapsulator, and just continuing to add on to your portfolio so that you can stay just in this line of work.*

### ***Discounts, Deals, and Bartering***

Because TSH's services, like other forms of CAM, are rarely covered by insurance, and as such, are accessible only to those who can afford it, one of the ways that these practitioners attempt to rectify these inequalities is to provide services for impoverished women at a discount, another is to offer them services in trade. Jane has delivered babies in exchange for landscaping, plumbing, electrical work, etc. All affiliates grapple with how often to offer discounts to low income clients

*Because we do this from the love of our hearts, we do this because we love it, we always do everything we can to make sure women are supported in their birth, no matter how that is going to have to happen, so we start with something as early in the process as just payment plans..., They pay me a little bit here and there all the way until they have the baby. Sometimes I will do reduced fees if necessary, or if we feel we are not able to at the time, we'll refer them to someone who can, or a student who is still working at a lower rate, or even getting a free birth if it's a doula. There's always that, sometimes we take free births because we just know there's absolutely no way this family can, and we know that they deserve to be supported. Every woman deserves to have that support that they want in birth, and we truly stand by that. There are times we do it, and I'm not going to say it's few and far between, but obviously, we can't do it for*

*every birth, and we have to make that call within ourselves, and perhaps we've done too many, and we need to get paid this month... We definitely would then refer them, and make sure that they do get, no matter what; they do get covered, no matter what they can pay. –Anna*

Anna outlines what seems to be a blueprint for discounting services within TSH. There are a number of distinct practices set up within the organization to accommodate for financial concerns on part of clientele. One is inherent in the “independent contractor” status of TSH affiliates. Since the company does not pay affiliates, they are free to discount their rates as they see fit, although most affiliates stated that this practice was “not encouraged.” Regardless of their asking price, affiliates (except student doulas) have to pay the \$50 referral fee to TSH such that the business continues to make its operating costs and moves toward its goal of self sufficiency.

Another cost saving measure for clients is built in to the student doula program. For a student doula’s first three births, she is not paid at all, so impoverished women who cannot afford to pay for services at all can be referred to a student doula. In fact, I did several births like this when I was a new doula, and this seems to be common practice nationally as a prescribed part of the DONA doula certification program. TSH adds to this that a student doula’s fourth, fifth, and sixth birth will be assisted at half the regular fee. Thus, regardless of a women’s financial need, doula care is quite readily available through TSH.

The story is only slightly different with midwifery services. Director Jane told me that in some cases, she is willing to discount her asking price for midwifery services by 50%. She claimed that she simply needed this amount to pay her expenses, and wasn’t

willing to go lower, but I sensed this was not always the case based on the commentary from other TSH affiliates. An alternative to paying cash for some practitioners is to take trade, or to barter for their services. According to Patricia, “[Jane] had someone do landscaping for her and she delivered the baby at home via VBAC.” Likewise, Janice laughingly stated, “One of our midwives got paid in tattoo vouchers ... who would never get a tattoo!”

Rosie also discusses her training in regards to bartering, which includes a reference to the previously mentioned mutual participation aspect of payment, which infers that payment does not have to be cash:

*As long as you are getting something back from the birth you are doing, because as we learn in training, it is important for us to get something - that is not just giving it away so people realize it is a job. Not just people going to births. So something, even if it even if it is little, I don't like turning away anyone. Just find anything that could be helpful.*

Here we see Rosie referring back to the frame of equal exchange of energy and mutual participation. As she encourages her clients to find something, anything of value that can be traded for birthing services, she serves the need to get paid for her work, and likewise finds a way to help a family without a lot of financial resources.

### **Competition for Clientele with Other Non-TSH Birthworkers**

A final issue that I was curious about is the competitiveness of the birthwork market generally, and how TSH compared to other independent birthworkers in this climate. I inquired with my respondents about the nature of their business relationships

with each other and other birthworkers. Generally speaking, these birthworkers do not find their business to be a competitive one. While, as discussed previously, there are very different philosophies toward birth and the medical model, and I would assume that this reflects in their clientele as well. As a result, regardless of their competitiveness or discontents with one another, a common sentiment among them is that there is a midwife for every woman, which was expressed by multiple women at the meeting. Inherent in this belief is a sentiment that difference is a good thing. Independent midwife Donna summarized this notion by stating, *“I never really felt [midwifery] was competitive. I tell women to interview two or three [midwives]. And there’s a right midwife for everybody and maybe it’s not me.”*

There seems to be a general agreement amongst my respondents that this event is pivotal in a woman’s life, and as such, she needs to employ a care provider with whom she feels completely comfortable. If this directive is truly employed, it removes competitiveness from the birthworker equation. Janice reflects a similar opinion: *“I try not to look at anyone as competition, rather just giving the women options of different types of care providers or support.”*

Within the birthworker movement of TSH, practitioners are carefully directed NOT to behave competitively. As many of these women told me, it is simply not accepted. Instead, they heed the ruling that there is a doula for everyone, and a special match must be forged between a mother and her care provider. In addition, discounts must not compete with student doula rates.

In both TSH, and in discussions I have had over the years with other birthworkers, it seems that the lion’s share of birthworkers do not believe in a competitive spirit in this

line of work. And further, Jane commented to me that competitiveness with outside systems is simply foolish:

*How could we ever compete with the medical model of care? That's where the money is! So that's where, from the media standpoint, from an advertising standpoint, I could never compete with their message. But I think it's good that human beings have to seek out truth.*

Here, Jane rests on her belief in the intrinsic value of her work. She knows she cannot monetarily compete with the medical model. She is also aware that she would not, at the current moment in history, win in a popularity contest against the medical model. But still, she sees her work as “truth,” and the age old adage of “truth will prevail” is employed in her motivational frame which fuels her work, and the work of her affiliates.

When all is said and done, this belief in “truth” and the intrinsic value of birthwork leads these women to continue to struggle through the obstacles in their path of providing alternatives to the dominant medical model. Even for Tessa, who admittedly struggles with the low wages of birthwork, there is a force greater than money. Here we see the Happy Ending Story (Fine 1995) of the birthworker financial dilemma. This and similar stories serve to justify the struggle and thus retain members within the movement:

*Some people do good by giving money, and some people go on trips and bring clothes to the poor, but for me, I think this is my calling. This is my way to help, and even though I'm not receiving money, I think I can receive blessings. There is some form of payment. Having a woman come to and tell you how happy she is and how pleased she was with her birthing experience. Money cannot pay that.--Tessa*

## **Inequality and Privilege among Birthworkers**

This dilemma of finance would not be complete with a reference to the privileges enjoyed by birthworkers themselves. As mentioned earlier in the chapter, only women of privilege are able to do this work. All of the TSH affiliates other than midwives have a breadwinner at home. None of the birthworkers are women of color:

*There's kind of a big movement – it should be a bigger movement, to encourage more diversity in the birth professional world, but you think about those women who are able to become birth professionals, it's because they're able because of support from spouse, personality, affluence. Being Caucasian often, religious organizations.- Kelley*

In terms of birthworker privilege, I see a number of things happening in this sample. Both of the male obstetrician respondents are making high incomes and have supported stay at home wives. In one case, the doctor's wife is now working as his office manager. Both of the TSH midwives are the primary breadwinners for their families. But amongst the other birthworkers, Certified Lactation Counselors, Childbirth Educators, and doulas, all but one of these female respondents are supplementing the incomes of their male breadwinner husbands. Clearly, someone has to pay the bills for the family, and in this study, it is typically not the birthworker. So, in the case of TSH, it is fair to say that the majority of birthworkers are privileged women. They can follow passion for work, and not to seek high income jobs.

In terms of race, as mentioned by Kelley, there are inequalities as well. Due to historical exploitation at the hands of the medical model, African Americans in particular may be more likely to distrust their physicians (Randall 1996; Laveist and Neru-Jeter

2002; Eiser and Ellis 2007; Wasserman et al. 2007). By extension, there should be concerns that marginalized populations feel trustful and represented when selecting health care providers. Within the studied birthwork community, there are very few options. In my observation, there are two black women in the studied region engaged in birthwork, one doula, and one CNM. I have also seen two Latinas, one doula and one Certified Professional Midwife (CPM). These four practitioners in no way constitute an equal ratio to those groups in their local population. This is a problematic issue which warrants further investigation.

## CHAPTER NINE: TSH AS A SOCIAL MOVEMENT IN AND AGAINST MEDICAL INSTITUTIONS

In this chapter, I explore the ways in which The Stork House (TSH) affiliates express their activities as activism in struggles with the medical institutions. I will address a number of concerns using the notion of diagnostic frames (Snow and Benford 2000) in which movement participants focus their grievances and find a party or parties outside of themselves to be responsible or to blame for these issues. These diagnostic frames cover intersections between birthworkers and the medical model on many topics ranging such as medicalization, hospital and insurance policies, paternalism within medicine, risk discourse, transfer of care of homebirth clients, and more. As best articulated by Donna, a former hospital employed certified nurse midwife turned Certified Professional Midwife (CPM), and the individual who trained Jane

*I went to every workshop or read every book about natural childbirth and delved into that. I came to the conclusion that our maternity system is pretty broken. We have a great system if you have a high-risk pregnancy and this is the country you want to be in, but we don't have another arm or model for low risk pregnancies. When I looked at the statistics, it validated what I was feeling, that it's broken. It isn't working for most of the women. – Donna*

I will now examine these diagnostic frames.



## Medicalization of Pregnancy and Childbirth

The first diagnostic frame stemming from the narratives of birthworkers regards the medicalization of pregnancy and childbirth. In this narrative, the way women are treated in the hospital, the heavy handedness of medication and interventions, the paternalism and physician authority, and the dehumanizing of mothers are all problems that need to be fixed. The critique here is that mainstream models of care are far too medically interventionist, painting with a broad brush and treating all women as high risk cases. This is a common sentiment among birthworkers, who concede that modern medicine has improved a number of outcomes, but is heavy handed in the use of technologies in what these women see as a natural process. Donna, who has experience as a CNM working as a medical practitioner claims that medical practitioners simply do not understand the low risk, natural, physiological birth:

*During my obstetrical rounds, I did not see a single un-medicated birth. Not one. That's when I had my first... 'what's going on here?' And further, Most of the nurses hadn't seen a [natural] birth. Not a single one had seen a water birth... Hospital delivery nurses are just not trained for un-medicated birth. –Donna*

When nurses and doctor are not trained for anything other than highly interventionist, medicalized birth, then that is all they will know about and all they will practice. We also live in a society that highly respects physician authority and many citizens will follow medical directives without question. That said, we see the numbers of C-section and other interventions in labor increasing, and birthworkers express concern that women are not asking enough questions about the routine, and what many see as

needless procedures. Drawing from the master frame of women's health movements that encourage agentic patients to learn about their bodies, and also from CAM movements which encourage practitioners and patients to make decisions in concert with one another, Maureen follows up on Donna's critique by talking about the patients of these highly medicalized practitioners:

*I see that when somebody walks through the hospital doors they are really giving up their rights to whoever makes a decision at those hospitals. So I think the bigger issue is what is going on with us as a society that we are willing and sometimes begging other people to make our decisions for us.—Maureen*

In this diagnostic frame, it is not only the practitioners to blame; after all, this is how they have been trained. What Maureen is taking issue with here is the society that, in her view, blindly accepts whatever the medical model teaches them. In this diagnostic frame, there is a hidden motivational frame to raise awareness of alternatives and teach people to question medical authority and physician dominance.

### ***Physician Authority***

A related diagnostic frame stems from the authority of medical practitioners, and relates to Lilly's commentary that, "*Insurance and hospital policy really dictates what women do.*" Despite the fact that the ideal TSH client goes into the birth room with a lot of information on alternatives, and often with a written plan of how they would like their experience to go, affiliates believe that the client will be shut down by these powerful entities. The following statement expresses Anna's frustration about how marginalized

and ignored she and other TSH affiliates are when it comes to working with their clients in the medical setting:

*The thing that's difficult is the obstacles that stand in the way. That is not being able to do certain things to help people achieve what they're actual dream birth is. Whether that be a hospital standing in the way, a policy standing in the way, an OB standing in the way, a nurse standing in the way, there's so much we can do, and we can do so much to help change the scenario...but sometimes there's just things that are out of our hands. And there's things that we can't change. And it just is a bummer that sometimes even that education and not being able to convince the Dr., or help them understand, or help the nurse understand can be frustrating, definitely. –Anna*

Doulas' experiences in the hospital birth room are extremely political as they must simultaneously (silently) advocate for their clientele and overtly interact in a polite and deferential manner with medical practitioners. Doulas technically have no right to be in the birth room, yet this is where they do their most important work. At the same time, they must behave in such a way that doctors and hospital staff will invite them back. Many doulas spoke of the dilemma of feeling powerless and as though their hands were tied in these situations.

In an inspiring motivational frame, Dr. Adams calls out his obstetrician colleagues for their condescending behavior. He is one of two doctors in the area known by area birthworkers for their support of women's choices, and as such, gets many clients

from other doctors who refuse to allow birth plans, doulas, and other client preferences.

Here, Dr. Adams addresses the behavior of his colleagues with disdain:

*It used to be paternalistic medicine. A couple loud and bossy [doctors] ... and their big mouths...you hear them in the doctor's lounge. "You can't have a birth plan. This isn't Burger King. You can't have it your way. I'm the doctor. I make the decisions." I'm thinking, "I get a lot of patients that transfer from you." [Laughter]*

By working directly in concert with TSH as he does, Dr. Adams is already bucking the system of physician authority. One of the dilemmas of his stems from his colleagues who laugh at him and call him "cowboy" for being such a "renegade" and in a sense relinquishing the power, or at least a lot of the power, that those in his position have long enjoyed. According to Dr. Adams, *"I'm called crazy by my colleagues. I'm called the granola doctor. All kinds of things. They make fun of me."*

### ***Counterpoint: Diagnostic Birth Plan Frames***

One of the things that makes TSH unique is their ability and effort to build bridges with members of and institutions within the medical model. However, they work against a model in which birth plans are seen as useless. Yet it is these birth plans the TSH doula work hard to help their clients create.

Again, drawing from master frames from women's and consumer movements in health, area birthworkers, including the two obstetricians in this study; attempt to work in teams with their clientele. The doulas and midwives from TSH work with their clients to construct birth plans, helping them to understand all possible options in concert with Child Birth Educator (CBE) classes. The two obstetricians in this study are known in the

area for accommodating women who want to exercise their options in the form of a birth plan.

A birth plan is a document, often typed, that expresses the goals, wishes, and preferences for a laboring woman. This document often covers matters such as whether or not the woman wants IV fluids, pain medication, to be allowed to labor in water, for her partner to cut the umbilical cord, and associated things. Birth plans often discuss the “what if’s” in case things do not go as planned, such as asking the partner to be present in the room should the woman need a cesarean section, or to accompany the baby to NICU should that unexpected outcome occur. I had an important conversation with Dr. Green about his feelings about patient birth plans. He revealed to me an inside joke amongst obstetricians: *The joke about birth plans is, "when do you want your C-section?"*

I probed for more information, “*What does that mean?*”

He continued,

*The [birth plans] that are problems are when they want to limit everything that can help them. Those are the problem ones, or where you run into trouble, because birth is not a controlled like making a widget. Screw A goes into Hole B. You have to be flexible, and if you're not, you can spin your wheels for a long time. And when you do that, you run into infections, or the baby goes into distress. Then you're in a situation where you need a C-section. I can't do anything else. That's where birth plans run into problems.*

Still, Dr. Green has a reputation for allowing women with birth plans. I use the word “allowing” here, because there are physicians who do not “allow” or simply will

refuse to work with women who insist on writing a birth plan. A part of the birth plan process is having the doctor sign the document. At this point, conventional wisdom would suggest that the document then becomes “Doctor’s Orders.” However, both obstetricians in the study said that these documents don’t carry as much weight as conventional wisdom might imply...

*Q: Do you sign [birth plans]?*

*A: I do, but there’s no reason to. When they’re in a hospital, and they say I have a birth plan and I say okay... But in a hospital, they have rules. You have to monitor the baby...you can’t get out of monitoring a baby because of liability. That’s a huge check. They’re not going to allow you to be there without monitoring the baby. You can say what you want on your birth plan, but you’re not going to get out of that one.*

I asked Dr. Green if he knew that some physicians do not allow birth plans, to which he responded, *“I couldn’t tell you who all that take birth plans, but I could tell you five [doctors] that don’t. I take transfers from the ones who don’t.”* In this way, accommodating clients with birth plans is a good business strategy. Regardless of whether a doctor agrees with birth plans or not, hospital policies are more powerful. The doctor’s signature is merely a symbolic gesture on these documents, and here is one area where the age old authority of physicians has been replaced by the power of the medical industrial complex as discussed by Kletke (1996).

### ***Diagnostic Frames: Risk Discourse***

Another diagnostic frame employed by birthworkers in outlining their dilemmas is what I call “risk discourse.” This discourse, which is key in the medical model and mainstream media, instills a fear of childbirth in both their clients and hospital birthworkers. Drawing from a famous 1944 book about childbirth entitled “Childbirth Without Fear,” obstetrician Grantly Dick-Read discusses the cultural obsession with the painful and dangerous aspects of childbirth. Certainly, childbirth is painful and can be dangerous, but it is so much more than that, and as Dick Read explained, the more we fear it, the more difficult it actually is. In today’s society, 99% of women will deliver their children in a hospital under the care of an obstetrician. The cultural discourse on childbirth focuses on pain, risk, danger, and mishaps. We can see this on television on the mainstream television shows about birth. As midwife Donna explains:

*Most birth depicted on television or movies...it’s either comedic or dramatic.... It validates the fear people already have about labor and delivery. For people that want home births, it repulses them.*

Thus, when I say “risk discourse,” I am referring to the very mainstream, commonly held, publicized, sensationalized ideas that we westerners have about the dangers of childbirth and the accompanying language that portrays the event as inherently perilous. As holistic and more natural minded practitioners, these birthworkers battle to overcome these very strongly engrained messages on a cultural level everyday in order to get their message out. It isn’t easy for them to present these ideas to a populous who has become so indoctrinated to the contrary. Just an introduction is enough to send a lot of people packing. As Mimi states, “*When I say midwives people think of witch doctors.*”

In my previous studies of birthworkers (Francis 2008, unpublished master's thesis), I found that these women were well accustomed to such name calling. Granola, Hippie, Radical, and Fringe were just a few of the words these women heard when their work was described to others. These nicknames and slurs are used to shame birthworkers, and sometimes their clients in an attempt to dissuade them from departing the mainstream medical model of delivery and straying to the more holistic, alternative methods. There were other ways that my respondents' clients experienced this risk discourse too, sometimes from friends, sometimes, from the medical practitioners.

*One of the biggest things that people say, what they hear most often is, "but the baby could die at home." Babies die in hospitals every day. Mothers die in hospitals every day how often do you hear about a homebirth dying? They don't happen as often as they happen in the hospital. But because that is where the media is that is where the news is. It is not news that a baby has died in a hospital, that happens all the time but it is news when a baby dies at home. So one of the things that people often said to me is, "your baby could die at home." That is true but hopefully we would know warning signs by listening to heart beats and we would be able to transport if that is the problem and get emergency care but there is nothing to say that a baby who died home wasn't also going to die in a hospital. – Maureen*

In this comment, Maureen confronts risk discourse head on with a dose of media skepticism. Many birthworkers over the years, in this study and others, and in my own personal experience, have had clients who have literally been bullied into fearing their



childbirth. The risk discourse is very pervasive and affects many women, regardless of their characteristics: age, race, education level, etc... Kathleen expresses her frustration thusly, *“It is like when you go into the hospital with smart, intelligent, educated people... they just blindly follow the doctors.”*

Since this risk discourse is so far reaching, birthworkers feel a challenge in combating it. They explain that risk discourse interferes not only with attracting potential clients to the business but also to their larger goal of raising awareness of birthing alternatives. A part of the TSH plan for remedying this issue is to create a community of like minded women, and a place where they can meet to share these views and bring them to others. By likeminded here, I mean to say women who experience less fear at the hands of risk discourse. As practitioners, birthworkers avail themselves to their clients and also refer them to various groups, websites, books, and movies where risk discourse is not present. In a prognostic frame, Anna discusses her own tactic for helping clients to deal with the fearful messages they receive when living pregnant in a risk discourse society:

*I always redirect people telling them “spend time in your day reading positive things for what you want. Go to positive websites, talk to people who have done it that support you, and just keep letting it roll off your back the people that are going to ask you if you’re nuts or if you’re crazy or say it’s ridiculous.” But that’s just unfortunate, and that’s why we’re here.*

### *The Doula Dilemma of Advocacy*

Another diagnostic is the problem of advocacy. TSH doulas specifically work around the imperative for doulas not to give medical advice or directly advocate for clients in the medical setting, by engaging in INDIRECT advocacy while in the medical setting. In my previous studies (Francis, 2008, unpublished master's thesis) specifically on doula care in the same area, I found that advocacy on the part of the doula is a highly charged issue. As literature suggests, a very important but challenging aspect of doula work is that of serving as a sort of intermediary for their clients (Block 2008, Campero 1998, Hodnett 2007). What I have found is that doulas develop a particular variety of advocacy which I will explain below as "indirect advocacy."

Rather than direct advocacy, which would involve directly speaking to those in power (in this case the medical staff) on the behalf of those with less power (in this case the patient), this indirect advocacy involves a sort of empowerment approach. Here, doulas help clients to advocate for themselves. Often times, the only words the doula speaks aloud would be along the lines of asking the laboring women if she would like more time to think about the intervention that is being presented. In the following excerpt, TSH affiliate Liz describes how this indirect advocacy operates:

*Our job was not to diagnose or suggest. Our job was to provide informed consent. Let's do a scenario: The nurse comes in and says "we're going to break your water now." I say, "Do you need a minute to think about this?" We can go over the pros and cons for the procedure. Is there a medical reason for this? What are the cons? Are there risks associated*

*with that? Is it actually going to shorten your labor any or help the baby come out any faster?*

Liz begins her commentary with deference, which illustrates that she understands the necessity to maintain the pecking order of these interactions and not to overstep her bounds. In this example, Liz models the indirect advocacy practiced by many doulas. Notice how she never speaks to the nurse, but instead to the mother. Liz prompts the mother to ask for time alone so that they can regroup together and privately discuss the medical directives. It is during this time that Liz can remind the mother of her original birth plans, discuss how the current medical recommend intersects those, and educate her on other options. Many doulas have expressed that doctors and nurses are usually not approachable in this way, nor are they forthcoming with information about alternatives to the cookie cutter, assembly line manner in which hospital protocols suggest birth is handled.

Ultimately, though, it is the patient who is a paying customer, and as such, should be able to choose how she wants her birth to be handled. This notion, however, draws from master frames from the consumerist health movement stating that since a person is paying for their treatment, they should be able to direct it. A few exceptions surface in this particular example, however, those of medical authority and legal issues. Women who are pregnant are sometimes seen simply as guardian hosts for unborn fetuses that have rights of personhood that must be protected. In this example, medical authority comes into play as the medical practitioners are seen as the guardians of the unborn child. Thus, larger legal issues enter this argument, and women as consumers of maternity services lose the ability to employ these master frames.

Because women who hire a doula are often looking for a less medicalized birth, the role of the doula in medical space is a particularly challenging role. As literature (Block 2008) and many practitioners have suggested, a doula is in actuality an uninvited guest in the hospital. The important parts of her job can conflict greatly here; working to achieve the ideal birth for her client, often at odds with highly routinized hospital procedures, meanwhile maintaining her ability to return. Here, Anna details her methods in maintaining her ties to the hospital:

*...if you get assigned a nurse that's really bad, "you're paying for this birth, you're paying for this nurse, you're paying for this hospital." You can absolutely say "I want another nurse." You can do that. We can't guarantee that there's going to be a natural birth friendly nurse on the floor at that time, we hope that there's at least one. [Laughter] a lot of times I think they end up being super supportive or super angsty. A huge goal in the hospital is to not step on their toes, step on the OB's toes, step on the nurses toes. And we will never speak up and advocate and say "this is what she wants, this is what she doesn't want." We have the mom say it, we have to dad say it, because we have no right to say any of those things. But we can be present, help encourage them, help educate them previous to their coming to their birth, as well as in it, help remind them so they can speak up on their own behalf.*

Thus, in Anna's prognostic frame, we see that doulas employ a sort of indirect or silent advocacy or empowerment behind the scenes. They, at times, in an effort to accommodate their client's wishes, must attempt to circumvent hospital protocol in a

quiet and courteous manner, such that they maintain their welcome. The relationships that doulas build with hospital staff are an incredibly important part not only of their ability to continue to practice in the medical space, but also of ensuring a comfortable experience for their clients.

### **Prognostic Frames: Building Alliances**

TSH, like many other Complementary and Alternative Medicine (CAM) organizations, has a goal work with, rather than against, practitioners of the medical model. The challenge has been to both make and maintain relationships with medical practitioners. These have been key goals for Jane in creating TSH. The success that the organization has had with this goal is evidenced by the Meet-The-Doula nights at City General Hospital and the two close-knit relationships that Jane has developed with the obstetricians in this study. This has been an articulated goal of director Jane since the beginning of the business. A part of this goal is to build relationships with doctors, but also with the other midwives. As Suzette states, “[Jane] has the connections with the doctors, and maintains that and constantly tries... meeting with new doctors in the Area...trying to make these connections. She’s really responsible for reaching out to those doctors, and she also has ties to the community, and tries to do events where the other midwives and groups are pulled in.”

A part of the challenge of working the system from the inside, which is a common goal for social movements, is to navigate the sometimes choppy waters that exist between conflicting parties. One of these dilemmas is found in the relationships between nurses and alternative birthworkers. It is well documented in the literature that there are multiple

layers of issues between alternative birthworkers and nurses. For one, nurses of the past were known for, and took pride in their bedside manner, while the current organization of healthcare leaves little to no time for that one-on-one care (Block 2008, Scott et al...1999, Van Zandt 2005). Meanwhile, doulas, for example, are completely focused on providing that care. Some nurses may see this as a benefit (Gilliland 1998, Wertz and Wertz 1986), and some might feel threatened (Adams and Bianchi 2004, Mainord 1997, Papagniand Buckner 2006, Schwartz 2002), especially since the ideology behind the care of these two providers can be at odds. Here, Suzette explains the prognostic frame behind TSH's doula training in terms of nurse relationships:

*I think that TSH has a pretty good reputation with the nurses. We're trained to not be confrontational. And I think that that's really important, and it's hard! It's hard when a nurse does an exam and the waters 'accidentally' break. And you're like, "I saw what you did there..." But I think that our focus is on building a good relationship with them, and I know that for a while there, I think things are going really well right now, but Jane used to bring goodies for the nurses, and we're encouraged to bring treats for them, and to really respect the nurses when we're there.*

### ***TSH's in Hospital Doula Program***

While Jane's doulas are building relationships on the ground level with the nurses, Jane is attempting to build larger and more structured hospital relationships through her project of creating an in-hospital doula program. These programs exist in other cities in the nation, but there is nothing like that near TSH. In my previous research (Francis 2008, unpublished master's thesis), I asked doula respondents for their feelings

about hospital doula programs and found their responses to be in line with the literature on the subject. There are mixed reviews of the concept of an in hospital doula program. From the perspective of the individual doula, a hospital doula program looks great in theory, as these practitioners would have guaranteed hours and guaranteed pay. From the perspective of the laboring woman, a hospital doula might seem intrusive because, as opposed to selecting one's own doula and building a prenatal relationship with her, the woman would instead receive whichever doula was currently on-call and meet for the first time during the actual labor process. From one perspective, such a program is excellent because it ensures that all laboring women would have access to such a provider. From another perspective, a doula participating in such a program would simply become a ward of the medical model and would encourage her client to obey medical directives, rendering doulas as agents of social change as ineffective.

*Okay, so I've given them a couple different options with the doula program, I wrote up this huge proposal and whether they would just refer us, so when I talked to [the hospital] the last time, it was going to be that we cross refer, they were looking for a budget to be able to pay for some of my doulas to come, I've given them a lot of freedom, in the proposal, if I get my foot in the door, I don't care under what premise it is, I will worry about the rest later. I just want to get them in the door and accepted, and let women's voices be advocated for. with the nursing staff, and I think we're seeing that more at City Hospital, they're seeing that birth can be normalized, it can be, I think it's taking Dr. Adams, the doulas coming in, to kind of educate people on what that is. – Jane*

In this example, Jane lays out her plan to “work the system from the inside,” in this case, with a doula program. In her mind, this would serve to get her foot in the door so to speak, on the ground floor of creating changes in how hospitals routinely treat pregnant and childbearing women. She is not currently concerned with the rules and regulations of the program and will work out the details later.

I asked her about some of the known critiques of hospital doula programs in terms of practitioners losing their ability to advocate for their clients as paid hospital employees. She explained:

*They would be contracting us out. I'm actually am not interested in answering to them, but I am happy play mediator between instances and set parameters by which the doulas work, and allow them to express grievances, so that we can better build that relationship. But I am not willing to give control over to the hospital and say “doulas have to do what the hospital staff wants them to do.” We're not there to make your job so easy that we are not willing to listen to our clients...My doulas answer to their clients, not the hospital. That's probably the hardest meeting of the minds.*

The hospital she is targeting for this program, City Hospital, is known by all respondents in this study as one of the institutions more receptive to birthing alternatives from the mainstream model, thus her entry there is an excellent starting point. Furthermore, the popular Dr. Adams has his own suite at this hospital and is very receptive to alternatives. In this way, he serves as a gatekeeper to TSH's plan, and



actually helps to foster these changes. Furthermore, he and Jane share an informal referral system, creating even more inroads for TSH:

*Dr. Adams has gotten referrals from us for years. It's that continuous relationship. Us knowing he honors birth plans. That he will kind of let women make choices. He doesn't harass them if they don't come in for induction dates, he is the kind our clients go for. The medical establishment sees him as a cowboy, because he does those. I don't think there's a whole lot of caregivers who want to be associated with home birth, water birth, anything risky. It's easier to have the relationship with the labor doulas than it is with the home birth midwives. –Liz*

As the practitioners in this section have discussed, there is a great importance in building alliances between care providers. These relationships can change the nature of maternity care in the area. Social movements are more effective when there are many participants who agree and work together toward a common goal. The prognostic frame of building alliances is an important part of reaching these ends.

### ***Few Supportive Physicians***

In order for TSH affiliates to make strides with the general public, one of the biggest challenges is the area lacks physicians who are willing to allow women to make alternative choices such as water birth, etc. In this community there are only two obstetricians that overtly agree to help alternative birthworkers in their cause to create change in the way that the way that women experience their maternity care.

*...[Dr. Adams] is the only OB in town that does water births, he is mostly the only OB in town that does a vaginal birth after cesarean which is also*

*referred to as a VBAC, other doctors will say they will do it, but often begin giving reasons towards the end of the pregnancy to back out of doing a VBAC. A lot of reasons OB's do that by the way is because by state law, when someone is having a VBAC, they have to remain in the hospital the entire time they're in labor. The entire time they're in the hospital, and a lot of OB's don't want to do that, so they find reasons not to. -Anna*

On a sunny Sunday afternoon, I met with Dr. Adams in the physicians lounge at the brand new hospital on the outskirts of town. This is the hospital where TSH affiliates prefer to send their clients, as this is the only hospital in town that will allow water births, and as such, they find that the staff at this facility is more familiar with alternatives. This hospital is also the residence, both figuratively, and literally as I would soon learn, for Dr. Adams, the most alternative-patient friendly obstetrician in town. I asked Dr. Adams to tell me more about what Anna and others had alleged regarding obstetrician attendance at VBAC births. He confirmed that per hospital policy, physicians had to stay on the hospital campus the entire time a VBAC patient was present in the Labor and Delivery unit and explained further:

*[Regarding his attendance at water births] "There are not a lot of my colleagues that will do that. It's hard for me to take time off. I also do VBACs. It's my Sunday. I'll be here all day. I have a patient upstairs with twins that had a prior C-Section. Another thing people won't touch with a 10 foot pole here in [this city]... Possible ruptured uterus, possible cerebral palsy...all that other stuff."*

And in regards to him living at the hospital as many area birthworkers had alleged...

*I have my own room at the hospital, my own personal room. On tours, they call it "Dr. Adams's suite. This is where Dr. Adams lives most of the time." It's a sad commentary I know. [Laughter] It's a nice place to flop if you're waiting. I'm trying to get some protégé doctors going.*

I then asked him if there were any other obstetricians who might be willing to join him in this goal of supporting women's birthing choices, and he claimed that at the moment, there was no one coming to mind. Dr. Adams expressed that there might be other doctors that would be agreeable to join in this project if the rules were not so restrictive. Here again, we see issues with the diminishing authority of physicians who are not always able to do what they think constitutes best practice in a given scenario due to the constraints of the medical industrial complex (Kletke 1996). So ironically, while this diminution of physician authority seems as though it would be a positive in one dilemma of the alternative birthworker world, it actually adds to another of their dilemmas, as we see here, that of creating more alliances with the medial model.

Still, TSH affiliates like Anna beckon their two strong medical alliances to continue to press for assistance: "... it's about talking to the OB's, and the ones that we have ins with, like Dr. Green and Dr. Adams, telling them "you've got to keep pushing your coworkers, you've got to keep telling them that this is okay, that this is normal, you've got to get more people on board with you!" Unfortunately, it seems this beckoning may fall upon deaf ears due to the structural constraints these physicians face should they join the alternative birthworkers in their quest.

## **Bureaucracy: Legal Issues, Insurance, and Licensure**

In the section that follows, I will explore a final, yet complex theme that surfaced in my interviews regarding the overarching dilemmas faced by birthworkers: that of interacting with the legal and bureaucratic structures of medicine. By this I refer to legal issues such as licensure, malpractice, and insurance. This section will present a multifaceted system of bureaucracy that affects all of my respondents, regardless of their level of authority or job title. Each of these practitioners has a unique set of challenges and marching orders that act upon them and upon which each must rely and also obey.

### ***Legal Issues***

Many aspects of the traditional midwifery practice are illegal. For TSH this is a particularly important issue as they negotiate a more medicalized approach. TSH practitioners are not covered by malpractice insurance and are in essence practicing medicine without a license. One of the advantages of TSH that affiliates discuss is that Jane has retained a lawyer for TSH:

*So we have a lawyer that we counsel with, he just helped us with the doula contracts after something that just happened, we realized that we needed new statements added to the doula contracts. We used to use prepaid legal but then we found them to not be that helpful, [laughter] so now we have a lawyer on retainer that helps us.—Jane*

I later learned from a number of respondents that the “something” that just happened involved the aforementioned death of an infant who’s mother was under

midwifery care. This matter was alluded to in a number of interviews, and discussed directly in others. Respondent birthworkers, including the obstetricians in the study recounted a story of an independent midwife who had a client with some rather risky medical issues. According to all of the narratives regarding this matter, the midwife did not act quickly to refer the mother to medical authorities. Within a short time, the mother and baby went into distress. Dr. Adams was the obstetrician on duty at the hospital when the woman was finally brought in for care, and regardless of working with the mother and the infant for quite some time, there was nothing that could be done.

I asked Jane if she was afraid of getting sued if something similar were to happen to her. I asked her what steps she had taken to protect herself legally. She described her legal dilemma thusly:

*We have people sign informed consent disclosures saying that they know we don't carry medical malpractice, that they know that were not practicing medicine, we're practicing midwifery, my lawyer would be the first one to tell you it doesn't hold any water. Whenever we're sued for something its medical malpractice, because I'm practicing medicine without a license.—Jane*

I also asked the doula if there were afraid of litigation, and generally speaking, their answer was “no.” Most of the doula's rely on the fact that TSH had retained counsel and felt that their \$50 referral fee to the company went a long way in terms of benefits, legal services being an important one of these. According to Melissa:

*I know that they do have a lawyer that that will oversee if you are affiliated with but that's kind of why you decide on the affiliation, because*

*there is a contract we all follow that has been approved by an attorney, and if there is an issue, that attorney deals with that. I don't know of any issues that have come up where we needed the attorney, but I know that he is there for sure to consult with if you need to.*

### ***Licensure***

A very important dilemma experienced by TSH and other alternative practitioners involve licensure. The subject area is one of a shrinking number of US states that does not have a program in place for licensure of midwives. At this point, there are no real regulations on the books as to who can call themselves a midwife, and what constitutes training. This is a very large bone of contention amongst practitioners in the community. Some midwives are in favor, and some very strongly oppose the concept of licensure.

Because their state has no licensure, and because of the recent event where a baby died, the issue of licensure is imminent. I was fortunate enough to be invited to attend a meeting welcoming a state representative on midwifery licensure to meet with all of the midwives or all types, CPM, Certified Nurse Midwife (CNM) , DEM, etc... The meeting was held at TSH's storefront location and advertised by word of mouth and through social media. Even before the meeting it was incredibly apparent how contentious an issue this was by reading argumentative and even downright insulting postings on social media regarding the meeting.

When I arrived at the meeting, I pulled up a chair next to two midwives I have known for years. Previously, I had attended a birth with one of these women as co-doulas. She gave me a hug, and whispered to me, "*Why are you here?*" I responded that I was still conducting my research, which she accepted, and shared her meeting outline

paperwork with me. I immediately noticed factions of midwives around the room. TSH midwives and their midwife apprentices on one side of the room, (previously) Manger Mommas midwives on the other. All of the medical model CNM midwives with hospital privileges clustered into another area, and independent midwives were seated together near me. A round woman with short white hair from the rural area of our state with over 35 years of experience in this field sat at the head of the room in a lovely old wooden rocking chair.

As the meeting began, this woman detailed horror stories from her experience as a nurse and then a nurse midwife that served to justify her passionate involvement in this movement. I learned that she was the state president representing the national organization, the American College of Nurse Midwives (ACNM). Coming from a very respectful place, she stated that CNM's do not have ill wishes for the other, less recognized sorts of midwives. But, "*Licensure is coming,*" she warned. All sorts of comments erupted from around the room. "*Oh, that just doesn't work for me...*" and "*I just won't be able to tolerate that.*" There were calls for collaboration and cross referrals. Some laughed, other became angry. The tension was palpable.

The state president smiled and rocked in her rocking chair. I could just picture her loving arms cradling countless children. She was absolutely non-confrontational, wore no outward signs of wealth or privilege, and was non-threatening and not at all judgmental. I listened to about two hours of bantering back and forth about what would be lost and gained by the seemingly inevitable upcoming licensure. I noticed that some women, despite their lack of a nursing degree spoke in highly medical terminology, and others

seemed to have no grasp on such language. I was struck by the difference in orientation and education in the room.

In order to better understand the dilemmas surrounding the licensure of midwives I asked a number of questions of my respondents. One of the main issues that causes midwives to take issue with licensure is how it limits their ability to practice. Jane explained to me that “*You can’t do twins for example you can’t deliver past two weeks overdue, you can’t have breech deliveries.*” Another large issue against licensure of midwives came from Donna who told me that this would restrict women from having a VBAC, which is extremely detrimental to birthworkers cause as there really are not many other opportunities for women to receive this service.

In a few prognostic frames, birthworkers stated that licensure was not such a bad thing as it creates minimum standards. In terms of the aforementioned occurrence of the baby dying, some suggested that licensure could have served to prevent it, and without licensure, there are no consequences meted out to that individual for their negligence. Dr. Adams was of a similar opinion:

*We need accountability. That would be a good thing here. You’d get rid of the substandard people. There would be a board where they’d have to stand in front of them. Like this other case I was telling you about. To be called on the carpet and have your credentials. You should be stripped of your credentials. There should be regulations.*

### ***Malpractice and Defensive Medicine***

The respondent that spoke the most about legal issues was Dr. Adams. In fact, he was extremely critical of legal matters and how much these interfere with his work.



According to Dr. Adams, these issues limit the amount of collaboration that obstetricians are willing to engage in with midwives. In this final section of this chapter, I will detail my discussion about the legal dilemmas faced by medical practitioners that serve to impede the ability and/or willingness to engage with or support the birthwork movement.

This entire discussion began at the top of our interview when I asked Dr. Adams what, if anything, he thought was different about giving birth in our area than anywhere else. He said that he had practiced in several other cities in our nation and claimed that the legal climate here was one factor that stood out in his head as a distinguishing factor:

*What I would say about [the area] is the litigious atmosphere we live in. Can't open a phone book, turn on the TV, or look at a billboard without seeing a lawyer's face. A lot of sharks in the water. We were actually a few years ago one of the red alert states...the American College of OBGYN...for malpractice being so high and having the most lawsuits too.*

I recalled the area's newspapers running stories on a mass exodus of obstetricians, so much so that pregnant women could not find care. According to these stories, the number of lawsuits in the state had risen to such a level that all of the insurance companies increased their rates to such an extent that doctors could not make enough money practicing here, so they left. Malpractice is a huge issue for physicians, and the goal of attracting more physicians to the cause is, and it seems will remain an uphill battle for birthworkers.

Dr. Adams recalled a workshop that he went to in which an obstetrical legal expert was detailing cases of malpractice with the attendees:

*I'm remembering [the birth injury expert] getting very upset. Slamming his book down on the podium. He said, "People, take your blinders off. You will never be sued for doing a C-Section. You will be sued for not doing one soon enough." That was the take home message. When in doubt, cut.*

*—Dr. Adams*

This practice of performing C-sections to avoid malpractice suite is the stuff of birthworker folklore. There is a common belief amongst birthworkers that obstetricians will perform c-sections in order to avoid lawsuits, among other not-medically-necessary reasons. Here, I observed a strong case of anecdotal evidence. Dr. Adams even went on to make the connection between the increasingly high rates of c-section and doctor's attempts at self preservation:

*A lot of doctors practice CYA medicine – cover your ass medicine. That also spilled into hospital philosophies and is why we have the highest C-section rate too.*

To Dr. Adams, this is reprehensible. By working with women seeking alternatives, he may indeed be putting his life's work on the line, but he refuses to back down. In the following narrative, Dr. Adams takes a stand against the litigiousness in society that many of his colleagues are afraid to take. Here we see the type of passion and dedication that it would take on the part of the medical model to reframe and which ultimately has the potential to change the landscape of the dilemmas experienced by holistically minded birthworkers in our nation. To do so, according to these practitioners, would ultimately honor women's choices, wrest control over women's bodies out of the hands of bureaucracies, and give birthing women choices and voices, all the while

availing to them all of the amazing medical technologies that have saved the lives of mothers and babies.

*I made a decision a few years ago that I refuse to be afraid of my patients. I **will** have a relationship with my patients. By the time we get to the point of delivery, we spend a lot of time together. I think there's that trust that you have to build up. It's the other problem too. That's distancing. People want to distance themselves from the patient because the thought is, "you're my potential enemy." I love being a doctor. I love what I do. I get up every morning and I'm excited to go to work. People ask me when I plan to retire. I don't want to retire. As long as my health holds up, and God willing I can make it to the hospital, I will come and take care of patients. That's just what I do. Now, it's very important...it's a very intimate thing we do. It's a very special event. You don't want to bring a potential adversity to that situation. It's not conducive to the environment you want as far as this type of practice. Come what may, I'm going to practice this way. It will probably take me down someday, but we'll have to see. So far it's gone pretty good.*

## **CHAPTER TEN: CONCLUSION**

Through my multi-method case study, I have examined the structure, services, philosophies and participant narratives of the business organization and social movement in complementary and alternative medicine (CAM) known as The Stork House (TSH). I have examined how these birthworkers position themselves as a midpoint on the continuum between medicine and midwifery. I have explored the ways that they negotiate their status through the use of collective identity, both amongst themselves, and also with the public, and further by creating demarcating boundaries which set them apart from others in multiple ways. Based upon these interviews and my experiences in the field, I have found that there are a number of important aspects to consider in the provision of maternity care both currently and in the future.

### **TSH on the Medical to Midwifery Continuum**

In this dissertation I have examined where TSH positions themselves in, around, and against the mainstream medical model and the midwifery model. Overtly, I find that TSH affiliates seek to integrate these models, and many of their services and practices serve that end. In their own personal narratives, and indeed in the practice of alternative birthwork, there is an inherent preference for midwifery models. I will now discuss the major findings to answer this question and to place TSH on the continuum between medicine and traditional midwifery.

### *Against the Medical Model, In the Midwifery Model*

Many TSH affiliates take issue with the tenets and claims of medicine and these grievances contribute to the resistance of the birthworker movement. For example, unlike the medical model, TSH affiliates do not tend to believe in a separation of body/mind/environment, instead preferring a holistic approach, which is part and parcel of the midwifery model, in which all of these items are considered in concert with one another. As my data show, ALL of the TSH birthworkers see the medical view of pregnancy as highly inaccurate. Further, like the traditional midwifery model, many of these birthworkers are skeptical of the high levels of technological intervention applied to what they consider a normal bodily process: childbirth.

TSH affiliates take issue with the power imbalances between practitioner and client and the ideology of physician dominance that holds them in place, instead favoring an egalitarian, more team-like approach. This approach is reminiscent of the women-centered-care that corresponds to the feminist movement in health and by extension, midwifery. Instead of deference to one's care provider, affiliates encourage their clients to take charge of their own bodily issues. One way they do this is by directing them to learn about their bodies and related concerns through the reading of peer reviewed research.

TSH practices a collaborative model of care with their clientele. In my observation of a prenatal consultation, midwife Julie sent the pregnant woman to the bathroom to test her own urine and also to check her own weight. Once the woman returned to the exam room, Julie asked her to read the results of the urine test for herself

while Julie entered the information into the patient's file on the computer. Here, we see a concrete example of the team approach to patient care fostered by TSH.

Furthermore, TSH affiliates are critical of the Biomedical Technical Service Complex Inc., and the corporatization of medical services in general and say that these take the human aspects of care and cooperation out of medicine and create a one-size-fits-all approach in which people become nothing more than numbers and dollar signs. TSH seeks to provide a large variety of services, products, and classes to meet a variety of needs for pregnant women. In this way, no two women need to have the same experience with TSH; each can customize her prenatal care according to her own needs and interests.

TSH affiliates have very strong feelings against the medicalization of childbirth. These women argue that childbirth should be a social event, and not a medical one. They point to the history of childbirth to support their claim in that women used to give birth with the assistance of local women: mothers, sisters, neighbor women, and midwives. In fact, these women express cultural feminist essentialist philosophies surrounding birth and in line with the midwifery model of care such as the notion that women are "made" to give birth, that our bodies intuitively "know" how, and that women are natural-born nurses.

### ***Against the Midwifery Model, In the Medical Model***

As previously mentioned, I find a conflict between the private convictions and public expression of TSH affiliates regarding the rightful place of maternity care on the continuum of midwifery to medical models. I find their sentiments to fall heavier on the side of midwifery models of care, although there are a few exceptions to this rule. I find that these exceptions often seem more related to financial matters, and concerns for the

legitimacy of their work in the public eye than the rightful place of medicine in maternity care. In the areas where affiliates lean toward the medical model, it is usually regarding emergency care and/or patient preference more so than their own personal beliefs.

These practitioners concede that although they do not agree with the sweeping medicalization of all childbirth, there is definitely a place for medical interventions here. They cite cesarean sections, for example, as an amazing medical breakthrough which has saved many a life, mother and child, but argue that this technique is highly overused. The specific ideology behind TSH also states that some women are best served by the medical model. Their objective in these situations is to free the woman from the physician's absolute authority by helping her to decode medical lingo and to understand the techniques and technologies being used, which they term "Truly Informed Consent."

I find a symbolic relationship between TSH and the medical model in the organizational structure of the group. Paradoxically, Jane as director and midwife of TSH serves as a lay expression of physician authority. In direct contrast to the midwifery-modeled team-centered approach espoused by this organization towards clients, TSH employs an authoritarian structure in terms of tenure, promotion, and decision making in their internal politics. There is an organizational imperative to accept and integrate the medical model as a part of the internal collective identity of the group. Only those who have shared in this and other organizational imperatives – read: agree with Jane – for the longest periods of time will be promoted to positions of power, which, ironically, do not pay anyway. Thus, this organization is arranged in a paternalistic fashion, which flies in the face of the tenets of midwifery.

The midwives of TSH have implemented tools and practices from the medical profession into their midwifery care as a part of the integrative strategy which serves to increase their appeal and increase their profits. For example, TSH midwives are skilled in administering IV's for their homebirth clients who might need extra fluids during the course of their labor. These women go against the grain of traditional, hands-off midwifery by bringing oxygen and pitocin to births, which are seen as tools of the medical model. Furthermore, in their quest to integrate with the medical model, TSH midwives have developed relationships with physicians and hospitals. Finally, these women detailed to me a belief that some women simply aren't comfortable with midwifery services, and instead of considering these women to be shameful or delusional, they adhere to a principle of non-judgment and refer them to their medical model connections for care.

With the development of the TSH birthing center, The Stork House Birth Center, Jane was definitely leaning in the direction of the midwifery model by providing a home-like space for women to give birth to their children. Furthermore, one of the rooms at the Stork House Birth Center had a birthing tub available for water-births, a strong component of midwifery philosophy. Jane found, however, that the consumer demand for these midwifery services was simply not present in her community. It was at that point that she abandoned that business plan in favor of the medical-clinic-like storefront space in use currently. In this study, I find that while TSH leans toward the medical on occasion, these practices are usually more in line with either attempts at legitimacy, or profit motives than with personal convictions.



## **Mainstreaming CAM: Legitimacy through Integration**

One major theme emerging from this project is that of the mainstreaming of complementary and alternative methods of maternity care. This project extends upon the literature in the field of complementary and alternative medicine (CAM) in a number of important ways. Through these interviews, I find that women are choosing, in increasing proportions, to seek alternatives to the medical model of care in their pregnancies and deliveries. This is not to say that women are rejecting the medical model, but rather that they are seeking to supplement it with more holistic care. This simultaneous usage of medical and CAM has been well documented in the literature (Hedley 1992; Shuval et al. 2002; Gaffney and Smith 2004; Adams 2006; Tournaire and Theau-Yonneau 2007; Harris et al. 2012), and this research builds upon this literature by presenting an organization specifically designed to help consumers to integrate these two seemingly opposite health care modalities. By positioning themselves in the middle of the continuum between traditional, hand-off midwifery and medical approaches, this organization is creating a “new midwifery” in their area to answer the calls of these consumers.

Few scholars have had the privilege of including physicians in a study about alternative birthwork. Most research concerning doulas and midwives focuses solely on the women who occupy these roles, but I have been fortunate to include the two most CAM friendly obstetricians in the area of study into my research. Thus, I am able to extend upon the research of Mizrachi et al. (2005) in a number of ways. Their findings of a “cautious approval” expressed by physicians toward CAM therapies for their patients, is also present in my study. Here, these obstetricians allow their patients to “believe in”

the services of TSH birthworkers and to incorporate these into their birth plans providing they do no harm. For one, this study brings their research, conducted in Israel, stateside and shows that these trends are present here as well. Further, my research extends the notion of “cautious approval” to the relationship between obstetricians and CAM birthworkers, whereas Mizrachi and colleagues focused on acupuncturists working in an internal medicine department within a hospital. Like Mizrachi’s CAM practitioners and MD’s, I find no *overt* conflicts between TSH affiliates and these obstetricians, instead, both overtly exhibit respect and support for the work of one another. Thus, both studies shed light upon the possibility that alternative and medical practitioners can work together without overt confrontation.

Another theme that has emerged in this project is that of legitimacy and integration of CAM birthwork. There are a number of sociologically significant principles at work here, for example, power and gender. As women working in low paying care occupations in the public sphere, TSH affiliates are marginalized as they interact with the powerful, patriarchal medical model. TSH has been accepted to some extent in the hospital setting through informal channels such as personal contacts and networking. Here, my findings are different from some studies regarding cooptation of CAM into medical institutions. While TSH affiliates express great cooperation with the overarching medical institutions, they are able to do very little to reshape formal organizations by using legitimate channels as suggested by Goldner (2004) and Shuval et al. (2002).

Instead, my findings are far more similar to those of Hall and her colleagues (2012) who find that in Australia, when CAM therapies are introduced into the hospital

setting, their presence does very little to change the status quo, and the practitioners remain marginalized. Here in the United States, my respondents from TSH have been incorporated into the hospital through their relationships with two obstetricians and with City General Hospital and their incorporation into the maternity program with the “Meet-the-Doula” night. Other than their presence at the hospital on the designated night, TSH seems to have little impact on hospital policy, and like the practitioners in the study by Hall and colleagues, TSH affiliates remain marginalized in the hospital setting.

My study also builds upon the research of Shuval (1999) regarding the accommodation of CAM within the medical model. TSH’s incorporation into City General Hospital and also into the practices of the obstetricians reflects the “Bear Hug” in which medical institutions grant entry, but strongly encompass CAM practitioners, controlling and monitoring their work, meanwhile sharing their clientele. This arrangement grants some legitimacy to the CAM practitioner in exchange for added economic benefit to the medical model. The presence of TSH in the hospital setting shows potential clients that their wishes for a doula will be accepted if not welcomed by City General Hospital, and because of their presence in the labor and delivery ward, TSH doulas are able to get acquainted with hospital staff as invited guests from an informally accepted business. Nonetheless, a large part of their shared vision which comprises the internal collective identity of the group involves deference to medical authority. TSH affiliates who fail to defer to medical authorities will be asked to leave to organization.

My research illustrates the ongoing tensions between medical authority and CAM, as marginalized practitioners seek to widen their appeal by penetrating what Shuval and colleagues (2002) refer to as “the well guarded fortress,” which basically refers to the

system of unchecked power and dominance of the institution of medicine and the knowledge of its practitioners. One of TSH's goals of penetrating this fortress is to increase the legitimacy of birthwork, and one of the tools that is used to do this draws from Powell and DiMaggio's (1983) notion of "isomorphism." The term isomorphism refers to a process of one institution mimicking the practices or structure of another successful institution. In the case of the TSH, we see isomorphism in the ways that affiliates seek to emulate the language, decorum, and practices of the medical model.

In an isomorphic attempt to legitimize their work, TSH has instituted a system of online charting like that of medical clinics and hospitals. This information is accessible no matter where affiliates travel, making them able to retrieve vital statistics, treatment plans, and other knowledge about their clientele that may be of interest to medical providers. Furthermore, the storefront location of TSH mimics the arrangements to that of a medical clinic, with consultation rooms with examination tables, a client waiting room, scales and stethoscopes, and health related literature and diagrams on the walls. This arrangement is familiar to patients who may have previously resisted visiting a midwife's office, and serves to make these services more familiar and accessible to the moderate woman and her family.

An important finding of this study is that of the integration of midwifery and medicine. Jane and Julie, as "integrative midwives" seek to combine aspects of midwifery care with aspects of medical care. This integration serves several important purposes. For example, by integrating the two, these midwives are able to attract more clientele, and further, by integrating, they are able to increase the visibility of alternatives to the medical model which clients of this model may not have considered. Thus, one

purpose of integration is fiscal; the other is related to their new social movement goal of changing aspects of cultural perspectives of society regarding childbirth.

### **An Eye on the Future: CAM, Midwifery, and the Medical Model**

Based on the findings of this study, I see a few potential paths for the future of CAM, midwifery, and the medical model in regards to the development and practice of integrative midwifery as expressed in the TSH organization. For example, I find it to be a distinct possibility that Certified Professional Midwives (CPM's) will need to adopt similar integrative techniques as a part of their long term business plan in order to adapt to the consumer climate.

My findings show, in accordance with other related literature (Hedley 1992; Shuval et al. 2002; Gaffney and Smith 2004; Adams 2006; Tournaire and Theau-Yonneau 2007; Harris et al. 2012), that women are increasingly seeking to simultaneously utilize both medical and alternative approaches to their maternity care. I argue that even those women who wish to attempt a homebirth with a midwife will be seeking answers in regards to backup plans and physicians. As such, CPM's will do well to develop such integrative relationships as the ones developed by TSH in order to make their services stand out from the traditional, hands-off models of midwifery in their area with whom they must compete.

While there will likely always be a small constituent of potential clientele looking for traditional midwives, trends in CAM illustrate that a quickly growing constituent of women are seeking to customize their care utilizing elements of both the medical and the midwifery models. Thus, the choice for CPM's in the future will be to integrate and seek

legitimacy in the public eye, or to remain on the radical fringe of hands-off midwifery. For anyone with a business mind, the choice is clear: to appeal to the largest number of potential clientele, CPM's must have a back-up plan in place.

My study of TSH affiliates and their integration into the medical model provides another set of unique possibilities for the future of the rapidly growing field of CAM. I find it most likely that the "Bear Hug" theory as stated by Shuval (1999) will continue its salience in that medical institutions will allow, in limited quantity and with great restrictions, CAM practitioners to gain legitimacy through integration, meanwhile drawing additional institutional income from these patients. Although I find the bear hug to be the most likely outcome in a market based economy such as ours, I do concede that there are other options for the future of CAM. Another possibility for CAM practitioners would be to cater to special interests and press for independent niche market opportunities to attract clientele. Further, CAM practitioners can engage in challenging the medical model, as Manger Mommas did, working for passion over profits in a new social movement attempt to change aspects of the culture, creating new awareness and community.

Finally, my study findings shed light on a number of possible future outcomes for the medical model of maternity care. My overarching belief, based on the findings in my study and the consumer trends I have witnessed through my participation in this field is that the success and authority of the medical model will remain untouched. Medically modeled maternity care structures are and will remain enveloped in "the well guarded fortress" (Shuval 2002) of the largely accepted and dominant institution of medicine. However, I believe that this fortress, in order to maintain its successful position, must

fortify itself in preparation for continual entry attempts by consumerist movements in health, patient's rights movements, CAM, and other social movements that may wish to rush its battlements. In this way, organized citizenry can gain some advantage by presenting a "culture of challenge (Scambler and Kelleher 2006:211)" to this established authority. The medical model will thus continue its power, tempered somewhat by neoliberal notions of agency and individualism and market demands.

### **Study Limitations and Suggestions for Future Research**

There are a few limitations that have potentially impacted the findings in my study. The first of these is not having access to all affiliates within the TSH organization. While I was able to speak with most of the affiliates, some were clearly not comfortable with my presence at events. I made multiple phone calls and email attempts to interview these affiliates, but to no avail. One woman continually put me off, cancelling all of our scheduled appointments, citing her babysitting turmoil as the reason for her lack of response. Other affiliates made promises publically in front of Jane and their other colleagues to meet with me, but then disregarded my telephone and email requests. After I had made connections with most of the affiliates, I decided to send out a message that I was conducting a final round of interviews. Jane posted my message on the private TSH Facebook page, and the non-response continued. I felt that my seventy eight percent response rate was sufficient, and as such, I proceeded without the narrative accounts of these affiliates. Thus, there is a potential lack of detail in the study due to not having access to all members of the organization. Nonetheless, I am pleased with the amount and

quality of data that I have received in this study and find it to be more than sufficient to provide the information I had hoped to provide.

Another limitation in my study is the dissolution of Manger Mommas. I left voicemail and sent email messages to the primary midwife from this organization in an attempt to include them in my study. I never received any response and as such was never able to speak with them about their unique philosophies. Fortunately, I had secured their mission statement and was familiar with their operating practices from my many years in and around this field. In this study, I am only able to report about Manger Mommas through third parties, although these stories did corroborate well with one another, so I assume that I am at least getting close to the truth regarding this organization.

My study is also potentially limited by the fact that I did not interview previous or potential clientele of TSH, for example parents and the general public. I chose not to extend my study's focus to include these individuals as I did not have the time or resources to conduct this research. Having these narratives would enrich my findings by adding the element of public perceptions of the state of maternity care and TSH's contribution to this care. I would suggest that in the future, scholars pursue research that seeks to understand the motivations and understandings of women and families who seek something other than mainstream, medically modeled maternity care in the United States.

Furthermore, in the area I have had opportunity to study; the birthworker population is not diverse. My study is thus limited by the fact that all of my respondents self-identify as White, and they are all married, most have children, and most of the affiliates are not the primary breadwinners in their households. Thus, my sample is comprised of individuals with arguably privileged characteristics. Future research would



do well to examine a more diverse group of birthworkers to see how outcomes differ. For example, I would be interested to see how racial and ethnic minority birthworkers, those of low income, and/or single female heads of household approach the issues of finance that were discussed in my study. Further, I would be interested to note the demographics of their clientele in terms of race, ethnicity, and class.

Finally, I recommend that similar research designs be applied to studies of other types of CAM organizations. For example, future research could compare the organization, boundaries, and collective identity of TSH to another collective of CAM providers. It would be interesting to note whether, and if so, how and to what extent these practitioners attempt to integrate their modalities with the overarching medical authorities in their areas.

## APPENDIX A: INTERVIEW SCHEDULE

What is your:

- Age?
- Marital status?
- Race/Ethnicity?
- Do you have children?
  - o How many?
  - o Ages?
- What is the last year of education or last degree you have completed?
- Are you employed now, other than being a midwife/childbirth educator/doula/lactation consultant?
  - o If so, please tell me about your work and career.
  - o If not, did you leave a previous career or job to become a midwife/childbirth educator/doula/lactation consultant? Please explain.

Next, I'd like to learn more about your midwife/childbirth educator/doula/lactation consultant education and interests:

- How long have you been in your field?
- Approximately how many births have you attended?
- What motivated you to enter your field?
- Could you tell me about the events that led up to your entry into this type of work?
- Where did you get your training?
- What was the training like?
  - o What did you like best about your training?
  - o What did you like least about your training?
- What do you like best about your practice?
- What do you like least about your practice?
  
- Please tell me a bit about what you, particularly, do in your line of work? In other words, can you please state your job description?
  - o Does it ever change?
  - o Is there anything about your job description that is difficult for you?
  
- Do you now or have you ever belonged to any professional organizations?

- o Why/not?
- o What are your thoughts about professional organizations?
- o Do you belong to any other, non-pregnancy/birth/lactation organizations that have an impact on your role as a midwife/childbirth educator/doula/lactation consultant? If so, please explain.

Let's talk about your experiences as a pregnancy/birth/lactation professional:

- Do you have a preference for a given obstetrician/pediatrician?
  - o Why/not?
  - o Do you discuss this preference with clients?
    - If so, When/How?
- Do you have a preference for particular birthing locations?
  - o Why/not?
- Do you discuss this preference with clients?
  - Why/not?
  - If so, When/How?
- Is there a difference between home vs. hospital births?
  - o What are your feelings about home vs. hospital births?
- If so, how does this difference carry over into pregnancy?
- If so, how does this difference carry over into the postpartum period?
- Have you ever experienced a conflict with a care provider?
  - o How did you handle that conflict?
  - o What was most/least helpful to you during that time?
  - o Looking back, what did you learn from that situation?
  - o Does this conflict have lasting affects on your work?
  - o Do you discuss these conflicts with clients?
    - When/How?
- Have you ever experienced a conflict with a specific birthing location?
  - o How did you handle that conflict?
  - o What was most/least helpful to you during that time?
  - o Looking back, what did you learn from that situation?
  - o Does this conflict have lasting affects on your work?
  - o Do you discuss these conflicts with clients?
    - When/How?
- Have you ever experienced a conflict a client?
  - o How did you handle that conflict?
  - o What was most/least helpful to you during that time?
  - o Looking back, what did you learn from that situation?
  - o Does this conflict have lasting affects on your work?
- Have you ever experienced a conflict with families of clients?
  - o How did you handle that conflict?
  - o What was most/least helpful to you during that time?

- o Looking back, what did you learn from that situation?
- o Does this conflict have lasting affects on your work?
- Have you ever experienced a conflict with a colleague?
  - o How did you handle that conflict?
  - o What was most/least helpful to you during that time?
  - o Looking back, what did you learn from that situation?
  - o Does this conflict have lasting affects on your work?
- What is the best thing about working with your colleagues at TSH?
- Do you have a uniform or specific type of clothing that you wear in the course of your work?
- Are there certain phrases you use/never use in particular pregnancy/birth/lactation consulting settings?
- If the wishes of your client are not being honored by medical staff or other colleagues, do you intervene?
  - o Are there certain times/places where you would be more/less likely to intervene?
  - o Are there certain issues regarding which you would be more/less likely to intervene?
- Are there certain situations/problems that you regularly encounter in hospital births/home births/childbirth education classes/lactation consultations?
  - o How do you manage these situations/problems?
- Can you tell me about a hospital birth in which you felt particularly empowered?
  - o How did you manage this situation?
- Can you tell me about a hospital birth in which you felt particularly un-empowered?
  - o How did you manage this situation?
- Can you tell me about a home birth in which you felt particularly empowered?
  - o How did you manage this situation?
- Can you tell me about a home birth in which you felt particularly un-empowered?
  - o How did you manage this situation?
- Can you tell me about a childbirth education class in which you felt particularly empowered?
  - o How did you manage this situation?
- Can you tell me about a childbirth education class in which you felt particularly un-empowered?
  - o How did you manage this situation?
- Can you tell me about a lactation consultation in which you felt particularly empowered?
  - o How did you manage this situation?
- Can you tell me about a lactation consultation in which you felt particularly un-empowered?
  - o How did you manage this situation?
  - o
- From start to finish, would you please tell me about your attendance at a typical hospital birth?

- From start to finish, would you please tell me about your attendance at a typical home birth?
- From start to finish, would you please tell me about your attendance at a childbirth education class?
- From start to finish, would you please tell me about your attendance at a lactation consultation?
- Have you ever been concerned that you would lose your ability to practice in a hospital setting?
  - o What caused you to fear this?
  - o Has this happened to anyone you know?
- Have you ever been concerned that you would lose your ability to practice your work?
  - o What caused you to fear this?
  - o Has this happened to anyone you know?

And finally for some more general questions about pregnancy/birth/lactation professional's roles:

- In general, how do you think nurses perceive your work?
  - o What makes you think this?
  - o How do you deal with this?
  - o Does this impact your work with your client?
- In general, how do you think doctors perceive your work?
  - o What makes you think this?
  - o How do you deal with this?
  - o Does this impact your work with your client?
- In general, how do you think midwives perceive your work?
  - o What makes you think this?
  - o How do you deal with this?
  - o Does this impact your work with your client?
- In general, how do you think doulas perceive your work?
  - o What makes you think this?
  - o How do you deal with this?
  - o Does this impact your work with your client?
- In general, how do you think lactation consultants perceive your work?
  - o What makes you think this?
  - o How do you deal with this?
  - o Does this impact your work with your client?
- In general, how do you think childbirth educators perceive your work?
  - o What makes you think this?
  - o How do you deal with this?
  - o Does this impact your work with your client?
- Is there anything you'd like to change about perceptions of your occupation within the medical community?

- Is there anything you'd like to change about perceptions of occupation within the larger birthing community?
- Is there anything you'd like to change about perceptions of midwives/doulas/childbirth educators/lactation consultants among expectant mothers?
- What do you foresee for the future role of the your occupation?
- Have you heard of certified professional midwife (CPM) programs?
  - Would you be interested in joining a CPM program?
  - Why/not?
- Have you heard of hospital based doula programs?
  - Would you be interested in joining a hospital doula program?
  - Why/not?
- Are you familiar with hospital based childbirth education programs?
  - Would you be interested in joining a hospital doula program?
  - Why/not?
- Do you consider your line of work to be a sort of activism?
  - Why or why not?
  - Do you consider yourself an activist at all?
- What are the most important roles for someone in your occupation?

Closing:

- Is there anything else about your occupation that I should know?
- Is there anything you'd like to ask me?
- Is there anything you think I should have asked that I did not?

## APPENDIX B: TERMS AND ACRONYMS

**ACNM:** American College of Nurse Midwives. (From the ACNM website) "...the professional association that represents certified nurse-midwives (CNMs) and certified midwives (CMs) in the United States."

**CBE:** Child Birth Educator: There are many different modalities offering certification of childbirth educators. Some of the larger, more common agencies are Lamaze™, The Bradley Method™, and HypnoBirthing™. Some childbirth educators work in the hospital and some are independent. No formal degree is required.

**CLC:** Certified Lactation Counselor. A national certification registered with the United States Trademark and Patent Office. A CLC does not require a formal degree. CLC's complete a training program that promotes competency in breastfeeding and human lactation.

**CNM:** Certified Nurse Midwife. Educated in both nursing and midwifery. Must have at least a bachelor's degree in nursing, though a master's degree is common. Has successfully completed a university affiliated accredited nurse midwifery program and passed an exam created by ACNM. Legal in all states. Most CNM's practice in hospitals and birthing centers.

**CPM:** Certified Professional Midwife. An independent midwifery practitioner who has met the standards for certification set by NARM. No nursing education required. Usually practice in homes and some birth centers. Not legal to practice in all states.

**DEM:** Direct Entry Midwife. No nursing education required, education in midwifery acquired through a combination of apprenticeship, workshops, and self-study. Not legal to practice in all states.

**Monitrice:** From TSH Website: "A Monitrice is a Labor Doula who has in addition to her Doula skills, some medical training. Most monitrice's achieve their skill level by apprenticing with a Midwife and studying for Midwife certification. A Monitrice can provide clinical skills at home before going to the hospital. She is able to listen to fetal heart tones, check your dilation, and take your blood pressure."

**NARM:** North American Registry of Midwives, developed CPM credential in midwifery in 1987. This credential is often used by states as a basis for licensure.

**OB:** Obstetrician. A physician who specializes in the management of pregnancy and childbirth.

**Placenta Encapsulation Specialist:** This individual has been trained in the proper handling and preparation of the human placenta such that it may be inserted into gel capsules and ingested by post-partum mothers.



## **APPENDIX C: SAMPLE DETAILS AND DEMOGRAPHICS**

In the following paragraphs, I detail the basic information given to me by my respondents about their income and education level as well as my own impressions based on our interview time together. As previously mentioned, all of my respondents are married and self report as White. Only five of the birthworkers in this study list themselves as the primary breadwinner within their home. Of all of my respondents, seventeen are currently affiliated with The Stork House (TSH), twelve of whom were also previous clients of the business, and in particular, home birth clients of Jane, the director, founder, and one of two TSH midwives. Two of my respondents were previously affiliated with TSH, one of these women was fired from the organization, the other left to pursue more lucrative CAM related work. I will now present a small descriptive paragraph on each of my respondents and list any factors about each that seem of particular importance in this study.

The first person I interviewed was Jane, age 42, the director, founder, and full time midwife at TSH. I have known Jane for approximately seven years. I met her through The Birth Helpers in 2008, when she had just recently founded TSH. At that time, I interviewed her for a different study in her home, which was in a middle class neighborhood in the valley. Jane and her family had a selection of professional family photographs and LDS (Latter Day Saints) religious memorabilia adorning their home. Previously, Jane supplemented the income of her husband with her birthwork, but currently, Jane serves as the primary breadwinner in her household, and also finances the TSH business through her midwifery earnings.

Rebecca, age 29, married, with an Associates of Arts degree who invited me to her home on the northwest side of the town. Rebecca came to be affiliated with TSH as a previous client of their doulas. Her neighborhood is middle class, with cookie cutter homes so typical in her city, with red roof tiles and beige and cream stucco exterior. The homes in this area are newer, most likely built within the past ten years, and most likely selling in the 200 thousand dollar range. Rebecca's husband was currently deployed, but her two children, ages six and two were at home. She had high quality and artistic family photographs framed on the wall. Alongside these was a painting of Jesus in the specific style of the LDS religion. Rebecca does not work outside of the home other than her doula work through TSH.

36 year old Suzette invited me to her home in the southwest part of the town for our interview. Her two children, aged eleven and nine were at school, and her husband was at work. Her home was very spacious yet sparsely furnished. It seemed that the home had many upgrades, including a custom woodwork spiral staircase, mahogany cabinets, and granite countertops. Suzette works as a full time midwifery student and doula and claimed that she was not making any money from her work at TSH. She had completed some college, but seems focused on etching out a career in birthwork, while her husband is the primary breadwinner for their home. She alluded to some discontent on his part as to the expenses associated with becoming a midwife and the low, or in this case, nonexistent wages of doula work.

40 year old Bridgette came to be affiliated with TSH as a previous midwifery client. She agreed to interview with me at my on-campus office, and I met her with change for the parking meter in the parking lot where she arrived in a very fancy brand

new white Audi sedan. A middle aged blonde woman, Bridgette works outside the home to a limited extent as a dance teacher. Her husband is the primary breadwinner for their home and three children. Bridgette has an Associates of Arts degree, and is currently working as a doula for TSH while she attends midwifery school and apprentices under Jane. I was fortunate enough to attend an event when Bridgette graduated as a full doula, entitling her to charge full price for her services. Like many other TSH affiliates, Bridgette mentioned her husband's misgivings with the low wages and heavy time commitment required of birthworkers.

Anna, a 29 year old mother of three young children invited me to her home for our interview. She made me a coffee and we sat on the couch while her baby slept nearby. Anna lives in a very new, neat and clean middle class home typical for the subject area. Like many other women in the study, Anna had high quality, professional photographs of her family framed on the walls throughout the house. Anna's husband is a minister for their Christian church and serves as the primary breadwinner for their home. Anna has a Bachelors Degree and had begun taking graduate classes when she began her family. She discussed going back to school at some point to finish a graduate degree, but is at present more focused on becoming a midwife. Like a number of TSH affiliates, Anna was once a client at TSH, having given birth at home with the assistance of both TSH midwives. She left a job as a waitress, which she said she really hated doing, to become a birthworker.

30 year old Patricia agreed to meet with me at a Starbucks near to the TSH office. A previous midwifery client of TSH, Patricia has a bachelor's degree in graphic design and operates her own business in that field. She also designed and manages the TSH

website, a task for which she is not paid. Unlike many of the other TSH affiliates, Patricia expressed disdain at the volunteerism required within the organization. She stated that she did not feel appreciated for her work, but instead taken for granted. She also stated that she was afraid to say anything about her grievances due to a fear of upsetting Jane. Patricia and her husband have recently lost their only child in utero. She cried when discussing the event and the entire tone of my interview with her was quite somber. She was the only person I interviewed who was currently a TSH affiliate that admitted to any discontent with the organization.

Michelle, a 28 year old mother of two invited me to her suburban, middle class home for our interview. Michelle's husband is the primary breadwinner for their home, and at the time of our interview, Michelle had yet to earn any money from her birthwork. Michelle began her work with TSH after the birth of her second child, delivered at home by Jane.

I met Melissa at a Starbucks for our interview, where she was carrying a newborn baby who slept the entire time. 25 years old and married with a Bachelors Degree in psychology, Melissa's husband is the primary breadwinner for the couple and their three children. Melissa began her work at TSH after her own birthing experiences with Jane. She reported an income of ten to fifteen thousand dollars a year from birthwork and reported seeing fifteen clients a year. Not only is Melissa trained as a doula, but is also a lactation consultant and a placenta encapsulation specialist. She referred to a wish to become a "Jack of all trades" within TSH.

I met Maureen at her middle class home within a gated community. At age 34, she holds a Bachelors of Science degree and has been working as a birthworker for two

years. In addition to being a doula, Maureen is a student midwife and apprentice of Jane, as well as a placenta encapsulation specialist. Her six homeschooled children, ranging in age from two to thirteen were some of the most well behaved and well spoken children I have ever interacted with. While we spoke, the older children tended to the needs of the young ones. I learned that Maureen was a devout catholic who is opposed to birth control. She is also a representative for DoTerra, a company who manufactures expensive essential oils for health and relaxation. Her husband is the primary breadwinner for their family and works for the government. The couple has delivered their children in hospitals and at home, mostly with midwives, although they did deliver one child together, unassisted.

Jaqueline is a 30 year old childbirth educator of the HypnoBirthing™ method. Six years ago, she left a job as a school teacher to be a stay at home mom, but instead took to the task of childbirth education which she found a natural fit considering her other teaching experience. In an older and quite large brick home, Jaqueline and her husband raise their three children. Her husband continues his work in the educational sector and is the primary breadwinner for their home. Jaqueline states that she makes around \$10,000 a year teaching her classes. The income is steady and she feels compensated and happy about her work. As a previous doula and midwifery client of Jane's, Jaqueline loves being affiliated with TSH and cites a supportive team for both her clients and associates as a mainstay of the organization.

I met Janice at a locally owned coffee shop for our interview. Janice is 25 years old, and married with two small children, the second of whom was delivered by Donna, mentor midwife to Jane of TSH. In addition to her doula work, she helps her husband

with his family business as an administrative assistant, a schedule which she described as flexible and thus a good fit for her birthwork aspirations. Janice is also a student midwife and an apprentice of Jane and Julie. Janice is the only TSH affiliate that disclosed to me that she was not religious, and stated this in the context of discussing the strongly religious convictions of her affiliates, specifically stating that many were LDS. Janice claimed that she makes approximately \$10,000 a year with her birthwork, which, along with her administrative work, supplements the income from her husband's family business.

Lilly, a 27 year old mother of three small children, the last two of whom were delivered by Jane, invited me to her home for our interview. She had just moved into the house in a central neighborhood of the city with older, but often rather large homes with generous yards. Her children played outside and watched movies while we spoke, with the eldest child being prone to screaming outbursts at being denied attention from her mother. Lilly holds a Bachelors Degree in English Literature and is now a stay at home mother, excepting her birth work, while her husband is the primary breadwinner for their family. In addition to her doula work at TSH, Lilly has recently begun a series of classes entitled *Birthing Naturally: Christian Childbirth Education*. Here, she teaches women and partners about the spiritual aspects of pregnancy and childbearing and how they can call upon their faith during these times to enrich their experiences.

I met Tessa for a cup of coffee in a swanky neighborhood café in the popular suburbs of town. Tessa was one of two women in the study who have never had children. She is 27 years old, married, and has worked full time as a nanny and newborn care specialist for seven years. Her husband also works full time, but despite their dual

incomes, Tessa made several references to her financial woes. At the time of our interview, she was training to become a doula, but still working at the free rate that covers the first three births as a student. Tessa was one of the more vocal affiliates of TSH in terms of the low level of pay, and spoke candidly against the free birth rule for student doulas. In fact, she cited a strong agreement on matters of TSH finance with an outspoken, and particularly business minded ex-affiliate of TSH, Kathleen. Tessa was also very outspoken in calling herself and birthwork in general “activist,” whereas most TSH affiliates were hesitant to refer to themselves or their work in that way.

Rosie is an 18 year old mother of one, and the daughter of TSH founder and director, Jane. I met with Rosie in an lovely upscale home belonging to her grandmother. Rosie is the only one of Jane’s children who has children of their own, and is also the only one of her children who works in the family business. After a self-described amazing home birth experience, Rosie, who told me she had been around birth and birth related things her whole life, decided to walk in her mother’s footsteps becoming a doula and a student midwife. Rosie graduated high school and gave birth to a baby girl. She is married, and her husband is the primary breadwinner for their family.

I have known Liz, age 33, for seven years, at which time I interviewed her for a previous study as she was just beginning her birthwork career as a doula. Since then, Liz has become a certified herbalist, teaches in-depth childbirth education classes, and also serves as the General Manager of TSH. This is one of three administrative positions within the organization. Within this position, Liz handles a lot of paperwork and serves as an assistant to Jane. Self-describing as more professional, Liz handles the parts of the business that require a more hardnosed approach, which Jane is notoriously not well

aligned with. Liz's husband works full time to pay the lion's share of the bills for the couple and their two children. Liz does not make any money for her managerial work at TSH, but sees paying clients in the role of herbalist, doula, and childbirth educator. With these transactions, Liz pays a portion of her earnings back into the TSH fund, as all affiliates do. In particular, she pays 10% of her fees for herbal consults, and the typical \$50 referral fee that all doulas pay into the TSH fund.

I was invited to interview Winnie at her home where she lives with her husband and two children. Winnie, age 41, has been a birthworker for four years and is currently serving as the director of the childbirth education programs at TSH. This is an unpaid position. She also works as a doula and teaches her own series of childbirth education classes, for which she earns between five and eight thousand dollars per year. Winnie's husband works as an artist and entertainer and is the primary breadwinner in their home. Winnie has a Bachelor's of Fine Arts degree and was a stay at home mother between her previous career and her current career as a birthworker.

Mimi is a licensed massage therapist and has worked at TSH for thirteen months. She was hired into the only paid administrative position in the organization: Office Manager. She has a background in finance and medical billing, which she feels why she was a good fit for the job. A previous midwifery client of Jane's, Mimi has three children with her husband, who is the primary breadwinner for their family. Mimi is able to bring home \$3600 a year from her office management work, and in addition, she works as a massage therapist at TSH and is also certified as a lactation consultant. When she performs these services, she contributes more to the family income after paying 10% of her proceeds to TSH.



42 year old Julie is the second midwife at TSH. She is a previous apprentice turned business partner of Jane's, and also serves as director of lactation services at TSH. A mother of seven, Julie stayed at home for fourteen years, but now supplements her husband's income with her birthwork. She has been doing doula, monitrice, midwifery, and lactation consulting services for seven years in total. These services are for profit, but her position as director of lactation services is volunteer work. She makes approximately \$25000/year in her current position.

While I primarily focused on affiliates from TSH, I also spoke with 6 individuals who are not currently affiliated with this business. Two of these respondents are obstetricians working in the area hospitals, both are Caucasian, married males with children. These men serve as "back-up physicians" for the midwives from TSH. In this role, these physicians are on a first name basis with the midwives and many of the doulas at TSH. They have an arrangement with the midwives in which they are willing to meet the midwives and their clients at the hospital should the midwives have to transfer care. I was able to arrange to speak with them through a referral from Jane, director and midwife at TSH.

The first of these was Dr. Adams, a 54 year old married man with three adult children who has been practicing obstetrics for twenty five years. Dr. Adams sees approximately 200 clients a week and earns \$250,000 per year. Every birthworker I spoke with knew of Dr. Adams as a strong advocate for women's choices. He is the only OB in the valley who will perform water births, and one of a very few who will allow his clients to attempt a VBAC. I interviewed him in the newest hospital in the city in the physicians lounge. He was in the process of delivering a VBAC at that time of our

interview, and although it was his day off, he was haunting the hospital campus as per policy; a doctor delivering a VBAC is not allowed to leave while the laboring woman is in the labor and delivery unit. Dr. Adams appeared to be very passionate about the current state of our maternity care, not only in the valley, but also in the country at large. In his estimation, doctors' hands are tied by the fear of litigation and as such, our maternity care suffers.

The second obstetrician I spoke with is Dr. Green, a married man, aged 47, with two adult children. Dr. Green has been practicing obstetrics for twenty years and reports making \$350,000 a year seeing 120 patients a week. Dr. Green did not express as much support for midwifery as Dr. Adams, however, he also serves as a backup, although a more reluctant, less supportive one. His tone was curt and short in contrast to the two plus hour interview I had with Dr. Adams. I met with Dr. Green in his office after hours and was let into the building by his wife, who also serves as his office manager. Dr. Green allows his clients to attempt VBAC, but does not support water birth. The main reason he cited for backing up midwives on transport cases is that he did not want to see these women being treated poorly by the on-call OB, which he stated was often the case.

Two of my other respondents who are not affiliated with TSH are midwives in their community. Both of these women are married with one child. They described their relationship with TSH practitioners in amicable terms. Both of these women are independent practitioners of midwifery who rent office space in a building previously occupied by TSH.

One of these women, Kelley, was previously a doula affiliated with TSH, and remained an affiliate until she gained her midwifery credentials, at which point she

opened her private practice. Currently, Kelley is willing to refer clients to TSH (as well as to independent practitioners) such that they might interview doulas, seek lactation consulting, and/or attend classes and workshops. She did not express a preference for any specific care providers, classes, or associated offerings, but she agreed that TSH offered many options for women in the valley. Kelley is 29 years old, holds a master's degree in education, has worked as a certified doula, and currently works as a CPM. She is married to her female partner who is the primary breadwinner for their home, and the two have one child who is four years old. Kelley estimated her current earnings at \$60-\$70K per year, from midwifery services provided to approximately four women per month.

The other midwife I interviewed, Donna, is 38 years old, and is married with one child. She has never been affiliated with TSH, but also described her relationship with TSH in amicable terms. Donna's perspective adds a lot to this study based on her years of local experience, and also her depth of education in midwifery. Donna is the only CNM in this study. By this, I mean to say that Donna is the only midwife to have an accredited degree in midwifery and the only midwife in this study who has had the ability to practice her work in the hospital setting. Donna worked for almost four years in her own private midwifery practice with hospital delivery privileges. With encouragement from her spouse, and also as a result of her own discontent with hospital policy, procedure, and protocol, Donna exchanged her hospital based practice for a home birth practice. Allowing her CNM credential to expire, Donna tested and certified as a CPM, or Certified Professional Midwife offering home deliveries. This experience with boundary shifting makes Donna's perspective a very important one in this study due to her ability to see things from both inside and outside of the medical model.

Another thing that makes Donna an important contributor to this study is the fact that she served as the mentor for TSH founder and director Jane as she apprenticed for her own certification as a CPM. The fact that Jane chose to work with Donna has far reaching implications – Donna is the only midwife in town that has that insider knowledge of not only the medical system, but also her education as a medical provider places her at a clinical advantage that most midwives do not have. Jane is seen as a medicalized midwife by some of the more traditionalist midwives in town, and this could be due, in part, to her apprenticeship under Donna, a former CNM.

The last two individuals who I interviewed for this study who are not current affiliates of TSH have previously been affiliated with the organization. One of these women left on her own accord, and one was released from the organization. Both women still perform services for pregnant women in the valley, and unlike most of the women in this study, these two respondents describe themselves as primarily business minded.

I interviewed 42 year old Colleen in her office where she practices a form of CAM known as Reiki, which she describes as a form of “*energy work*” which is an attempt at “*fine tuning and resetting our nervous system.*” Colleen is a married woman with no children who found TSH in a roundabout sort of way through her Reiki work. She explained to me that she had previously worked as an assistant for a chiropractor while building up her Reiki business. After meeting Jane and learning more about TSH, Colleen decided to pursue a position as a doula. She felt that the work of a doula was a sort of extension of Reiki in a hospital setting. Colleen assisted six women in birth, three for free, and three at the reduced, new doula rate. Shortly after these, Colleen decided that the position was simply too time consuming and not lucrative enough financially for

her goals. She still accepts referrals from TSH for Reiki, and expressed only positive sentiments toward Jane and the organization as a whole.

48 year old Kathleen holds a Bachelors Degree in English Literature, is married, and has two adult children. Kathleen is the primary breadwinner for her home, and reports earnings of \$50,000 a year. She was, for a time, a doula at TSH, but was released from her affiliation and has since opened her own doula business. While she continues to interact with TSH in a number of ways, I would describe her commentary and demeanor toward the organization as negative or at the very least terse. Kathleen is self admittedly bold and outspoken, which is a rare, if not poor fit for the TSH organization. A reoccurring theme in her interview involved the financial issues of birthwork. Kathleen is in strong disagreement with the doula fee structure at TSH. She argued against not only the 3 free student births, but also that the regular doula fees are not high enough and must be raised to properly compensate these workers for their time and efforts. In her own organization, she charges more than twice the rate of TSH for her own and her students' doula services. Several affiliates of TSH described Kathleen's business in terms of its high cost and elitism. Kathleen's determination to charge a higher price is very uncommon for the birthworkers in the area. It seems to me that she has found a way to reconcile the division our society places between love and money.

## APPENDIX D: TABLE OF SAMPLE DEMOGRAPHICS

Sample Demographics								
Respondent	Age	Sex	Kids	Ages	Race	Education	BW Years	Income/Yr USD \$
Jane	42	F	6	19, 17, 15, 13, 11, 9	White	2 Year Degree	9 Yrs	100,000
Liz	33	F	2	6,9	White	11th Grade	8 Yrs	\$7,200
Julie	42	F	7	23,22,20,18,17,14,12	White	2 Years College	7 Yrs	\$25,000
Tessa	27	F	0	~	White	Some College	1 Yr	\$0
Lilly	35	F	3	5,3,18 Months	White	BA English Lit	6 Mo	\$7,200
Rosie	18	F	1	1	White	12 Years	1 Yr	\$3,600
Mimi	33	F	3	9,3,19 Months	White	LMT	13 Mo	\$3,600
Patricia	30	F	1	Passed Away	White	BA Graphic Design	6 Mo	\$0
Maureen	34	F	6	13,11,9,6,4,2	White	BS	2 Yrs	Varies
Janice	28	F	2	4,2	White	Some College	2 Yrs	\$10,000
Jaqueline	30	F	3	6,3,2	White	BA	6 Yrs	\$10,000
Winnie	41	F	2	7,4	White	BFA	4 Yrs	\$5,000 - \$8,000
Melissa	25	F	3	3,1,0	White	BA Psych	1 Yr	\$10,000 - \$15,000
Michelle	28	F	2	5,2	White	Some College	8 Mo	\$0
Anna	29	F	3	4,2,4 Months	White	BA/Some Grad Work	1+ Yr	\$14,500
Bridgette	40	F	3	7,5,3	White	AA	1 Yr	~
Suzette	36	F	2	11,9	White	Some ollege	9 Mo	\$0
Rebecca	29	F	2	6,2	White	AA	7 Mo	\$1,000 To Date
Kathleen	48	F	2	23,20	White	BA English Lit	5 Yrs	\$50,000
Coleen	42	F	0	~	White	Some College	~	~
Kelley	29	F	1	4	White	Master's	7.5 Yrs	\$60,000-\$70,000
Donna	38	F	1	2	White	Master's	10 Yrs	80,000
Dr. Adams	54	M	3	26, 24, 20	White	M.D.	25 Yrs	250,000
Dr. Green	47	M	2	Adults	White	M.D.	20 Yrs	350,000

\* Not affiliated with WRM

\*\* No longer affiliated with WRM

## APPENDIX E: TABLE OF PRICING FOR TSH

TSH Pricing Structure	
Service	Price In USD\$
Doula	\$700
Student Doula	\$350
Midwife	3200 Including Prenatal Care & Delivery
CLC Private Consult	In Home/ Hospital \$100 OR at WRM \$50
CBE - The Journey	\$150/ 3 Three Hour Classes
CBE - Christian Childbirth	\$250/5 Three Hour Classes
CBE - Thoughtful Childbirth	\$250/5 Three Hour Classes
CBE - HypnoBirthing	\$275/ 5 Three Hour Classes
Placenta Encapsulation	\$200 OR \$250 Including Tincture & Salve
Herbal Consult	\$40/ Half Hour OR \$60/ One Hour
Massage	\$40/Half Hour OR\$ 65/ One Hour
Reiki	\$50/ Half Hour
Prenatal Pilates (45 Mins)	\$15/One Class, \$50/Four Classes, \$110/Ten Classes
Mommy & Me Pilates (45 Mins)	\$15/One Class, \$50/Four Classes, \$110/Ten Classes
Prenatal Yoga (1 Hour)	\$10/One Class,\$ 50/Unlimited Monthly
Breastfeeding Class	\$30/Couple/Two and a Half Hours
Newborn Care Class	\$25/Couple/ Two and a Half Hours
Waterbirth Class	\$25/Couple/ Two Hours
Babywearing Class	\$15/Couple/ One Hour
Cloth Diapering	\$15/Couple/ One Hour
Sibling Preparation	\$25/Family W/One Child, \$5 Per Additional Child
Circumcision Education	\$30/Couple
Intro To Doula Work (For Birthworkers)	\$175/ Six Hours
Advanced Doula Training (For Birthworkers)	\$250/Eight Hours

## APPENDIX F: IRB INFORMED CONSENT DOCUMENT



### INFORMED CONSENT

Department of Sociology

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**TITLE OF STUDY: Pregnancy & Childbirth Options in Las Vegas**

**INVESTIGATOR(S): Dr. Barb Brents & Kerie Francis**

For questions or concerns about the study, you may contact Dr. Barb Brents at **702-895-3322**.

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu**.

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#### **Purpose of the Study**

You are invited to participate in a research study. The purpose of this study is to explore the narratives, understandings, motivations and meanings of both care providers and clients who participate in alternative options to the mainstream medical model for pregnancy and childbirth (*specifically options other than hiring an obstetrician/M.D. and delivering at a hospital*). I also seek to explore the organizational context in which these meanings are created.

#### **Participants**

You are being asked to participate in the study because you fit this criteria: Healthy adults over the age of 18 -- Specifically, women employed as midwives, lactation consultants, childbirth educators, and doulas, as well as the pregnant and childbearing women they serve.

#### **Procedures**

If you volunteer to participate in this study, you will be asked to do the following: Participate in an audio taped in-depth interview regarding your experiences, understandings, feelings, and motivations related to pregnancy and childbirth and/or your work in these areas.

#### **Benefits of Participation**

There may not be direct benefits to you as a participant in this study. However, as mothers who are interested in birthing options, or as workers in the field of pregnancy and childbirth, you may benefit from this study in terms of possible changes in societal attitudes concerning the alternative birth process, and a raised interest in pregnancy and childbirth options.

#### **Risks of Participation**

There are risks involved in all research studies. This study may include only minimal risks. For example, you may become uncomfortable when answering certain questions.

*Approved by the UNLV IRB. Protocol #1208-4224  
Received: 07-04-14 Approved: 07-22-14 Expiration: 07-21-15*

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**TITLE OF STUDY:** PREGNANCY & CHILDBIRTH OPTIONS IN LAS VEGAS

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**Cost /Compensation**

There will not be financial cost to you to participate in this study. The study will take approximately 1-2 hours of your time. You will not be compensated for your time.

**Confidentiality**

All information gathered in this study will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for 3 years after completion of the study. After the storage time the information gathered will be shredded or otherwise destroyed.

**Voluntary Participation**

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

**Participant Consent:**

I have read the above information and agree to participate in this study. I have been able to ask questions about the research study. I am at least 18 years of age. A copy of this form has been given to me.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant Name (Please Print)

Audio/Video Taping:

I agree to be audio taped for the purpose of this research study.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant Name (Please Print)

*Approved by the UNLV IRB. Protocol #1208-4224  
Received: 07-04-14 Approved: 07-22-14 Expiration: 07-21-15*

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