AN ABSTRACT OF THE THESIS OF

Leah S. Houtman for the degree of Master of Arts in Applied Anthropology presented on June 10, 2019.

Title: Making the Shift: Narratives of Transfer from Planned Home Birth to the Hospital in the Pacific Northwest.

Abstract approved: _____

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About 1% of U.S. births each year are planned home births (Vital Statistics Reports 2017). Of these, roughly 10% transfer to a higher level of care during labor (Melissa Cheyney et al. 2014), yet their experiences are rarely heard. Storytelling has long been used not only as entertainment, but as a way of teaching and learning (Gidman 2013; Carter-Black 2007) and to help clinicians understand their patients' experience of illness (Kleinman and Benson 2006; Brown and Closser 2016; Clarke, Jane Hanson, and Ross 2003). Using an experimental methodology inspired by both medical anthropology and the medical humanities, I share full narratives of transfer in order to amplify the voices of those who have experienced transfer immediately before or during labor; to highlight the responsible evaluation of risk involved in the decision to plan a home birth; and to offer an experience near analysis (Geertz 1974) for those who have not experienced a transfer of care during labor. In doing so, I aim to break down the binary of 'home birther' and 'hospital birther' to better facilitate smooth articulations (Robbie Davis-Floyd 2003) between patients and providers during transfer.

Making the Shift: Narratives of Transfer from Planned Home Birth to the Hospital in the Pacific Northwest

by
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A THESIS

submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Master of Arts

Presented June 10, 2019
Commencement June 2020

Master of Arts thesis of Leah S. Houtman presented on June 10, 2019

APPROVED:

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

Leah S. Houtman, Author

ACKNOWLEDGEMENTS

The author expresses sincere appreciation to Rachel Houtman, without whom I may have given up several times over – your patience is legendary, your belief in me is incalculable, and your ability to make statistics make sense is probably magic;

To Darwin and Linnea, who inspired this work;

To Jordan, Erin, and Morgan, who never stopped calling me The Smart One and have always championed my success, even from afar;

To Maria Danna and Kylee Barnes for your tireless support as my emotional doulas;

And to Dr. Melissa Cheyney: Advisor, professor, midwife, and mentor extraordinaire.
I could not have done it without each of you.

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DEDICATION

To my brilliant children: Darwin, who was there when I started this work; Linnea, who has never known a time when MamaLeah was not a student; and Firefly, who still lives in a sparkly future time. All of the work I do is in hopes of leaving a better world for you. Use it well. I love you.

Introduction

In 2017, approximately 1.5% (58,221) of U.S. births occurred in the community setting – that is, at home or in a freestanding birth center unaffiliated with a hospital (Vital Statistics Reports 2017). Roughly 10% of those planning a home birth between 2004 and 2009 transferred to a hospital during the intrapartum period, after labor began but before the baby was born (Cheyney et al. 2014). If these rates held steady through 2017, then we can assume that roughly 6,500 individuals in that year planned to give birth in the community setting, but transferred to a higher level of care for a variety of reasons.

There is a small but growing body of literature on the reasons for transfer, and these studies indicate that they are due primarily to prolonged labor, maternal exhaustion and maternal request for pain relief – not for medical emergencies (Cheyney et al. 2014; Rooks, Weatherby, and Ernst 1992). Other research focuses on the provider experience of transfer from both the referring community-based midwives and the receiving physicians, nurses, and Certified Nurse Midwives who work in the hospital (Cheyney, Everson, and Burcher 2014; Vedam et al. 2014; Davis-Floyd 2003).

However, to date, there have been very few studies published that center the birthing person's experience of transfer to the hospital during the intrapartum or early postpartum periods (for exceptions, see Creasy 1997, Fox, Sheehan, and Homer 2013; Kuliukas et al. 2016; Creasy 1997; Walker 2000). Of the literature that is available on the topic, I have found none that reflects the experience of transfer specifically in the United States. This leaves a gap in the literature, given the way geographical location has been demonstrated to have a measurable impact on experiences and outcomes of transfer not only due to obvious differences in the

structure and function of the medical system across various locales, but also insofar as location corresponds with the integration of midwifery into each system (Vedam et al. 2018). Therefore, the purpose of this project was to elevate the narratives of women in the context of the U.S. maternity care system – and more specifically, the context of the Pacific Northwest, a region with a relatively high level of integration compared to the rest of the nation (Vedam et al. 2018)— who go in to labor planning a home or birth center, but then find themselves in need of a higher level of medical oversight or intervention.

Dr. Sherwin Nuland, surgeon and professor of bioethics and medical history, quit his surgical practice in 1992 to focus on writing. One of his many resulting books was *The Soul of Medicine: Tales from the Bedside* (Nuland 2009). In this book, Dr. Nuland takes on the pseudo-Chaucerian role of narrator, telling the stories of his colleagues ("The Dermatologist," "The Gastroenterologist," and so on) in a riff on *The Canterbury Tales* (Chaucer and Mann 2005). Nuland gave each storyteller a prompt to elicit the narrative of their most memorable case; the intent was to explore their stories, not to collect data in pursuit of generating hypotheses, to answer a research question, or to demonstrate the generalizability of any of the resulting themes to a broad group or demographic of clinicians. Instead, his goal was to use creative non-fiction, taking certain liberties with each narrative and at times adding commentary connecting the individual story to larger socio-historical contexts in order to create a compelling story that, while keeping the core tenets of the events intact, is more literary than scientific.

Likewise, this project is not intended as traditional scientific research, nor does it aim to provide a broad understanding of a given culture or population. Rather, I aim to explore the intersections of ethnography and creative non-fiction, of narrative inquiry and medical

humanities, and of individual experiences and shared community knowledge. My objectives here are multifold. First, I intended to collect the stories and experiences of a small number of individuals who share this experience in order to amplify their voices and to begin to tell the stories that are as-yet untold. Next, I aim to demystify not only why some people plan to give birth outside the hospital, but also to make clearer what it is like to make that choice – if indeed it is a choice, given the narrow range of options available in some contexts – including the stress of having to continually defend that choice, only then to make the shift – physically, mentally, and emotionally – to the hospital setting. Some of the questions I sought to answer in pursuit of these objectives are: What goes into the decision to transfer, especially when it is not for a medical emergency?; What kinds of interactions do these individuals experience when checking in to the hospital?; What is the reception like from the receiving doctors, midwives, and nurses?; what effect does a transfer experience have on a person's ability to birth and parent in a way that is meaningful to them?; and how to do those who transfer make sense of their experience in the days, weeks, or even years that follow the birth?

Medical Anthropology and Medical Humanities: The Role of Narrative

My aim for this project is the same as Dr. Nuland's – to tell a story and to offer an 'experience near' interpretation (Geertz 1974) for those who have never navigated the transfer from a planned home or birth center to the hospital in the time immediately before or during labor and birth. Anthropologists have long used narrative to convey the worldviews and experiences of other cultural and subcultural groups they study (Reck 1983). Indeed, other

creative expressions such as photovoice and artwork are becoming popular methodologies for exploring the human experience in the field of anthropology (Banks and Morphy 1997).

Although traditional ethnography seeks to give the reader a sense of the place, the people, and the culture of interest through the use of thick description (Geertz 2008), the text that a reader sees has been highly interpreted and theorized – first in the recording of the narrative and its context by the ethnographer in field notes, and again during the process of writing the manuscript. In this sense, the intersection between medical anthropology and the medical humanities may be found in the use of full, uninterrupted narratives told from the perspective of the individual who lived them. It is this raw material, tidied only for readability and comprehension, that allows the reader to fully understand not only the outward actions, behaviors, and practices, but also the internal monologue, the emotions, and the motivations of the storyteller. It is important to note, however, that while the words of each storyteller are altered as little as possible, they are never truly 'raw,' as each answer is in response to a particular question, framed in a particular way and through a specific lens by the interviewer in order to answer a question or reach an end goal. What questions are asked, how they are framed, and what is highlighted in each story are subject to the standpoint from which the ethnographer approaches the topic. Each answer is also molded and framed by the storyteller herself, portraying herself and her experience in a curated light. The difference, perhaps, between this narrative method and a more traditional approach to ethnography is in the way that the ethnographer and the storyteller share the task of shaping and theorizing each story. In this way, each narrative is not only an interpretation of a series of events, but is indeed a performance of a series of actions, decisions, and behaviors that communicate some larger,

more coherent message than the experience in itself may have done, as storyteller and author-ethnographer alike seek to portray themselves and others in the narrative in a certain light as well as to make meaning from the experience on individual and social levels. This methodology is at once experimental in its diversion from the more familiar style of ethnography, while also following in the footsteps of such innovative scholars as anthropologist Erika Friedl (see Friedl 1989) as well as bioethicists such as Dr. Nuland (2009).

To further the project of allowing the experiences of the storytellers themselves to shine through, it is important that the reader understand the standpoint of the author-ethnographer. This helps both the author-ethnographer and the reader to sift through the stories and recognize what is captured and what may be missed in each. In this case, it is worth knowing that I had been studying birth for several years, including the evolved physiology that makes human birth so unique as well as the cultural constructions of how birth is performed, before the initial idea for this project was conceived. Additionally, I had trained as a doula several years before I began collecting these stories. This extensive knowledge of and understanding of human childbirth gave me the conviction that, broadly speaking, biomedicine influences the performance of – and indeed, the outcomes of – labor and birth in ways that stifle the autonomy and even the health of birthing people. Although this conviction has since been tempered, in no small part through my work on this project, it contributed to a general wariness of obstetrics and hospital-based birth as well as an advocacy for midwifery and support for home birth. Further, I began collecting the stories of transfer when I was pregnant, and after accompanying my partner to the hospital when she transferred from a planned home birth with our oldest child. Thus, the project was intriguing to me on an intellectual but also a

very personal level that likely had a direct impact on what pieces of the story I was particularly interested in and thus what questions I asked. Finally, I come to the issue from a place of great social privilege. I already held a bachelor's as well as a master's degree and the ability to understand and articulate my wants and needs. I hold privilege based on my race and socioeconomic status as well as my gender expression. Although I am in a same-sex relationship, I live in a time and especially a place that is largely supportive of, even protective of, my family structure and relationship status. All of these factors certainly had a bearing on how I approached the topic and what I prioritized both in the elicitation as well as in the editing of each narrative.

Following a format similar to the one Dr. Nuland utilized in his book, this project sought to act as a conduit for individuals to convey their lived experiences of transfer rather than to develop an analysis of specific outcomes, though I do attempt to highlight the common threads or themes that run through the stories. Through this effort, I seek to offer readers the chance to experience an antepartum or intrapartum transfer vicariously, to better understand the thoughts and feelings that contribute to the overall experience, and perhaps to come away with a more nuanced understanding of themselves and their relationship to birth and birth setting in our particular time and place. I use this methodology as a way to explore theory building via storytelling, using full narratives rather than exerpts from interviews or field notes to support and illustrate data-driven theory.

This detailed understanding of the experience of transfer before or during labor and childbirth is not simply for human interest, however. Storytelling has been used as a method of teaching throughout history and across cultures; it can be a way to instill pride in and

knowledge about one's family or culture (Thompson et al. 2009), teach cultural competency to others (Carter-Black 2007), and even to teach skills through participatory learning, such as how to feed oneself in the wilderness or how to better understand abstract concepts in math or physics (Gidman 2013; Hadzigeorgiou 2006; Balakrishnan 2008).

The positive effects of listening to the stories of others are well documented in the context of health care, and they benefit patient and clinician alike. Medical anthropologists understand the importance of a clinician's ability to elicit an explanatory model, or explanation of how the patient understands her health conditions (Kleinman and Benson 2006). These stories not only help to establish trust between doctor and patient, but may also increase the likelihood of compliance with treatment plans and decrease unnecessary emergency room visits, as the patient is more willing to be forthcoming with the physician and trust the recommended course of action (Kleinman and Benson 2006; Brown and Closser 2016). Clinicians and bioethicists, among others in the interdisciplinary field of medical humanities, are well aware of the impact that patients' stories can have on medical students or clinicians, especially early in their careers. Patient narratives can help newer clinicians to envision various cases in which they could someday be involved, and allows students the opportunity to consider how they would respond; later, these clinicians tend to be less rigid in their practices, as their understanding of human physiological and cultural variation has been enhanced (Gidman 2013). Further, personal stories help care providers to "see the person behind the patient" (Clarke, Hanson, and Ross 2003, 701), and to provide more holistic care that is more effective as well as more satisfactory to the patient (Clarke, Hanson, and Ross 2003; Brody 1994).

The storyteller herself benefits from the process of sharing her narrative, as well. The simple act of telling one's story and knowing it was heard and acknowledged has been demonstrated to be empowering for the storyteller, allowing them to own and shape their narrative, as well as to internalize the meaning that they make of their experience (Frank 2013; Gidman 2013). This meaning-making is crucial to the ability to construct "a sense of mastery or control [which] is vital if the patient is truly to feel empowered and to take specific actions that will promote health and ameliorate symptoms" (Brody 1994, 80). Thus, it is not only empowerment, but the agency and ability to make positive health choices that can be traced back to the feeling of having been heard and understood. Labor doulas, professionals who attend labor and birth to offer "continuous physical, emotional, and informational support to a mother before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible" (DONA International 2019), are often taught to elicit birth stories from their clients at the first postpartum visit. This helps the new parent to process the birth, shape the narrative in a way that is meaningful, and begin to integrate the story into their life and understanding of themselves (Green and Hotelling 2014; Simkin 2004), setting the new parents on their path more confident in themselves and their abilities.

Beyond individual empowerment, the sharing of stories that have been at best ignored, and at worst actively silenced, can empower communities by demonstrating the extent to which the individuals within the group unknowingly share experiences. As with the consciousness raising groups of the so-called "Second Wave" of feminist activism in the 1970s (Sarachild 1973), by explicitly bringing to light power imbalances that may be at play in people's experiences, such imbalances may be exposed, and thus, redressed. A single person

experiencing a difficult birth or postpartum period may feel alone until she hears a story that resonates with her own. Suddenly she has a connection with at least one other person, and together they may be able to connect with still more people and to take collective action to resolve the cause of the problem.

Choosing Home Birth: Model of Care or Group Identity?

There is no single reason why people plan home births. Respondents to one survey in the United States gave explanations ranging from a previous negative experience in the hospital to a trust in the body's ability to give birth without intervention, and from concern over the cost of going to the hospital to a history of precipitous birth (Boucher et al. 2009).

Midwife and clinical medical anthropologist Melissa Cheyney, in her work on the reasons that some parents choose home birth (2008), found three common threads running through the stories that were shared with her. These themes were summarized as knowledge, including both unlearning dominant discourses as well as learning and constructing new ways of understanding pregnancy and birth; power, with sub-themes of knowledge as power, empowerment as an inherent part of the intensity of birth, and power as healing; and intimacy in the relationship between midwife and client as well as in the birth place (Cheyney 2008).

Redefining authoritative knowledge was a process that occurred as participants questioned or challenged the dominant narratives of what birth is and how it should be performed. This included "unlearning" the authoritative knowledge – that is, knowledge upon which action is taken and decisions made, often "associated with a stronger power base (structural superiority)" (Jordan and Davis-Floyd 1993, 152) -- that positions home birth as

inherently dangerous. One participant noted that, in contrast to the way birth is often portrayed in the media, “I started to realize that as a healthy woman with a straightforward pregnancy, it was very likely that my birth would not be a terrifying emergency” (Cheyney 2008, 258). The process of redefining authoritative knowledge also included learning and trusting the ‘knowledge’ of the body as well as constructing new ways of knowing in collaboration with partners and midwives through information sharing and collective decision-making.

This unlearning of common understandings of birth followed by co-constructing a new way of viewing the event is often a part of the process of finding or trusting one’s personal power. The experience of birthing within this paradigm that positions the birthing person as the expert on their own body and baby was further empowering for participants, and in some cases was experienced as “heal[ing] the scars of past ‘medical abuses’” (Cheyney 2008, 262). The co-construction of knowledge in collaboration with the birth team also serves to build trust between the pregnant or birthing person and their midwife. Trust supports feelings of safety during labor, which in turn helps the birthing person to “surrender” to the process. Cheyney writes that “Intimacy, trust, feeling safe, and the ability to surrender are viewed as intertwined and essential components of a positive home delivery” (Cheyney 2008, 263).

My own work in Ireland on why women chose to plan home births found that participants had different definitions of safety than the clinical definition of a live and uninfected mother and baby, including safety from unwanted interventions as well as the security of a familiar place (Houtman 2015). Participants also shared that they trusted themselves and the process enough to opt out of the ‘just in case something bad happens’ mindset (Cheyney 2008) that encouraged others to birth in the hospital near medical

intervention, and that they found empowerment and community with other 'home birthers' (Houtman 2015). Despite these varied responses, many of the arguments or explanations in favor of home birth are simplified down to a difference in worldview.

Obstetricians and the nurses who work with them have been argued to have a fundamentally different understanding of birth, what it should look like, and how it should be performed than do the midwives who attend home births (Rothman 1991). These worldviews and expectations of how birth should occur are often referred to as models of care, and frequently position home birth as diametrically opposed to hospital birth (O'Connor 1993). Sociologist Barbara Katz-Rothman coined the terms "medical model" and "midwifery model" to denote the differences she saw in worldviews and approaches to care between obstetricians and midwives (Rothman 1991). The medical model included a male's view of women's bodies, an emphasis on technology and intervention to manage labor, and power differentials between physician and patient. The midwifery model, on the other hand, "took women as [the] norm, and focused and centered on women" stating that birth is natural and that "when we do it we are no more 'stressing' the system than we are when we are digesting a nutritious meal" (Rothman 1991, 24).

These terms were later adapted and re-named the "technocratic" and "holistic" models by anthropologist and birth scholar Robbie Davis-Floyd, who noted that midwives could be quite technocratic, and doctors and nurses could have a style more in line with Rothman's midwifery model (Davis-Floyd 1993). The technocratic model is primarily defined by the assumption that the mind and body are separate and that the body is analogous to a machine, something to be managed and fixed when it malfunctions. In this model, the physician is the

expert on the body and birth, much in the way that a mechanic is the expert on the workings of a car engine. The holistic model portrays mind, body, and spirit as parts of a whole. The birthing person, including her reproductive system, her mind, and even her baby and the birth team all as interconnected and working together (Davis-Floyd 1993; Davis-Floyd 2001). Davis-Floyd later modified these to add a third category, the humanistic model, which sees mind and body as connected in one organism, with decision making and knowledge shared between clinician and client (Davis-Floyd 2001).

These categories may be useful in understanding various lenses or worldviews and how they may impact the biopsychosocial aspects of labor and childbirth (Engel 1977), thus helping us to understand why some models work for some clinicians or birthing people and others do not, but they also have some demonstrable drawbacks. The first is simply that birth occurs differently every time, even in the same individual, meaning that different elements of care will be warranted each time. Certainly no physician believes that a cesarean is always the right answer, and, similarly, many midwives understand that there is a time and place for pharmaceuticals and other medical interventions. It is unlikely that all clinicians believe in and adhere to a single model of care, or that their clients do so. Indeed, Cheyney (2011) writes of the ways that the medical versus midwifery binary breaks down in practice, regardless of level of adherence to one model or another professed by a given clinician, saying “I began to realize that midwives tend to adjust their models and practices to deal with mothers who have distinctive viewpoints or special needs” (Cheyney 2011, 20). She goes on to describe the ordering of tests that a midwife does not feel are necessary given a client’s risk profile when the midwife believes the client would be reassured by the data; alternatively, for clients who are

opposed to the medicalization of pregnancy and birth, the midwife may suspend the normal use of tests. This example demonstrates the flexibility necessary for clinicians to exercise in order to best meet the needs of individual clients, rather than adhering to a specific model of care in a one-size-fits-all approach.

However, it can be comforting to identify with a group, to see oneself reflected in a philosophy or community and feel understood – especially when making a decision that is outside of what is considered 'standard' or 'normal.' Thus, individuals who choose a midwifery or holistic model of care may begin to identify as 'home birthers;' yet this construction of an in-group of people who have home births necessitates the simultaneous construction of an out-group: 'Hospital birthers" (Tajfel 1982). Thus the opposition that Davis-Floyd sought to mitigate by changing the terms "medical model" and "midwifery model" to "technocratic" and "holistic" is revived and refocused, this time on location rather than provider type.

A home birther's sense of identity, group membership, and self-image runs the risk of being undermined if the choice is made to transfer to a higher level of care. Is she still a 'home birther' by virtue of having planned a home birth, even if the baby was born in the hospital? This body, formerly so trusted to know how to birth a baby, was unable to live up to expectations; what impact does that have on the ability to trust other instincts such as how to respond to baby's cues, how to breastfeed, how to parent? When group membership is based on something as tenuous as place of birth, the transferring person may find themselves grappling with new questions about identity, their sense of place, and where and with whom they now belong.

Transfer Costs

Because the rates of home birth are already so low in the United States, the rate of transfer from planned home birth is correspondingly miniscule. Less than two-tenths of a percent (0.165%) of U.S. births are transfers from planned home birth to the hospital annually (Vital Statistics Reports 2017; Melissa Cheyney et al. 2014). Because of this, and because of the lack of literature on the topic, it is difficult to describe what a transfer would look like in any general sense. Because most transfers are for non-emergency reasons, though, such as failure to progress or maternal exhaustion and need for pain relief unavailable in the community setting (Cheyney et al. 2014), we can guess that most of these were long labors at home and transferred in a personal vehicle – that of the birthing person or their family, or perhaps a midwife or doula – rather than in an ambulance or other emergency transport. Some, perhaps many, transfer clients enter the hospital through the emergency room, but this can be because the main entrance to the hospital is locked overnight rather than because there is a true emergency. When the client and her birth team arrive, they are checked in and sent to the labor and delivery ward where they are officially admitted, the client's medical history taken, and any relevant tests are ordered by a CNM or obstetrician. Costs of care are not always discussed; the assumption is typically that hospital policy and procedure is non-negotiable and that any interventions given are necessary – after all, what was the transfer for if not for more medical oversight and management? – and thus will be given or performed regardless of the price tag.

In the U.S. context, giving birth is not only a physiological event and socio-cultural rite of passage, it also often marks a huge financial investment (Craven 2010), particularly when

performed in a hospital. Depending on whether a new parent is on Medicaid or private insurance, how comprehensive a given insurance plan is and whether the care provider is in network or not, or what kind of interventions may have been used, they may never see a bill or they may spend their first weeks or even months postpartum gathering the bills as they come in. These arrive from the hospital, anesthesiologist, or lab, demanding money for things as many and varied as epidural anesthesia, room and board for parent and baby, an operating room fee, and bloodwork – just to name a few. The average cost of a vaginal birth without complications in a United States hospital was $10,808 in 2018 (Hoffower 2018).

Home births are nearly always lower cost overall (American Pregnancy Association 2017), though insurance plans often do not cover home birth given its reputation as more dangerous and higher risk than hospital birth, making the out of pocket costs higher than a hospital birth that is covered by insurance (Craven 2010). It can be difficult to know or understand what will be covered by insurance and what will not, though, due to varied and oftentimes contradictory information provided by the insurance plan guidebook, a company's website, and its customer service representatives. Thus, some individuals or families may be struggling not only with how to integrate a newborn into their life and their family, but also how to absorb the often exorbitant costs associated with bringing the baby into the world.

In the case of transfer, home birth is sometimes chosen for the low relative cost as compared to hospital charges. Yet when a transfer occurs, the costs may well be over and above the cost of a planned hospital birth due to ambulance bills or redundant tests that the home birth midwife completed earlier in pregnancy but are repeated in the hospital during labor. Thus, what may have originated as a strategic decision made to help the newly expanded

family's income go further, it can instead result in additional financial distress. This then compounds any other stress or trauma that may have been associated with transfer or the birth more generally, and can contribute to postpartum depression or other psychological distress.

The Need for Counternarrative

In many ways, the birth stories in this collection directly oppose the common narratives that are circulated about home birth. When we hear stories in popular media about home birth, they often frame the birthing person as someone who puts their experience at the forefront, even before the safety of themselves or their babies (see Modmaternity, 2017). Other stories seem intent on demonstrating the danger of home birth and emphasizing how many things can possibly go wrong, as seen in headlines such as "Home Birth Nightmares: Mothers Share Their Stories" (Friedman 2010), "Home Births Safer? Rubbish. Mine Nearly Killed My Baby!"(Wharton 2014), or the self-identified Skeptical OB, a former obstetrician turned blogger, who writes pieces such as "2015: This Year in Home Birth Deaths and Disasters" (Tuteur 2015). When transfers are portrayed at all, they are usually emergencies that serve to highlight the folly of a planned home birth.

In her 2009 TED talk *The Danger of a Single Story,* Chimamanda Ngozi Adichie said,

> There is a word, an Igbo word, that I think about whenever I think about the power structures of the world, and it is "*nkali*." It's a noun that loosely translates to "to be greater than another." Like our economic and political worlds, stories too are defined by the principle of *nkali*: How they are told, who tells them, when they're told, how many stories are told, are really dependent on power. (Adichie 2009)

To this point, the media, as well as the medical establishment, has held the majority of the power due to their ability to control the story and the discourse. When we are able to tell our own stories, though, we are able to reshape the narrative. The parts that are important to the

laboring individual may or may not align with the pieces that are considered key components by the media, clinical practitioners, supportive partners, or other members of the birth team. If our stories are only told by others, our priorities are never given precedence either.

Mary-Jo DelVecchio Good wrote of the "medical imaginary" as "that which energizes medicine and makes it a fun and intriguing exercise" (DelVecchio Good 2010, 273). It is this medical imaginary which leads to innovation such as new ways of diagnosing and treating patients. It is this same energy and enthusiasm, however, that drives the search for ultimate knowledge of the body and its processes regardless of the implications of that knowledge. The biomedical paradigm is concerned with determining what is 'normal' and then using that as the standard; anything outside of that often narrow range is 'abnormal,' or pathologic (Lock and Nguyen 2018).

The medical imaginary leads clinicians and scientists in the search for new systems or functions to measure, which leads to the discovery (or perhaps the creation) of new diseases as individuals find that their systems do not measure up to the new idea of normal; subsequently, treatments and interventions are devised to 'fix' them. DelVecchio Good argues that this drive then leads to "a particular political economy of hope that functions to propel patients toward more testing and more intervention" (Cheyney 2015, 37) as they seek more obscure and occult knowledge about the inner workings of their bodies. After all, knowledge is power, we have been told; more knowledge must translate into more control. Cheyney has adapted this concept to apply to pregnancy and birth, dubbing it "the obstetric imaginary," and uses it to describe "the widely held belief that the massive application of U.S.-style obstetric technology in the birthplace will improve care, save lives, and reduce maternal and neonatal suffering"

(Cheyney 2015, 37). By extension, then, those individuals who opt out of this quest to translate the functions of their bodies into numbers to be cataloged and compared to the set standard – including those who plan to birth at home – may be seen as irresponsible, even negligent.

Bioethicist Alan Petersen (2003) writes that citizens as patients, living in what he calls the "stakeholder society," are expected to "play their role in minimizing their contribution to health care costs by becoming more responsible health care 'consumers,' and adopting appropriate practices of prevention" (Petersen 2003, 194). Because the discourse in popular media and in the medical literature positions home birth as irresponsible, unsafe, and counter-cultural, it is not difficult to see how those who transfer from a planned community birth may be viewed as having shirked this responsibility, and thus, are to blame for – or even deserving of – whatever their outcomes may be.

Methods

I used common ethnographic methods to collect the stories for this project. First, I used my position as a trained labor doula to observe births in the community over a period of several years, and to become familiar with the policies and procedures common to both home birth midwives as well as obstetricians and Certified Nurse Midwives. I also attended various doula and midwifery- related events, which allowed me to get to know other care providers in the area and hear how they talked to their clients, to each other, and what they might think or believe about birth generally and transfer more specifically.

Then, beginning in January of 2016, I began collecting stories from individuals who I knew that had experienced transfer from planned home birth to the hospital. It was a convenience sample, consisting of those who I knew or who were referred to me by mutual

friends or acquaintances for participation. I did not sample for diversity or attempt to manage the demographics of the participant pool in any other way. However, my participants did reflect the most common demographics of those who plan home births in the United States in some key ways. All of the participants were well educated, holding at least a bachelor's degree as well as an advanced or professional education. They could all be read as White racially, though ethnically or culturally they may have identified otherwise. The area in which participants diverged most obviously from the 'average' person who plans a home birth is that most home birthers are middle to upper class, while those who shared their stories for this project were in a somewhat lower bracket. Income information was not collected specifically, but participants described themselves as lower-middle to middle class. None of the participants experienced food insecurity during their pregnancies or immediate postpartum periods, but none ever felt completely confident that they would be able to cover all the costs associated with birth or raising a child without some amount of sacrifice or tightening of the proverbial belts.

Initial stories were collected, prompted with the statement and question, "I am interested in your experience of transfer from planned home birth to the hospital. Can you tell me your story, from wherever it begins for you?" I asked follow up and clarifying questions as needed, and in one case a follow up interview was conducted as the storyteller felt she had more to say than she was able to convey during a single session. In another case, several short, informal conversations contributed to the complete story after the initial narrative was collected. However, I took care not to interrupt the storytellers as they shared their experiences. Their labor and birth experiences had already been interrupted, and it was important to me that they were able to tell their stories without the same need to stop and

start at the whim or impulse of an outside actor. All interviews were audio recorded, though the informal conversations were not; instead, I took notes at these to record key points or ideas that added to the original story.

Recordings were transcribed and then edited for clarity and flow. While I did attempt to keep the stories as true as possible to the way they were told to me, these memories were rarely told in a linear fashion. Therefore, I would rearrange pieces of the narratives to build a coherent story with a beginning, a climax, and a resolution, but always using the storyteller's own words to the extent possible. I also edited for confidentiality in order to protect the identities and personal information of my participants to the best of my ability. Finally, stories were returned to the storytellers after I had completed my editing process, so that they could give feedback or re-write the story. This not only helped to ensure accuracy, but also to maintain the storytellers' sense of control and autonomy as these personal stories of vulnerability were shared. This did allow for a certain performative quality, as the way we remember events such as childbirth changes over time and as our self-image and identity develops and evolves. Thus, these are stories of transfer not necessarily as they happened, but as they were interpreted through memory and then interpreted anew through my curation of the collection as a whole.

In writing these stories, I sought to illuminate the consideration and thought that goes into the decision to plan a community birth, as well as the process of making the shift – physically, mentally, and emotionally – to a higher level of care in the hospital. The stories that follow help us to see the sense of responsibility shouldered by those planning to give birth in a community setting. Each story is framed by a particular lens. The Birth Worker's Tale

emphasizes what it is like to give birth in the hospital after years of experience supporting others through their labors. The Nurse's Tale explores the tensions between a career in the medical field, a desire for a low-intervention birth, and medical risk; and the Economist's Tale approaches the story as a narrative of risk evaluation. The themes from these three accounts are interwoven and synthesized with my own story, the Graduate Student's Tale, as I carried these stories and their implications with me into my labor, transfer, and birth experiences.

The Birth Worker's Tale

It was a Thursday evening, and I was at the movie theater with my partner. We were seeing a movie, trying to distract me from the fact that I was still pregnant, and lo and behold I started to feel contractions. The contractions eventually dissipated for a while, though I continued having some on and off over the next few days. I began to realize I was having serious prodromal labor [early labor that effaces or thins the cervix, but typically does not result in dilation], which, let me tell you, is not appealing to anyone. At night I would wake up and have a contraction, but then I would just sleep. They were enough to bother me, but not enough to indicate active labor. Then, four days later on Sunday afternoon after lunch, they started getting intense, to the point where I had to stop and breathe through them. They were coming more frequently but even then, it was only every 15 minutes or so; still not impressive. By midnight of what was actually Monday morning, though, they were finally picking up, lasting about 45 seconds and about 4 or 5 minutes apart so I started getting excited. I was a first-time mom, called a 'primip' in medical lingo to mean 'primiparous.' In other words, it was my first pregnancy; as a birth worker I knew it could be a really long process so at least there was no surprise there. After a few days of this slow prodromal labor, things seemed to be moving forward and my partner called the midwife, Annie. It was close to 1 am on Monday morning when Annie showed up. She checked my cervix; I was 3 cm dilated and 100% effaced, which was a favorable situation in terms of dilation and effacement. I thought, "Sweet, it's just taking a little while to get started, but everything's going to be smooth sailing after this."

I like Annie because she's no bullshit; she says "Here's what's being done, here's why I need to do it, let's get it done." And often when we disagreed on something, it was a

conversation where we were compromising and accommodating each other's viewpoints, it wasn't a situation where she was directing me to do something. I was never in a situation that was serious enough that I didn't have other options, though. When you have preeclampsia, for example, there's no trying to treat it with herbs, you go to the hospital! But overall, my situations were benign—or if not benign, they were mild enough that we could negotiate on those. Like there are natural remedies for some kinds of infections, which I'm grateful for because then I had to take antibiotics when I went to the hospital because I was GBS positive, so at least I hadn't had to be on them so much earlier in my pregnancy. Annie and I get along in that way, she's very straightforward and up on the literature. Everything is data-driven. I knew when she said something that was different from my view, she had the information to back it up. She's also very honest, and that's something I really value, especially in a health care provider. I just needed to know what was going on and what she was truly thinking so I could make my own informed decision.

When the contractions started getting even more intense, I realized they were all in my back, and I knew I was having an OP [occiput posterior] labor. The optimal position for a baby to come out is called OA, which stands for Occiput Anterior, and has to do with how the head is oriented to the mother's pelvis. You want the back of the baby's head to be towards the front of the pelvis – essentially, babies should be born facing backwards. But having the kind of pain I was having, I knew the bigger, harder part of the baby's head was pushing right up against the nerves in my sacrum, likely to slow down my labor and portending an extra painful experience. I was trying to do things like squats, and get into different positions to facilitate a better rotation for the baby's head, hoping she would rotate into a position that would be easier on us both. I

labored like that throughout the morning on Monday, but later that day I started having serious acid reflux. I vomited that morning, and then couldn't keep any water or food down which is never a good situation to be in, but especially when you're having such a long labor.

I had planned a home birth because I didn't see pregnancy and birth as a medical condition. Sure, for some women it is, for women who have pre-existing conditions or who have gestational diabetes that can't be controlled by diet, or preeclampsia, those are real medical conditions that warrant medical settings. But as long as I stayed low risk, I just didn't see my situation as a medical condition. I didn't see the point in having to go into a situation where the training of the people who work there is to intervene. The midwifery model of care actually is probably what drew me to it more than the fact that I was having my baby at home. Every time I had a prenatal visit it was an hour long. For postpartum care, they come to your house. So just having a more optimal model of care was most important to me, not necessarily a specific setting.

At 4 p.m. on Monday Annie checked me and I was dilated to 5 centimeters. It was encouraging that some progress had been made, but discouraging that I had dilated only 2 more centimeters especially considering how promising things had seemed nearly 16 hours before. Even my midwife was surprised; everyone seemed surprised except for me for some reason. I had a feeling that things were going slow, and I was right. I continued trying different things. I labored sitting up on the toilet, I labored on hands and knees, I did squats, I tried everything. My partner helped me, letting me hang off him and use him as leverage. I tried what they call 'pancake flips,' where you start on all fours, have three contractions, turn to one side have three contractions, and then get on your back have three contractions, get to the

other side have three contractions, then back on hands and knees have three contractions. You're trying to turn the baby, but you can't move during the contractions and it feels like the worst thing in the world. I still had not felt any labor in the front, so I still didn't know what "normal" labor felt like—whatever that means. Textbook labor.

By the time it got to 11 o clock Monday night, seven hours later, Annie checked me again and I was dilated to six; it was taking a long time and I was starting to wear out a little bit. I hadn't been able to keep food or water down because of the reflux, so I was dehydrated, vomiting, and low on energy. Annie suggested administering IV fluids to replenish my hydration, as well as to stimulate the contractions to be even stronger. She was pulling out the 'big guns,' one of the last options to try to move things along other than what's called an AROM, or artificial rupture of membranes, otherwise known as breaking the waters with an amnihook. This is a tool that can look something like a knitting needle or long crochet hook, and is inserted into the cervix. It snags the membrane of the amniotic sac, puncturing it and releasing the fluid. Because of the dehydration, though, Annie was unable to get an IV placed even after eight separate attempts – and normally I have good veins! We decided collectively to break my waters, and we would plan further action from there. If the waters were clear we'd stay at home and keep laboring, and if there was any meconium present then we'd decide about whether or not we needed to go to the hospital.

When Annie ruptured my membranes the fluid was clear and the baby was still doing well so everything seemed to be fine despite the slow pace. I labored for four more hours before Annie checked me again. After breaking my water things were much more intense; the pain was far worse. I assumed that because it was so much worse I must have made some

progress, but I hadn't dilated at all in those 4 hours. It was at that point that I knew that the window for me to have a home birth was closing. I realized that I was running out of options and I wasn't dilating fast enough to feel safe laboring at home. I also knew that I wasn't willing to risk either the integrity of midwifery care or the health of myself or my baby for that. I saw the writing on the wall, and personally was already starting to plan for such a decision long before we actually transported.

As a birth worker, I've spent a lot of time reading about issues surrounding maternity care, birth, and the childbearing year. In my work, I accompany my clients to the hospital or birth center, or I help them labor in their homes. I help with preparing the birth plan ahead of time, and I remind them that birth rarely goes to plan. I help them come up with a plan B and C, thinking through various possibilities and the preferences they have in each situation. During a client's labor, I tailor my approach to the individual, which might include massage or other comforting touch, suggesting and helping to implement position changes for comfort and optimal fetal positioning, and serving as a source of information, clarity, and morale. Sometimes I am called on to explain medical jargon, or the implications of a suggested intervention; occasionally I am asked by my client to explain my client's needs or wants to a medical provider when they don't feel able to explain it themselves. All of this is to say that I spend a lot of time in hospitals, and a lot of time helping people understand and experience birth in a safe and supportive way. I also know a lot about the biological and physiological aspects of childbirth, from the initial cascade of hormones kicking off those first contractions to the positive feedback loop between cervical pressure and uterine contractions called the Ferguson Reflex. I know the impact of stress on maternal and infant birth outcomes, and I know

how it can slow labor. I know that having a strong, supportive team helping anyone through labor is associated with improved outcomes and less medical intervention. I've seen enough to know what kind of birth I wanted, regardless of location.

As I said earlier, I labored for a few more hours after the AROM and then requested another cervical check. I thought I'd see where I was and then make a decision on what I needed to do. The nice thing about this is that Annie really let me run the show. I don't know if she does this with all her clients or if she felt more comfortable with me making those decisions because I know so much about birth, but I really felt like I was running the show. Despite the fact that things did not go according to plan, the process felt really empowering in its own right. So, when they checked me and I was still dilated to about six, I knew I needed to rest. The baby was still doing well, but I hadn't had anything to eat or drink in two days, and I was exhausted. I needed a break. So, I decided to transport and go in. We already had a bag packed and it was a pretty seamless transition out of the house.

It's only a ten-minute drive from our house to the hospital, but I remember thinking between contractions in the car about what the best options were for me. When you come in to the hospital in active labor, especially after being in active labor for that long, there are decisions that are optimal and there are decisions that may not be optimal, but it's kind of hard to say what the best choice is. So I was thinking, "I can go in and have Pitocin, but that'll just make my contractions stronger and that could stress the baby, but it could potentially get things going. I could go in and get fluids and see how long that takes but are fluids going to be enough to move things along? I could get an epidural and rest, but then I'm exposing myself to a class C narcotic. I tested positive for Group B Strep and have been in labor for days so I'm

going have to take antibiotics no matter what at this point," so there are all these things I had to negotiate. I tell people that I don't know if it's fear or what that motivates the ability to be so clear when you're supposed to be in "labor land". But I remember really strategically thinking about those things during my labor and while enroute to the hospital.

I have done a ton of work in the hospital so I knew what kind of attitude to have. I've seen how even when clients are really aggressive and assertive, up front about what they want in order to protect their vulnerability, the position of the medical staff changes. Being aware and having personally witnessed how vulnerability can be exploited, I also knew that was something I wanted to keep in check. So, I tried to project this aura of invulnerability by strongly asserting what I needed and what would happen once I was admitted. When I was planning my birth, I never felt like place of birth was as important to me as the ability to exercise autonomy over my body, and you don't get that in the hospital setting unless you come in acting like the boss, like you know what's up and what to do. So that's what I did, and it worked.

When we got into the hospital room, I just bluntly told them, "I'm not laying down, you'll have to monitor me standing up, I'll need a bag of IV fluids," and so on and so forth. Just really took charge. It took three nurses to finally get my vein to get the IV in, I was just so wildly dehydrated at that point, but eventually they were able to give me some fluids and I labored another hour in the room. They checked me again and I was still at six centimeters. By this time, I was just totally burned out and I knew baby was still doing alright but I was worried at some point things would take a turn for the worse – and the worst thing to me was to have my baby whisked away from me after giving birth. At this point, I had to prioritize whatever I had to do

to increase the likelihood that we could stay together after birth. Even after an hour, I was still on the monitors because it took so long for them to get my baseline. They usually ask for 20 or 30 minutes on the monitors, but I was being very noncompliant and moving around, not lying still in the bed, so it took longer. Finally, I decided to get an epidural – thinking to myself that if this doesn't help things progress, at least I've made every compromise necessary before I needed something more extreme such as a cesarean birth. I told the nurses I wanted to sleep for three hours, have another cervical check, and make a plan from there. I was basically telling them what to do, and they listened, and they respected that. I don't know if everybody has that experience going in to the hospital under similar circumstances, but I also know that not everybody's armed with the kind of knowledge that I was, either.

The medical staff, Annie, and her assistant Becky all suspected that the baby was asynclitic— that is, her head was tilted in the birth canal. The head wasn't engaging properly, which is of course why I wasn't dilating effectively. Even if she'd just been sunnyside up, straight OP [occiput posterior], she would have engaged at least a little bit. But they could tell from the cervical checks that she wasn't engaged properly so they suspected she was in there a little wonky. My midwives, Annie, Becky, and the CNM at the hospital, were beside themselves by this point because when you're a primip that has an OP and asynclitic baby, you're on the fast track to having a cesarean birth.

I got an epidural about 5 am on Tuesday morning – 41 hours after my labor started getting more intense— which is one of those things that's a big compromise to make for a lot of home birthers, but I didn't have many options and I wasn't willing to risk it. I was trying to make the most optimal decisions given my circumstances. The CNM came in to check me at about

8:30 Tuesday morning, a little past the three hours I'd requested. They had noticed my contractions had slowed considerably, and they wanted to place an intrauterine pressure catheter (IUPC) in to monitor the strength of each contraction. I told them I didn't want to make any kind of decision without Annie and Becky there. They'd gone to sleep in the waiting room down the hall so when they came in, the CNM shared her plan and we all agreed on more intense monitoring of contractions if I hadn't progressed. So the CNM checked me and I was at plus three station! Station denotes where the baby's head is in the birth canal; for reference, zero is when the baby first engages and plus five is fully crowned, so plus three is really good! The baby was basically just beginning to emerge. The progress I had made in those few hours was amazing and I could feel something different – so I was glad my intuition was right. So I didn't get the IUPC, instead I pushed and she came out! And when she came out Annie said she could tell the baby was asynclitic. She had a little bit of molding on the side of her head, but overall her head was very very round. I'm used to seeing babies with intense cone heads from spending all that time in the birth canal, but not this one. Once she engaged and started down the birth canal she just flew through! There wasn't a lot of resistance. She was a small baby, and I suspect my body could have handled much bigger.

Ninety-nine percent of the time I knew what was best for me and my baby, and when I didn't, Annie and Becky made suggestions but ultimately let me make the choice for myself. They let me run the show. They said that's unusual, that most transfer clients are so thrown about the fact that they had to be transported that they don't know what to do once they get to the medical setting, but I think that what I do professionally helped me immensely in that situation. It made me think about how to translate that knowledge for other people who aren't

birth workers or who don't know the research because I think it is really key that we feel comfortable in both settings and feel prepared for that. I've worked with people who say "no, this is the way it's going to be," and I have to say "Ok, well, sometimes that works and sometimes it doesn't."

One of the unfortunate things about a hospital birth is that they give you literally two seconds once the baby is out, and if it isn't breathing everybody freaks out; at least that's what happened with me. The minute the baby went to take a breath the CNM had cut the cord and my partner was super bummed because he had really wanted to do it. I could tell that he was pissed, and she was breathing just fine, so that was disappointing. In some ways, I think the experience was harder for him because he felt like all the people were in his way. The CNM let Annie catch the baby even though we were in the hospital so that was cool, but the nurse was between me and my partner. I could tell that he wanted her to move so he could be closer, but I was so focused on my goal and it didn't really register. When they put her on my chest, she wasn't breathing for a second, so they cut the cord on the perineum and put her in the warmer. She started crying like 1 second later, and they brought her over to me right after that. She had her first bowel movement on the nurse as if to say that's what she thinks of being taken from her mama!

I shouldn't talk badly about the nursing staff, I had really great support to be honest. I've worked with a lot of them so I knew them, and I knew which nurses I didn't like, so I told my partner that if I saw them, and I didn't want them there that he would need to get them out of there. Luckily, he didn't need to do any of that; I only had great nurses during my time there. In

fact the nurse that I had had during the day shift had her babies at home with one of the local community midwives, so I not only had supportive nurse,s but even some like-minded ones.

Once the baby was born and they brought her over to me, she started nursing right away and everything was fine. Everything went really seamlessly after that. They had turned my epidural off before I started pushing, so I could push and feel everything so I was able to do unassisted pushing, just self-directed, running my own show again. I was also very mentally aware for all of that, probably because I got some rest, which is unusual for that stage. I had to be in a supine position which was unfortunate, but I was kind of leaning onto my left side since I did have some mobility in my legs. I hadn't ever used the bolus for the epidural, I just let the medication run on minimum, so I wasn't as numb or immobile as you sometimes see. We were in the labor and delivery room for probably two hours after the birth, and then we walked down the hall to the postpartum recovery room. They offered me a wheelchair, but sitting at that point after having an OP labor didn't seem like a great idea. I thought, "I would actually rather walk, thank you."

I think some home birthers are not as holistic as they might need to be about considering their options. They'll be very thorough in terms of what will happen for them at home, but then they also need to think about what happens if they aren't at home or if they need to transport – I know the midwives help with this, but that doesn't guarantee they will have built it into their mentality. I've worked with people who won't even have that conversation with me. You know you want to talk to them about their plan if one thing happens. What's the plan if this other thing happens? What's your plan if you have a cesarean birth? But they won't even go there. You can't make an informed choice if you refuse to

acknowledge that that's one of the possibilities. Transports aren't fun for anybody; nobody wants to be in labor in their car, but people need to be informed. I think the only reason things went as well as they did for me was because I was informed and I was making decisions for myself. I wasn't letting others make my decisions for me. It's really hard to have those conversations at the last minute, so you have to think about it ahead of time, talk about it with your home birth midwife too. They should be having a conversation with you, saying, "Here are the possibilities and, based on my experience, here is what I think is the best route for you, what do you think?"

After the birth we did have have the choice to leave, but they said that they wanted us to stay to do the bilirubin testing the next morning, which would have been Wednesday. Maybe it's silly, but we just didn't feel like fighting it. We figured it wouldn't kill us to stay a little longer, though I did request cluster care while we were moving from the labor and delivery room to the postpartum recovery area. Cluster care is when they come in and do all the testing at once so they aren't coming in every hour, and they did that for us. They came very infrequently, and when they tested me for something they tested her, when they took all my vitals they took all her vitals and then left.

One of the things that was so interesting was that there were people who came in to check on me, and I was never exactly sure who they were. So, I had to literally say "Hi, who are you?" It was interesting that they didn't introduce themselves, "Hi I'm an obstetrician," "Hi I'm a resident," there was none of that. They just acted like they could come in and do their thing. They weren't being rude about it, but I was like "Hello, who are you before you start poking on my fundus?" Maybe it was an attempt at being less invasive, but they were coming in to inspect

my body or *my* baby and they needed to tell me who they were and what they needed before touching us. And then the pediatrician came in with a lot of the doom and gloom conversation. She was like what are your sleeping arrangements? Just so you know, the first thing you don't tell a pediatrician is that you're co-sleeping.

On Wednesday morning we used our midwife as an excuse to get out of there. We told them we had an appointment at our house at noon, so we needed to leave! And then we left.

Annie was telling me that it's so awesome to transport in our town (she usually works in a nearby urban area) because you still go to work with another midwife, just in a hospital setting. We know that statistically, a lot of the bad outcomes are due to conflict in transport, wasting time arguing between providers instead of taking care of a woman and her baby that need help. But it's hard because you can't take a public health approach to it and say this is what everyone should be doing, because each experience is so individualized. It's a never-ending challenge and I don't think there's a perfect answer for it, but it's kind of a give and take between the provider and the consumer, the client. But everyone has to be ready for a variety of possibilities, not just for their ideal birth. Because non-ideal is real. It's real.

Commentary

This tale shares the story of an experienced birth worker as she navigates her own labor and birth. She is knowledgeable about how birth works physiologically in addition to understanding the implications of various symptoms, feelings, or occurrences, including the medical interventions that accompany them. She went in to her birth experience with a high level of education, both formal and from her own experience, and she was familiar with the

research, the statistics, and the trends. What she found, of course, is that knowledge is not all it takes to ensure the desired outcome.

Even as she struggles through a long, drawn out prodromal labor, the Birth Worker's narrative demonstrates how she was aware not only of what was happening in her body, but also of what the socio-political implications of her choices could be. She states that "I wasn't willing to risk either the integrity of midwifery care or the health of myself or my baby for [a home birth]," referencing the blame so often laid at the feet of home birth midwives for anything that goes wrong in a birth that they are attending (Scamell and Alaszewski 2012; Greenfield 2019) in addition to the potential for undesired health outcomes such as technological birth or maternal or infant morbidity or mortality.

The Birth Worker's positionality as someone who has supported countless other parents while also being a birthing mother herself is central as she integrates her own experience with her practice. She not only takes her own advice in thinking about the various possibilities and outcomes ahead of time, but then also uses her personal experience to consider how she can better reach people she works with and help them to think more holistically about the process they are entering into.

The Birth Worker also recognizes the privilege of living in a town with a high level of integration between home birth midwifery practices and the hospital; the local hospital practices midwife-to-midwife transfer in non-emergent cases, allowing the birthing person the highest level of congruence between their ideal and their actual experience of birth. Many other locations in the United States, even in the Birth Worker's own state of residence, do not share this same level of integration and collaboration (Cheyney, Everson, and Burcher 2014;

"Best Practice Guidelines: Transfer from Planned Home Birth to Hospital" n.d.; Comeau et al. 2018).

Vedam et al. (2018) created the Midwifery Integration Scoring System to evaluate how well midwifery is integrated into health systems across the United States (Vedam et al. 2018). Higher scores were associated with better outcomes, including spontaneous vaginal delivery, vaginal birth after cesarean (VBAC), and rates of breastfeeding, among others (Vedam et al. 2018, 1–2). The Pacific Northwest states rank highly; Washington State had the highest integration score in the nation, and Oregon has the third highest (Vedam et al. 2018). In other states in the U.S., it is still a felony to practice as a home birth midwife, and thus, transfer from a planned home birth to the hospital is much more fraught ("Legal Status of U.S. Midwives | Midwives Alliance of North America" n.d.; Big Push for Midwives 2019). Scores ranged from 17 in North Carolina to 61 in Washington state out of a possible total of 100, suggesting wide variability throughout the nation (Vedam et al. 2018). Despite the relatively high integration score in the Pacific Northwest as compared to other regions, however, it is worth noting that the highest score yet attained is still only 61, which in an academic context would be a failing grade.

Cornthwaite, Edwards, and Siassakos (2013:571) note that "Poor teamwork results in preventable morbidity and mortality for mothers and babies… A few simple teamwork and leadership behaviors can make a huge difference to outcome and experience for women and their companions, yet they are often missing from maternity care" (Cornthwaite, Edwards, and Siassakos 2013). In the case of transfer, teamwork necessarily refers to the home birth team as well as the team of obstetricians, nurses, and CNMs at the hospital – but also the articulations

between the two teams as they come together via the transfer of care. Vedam et al. (2018:3) write “Poor communication, disagreement, and lack of clarity around provider roles are identified as primary determinants of these adverse outcomes” but that “collaboration among health professionals can improve safety and quality, particularly when care is transferred from low to high resource settings” such as when care moves from the home to a hospital (Vedam et al. 2018, 3). In locations where midwifery is viewed and regulated as a legitimate profession and is integrated into the wider health system, articulations between the home birth team and the hospital birth team are smoother and thus result in better outcomes.

As is highlighted in this tale by the midwife’s comment on how wonderful it is to transfer in this particular city, the actual experience of transfer can vary not only between countries but also from city to city and even between hospitals in the same town, regardless of the state’s overall midwifery integration score. Much of this variability can depend on the experiences obstetricians and other hospital staff have with transfer clients and their referring providers. When the Birth Worker spoke of protecting the integrity of midwifery, this was likely on her mind. Not only can community midwives be convenient scapegoats, blamed for causing or improperly addressing complications or medical events, but the way they interact with the doctors is also subject to scrutiny. In their interviews with maternity care providers on experiences of transfer, Cheyney, Everson and Burcher (2014:448) found that “distinguishing between ‘good’ and ‘bad’ midwives was a common theme” and that physicians were more likely to remember and discuss negative interactions even though the majority of transfer experiences were considered positive, and even when the physician in question had not personally had a negative transfer experience at all (Melissa Cheyney, Everson, and Burcher

2014, 448–49). Thus, in addition to evaluating her own changing risk factors, the Birth Worker had to think about how she and her birth team would appear to the receiving providers at the hospital. Whether this tension is commonly understood by other birthing individuals who transfer in this or other locations, it does illustrate the various aspects of the decision-making process. Although the birthing person and their baby are ostensibly the most important concern within the transfer process, the impacts of each step can ripple out to touch others in their community, whether clinicians or clients.

The Nurse's Tale

I had a pretty uncomplicated pregnancy, though I had lots of nausea and one preterm labor scare at about 30 weeks. I was in nursing school, and towards the end of pregnancy especially I think that may have precipitated what occurred with my birth. I was finishing up at school, and staying at home again instead of staying near the school – it's a 2 hour commute each way so I had spent a lot of time away in the months preceding the birth of my baby— but 'home' was also changing, as we our lease was up and we were moving. So quite a few changes were happening all around the same time, in addition to becoming a mom. I didn't even process or really think about that until much later. I was just living on the day-to-day, trying to manage the stress.

I felt thankful throughout my whole pregnancy that I was healthy. In fact, my final term of nursing school was the practicum term, and I was at the perinatal specialty care unit at a hospital up near the nursing school. There were people who had preterm labor and gestational diabetes and all kinds of complicating factors that they needed care for. People would ask if it was weird to work there while I was pregnant, but I would say "No, I'm just so grateful that I'm healthy." However, at 38 weeks I started having a couple of high blood pressures, one to up into the 130s, and then a couple days later it went down, and I had a little bit of protein in my urine. When that was tested a couple days later it had also gone down. I was also in the middle of a transfer of care. The plan had been for me to transfer from one home birth practice to another towards the end of pregnancy because my original midwife was having surgery the week before my due date. So, I was transferring to another practice with differing ways of approaching high blood pressure just as I started to have symptoms of a serious complication.

My original midwife, Pamela, had always been a sort of champion of my success in the academic world. She had been my professor and mentor while I was in school, and I really respected her not only for the way she communicates and the store of knowledge she has about midwifery, but also her ability to interface with many different people. I was so thankful that she was able to come to the hospital. Historically there has been a disconnect between the home birth community and the hospital based community. Even though the hospital has midwives too, there's still a disconnect, especially amongst the nurses and obstetricians. All midwives get similar training, the major difference is one group is nurses and the other group is home birth based. Even so, some nurses still call home birth midwives 'lay midwives,' which really gets under my skin. But I knew that Pamela, with all her research background and ability to throw out medical jargon on the fly in any situation, would really be able to interface with the hospital staff. I knew that she would be able to advocate on my behalf in an appropriate manner within what is essentially a subculture within the hospital. I felt that would help me get the best care that I needed. And you know, she was able to do that.

At the same time she also really connected with my husband. Throughout the pregnancy he was able to ask her questions and he felt like she gave good answers. She didn't give too much information or use a lot of jargon, and so I knew that the relationship that they had built would help us at the hospital too. She would be able to explain things to him that I couldn't if I wasn't able to talk, and she would be able to help him through anything.

The midwifery practice I was transferring to recommended that I eat a lot of protein. There's a theory that if you have protein in the urine, it's because your body doesn't have enough protein and is breaking down some of the protein from the muscles in order to provide

you with nutrition, and then it shows up in your urine. That's the hypothesis the new midwifery practice was working with. So I worked on eating more protein for a few days and the blood pressure and the protein in the urine went down so it seemed like it was working.

I graduated from nursing school and we moved into our new house. Then the blood pressure went up again into the 130s and 140s, and this time it didn't go back to my normal baseline. I tried to remind myself that blood volume goes up during pregnancy and tried to believe that it wasn't necessarily an emergency. But then on Monday of that week, the 14th of December, the protein went from trace protein to 3-plus. An increase in that much protein in the urine is alarming, and the next step is to do a 24-hour urine test. That's where you collect all of your pee for 24 hours and then you measure how much protein and other liver enzymes and things are in your urine during that period of time. That's when the shit hit the fan.

The trace protein was basically an alarm bell, so we did the 24-hour urine test and sent it to the lab at the local hospital. My husband and I went home and discussed how, when lab values indicate pre-eclampsia, the only real treatment is to try to have the baby as soon as possible. The idea is that the placenta is the cause and the issue will only get worse until the placenta-- and thus the baby-- is delivered from the body. So we went home with the idea to have sex to try to induce labor, but instead we went out to lunch. After lunch we got the news that sure enough, the lab values were indicative of preeclampsia and that I would need to go in to the hospital for monitoring. The value that was pretty high was the protein/creatinine ratio; that, along with the chronic hypertension, is required to diagnose pre-eclampsia.

There are a lot of things that were fortunate about my situation. One of those is that I had just graduated nursing school, so I understood a lot of what was going on. I'm really

thankful for the fact that I had gone to nursing school because if I hadn't, I would have been a lot more resistant to everything along the way. Everything, every step of the way, even getting an IV, I would have been questioning. They collect your urine at the hospital and drug test every patient. I knew that. I would have been resistant to that, but it would have set my baby up to be drug tested instead because I was resistant, which they might have interpreted as indicating that I did drugs or something, that maybe I had something to hide. But since I knew all these things, not only did I understand how the hospital worked, but I understood my condition. I understood what was going on for me, and I knew what would happen. I knew I would go on magnesium, I knew they would be looking at my liver enzymes, I knew they would be monitoring my blood pressure, I knew I would be on food restriction. And I knew my partner had no idea what was in store. But I think that I was really fortunate that I knew what was going to happen.

I was fortunate in this other way in that I have lived in this community and been a birth worker in this community. I had volunteered with a group that was trying to start a birth center, so I knew some of the midwives at the hospital already, we were friends with the midwife that admitted us, I knew one of the nurses who happened to be working that day. I feel really thankful to have had people in my community that I already knew at the hospital. I think that there can be a real disconnect in knowledge for people who want to have a home birth; many don't want to have interventions, that might be why they chose a home birth, so they might be resistant to the interventions if they don't understand them. It's harder to understand things while you're in labor, it's harder to get things explained to you if it's an emergency, it's harder to get things explained to you in a way that feels respectful, and you are a person who can

make decisions. Nurse culture is not always very respectful of you making your own decisions. The idea that you are in charge of your own body is really outside of the biomedical model especially when the situation is perceived as urgent. This attitude of “This is what we do, these are our protocols,” is really common.

When people transfer to the hospital from home, they get whichever provider or practice is on call that day. That day the midwives were on call, while the next day it would be the OBs. Pamela, my husband, and I decided that since we needed to transfer to the hospital, the best time to do that would be when the midwives were on call. So we got ready and went to the hospital that evening. With first time labors and births, I think that the mom often thinks it’s going to happen way faster than it usually does. We definitely did. We went and we were like alright! Let’s have a baby tomorrow! We had no idea that’s not how it was going to happen.

We went for monitoring, and the baby looked great on the electronic fetal monitoring system. I was having some contractions, but I had been having them for the previous few weeks so that was fine. There was nothing new or notable there. We tried some natural induction measures, like nipple stimulation with a breast pump, but there was no change. We went to sleep with the plan to start a medical induction first thing in the morning.

They got us up at 5 or 6 in the morning to do some labs and start some Pitocin to initiate labor. I was on the Pitocin most of the afternoon. They go up by increments of 2 units every half an hour and we were up to a pretty high level. The contractions definitely heated up a bit in the late afternoon, but I wasn’t really having much cervical change. Another thing that happens with pre-eclamptic patients is that once you’re in active labor, you get infused with magnesium which is a neuroprotective to keep you from having seizures from the pre-eclampsia. These

inductions take a really long time because pitoicin and magnesium are essentially working against each other. Pitocin is initiating and strengthening uterine contractions while magnesium is telling the body to have everything relax so it doesn't have a seizure, so these labors end up taking a really long time while the uterus figures out whether to contract or to relax.

Sure enough by the end of the day I was probably only at three centimeters dilated, though I had been laboring since 6 a.m. We tried all kinds of other things to try to augment the labor, such as a Foley bulb. They insert a bulb into the cervix and inflate it a little bit over time to help open the cervix. They also swept the membranes, and eventually ruptured the membranes. Once we did that, they could put in a IUPC—intrauterine pressure catheter, which is a contraction monitor – to gauge how strong the contractions were. I was a little reluctant about the artificial rupture of the membranes because then you know you're on a timeline because of the risk of infection in the uterus. But they broke the water and then were watching closer to make sure I didn't get an infection. That meant doing fewer cervical checks to avoid introducing more bacteria or germs into the vaginal canal.

So then the midwife on shift, Sandra, came in to see how all the interventions had worked and I was at four centimeters that time. I just started crying. After all those hours, fucking four centimeters! So by then I knew that no, I was not going have a baby that day. I started thinking, "How am I going to do this? I don't want to do this anymore!" It was a very overwhelming time, one of the more trying times in my life.

While on the magnesium, I was on food and fluid restriction. I had not eaten anything since 6 that morning, and was only allowed to drink ten or twenty milliliters an hour, which is basically the size of a Dixie cup. I had a great nurse on the first day of labor, a personal friend,

and she would come in right on the hour mark and ask, “What would you like for your next hour?” offering cranberry juice, or water, or other clear liquids. I had Jell-O one time, I had a popsicle one time.

Finally at about 3 a.m. the next day, I still hadn’t made much cervical change and we knew labor was going continue a lot longer so they suggested an epidural so I could sleep. My body might even continue to make cervical change since the pitocin and magnesium would still be going, and then I would be able to wake up the next morning and continue laboring having had some rest. I was right on board with that, so they put in the orders.

There can be a disconnect with knowledge, like I talked about before, but there can also be a disconnect with relationships. When you have been seeing a home birth midwife all through your pregnancy and then transfer, the hospital staff wouldn’t necessarily know you, they wouldn’t necessarily know what you want, they wouldn’t necessarily know how to talk to you, how to negotiate with you, how to warm you up to the idea of things you didn’t want or at least didn’t plan. There can be a lot of traumatic experiences with home birth transfers, we’ve all read the horror stories – dropped lines of communication, there’s a cascade of interventions, things get out of hand and then people end up with post-traumatic stress or postpartum depression. All of those things are common with transfers. So while I still think I have experienced some post-traumatic stress issues as well as postpartum depression, I am super thankful that I had both my nursing knowledge and my relationships.

When you get an epidural it’s a sterile procedure. The anesthesiologist comes in and only one other person can be in the room with you. You have to lean forward as if you’re a cat arching its back, and they put a little tube into your epidural space in your spine and then they

put some numbing medication, a nerve block, into it. They give you a basal rate but you also have a button that you can press when you want extra medication. It's a little bit of a scary procedure for the patient because it's a huge change from what you were doing before, especially if you're trying to go no intervention. For those of us who planned a home birth, an epidural is sometimes thought of as the most evil of all interventions besides you know the evil of c-section. I say that in jest, myself, because these things are actually compassionate and useful tools, but they are demonized sometimes by the low intervention culture of home birth. It can be really scary for whoever is there with you, since contractions are still happening and they see someone they love in pain and unable to move or comfort themselves. Most anesthesiologists who deal with laboring women are used to coaching them through a procedure in spite of a contraction, but if the needle starts to go in, you have to keep going in order to get it in the right spot, even during the contraction. So that happened to me, of course, and I'm sure it happens to most people, but that was the point where my partner realized how much had changed from what we had intended or hoped for. That was the scariest thing that had happened yet. For someone not in a medical field, or who doesn't otherwise understand the implications of all the lab results, watching a needle get shoved into your partner's back is pretty overwhelming.

To make matters worse, we had a really terrible interaction with a nurse. When you get an epidural it's really common to have your blood pressure bottom out. It happens to a lot of people, so they have ephedrine, a form of epinephrine, ready at the bedside to add to your IV in case that happens; sure enough that happened to me. I started to get a little dizzy and the nurse came over and started to put that into my IV. And I said, "What's that?" She acted quite

defensive but told me what it was, and, and I said, “You can’t just put something in my IV without telling me what it is, I want to feel like I am agreeing to treatment!” She said “I can if it’s an emergency!” I just said “All you have to do is say this is what your blood pressure is, I’m giving you this.” She had a really hard time with receiving feedback or criticism from a patient, and she must have taken it really personally. She had really poor communication skills with me for the rest of the shift. She did a total 180, and every single thing she wanted to do she came in and was like “I want to take your blood pressure. I want to do that because you have preeclampsia and that’s a condition where people get high blood pressure. Can I take your blood pressure now?” In a snotty patronizing way. She didn’t seem to have the ability to bounce back from being criticized by the patient. I could have said something, told her she didn’t have to act this way, but I realized that she was doing what I asked her to do, which was tell me what she was doing before she did it, even though she was doing it in a really immature manner. So I actually never said anything beyond that. I was just polite with her and waited until the next shift when I got a super awesome nurse again.

I was a nursing student so I knew that nurses sometimes write snide comments about patients in their charts, or go out and tell the other nurses something based on their interpretation of the situation. I worried that my care could be affected by one nurse’s opinion of the situation. Later when I spoke with the CNM I knew at the hospital she said “Yeah, she seemed overwhelmed by the situation. I just told her it was a misunderstanding and she had to do her job.” I had hoped for a little more advocacy, it didn’t seem like such a big ask to be informed of what procedures were being done to me, but it didn’t seem to affect my care going forward. I had a wonderful nurse the next day and we bonded great, and she’s a good friend

and colleague of mine now. But that was a difficult interaction during an already difficult experience.

I was really grateful that we had Pamela and her assisting midwife there with us as well. They had been there for the earlier part of the induction and they were there the next day when the birth actually happened. When you transfer to the hospital here in town from a planned home birth, your birth team can come with you and stay for as long as they want, or as long as you want them. They don't limit how many other providers you can have at the hospital with you. So I got the epidural and we went to sleep for the night.

By the morning I had made some change, to about eight centimeters. I wasn't as able to be active anymore, between the epidural and the magnesium. The magnesium kept me from being able to engage my muscles properly, and then the epidural made me numb from the waist down so I was a fall risk. Walking around, bouncing on the ball, trying different positions to augment labor and help me through the contractions, none of that was in the cards. However, you can configure the hospital beds in different ways to allow for position changes. You can get the ball in the bed and put a leg up, you can drop the front and lean over the second half of the bed, you can put up a squat bar and hold yourself up, there are different positions you and your partner can get into, so that's really helpful. It felt like we were making something good out of a shitty situation because not being able to move around or eat or drink is pretty shitty when you're trying to have a baby!

That day was kind of a blur. That afternoon boils down to a blur of having the rest of the contractions, breathing through the contractions in a laying down position, and then later on trying some Fentanyl when the epidural stopped working on one side. Fentanyl is a pain

medication that we give to people all the time in the hospital, but it made me very woozy. The CNM who was on that day checked me and said that I was not ready to push yet, I was still at nine centimeters. I got the Fentanyl because I could feel all the pain and I couldn't move around and I was just over it. I didn't want to deal with the pain anymore especially since I couldn't even change positions. Shortly after that – shortly in labor time, which could mean an hour or could have been three, I don't know – they came in and checked me and I was fully dilated so they said I could start pushing. The monitors looked good, suggesting the baby was in good shape, so everything seemed on the up and up.

Pushing is very difficult when you can't move that well and can't really feel your body; you have to use your brain a lot and you have to use the help of a shit ton of people. For me, the best position for pushing was having my partner behind me to support me and supporting my upper thighs and lower glutes, my knees up in the air and one person on either side holding my lower legs and feet. We were trying to open up the vagina and pelvis. I scooted all the way forward on the bed, kind of tipping the pelvis forward, and we used this rubber thing that looks like a dog toy to use like a tug of war with another person to help you bear down. So I had four people helping me get in position. I was trying to engage my core, but had to really use my brain in order to visualize what would it feel like if I was tucking my tailbone down and squeezing all of my pelvic floor muscles? Because it's not easy or automatic when you have all those medications interrupting normal sensation. Every push, I had to think about doing that, and send my intention to that area and consciously tell it what to do.

During pushing, the baby started to have what we call 'late decels,' meaning his heart rate was dropping after the contractions. It's normal for the heart rate to plummet during the

contraction but then it usually stabilizes. When it happens after the contraction it just indicates that the heart rate didn't come back after the contraction, and often that's helped by putting the mother on oxygen. So I was on oxygen the whole time I was pushing. It's helpful medically but it dries out your face and it continues to immobilize you. I had three IVs and the intrauterine contraction monitor and things hanging out of my vagina and my veins and now strapped to my face. All these things I had hoped to avoid by planning a home birth, I now had hooked up to me.

Then we discovered that he was positioned asynclitically. You want the place where the sutures all come together at the top of the head to point outward, that's called OA, or occiput anterior, but his were positioned laterally, to one side. The spot just above the baby's ear was pointed out instead of the center. That increases the surface area that you have to push the baby out and makes it a lot harder and more painful. Often the OB will try to manipulate the fetus' position using forceps; they'll twist and pull a little bit during a contraction to free the baby from the position they're in. It isn't without risk, though; it can cause some internal lacerations in the vaginal canal, and also intracranial bleeding for the baby. I was not having that. It was discussed – I was hyper aware of the conversation that was happening between the midwives and nurses about which OB was on that night: "He does forceps, the baby is positioned asynclitically, he might want to come in and consult and use the forceps." And that awareness just added to the stress.

The doctor came in and it was this monumental moment in the labor; he was the only other male in the room besides my husband. It was all these women with this little man in the center, standing there staring at my vagina. They explained to him what was going on, and he

watched the electronic fetal monitoring and the contractions and eventually concluded, “Well, looks like she’s doing it.” In spite of the issue, I was successfully making some headway – pun intended – on pushing this child out. They decided they didn’t need the forceps, though, it was suggested. They talked about it a couple of feet away from me, and then decided that they didn’t need to bring the conversation over to me. Just like before, though, I was hyper aware of the conversation. I was very much part of it even if they didn’t realize it. Pamela was present for that part of the labor and then later for the birth as well, and she was right up in my face, telling me that I was gonna push that baby out. She was right by my side saying “Amazon woman! You’re an amazon woman! You’re going to push that baby out!” the whole time. It makes me tear up to think of it now.

Pamela had just had surgery but she showed up for my labor anyway. She was telling me what was happening and what the CNM and OB were talking about, what they were thinking about doing with the forceps. I said “But what about intracranial hemorrhage?” and she just looked at me with this look of love and pride, like “This is my student; this is someone I care about and am so proud of! She’s pushing and still saying things like ‘intracranial hemorrhage.’” It was so meaningful to have that kind of encouragement from someone that I knew really well throughout my pregnancy, but also through the previous years in school and finally as a friend.

It was clear on the electronic fetal monitoring strip that the baby’s heartrate was not doing well. There weren’t too many decels, because if there had been then they would have pushed me to have a cesarean. But the variability, which is an indication that the baby is responding healthily to the contractions, was minimal. With minimal variability, they have to

start thinking about why baby isn't responding well. I had the oxygen on, and it was clear that I wasn't going to get to have him be scooted up onto my chest for immediate skin-to-skin contact or to breast feed him right away or anything like that, which again are things that I had planned and anticipated. Instead he was going to come out and need some resuscitation; he probably wasn't going to be breathing. That was becoming apparent with these decels and the lack of variability in the heartrate. But I had negotiated with the hospital midwife that I needed to get a cheek bump. I wasn't going to get my skin-to-skin, but I said "I wanna have a cheek bump, I can't hold my baby, I must have a cheek bump." Just some way to connect, you know? I pushed the baby out at 6:28 pm, 18th of December, so the CNM is like "Ok get in the game! Here's your cheek bump!" And he kind of gets squished up to me, I grabbed him for a second, and I get this squishy, sticky cheek bump. And then he was whisked away, the cord was cut—no delayed cord cutting for me— and he was put in the warmer, he got some partial pressure ventilation because he wasn't breathing. A little while later, he went off to the nursery with my husband so that he could be stabilized. When they clamped his cord, they clipped a little bit close to the skin and so he was bleeding a little bit and they wanted to patch that up too. So my husband left with my baby and I chugged some water – remember I hadn't been allowed much water for so long – and I tried to come back to Earth. I got some gloves and got to touch my placenta and feel around for calcifications and look at the cord and at least have that piece of ritual that I had imagined I'd have if I'd had the birth I planned.

Then I remember really distinctively, my baby was being wheeled back into the room and he started to cry and I pulled a blanket over my head and thought "Go the fuck away." Rather than thinking "Oh this is super poignant, oh this is my baby, oh I have this oxytocin, oh

let's bond," I thought "Go the fuck away. I'm so tired." It was a fleeting thought, it passed and I got a bunch of adrenaline and realized "Oh it's time to wag your nipple in the baby's face and try to get him interested," but I knew my baby was not going to be interested in breastfeeding right away, I knew that he was going to be what we call 'magged out.' He would be extra tired for a while and not able to feed. I told the nurses that they should give him some donor milk because I knew I wasn't going to have anything, he wasn't going to be interested in eating anyway, and I wanted them to give him 5 milliliters of donor milk. So they did that. Later on, I realized he didn't need to eat, his stomach was so small he didn't need to eat. But at the time it seemed important.

And then, the first time I finally got to hold my baby, whom I had spent so much time and energy and literally blood, sweat, and tears, to get out of my body – I vomited. I had chugged so much water that I just vomited. I got dizzy, hot and sweaty, and I vomited into a little bag, and then he started bleeding from his umbilical cord. So even our first time ever holding each other was a little haphazard and kind of a shit show. He got whisked away again because they couldn't tell that it was just that little nick where they'd clamped the cord, they just saw me vomiting and covered in his blood, so they took him away.

I'd love to see more communication going both ways between the hospital staff and the home birth community. I'm a handout person, maybe a pamphlet would be helpful to give to incoming transfer patients saying, "Here are some ways we'll try to make your transition as smooth as possible." It'd be great if there were more education for staff about the culture of people who have home births, so it doesn't have to be a scary thing to nurses. It could be really simple, like let the nurses know that when people transfer in from a planned home birth, they'll

want to make their own decisions, they'll want feel like they're having a more private experience, and that if their birth is uncomplicated then that's ok. It makes people nervous to have emergent transfer experiences with patients. If the home birth midwife and the hospital providers clash on what they want or what they think is the best way to proceed, then it's a weird place for the nurse and the other receiving providers, as well as for the home birth midwives. Everyone has an opinion, but it can't get in the way of providing the best care for the person who's laboring in front of you. So you know I would say being open and respectful to the patient. I think people try to do that anyway, but it can be hard to acknowledge for the patient that we the nurses know this isn't what you wanted but we want to help you cope in the meantime. Some are better at that than others, and that can be helpful for some patients to have their experience acknowledged – though I think it's important to assess whether that's actually helping or not. For me I thought that was kind of patronizing and annoying. I'm an educated person, I know that this wasn't what I wanted but you get what you get. Let's not dwell on it, let's just have a baby and deal with jaundice and move the fuck on, you know? I think that was also part of how I could cope with it, by blocking it out like "I'll deal with it later emotionally, let's just deal with what we're doing right now. We're at 4 centimeters, we're getting the epidural, we're not doing forceps, the baby's out, let's get some PPV, ok he's bleeding I'm vomiting, ok let's do the bilirubin bed, ok he's crying for months. We're just dealing with one thing at a time."

With that said, though, education and respect for the providers, maybe some kind of transition document for the patient, and maybe just some increased communication skills, all of that would be helpful. "Your blood pressure is this, I'm going to give you ephedrine." Boom,

done. That kind of thing I feel is really important to people who want to make their own decisions and feel like they are the center of decision-making; they want to be told what's happening to them. It's very important. So I think communication and understanding is the big piece on that.

Because he had been in the asynclitic position during pushing, the baby's head was really swollen and bruised around his ear; he even got a little bit of Tylenol for all the bruising that he had on his head. It's amazing how quickly it goes down because the next day it was much better and then the subsequent days after that it was even better. But he has a massive head. His head has been in the 100th percentile since before he was born—and continues to be – and the swelling didn't help him at all with that.

It didn't stop there. He was extra tired from the magnesium, like I knew he'd be, but what I learned later is that it's also really common for babies on magnesium to have hyperbilirubinemia, or jaundice. Their liver is working on processing out the magnesium until it's metabolized, and since it's working overtime like that, it's not metabolizing out all of the dead red blood cells from the mom's circulatory system and it builds up. When they start nursing a lot it helps work all those blood cells through the system, but until the milk comes in baby can't actually drink anything. And no one thought to get some donor milk on board to prevent jaundice – I'm not sure how clear the evidence is on the connection between nursing and clearing jaundice, so maybe it isn't standard practice. In any case, he got jaundice, and then he didn't get donor milk, but we wanted to leave the hospital as soon as possible. His bilirubin level was high-intermediate rather than high-high; they probably wouldn't have let us leave if it

was high-high. Since it wasn't super high though, we negotiated a plan to leave with the promise that we would come back the next day and get it checked again.

When you transfer to the hospital, the home birth midwives don't just drop you after that; they follow you back home again. For a lot of people, certainly for me, part of the reason to plan a home birth is that they come to your house and help you in the postpartum period for six weeks! That's huge. They'll answer questions at any hour via text message or phone call, come to your house when you schedule it but also when you need it. We had a pretty good postpartum period, breastfeeding went great and there were no issues with baby past the jaundice. Yet I was super thankful to have someone help me transition back to being home again, someone who knew me and could help me assess what we would need as we went along.

When we came back the next day the baby's bilirubin level was even higher and they wanted us to get him on this light bed, the bili-bed. It obliterates those dead red blood cells by shining a light through them. If we'd had had a summer baby maybe we would have been fine to lay out in the sun and let the sun do it all naturally, but here we were in the middle of December. We were able to borrow a bilirubin bed to have at our house instead of having to be readmitted to the hospital, so we were able to go back home, but he had to lay on this bed and we had to feed him every two to three hours. The idea was to have the baby breastfeed, then give him supplemental donor milk or formula, and then I would pump. Breast-bottle-pump, it's called. The 'breast' portion is to get them to practice breastfeeding as well as to stimulate the breast to keep producing milk, and the pumping is also to stimulate the breast and encourage

milk to come in; the 'bottle' portion, though, the supplemental milk or formula, is actually what's helping the baby poop out all the jaundice.

After one or two times of trying to nurse and watching the baby exhaust himself working so hard for milk but not actually getting anything, I just thought, "Screw this! We are giving him the milk and then I will pump. I'm not worried about my supply, I'm not worried about teaching him to breastfeed, I would like to get him off this light as soon as possible." So any time his mouth was open in the following 24 hours, we were shoving a bottle in his mouth. "Your mouth is open because you're crying? Here, have some more milk. It's dripping down your face? Here, sorry, have some more milk." We started calling him "Foie Gras Baby" because we were basically force feeding him milk.

Luckily for me, I had a friend who was willing to bring over some breast milk, which is a super awesome community led practice that people do, sharing milk with each other's babies; it's a great way to avoid having to use formula. It allows us to colonize their guts with the great antibodies and human milk that their gut was meant to have as opposed to dairy-based formula, and just gets them off to a strong start. So I was super grateful, and still am, to that friend for 'hooking it up phat' on that one during a really difficult time. Community breastmilk sharing is a really great thing because even though we do have milk banks, it's regulated and pasteurized and tested and everything which brings the cost up to around $4.50 an ounce which is cost prohibitive to most people. And so this age old practice of sharing breast milk is so important, and was so meaningful and materially helpful for me. Even then, though, I cried when she got to the door and there was the baby over there in the corner, lying on the tanning

bed; we couldn't pick him up and snuggle him together, I couldn't show her this baby I had worked so hard for. He had to just lay on this bed.

It was a fascinating juxtaposition of this community based, woman centered birth I had planned and the heavily medicalized, technocratic birth I got. Here I was, home with my brand new baby, and it was like the hospital followed us home. I still couldn't hold him like I wanted to, I couldn't co-sleep and nurse on demand and follow my intuition the way I had always thought I would. But here was my friend, who had also planned a home birth a few months before, bringing milk for my baby and supporting me in the postpartum period. And of course my midwife came and provided postpartum care in my home as well. But through it all, there was still this bili-bed in the corner, reminding me of how I wasn't getting the experience I had expected. I really wish someone had discussed with me that for first time moms who have really long inductions, or any highly technological intervention, there is a correlation with postpartum depression. I have definitely experienced, and am now treated for, postpartum depression. If that had been part of the conversation that could have been really helpful. It could have saved me from waiting too long to have real conversations with my provider about where I was struggling.

Now that I'm a nurse, I know that nurses dread having transfers because it is socially awkward for them. Whether it's because they've been treated kind of snidely by the home birth midwives, because the patient is scared of their providers and isn't honest with them, or whatever other reason. Especially if the patient comes in for an emergency c-section, you know shit's hitting the fan quick and you don't know this patient and you don't know how the baby has been doing in terms of the heart rate throughout labor or how the mom's been coping or

what the key things would be to say to them to help them through, or anything like that. The nurses don't feel fulfilled often in the experience either; now that I'm a nurse I know that it scares the shit out of nurses to have home birth transfers, and for good reason on their end. I used to have very little compassion. I'd be like "This is your job, learn how to do it, just be a good nurse!" Now I realize that it scares the crap out of people and that's legitimate! That's valid. I think improving things for the nursing staff **and** the OBs **and** the home birth midwives **and** the patients is really important. Maybe that's a holistic way to approach the issue.

Commentary

The Nurse's Tale offers a unique insight into both the home birth and the hospital subcultures. The Nurse had been active in birth worker circles for years before going to nursing school or getting pregnant herself; in fact, she had considered midwifery school as a potential academic and career trajectory. She had always planned to give birth at home, despite her training in the medical field, and the transfer to the hospital was particularly difficult for her as she tried to reconcile what she knew of her medical condition, the treatment she knew was coming, and the birth she had planned. What is more, she had to work harder to justify her choice to plan a home birth given her training while also essentially giving birth at work.[1] Later, she had to bring a part of work home with her when she borrowed the bili-bed so that her

[1] The Nurse did not work at the hospital in question at the time of this narrative, but was hired as a Labor and Delivery nurse at that same facility not long after the events in this story transpired.

newborn son could stay at home rather than being readmitted to the hospital for acute jaundice.

The Nurse illustrates the caution that is required when anyone transfers from a planned home or community birth into the hospital. Because the receiving providers – whether they are nurses, CNMs, or obstetricians – do not always understand or support the choice to birth outside of the hospital, they may react with fear, defensiveness, or other responses that inhibit rather than enhance communication and the ability to offer the best care to their new patient. Further, the Nurse notes how the division between 'home birthers' and hospital staff can lead to what are called "fractured articulations" (Davis-Floyd 2003), or the breakdown of communication between referring midwives and receiving obstetricians. These stand in contrast to "disarticulations," when there is no communication or collaboration between referring and receiving providers at all, and "smooth articulations," when mutual accommodation, or the close collaboration between providers, is a focal point of care (Davis-Floyd 2003). These fractured articulations are difficult not only for the providers (Cheyney, Everson, and Burcher 2014), but for the patient as well. The Nurse mentioned more than once that she was hyper aware of the conversations happening around her – this is no less true during the transfer of care itself, and hearing an obstetrician or other receiving provider openly disagreeing with or acting hostile towards a trusted midwife can undermine the confidence and compliance of the patient.

Finally, the Nurse's Tale is the only one in this collection that tells the story of transferring to the hospital before labor begins rather than after it has been active for some time. It was included despite this notable difference because the abrupt change in plans from a

low intervention, familiar environment to a relatively unfamiliar, sterile hospital room with "intimate strangers" (Cheyney 2008) is similar whether the decision is made after 40 weeks of pregnancy or 40 weeks of pregnancy plus 24 hours of labor. Both situations require the same 180-degree change in the direction of thinking and expectation, as the Nurse explains when she says "many [home birthers] don't want to have interventions, that might be why they chose a home birth, so they might be resistant to the interventions if they don't understand them."

The major difference between this and the other transfer stories included here is not the medical training that the Nurse has, but the medical condition that precipitates the transfer. It adds a different kind of urgency to the unfolding of events, while also lending increased weight to the medical and technological interventions used. As she notes, despite the fact that many people choose home birth in order to avoid unnecessary interventions, those medical and technological interventions are simply tools, and in her case, they were used appropriately.

In the time since the events related here, the Nurse has gone on to have a home birth with no complications or interventions.

The Economist's Tale

It was a Tuesday, the day after my due date, at 10:58 am. I knew it was my first contraction because I had been having Braxton-Hicks contractions since 16 or 17 weeks, but no painful contractions at all up to that point. It was textbook, I remember thinking, "That feels like menstrual cramps." They were very light but I knew that was my first contraction – nothing, nothing, nothing, then boom. So I had a suspicion. I started timing contractions almost immediately; they were relatively irregular for the first hour, maybe 5 or 10 minutes apart but variable. It wasn't easy to say how long they lasted because it was just a feeling of crampiness; it wasn't obvious then, but later on it was very easy to tell when the contractions started and ended. I was in my office when my first contraction hit and I told my wife. She was a student and I work on campus, so sometimes she would come work in my office. I had three or four contractions before I said anything. I had a loaf of homemade bread that I was going to take over to my dad's office, about a fifteen minute walk from where we were. So I said "Why don't we walk this over, you know walking is supposed to be good for labor and then if it's nothing, it's nothing. No harm done."

So we walked it over, and by the time we got back to my office, I was having pretty steady contractions every 5 minutes or so, and I said "Alright we should probably think about heading home." We got packed up and walked to the car. My wife stopped to drop off a job application. She kept asking, "Do we need to do this, is this ok?" I was just saying "Yeah just do it, I'm fine." I had texted my midwives on the way to do that. Thinking back on it, I was definitely contracting regularly, it was definitely active labor. I was having contractions every five minutes and they were getting more intense.

Deborah really knew her stuff when I would ask her questions, and if she didn't know she wouldn't try to bullshit me about it. I have a friend who just had a baby and they tried to tell her she had gestational diabetes, but when she looked at her test results and started looking at things, she didn't have diabetes. In fact she wasn't even at risk for diabetes. They were just wrong. When she confronted them about it, they wouldn't admit it, they said "Oh your diabetes must have reversed." She was so angry, and rightfully so. But I never felt like I was getting anything from my midwife but honesty. I always felt like she was very upfront with risks and with any information that I wanted, and she also didn't try and scare me. She knew what an ROP baby meant, that it increased my risk of long labor, that it increased my risk of back labor. She never suggested that it meant I should plan a hospital birth or a c-section. She would just say, "This is part of the range of normal." That felt really good, that she could acknowledge all these ways that things could go and still be considered normal. I always felt comfortable and safe, I also felt like she knew her stuff. I knew other women who had her at their births and I knew that when it came down to it, she would do whatever needed to be done to make sure that I was safe and that the baby was safe, but never without my informed consent. I didn't feel like I could guarantee that from an OB. I could be wrong; I'm sure there are OBs out there that are absolutely morally and ethically solid on that count, but I think the training is "You do what you need to do and damn the mom." Or if not damn the mom, it's at least that their emotional needs are not as important as their physical needs. Their emotional needs are someone else's problem. I'm sure there are individuals who practice another way and are able to maintain the emotional considerations, but I don't think the mainstream medical system encourages that.

We got home within an hour of those first contractions. By the time we got there I was having contractions that were three minutes apart and one minute long. So that was starting to enter the three-one-one phase that our midwives had said meant you're in active labor. Actually we found out later it was supposed to be four-one-one, but we thought it was three at the time. That's three or four minutes from the start of one contraction to the start of the next, each contraction is about one minute long, and that goes on for one hour. So we were supposed to call when contractions were four minutes apart but honestly mine just went right to three so quickly anyway it didn't really matter.

We had been planning for this long pre-labor because I had had no labor symptoms, no prodromal labor or so-called "false labor" or anything like that. We had bought some new video games and had all these things lined up so we'd be ready for a long wait, but we didn't end up needing any of it. By the time we got home, I was already wanting to be on the birth ball, wanting to sit and be in different positions. I'm not sure exactly when our first midwife showed up; she had about an hour's drive. I think she was there an hour or maybe two hours after we got home. I was already having the labor land feelings, I was definitely not tracking time well even at that early point. My mom and dad came over at some point; my dad took our dog so she wouldn't be worried or in the way and so my wife wouldn't have to worry about taking care of her as well as me if things went long. My mom was hypothetically going to be there for the early labor, but since I didn't really have that she ended up being there until late at night when my wife sent her home because I was not progressing and it was stressing her out.

My mom had a long labor with my older brother – Over thirty hours before it ended in a cesarean. Then, when she got pregnant with me, she scheduled a cesarean right off. The doctors told her she'd be a great candidate for a VBAC, a vaginal birth after cesarean, but she said "No thanks! I know what to expect with a cesarean, I know what the recovery is like and I do **not** want to go through thirty hours of labor again. I'll take the repeat c-section." But then I decided to come early and she had to deal with labor first anyway, until they could get her to the hospital and into surgery. And I think that feeling of being out of control and in pain and having things go totally against how she planned, I think that affected how she feels about birth now. I had to spend some time convincing her that a home birth is safe and wouldn't be putting my baby or myself – her baby – in danger. But I'm trained as an economist, you know, I spend a huge chunk of my time evaluating risk. It's what I do. So I was able to show her the statistics and the research and how for low risk women, low risk pregnancies like mine, it's as safe as hospital birth, even safer by some measures. That's why I wanted it. It's not because of some romanticized idea of how I want my birth to be, it's because I know it's the best option for me in my context and condition.

Betsy was the first midwife who showed up, and then Cassie who was the apprentice midwife. Deborah arrived last, later in the evening. I was walking up and down the hallway with the birth ball and I would drape myself over it whenever I had a contraction. Betsy was sitting in the living room flipping through a magazine, saying "You're doing great, sounds great you're doing a good job." The whole thing felt very laid back and relaxed, which felt great. It was really nice to labor at home.

I knew that the baby was on the right side and facing the wrong direction, ROP. Right occiput posterior. I had done research beforehand, so I had expected that it would be a longer labor and I was more likely to have back labor because of that position; it did not take long for the back labor to kick in. It was only a few hours in that I started vomiting. The last thing I ate was yogurt around 5 pm. My labor started at 11 a.m., I ate at 5 p.m., and then threw that up. I had thought, "Oh I'll eat through my labor, I'll drink through my labor," but there's no way I could have done either of those things. I couldn't even keep water down, which was a big part of why I ended up transferring when I did.

Sometime in the middle of the night, around 11:00 p.m. or Midnight, they did a cervical check and I think I was at seven centimeters; the midwives told me, "You're dilating, but the baby's head isn't engaged." What was dilating my cervix was actually my bag of water. My midwife liked to refer to it as my "bionic bag" because it was strong enough to dilate my cervix but somehow never broke. The midwives were all just fantastic, trouble shooting and trying to figure out how to turn or at least engage the baby in my pelvis. Babies don't have to turn, they can technically come out in other ways, that's just the easiest way for them to come out. But they do have to engage! I was getting exhausted. I tried to sleep, but I had been in active labor for twelve hours at that point. I was having back labor, and it *hurt***.** My midwives had both had ROP babies so they understood the pain and work that it takes to get one out. My saving grace was that my cervix was at least dilating because I guess some women in this situation never even dilate so it's basically a guaranteed c-section. You can't push a baby out of a cervix that won't open!

After the baby was born, Deborah told me "You know the fact that you even dilated meant that we knew you could have a vaginal birth." That was really important to me, having a vaginal birth. When my midwives asked me my birth plan, my only plan was for the baby to come out, but preferably vaginally. It was very simple. Like I said before, I wasn't married to some specific idea of where or how I wanted to give birth. I didn't want a water birth, I wasn't looking for some special conditions that you can't have at the hospital. I just didn't think I needed the hospital, and I know that obstetricians are trained to treat people who need the hospital. I didn't want them to treat me for something I didn't need. So I stayed home until I needed the hospital, and then I went. I don't have any regrets about that decision, because I knew that once I needed the hospital, the risk assessment had to change. There was new information to take into account. I'm not a clinician, it's been years since I've even taken an anatomy class, but I know the basics and more importantly, I know my own body. I knew that I was starting to wear out, and I knew that I had a better chance of having a low-intervention birth if I was able to rest; the trade-off was some interventions instead of all the interventions. It was a calculated choice to stay home, and a calculated choice to transfer.

We did several other things to try to get the baby to turn. We did belly lifts which are the most painful thing you will ever do in your life, if you're unlucky enough to have to do them, harder even than pushing the baby out. The midwives thought maybe the baby was kind of resting on my pubic bone, so I was essentially lifting my belly during each contraction trying to get baby to get around the bone and into the pelvic inlet. It made sense and was a great idea but man oh man, it was painful to be maneuvering like that during contractions! And then it didn't make much difference anyway. Later, I tried high stepping down the driveway, marching

down the driveway at three in the morning, knees up high, in my nightgown. Just all sorts of different ways of moving or lying or positioning my body to try to encourage the baby to turn.

I got in the shower at one point and I did a lot of singing to the baby; that was really awesome. My wife was amazing. Every time that I would ask for anything she would do it immediately, putting pressure on my back or letting me hold onto her, doing whatever I needed. She sat next to the tub, positioning the spray at different places on my back, and singing with me. My wife is a labor doula, plus she knows me well enough that she always knew just what to do. I don't remember it but she told me later that when I was on the bed, trying to rest, she was afraid to leave my side for fear I'd need her and she wouldn't be there, so she just curled up on the corner of the bed like a cat and dozed off until she was woken up every three minutes when I had a contraction. The midwives, especially Cassie, took as good care of her as they did me, though. Cassie was like a doula to the doula, bringing my wife food and making sure she took little breaks and everything. We didn't hire her, she kind of came with the package of Deborah and Betsy, but I feel so lucky to have had her at my birth. I know that the only reason I was able to labor at home so long, and the reason I feel like my birth was such a success despite the transfer, was because I was surrounded by amazing women. I trusted them to give me the information I needed and they helped me make the best decisions that were most consistent with my birth plan, my values, and my emotional as well as my physical needs.

They checked my cervix again a little before four in the morning and I hadn't changed much, if at all, since that last check around 11:00 p.m. I was still around seven centimeters. So I remember being on the bed, my wife was sitting next to me and Deborah and the other midwives came in and said, "We can see that you're getting really tired and we want to check in

and see what you're feeling. Are you feeling like you need to transfer?" A transfer meant an epidural, rest, and fluids; Deborah and the midwives couldn't give me IV fluids for some reason. I think one big thing that would have made a huge difference in my birth was if they had been able to administer fluids. I'm not sure why they couldn't but I think that would have made a big difference in my ability to complete a home birth. I guess the lack of rest might have pushed it anyway. And I just remember thinking, "I haven't changed and I have done all this work and I want to be able to push the baby out! I don't want to have a c-section if I can avoid it. I can get the rest and the fluids I need. I don't want to have an emergency transfer." That was more important to me than having a home birth, honestly, avoiding an emergency transfer. The whole point of having a home birth is that I'm risk averse. There are more outcomes than just whether the mom and baby are both alive and physically healthy.

I had seen someone close to me go through a really traumatic birth about 2 years prior. I mean the hospital was great; she had preeclampsia and they couldn't have done anything more than they did. But she came out of that with a lot of baggage and it's harder to take care of your baby when you have a lot of stuff to deal with; you have a baby, you can't just not take care of your baby while you take the time to deal with your trauma. So having a non-traumatic birth was really important to me. It was still about the best thing for the baby, just not in the same way that some people might expect.

Around 4 a.m. we got ready to go. I had packed a bag for the baby but I hadn't packed one for myself. I remember my wife running frantically around the house throwing things into the bag; she was awesome, such a super hero through all of this, just making sure everything happened as smoothly as possible with the hand we were dealt. The midwives called ahead to

let the hospital staff know we were coming, which made the transfer of care smoother. When we got to the ER it was 4:30; it's usually a shorter drive but we were in two cars and driving really slowly so the midwives in one car would know to stop if my wife and I stopped in the other car.

When you go to the hospital in the middle of the night, you're admitted through the ER even if it's not an emergency; that's just where they admit you. The guy at the front desk was awesome. He asked me if I wanted a wheelchair but he didn't demand that I sit in it or anything. There was no way in hell that I was going to sit down! I walked up to the elevator and I remember when contractions started up again I just squatted in front of the elevator waiting for it. Another contraction started just as the elevator arrived so I crawled into the elevator rather than waiting for the next one because I knew that there was an epidural waiting on the other side!

We got up to the labor and delivery ward and into a room. I wasn't able to get the epidural right away, even after they put the orders in, since I still had to have fluids first. They do that for everyone to avoid the drop in blood pressure that sometimes happens with the epidural, but I was so dehydrated they had to give me extra. They had to get at least a liter into me before I could start the epidural, but I think they gave me two. My body just soaked it all up.

The anesthesiologist was fantastic. He was so fast, I didn't really have any time to think about it. I was absolutely exhausted; I was just like, "Do anything that you need to do to me to make the pain stop!" I had such a fear of needles leading up to all this, but he was excellent. Part of it is probably labor memory but even so I know he was very fast. I didn't have time to be

scared, but even if I had, I knew the epidural was going to make me feel better. It actually cured me of my fear of needles. I should write that man a card.

The anesthesiologist placed the epidural at 6:00 a.m. and by 6:06 I started feeling relief. They had said that I probably wasn't going to feel it right away because it was just a test dose and most people don't react to it. It's just to make sure your body will tolerate the medication. But the first contraction after the test dose was amazing in how muted it was—the medication just numbed everything. I'm very sensitive to drugs and so I got almost immediate relief from the contractions.

The anesthesiologist was great, but our first nurse was terrible. I did think she was great for the IV, she was really fast and painless with the needle. My wife later told me that the nurse was making nasty comments about home birthers in general though, and I was very polite to her. I don't remember much of the conversation but apparently she said "You need to go tell your home birthers that we're not so bad here at the hospital." That's just ridiculous. It was really disrespectful, but she was going off shift soon so we just gritted our teeth and dealt with it. She also told me I had to lay flat on my back, telling me "Your epidural won't work if you are on your side." I said I was worried that the baby wouldn't turn but she insisted I had to lay flat.

When the shift changed, the new nurse came in. Beth. Beth was wonderful. She took one look at me and said "Your baby's not gonna turn if you're laying on your back! Let's get you all moved around." And she did. She got a birth ball and used it to lift my leg in the air; I was all contorted around and it shouldn't have been as comfortable as it was, but I had had the epidural and I went with it so the baby would have more of a chance to turn. Beth was

awesome, and I still see her to this day. She knows who I am when I see her around town. She retired from nursing though, and is working as a doula now. I've recommended her to two of my friends – actually I recommend her to everybody. Anyway, she came in and I got some Tums because I was having horrible heartburn. She also helped put me in another position and then I slept for an hour. When I woke up she checked my dilation and I was finally at ten centimeters! So that was awesome.

Seeing how effective it was to get the epidural and get some rest really demonstrated to me that the transfer was the right decision. I didn't want interventions if I didn't need them, but the fact is that they were created to meet a need – they're tools just like anything else. Do I think they're overused in the United States medical system? Yes. But not in my case. In my case they were used appropriately. If I had been in the hospital the whole time, I know I would have had interventions earlier so even though I transferred, I don't feel like planning the home birth was the wrong decision. It was still the right call at that point in time. I didn't get anything before I needed it and probably had a lot fewer interventions than I would have had otherwise.

I fell asleep around 7:30 a.m. I had been waiting for the nurse to come in to give me antacids, but she didn't come in for quite a while; my wife ended up going and looking for her and it turned out she had been told I was asleep. It was just a little miscommunication, so my wife cleared it up and I got the antacids. I promptly threw them up and then I fell asleep, but not before Beth moved me into another position to help the baby turn and dilate me and all that. I woke up an hour later and Beth checked me again, and I was dilated to ten centimeters!

The obstetrician talked about breaking my bag of water and I was against doing that. It was probably a good thing it was a woman because I think I would have told a man to get out.

But she suggested that we break the bag of water to move things along. I was still having contractions every three minutes, and I knew that breaking the bag of water often puts a timer on your labor. They worry that it can produce an infection and all these negative things, so I asked, “Can you explain to me why you feel like this is a good idea at this point?” And she didn’t seem to be able to do that. She just kept saying “It’s a good idea,” from what I remember. It was kind of obstructionist, not telling me why it was so important. I should just believe her, it’s just important, that’s all I really got. But I’m nothing if not an advocate for myself, even in the midst of labor, so I said “Well I want to talk to my midwife, I want to talk to Deborah. Deborah will tell me why.” So we called her and she came in and she explained all the reasons why at this point in labor it’s fine to break the water bag and could help things progress.

I trusted Deborah. That’s why I hired her, right? I trusted her, and my wife trusted her, and the whole team just worked really hard all through my pregnancy, at every prenatal and everything, to build that sense of trust. Having someone you absolutely trust at your labor help you make decisions, especially when you’re exhausted and don’t have all the information or knowledge at your fingertips, or you’re not able to weigh the information well because you’re not thinking clearly, that is so important. I didn’t have that with the obstetrician, and she didn’t really seem interested in building that trust, so I was really grateful to have Deborah and the others there with me.

I consented, and they broke my water. It was a weird sensation, and I think I wouldn’t have noticed if they hadn’t told me they had done it. It felt like there was movement but it was very muted because of the epidural. I do think that helped move the baby down some, though she was still turned funny and not in a great position, but they wanted me to do some practice

pushing to see if I was able to move her down at all. It did move her down some, but then Deborah suggested to Beth that she could do finger forceps. Deborah couldn't do it since she didn't have hospital privileges – she would have been considered to be practicing medicine without a license – but Beth could do it. She put two fingers from each hand into the vaginal canal and pushed outwards to help open the pelvis. It seemed to help, so then I pushed. I pushed and I pushed and I pushed. At some point they realized I hadn't had a catheter put in – I think they usually do that after they place the epidural, since you can't really control your bladder if you can't feel it – so they placed that. I hadn't peed in forever and they had put in about two liters of lactated ringers, but even so my urine was dark yellow. I was that dehydrated. Again, it was a good indication that we came in at the right time, I don't think my body would have been able to function much longer at that level of dehydration.

I believe my total pushing time was three and a half hours; the baby was a rock star through the whole thing. Her heart rate was great, she was really resilient and just rolling with it. In the last hour or so my mom showed back up at the hospital; she had gone home the night before around 11 when it became clear that it was going to be a while. She just showed up at the hospital; my mom is great, we have a really good relationship. She was worried about me, so she came to the hospital unannounced, and they let her in, thank goodness. I don't remember if I ever filled out one of those lists of who is allowed to come visit, I don't think I had yet. I don't know what their policy is if someone shows up unannounced like that, but I think she would have gotten herself arrested if they hadn't let her in. She can go into full Mama Bear mode when she needs to. It was wonderful to have her there, and she was able to be there when my daughter was born, which was really powerful.

I loved the monitors because I could watch when my contractions were going to hit; with their help I could feel them enough that I knew when they were going to come so I knew when I needed to push. They also offered to bring in a mirror so I could watch myself pushing her. It was so helpful to be able to see what was working, what kind of pushing was most effective. I like data. Often I could feel it coming and I would look to the monitors to confirm I was right. I liked that. I'm not anti-technology, I just think that in terms of pregnancy and birth practices we often use technology to the point where it ends up finding too many problems that aren't actually there, so I really wanted to minimize the amount of technological use unless it was necessary.

It felt like I pushed forever. The baby crowned for 26 whole minutes. She did great until the very end when she had some late heart rate decelerations. That happened a couple of times and then she was ok so I don't know if it was cord compression or what, but it didn't seem to be too much of a worry. I kept pushing until she had been crowning for over twenty minutes, she was *right there,* and the OB came in – it was a new OB because another one had come on shift – she had been out of the room for most of it because they were really busy, thank goodness. She was getting ready to help my wife catch the baby and got her all suited up in a blue apron-like thing and gloves and everything which I just thought was funny. It just seemed so over the top.

I had been pushing for so long, and it hurt so badly and I was just so tired. I remember saying, "I don't think I can do this." And it was this striking difference between what I'm told midwives usually say and what the OB said. I hear birth stories where the midwives' response to "I can't do it" is "You are doing it, you are literally doing it right now, there is no can't." But I

said “I don’t think I can do this” and the OB said “Well I can give you an episiotomy, and she’ll just slide right out.” The difference between those two statements epitomized the reason I didn’t want to plan a hospital birth. I wanted the support to birth the baby. I didn’t want to be told that they could make it easier for me in the short term, only to possibly create issues in the long term. Birthing a baby is hard. It just is.

I knew I was close to pushing her out and I knew the risks of an episiotomy, so when it was offered I said “NO,” very firmly, and reached down with my hands, and very slowly worked the baby’s head out myself, and kept pushing. Just used my fingers to stretch and push around her head. I think it was the next push, or maybe two more, and she was out. No episiotomy needed. I did have a second degree tear but that’s really common with first babies so I wasn’t that concerned. It was uncomfortable for a while but not any big deal. Then she was there. Her head came out and the OB showed my wife what to do so my wife caught her. She was terrified of dropping her, but she didn’t. She did a great job. She put the baby up on my belly and I pulled her up to my chest and Deborah said “Is it a girl? Do we know it’s a girl?” We had all been saying that it was a girl but we hadn’t actually found out beforehand. I had seen that she was a girl. I was like, “Yep that’s a vulva.” But my wife hadn’t seen so she pulled the baby back down and looked. I just thought that was hilarious, but she needed to be sure I guess.

The baby started nursing 17 minutes after she was born. She had a great latch. All the things I was worried about with an epidural didn’t come true. I was worried she’d come out drugged, I was worried about her being sleepy and not wanting to latch to nurse. This kid is a champion nurser. There is absolutely nothing wrong with her nursing. After she started nursing, I pushed out the placenta but otherwise just let her nurse.

I'm actually grateful to the OB in a way. She gave me the opportunity to empower myself; even though I had told her I didn't want an episiotomy and she offered one anyway, it gave me the opportunity to say no and that felt really good. So much of birth is out of our control. The way that a birth progresses is just luck of the draw and I knew that going in. I always said that I was *planning* a home birth not that I was *having* a home birth, because I always knew that there was a possibility of transfer. My mom had two cesareans, one with me and one with my brother, and I believe that my grandmother also had cesareans with her kids. I know that that increased my chances, as the offspring of surgical births, to having a cesarean for my own birth. I absolutely believe that if I hadn't had the opportunity to labor at home, and then had Beth as my nurse once we got to the hospital, not to mention my midwives and their continued support both at home and at the hospital, then I probably would have had to have a c-section. Being allowed to make my own decisions about how I was going to move my body when I got to the hospital was also so important. That was something that I had been worried about because I knew I didn't want to sit in a wheelchair, it's too painful to sit in that position while you're in labor! So being able to make the decision and even when I was squatting on the floor, not having anybody try to say I had to be in a wheelchair or on a gurney or something. They let me move the way I needed to move, and it was good to not be forced to use those things. I don't know if that's typical but it was perfect.

Part of what I'd been looking forward to with a home birth was snuggling in bed with my new baby and my wife. Instead we got a private room at the hospital, so that helped take the sting off. I know they were really full, so I have wondered if somebody pulled some strings for us, knowing it might be hard as a transfer couple. We had a room with a window and it was

beautiful outside. It was a double room but they didn't give us a roommate, so that made the transfer easier, being able to have our own space.

Coming home was harder than I thought it would be. The hardest part was coming home and being bombarded by all of the memories of my labor that didn't end up panning out at home. Things like the tape measure by the side of the bed, the Chux pads and all the little preparations that the midwives had made for the baby's arrival. I had really been looking forward to birthing the baby and then having a meal with my midwives. They say breaking bread is a good way to release oxytocin too, to develop trust and bonding, so I had been anticipating that. But it was just part of the process of grieving the experience that I couldn't have had. Looking back on the process, I made the right decision at every step with the information I had at the time. My wife and Deborah were very good at helping me frame it that way after the baby was born, so I have not felt in any way traumatized by my birth or how it proceeded.

Everything that happened, happened in the best way it could under the circumstances. It didn't shake my foundations or anything. Becoming a mother has changed how I see the whole world but I don't think my experience changed how I see or think of birth as much as it just changed how well I understand it, and how flexible you have to be. You have your plan, and then you have what happens. It was not what I had hoped for, but it was ok. It got me to my baby.

Commentary

The Economist bases her decisions on an assessment of risk, in direct opposition to the discourse that sets home birth in opposition to the health and safety of mother and baby (for

example see Chervenak, McCullough, & Arabin, 2011). Indeed, a large, nationwide study on the outcomes of planned home birth was published during her pregnancy that demonstrated lowered rates of medical intervention at planned home births with no corresponding rise in adverse outcomes as compared to hospital births (Cheyney et al. 2014). She, like the Birth Worker, placed less emphasis on a specific location for her birth; instead, she focused on making the decisions at each juncture that would be most likely to lead to a vaginal birth, as this was the result she felt represented the lowest risk for her and her baby. The Economist is a self-professed "data hound," and, like the other individuals who shared their stories, has a high level of science and health literacy. She spent a significant amount of time and energy reading research and statistics in an effort to better understand the implications of various choices, and subsequently considered those options carefully. This ultimately helped her process the emotions that came with the change in location, as she was able to look back at each crossroads and see that she made the best move she could with what she knew and was experiencing at the time.

Within this assessment of risk, which may seem very measured and logical on the surface, was the more subjective theme of trust. Broadly speaking, we are taught in our society to trust those with degrees, especially medical degrees. We are to assume that they not only have more information at their fingertips, but that they also use it for some vague "Greater Good," even to the point that we may forget that they, too, are humans with biases and priorities of their own. The Economist, though, put her trust in data rather than degrees, and was more interested in doing her own review of the literature than in trusting a clinician simply on the basis of their diploma. Because of this, she understood the power of trusting

relationships on the birth process. When she spoke of breaking bread to release oxytocin, the Economist was referencing the pro-social effects of the hormone oxytocin on building and maintaining relationships (McClung et al. 2018; Love 2014; Leng, Meddle, and Douglas 2008; Feldman 2017). Less directly, this comment acknowledges the role that oxytocin plays in growing and birthing a baby (Blanks and Thornton 2003; Thornton, Davison, and Baylis 1988) and how the various functions of oxytocin can affect each other.

The Economist may or may not have also been aware of the other effects of trust on birth, but impacts of fear and tension on birth outcomes have been documented. This includes the decreased likelihood of perineal tearing in midwife-supported births related to physical support of the tissues as well as psycho-social support that enhances the body's ability to relax (Lindgren, Brink, and Klingberg-Allvin 2011). In a study by Lingren et al. (2011:4), one midwife shared that "when the woman is frightened, her pelvic floor tightens and is more likely to tear" (Lindgren, Brink, and Klingberg-Allvin 2011, 4). The development of trusting relationships between a birthing individual and their birth team is crucial not only to immediate and long-term emotional well-being, but also in terms of direct impacts on physical morbidity as well. This is simply one illustration of how having a team of trusted providers and support-people is a crucial part of risk assessment as it pertains to birth.

In a later conversation I had with the Economist, she explained that choosing a birth team who had a great deal of education and experience, who spent time getting to know her, and who she knew shared her values and priorities, was deliberate and played an active role in her evaluation of the risks involved in any birth, but especially in giving birth outside of a hospital environment. She knew that if something unexpected happened or if she had

questions about how to proceed with any action or intervention, they would be able to give her the information she needed. Further, if she was unable to make a decision for herself for any reason, she knew that they would make the call that most closely aligned with what they knew of her desires and values. Thus, the integrity of her physical health was ensured to the best of her ability by choosing a birth team – both at home, and later by choosing to transfer – that had the expertise to support the biological and physiological aspects of giving birth. Likewise, her emotional and mental health was supported by knowing she had a team of people in her corner should she need additional information, support, or advocacy. Although the receiving providers at the hospital were not as forthcoming with information and in some cases were antagonistic towards her original plan of a home birth, the Economist still had the support of her original birth team as well as the later addition of the RN, Beth, who were all able to mitigate the damage that might otherwise have occurred as a result of those interactions.

To explain the particular mindset required to make a risk assessment, economist Emily Oster (2019) wrote,

> I analyze data, trying to tease causality out of the relationships I study. And then I try to use that data inside some economic framework – one that thinks carefully about costs and benefits – to think about decision-making… If you want to think about [things] like an economist, you've got to start with data. (Oster 2019, xvii–xviii).

The Economist's Tale emphasizes the flexibility necessary to the decision-making process. Because an economist bases a decision on data, considering the costs and benefits of each potential option in order to determine which will bring her closest to her goal while sacrificing the least, any new information has to be incorporated into the equation which has the potential to alter the resulting decision. As noted, the Economist was less tied to a specific birth setting and more interested in making optimal decisions as each choice arose. As labor

continued, she recognized that changes in her own body or in the baby's wellbeing would indicate that a new decision-making process needed to be initiated. Whether the choice was to continue as established or to change the circumstance, new information had to mean a new decision. This continued throughout labor and birth, both at home and in the hospital, and culminated in the vaginal birth that had been the Economist's ultimate goal from the start.

The Graduate Student's Tale

I had started the first term of a new graduate program just a few weeks before I found out I was pregnant. I spent most of my pregnancy – and therefore most of my first year of graduate school – struggling with acute anxiety, compounded by unstable blood sugars. As someone who has been overweight most of my adult life, I was trying very hard to avoid gestational diabetes; unfortunately, a sweet tooth combined with pregnancy sickness made every meal a struggle. It eventually got to the point where my anxiety would spike on the days when I had a prenatal appointment because I knew they would check my blood sugar and every high reading made my home birth feel further away and less attainable. The high anxiety also began to cause blood pressure spikes which are similarly bad news, especially at the end of pregnancy.

I had already collected the stories that became the Tales shared here by the time I reached my due date, and therefore had the chance to consider their lessons and the messages they might hold for my own birth. Despite that fact, and the fact that my midwife and I discussed the possibility of transfer frequently during my pregnancy, I was still somehow unprepared. I had thought I would love being pregnant, and I didn't. I had expected that somehow I would be the exception to the statistics that show how many primips transfer from a planned home birth to the hospital. I had expected that somehow I would have more stamina and more resistance to pain than the individuals represented in those statistics. Somehow I simultaneously knew that I would transfer and was also completely blindsided by it. But at least I was following a path that had already been blazed by the women whose stories you've already read. I knew exactly where I was going and what to do when I got there.

My due date was on a Friday. I was uncomfortable and tired all the time, but there was no real sign of impending labor. Both my sisters had gone into labor and had their babies at 37 weeks and 5 days, and I was grouchy that I hadn't followed suit. My midwife, Bea, and I had made the agreement that if I hadn't gone into labor by the day after my due date, she would check my cervix and, if indicated, do what is called a 'stretch and sweep.' This is where the midwife runs a finger along the inside of the cervix and loosens the attachment of the amniotic sac and manually dilates the cervix a bit. This often has the effect of stimulating the onset of labor. I spent all of Friday looking for any sign of labor to no avail, so I saw Bea first thing in the morning on Saturday. After the stretch, I was still only dilated to two centimeters, but I was hopeful that it would prompt my body to action.

I had known Bea for years before getting pregnant. I read her book before I even came back to school and it was what inspired me to finish my undergraduate degree. After that, I knew I wanted to work with her for graduate school as well, and it was always understood between my partner and myself that she would be our midwife when we were ready to have babies. I knew she had plenty of experience both at home as well as in her articulations with hospital providers during and after transfers of care. Bea was there when my partner gave birth to our oldest daughter; hers had been a planned home birth, but we transferred to the hospital after about 18 hours of labor. The way that Bea continued to show up for us even after care was officially transferred to the hospital was never surprising, but was deeply meaningful nonetheless. I knew others who had experienced transfer with her as well, which helped me feel secure and cared for even as I contemplated giving birth somewhere other than my own home.

That evening I went to a baseball game with my family. It was a few days before Independence Day, and the local minor league team has a traditional fireworks show after the game closest to the holiday; it just happened to be that night. The stadium was packed, and I was getting claustrophobic and extremely uncomfortable so I insisted we leave early. I was in a terrible mood, and just felt like climbing out of my skin. In retrospect I should have known that this was an indication that my body was gearing up for something, but at the time I just thought I was grouchy because I wasn't in labor.

That night I was lying on the couch – I had been sleeping there for the past few months, as it was impossible for me to get comfortable in bed – with my daughter and partner asleep in the bedroom. I couldn't sleep, couldn't get comfortable, couldn't settle. Again, I probably should have known something was happening, but I just felt squirrely. Around midnight – at 11:56 p.m., to be exact – I had my first contraction. It wasn't terribly painful but it also was clearly not a simple Braxton-Hicks contraction. I got up and started walking around a bit, even doing a few squats, trying to get things moving. If I'd been smart, I would have recognized that it was the middle of the night and nothing about my labor was likely to be fast, so I should try to sleep as much as I could and get ready for active labor in the morning. That's what I would tell my doula clients, but unlike the Birth Worker, I'm not always good at taking my own advice. Instead, I was so thrilled that something was happening that I just tried to move it along as much as possible. I labored like that, walking, squatting, swaying, by myself all night. I knew it was early and didn't want to wake my partner until it was necessary, and was also relishing the ability to just focus inward and experience what was happening. At 8 the next morning, I texted my partner who was still in the bedroom with our daughter, saying "Just so you know, I've been

having contractions since midnight." I still didn't want to wake her if it wasn't necessary, but figured she should know.

Sometime a little later that morning we called the midwife and she came out to check on me. My contractions were not overly intense, and still irregular despite being fairly frequent. I would have one, then another four minutes later, then no more for ten or more minutes. Otherwise, everything looked ok so Bea left and said to call her when the contractions were closer together and lasting about a minute. We called our doula, a close friend of mine, to come over. I didn't feel like I needed her yet, but I wanted someone to be with the toddler until my in-laws could come get her.

My doula, Amira, was – and is – a dear friend. I met her in my very first class of my very first term of grad school, and she was the first person other than my partner that knew I was pregnant. We became close very quickly, and she offered to be my doula. I wasn't really sure I needed a doula since I was planning a home birth, but I took her up on her offer and I'm so glad I did. Not only was she amazing during the birth, but she became one of my biggest supporters. She helped me keep perspective on what was important and what I could let go of in school contexts, she helped remind me not to binge on too much sugar when we went for snacks between classes, and she helped me communicate with Bea when my anxiety got in the way of my ability to articulate my concerns. She also became a trusted 'auntie' to my daughter and a friend and support for my partner as well. I was lucky to have her on my birth team. The Economist said that the most important part of a birth plan is surrounding yourself with people you trust; Amira earned my trust quickly and never lost it.

I honestly don't remember a whole lot of what happened after that. I remember laboring in the bathroom with the door closed, because I liked the dark. I remember being really agitated by loud noises. And I remember locking the midwives out while I was in the middle of a contraction because they wanted to listen to the baby's heartbeat and take my blood pressure, but I didn't want to be bothered. Every interaction with anyone other than my partner was agitating and increased my anxiety.

As it got later, my contractions became more intense and painful. I labored in the shower for a while, and my doula came in to take my blood pressure. It was high; I can't remember the actual numbers but I remember it was high. I got a little mad because I was in the shower, on hands and knees, and had just had a contraction – of course it was high! But I don't remember if I actually said anything about all that. My midwife came in to talk to me about the high reading, saying that it was high enough that the state guidelines on home birth stated that it should require a transfer. I immediately began sobbing, saying I wasn't going to go, I wasn't ready yet. I protested that the reading was almost certainly falsely high given the conditions under which it was taken. Bea called a colleague to consult, and we negotiated a re-check. I took the blood pressure cuff into the other room – it was an automated one, so I could take it myself – and my partner accompanied me. I sat quietly for a minute, breathing deeply, and re-took my blood pressure.

There are only a few scenes from my labor that I remember with any sort of clarity, and this is one of them. I sat in my bedroom, and closed my eyes. I took a few deep breaths, and visualized myself as a jellyfish. I was boneless. Weightless. Buoyed by the water and drifting

with no direction or agenda. I just *was***.** The blood pressure monitor beeped and showed -- a completely normal reading.

I have no idea what time that was but I know things didn't get easier from there. I tried laboring on my side. I tried hands and knees. Everything hurt, and nothing was making a lot of progress. There was some suspicion that the baby was in a suboptimal position – maybe not direct OP [occiput posterior], but certainly not OA [occiput anterior]. Perhaps lateral, or asynclitic. The problem was that my placenta was directly on the front center of my uterus, which effectively placed a barrier between the baby and any attempted palpation. It was like trying to guess baby's position not only through a water balloon, but through a water balloon with a pillow in it. Because we suspected malpresentation, though, we tried pancake flips to encourage baby to turn on her own. I don't remember how many times we tried the full rotation, but I remember those contractions hurt worse than any others had to that point. Nothing felt good anymore.

I don't remember how aware I was during my own labor of the similarities between my experience and those of the others collected here, but there were so many common threads – especially between those of us that began labor planning to birth at home. Even the Nurse, though, who transferred before labor had even started, experienced prolonged labor, an asynclitic presentation, and stalled dilation. While presentation may or may not be a part of the equation in all or most transfers, the fact is that most intrapartum transfers occur because of prolonged labor, failure to progress, and the laboring individual's need for pain relief and rest. I had thought I might beat the odds, but it turns out I was in good company.

After a few tries, Bea and her assistant and student midwives came in to talk to my partner and me about our next steps. I had stopped dilating at around eight centimeters. Usually, the next step would be breaking the water, or artificial rupture of membranes, to encourage the baby's head to engage and stimulate the Ferguson reflex; in my case, though, the baby was still too high for that to be a safe option. The umbilical cord could get trapped beneath the baby's head causing umbilical prolapse; the pressure on the cord could cut off oxygen to the baby which would be a true emergency and would likely require a cesarean birth. Further, the baby was showing signs that she wasn't tolerating this prolonged labor well, and though my blood pressure came down every time, the repeated spikes were concerning. I finally acquiesced to the seemingly inevitable transfer.

Making the decision to transfer was such an interesting experience in itself; it was like it gave me permission to let go of the anxiety that I *might* transfer and thus to stop trying to control my birth experience. The midwives suggested I get in the shower for some pain relief while they called the hospital and brought the charting up to date so that everything would go as smoothly as possible once we got there. Typically, receiving providers don't feel that they need the in depth, subjective components of the charts that midwives often include, so putting all of the 'crucial' information that the nurses and obstetricians might be looking for on one sheet of paper for easy access would streamline the whole process. Because laboring in a car can be uncomfortable, the midwives also suggested I have a little drink, maybe a beer– it was too far into the process for the alcohol to have any effect on the baby, but might serve to slow my contractions for the duration of the transfer.

That scene is honestly the highlight of my labor. I was in the shower in the near dark, drinking a truly terrible watermelon-flavored lager, and chatting and laughing with my doula. It's what I had always envisioned the early parts of labor might be like (though probably *sans* alcohol). I certainly didn't expect it 24 hours into the process, but I'm glad I got it eventually. I stayed in the shower until we were ready to get into the cars; one of the midwives had been van camping until we called her to come to my birth, so I climbed into the back of her van where there was already a bed made. It was the first, and only, time I've ridden in the back of a van on my hands and knees while driving down the road in the middle of the night. The beer did its job, and I only had a couple of contractions on the drive. Later, I would think back to the drive and consider the juxtaposition of the transfer of bodies through space and time with the transfer of care from one provider to another. The physical transfer marked an ideological one for me, further reinforced by the shift from close, familiar, and intimate to bright and sterile with intimate strangers rather than well-known loved ones.

I had been in labor for nearly 24 hours by the time we transferred, but making the shift from home to the hospital marked a turning point in my labor. Although my blood pressures had been high for a home birth – that is, away from the technology required for fast intervention if something like pre-eclampsia became an issue – my readings were actually not remarkable in the context of a hospital birth at all; thus, Bea had not put any special emphasis on my blood pressures when calling the hospital to inform them of my impending arrival. She just let them know that I was exhausted and in need of pain relief. This served me in two major ways; the first is that it made my transfer about my comfort rather than about a medical issue, which kept hospital staff from being on high alert for potential complications, and because of

that, it also meant that I was able to transfer to a CNM rather than to an obstetrician. This in turn meant that I was able to have a birth that looked much more like the one I had planned, albeit in a different setting, rather than being pushed to have a cesarean or other instrumental birth due to a sense of urgency that may or may not have been medically necessary. My partner had also been in contact with the Nurse who was a close friend of ours and was, at the time, working in the postpartum wing of our local hospital; she was able to send a sympathetic labor and delivery nurse to work with us that night. As a result, our reception at the hospital was as smooth as is possible when showing up in the middle of the night after 24 hours of labor.

After the nurse got me checked in, the CNM who was on call that night came in to see me. She was very kind and supportive, and reminded me that just because orders were in for me to get an epidural, it didn't mean that my work was over yet. "Many women think that once the orders are in, it means they can stop working. But it'll be a while before he comes in to place it, and a little longer before it'll take its full effect. So don't stop yet, ok? Stay with it a little longer." I'm not sure what it was about those words that was so impactful, but they've stayed with me ever since. Perhaps it was simply the acknowledgement that what I was going through was perfectly normal, but is also a lot of work. I felt seen and honored in the work I was doing, even while I was being cared for in this place I had never wanted to be.

After I got the epidural, the CNM, Jess, came in to check on me. I can't remember how dilated I was, maybe eight centimeters or so, and she suggested Pitocin and an artificial rupture of membranes. I didn't want to make any decisions without Bea, so Jess said "Why don't I step out, you and your partner can talk, and you can let me know when you've decided what you want to do." My partner pulled out her cell phone and called Bea, who was asleep with the rest

of the birth team in the camper van down in the hospital parking lot. Bea recommended consenting to the AROM but foregoing the Pitocin for the time being. If the AROM would give the baby the ability to engage in my pelvis a bit more, Pitocin might be overkill but would remain an option if the AROM wasn't enough. We called Jess back in and she agreed to the plan.

When the amniotic sac broke the fluid wasn't clear; there was a little bit of meconium in the water. I was worried, knowing that meconium often signals that the baby is in distress, but Jess seemed unfazed. She said "It just means baby had her first poop already and we'll have some extra people in the room when she's born just in case she needs extra help breathing or anything." Again, I felt reassured and taken care of by this person I had never met before. I doubt I was thinking in these terms at the time, but looking back I think, "This is what smooth articulations look like!" After having been awake, anxious, and working hard for more than 24 hours, I was finally able to relax and rest.

I remember something Bea said when my partner gave birth just a few years before I did. "A home birth doesn't have to happen at home. Sometimes, when a client transfers to the hospital but is still able to keep control of the situation and is able to have the kind of birth she wants even if it's in a place she doesn't want – even if she has to have interventions she didn't plan on, but is able to make informed choices and weigh her options to make the best choice for her and her family – sometimes we call that 'a home birth in the hospital.'" Maybe that's what I got to do. I still gave birth under the care of a midwife, not an obstetrician. I had an epidural for pain relief, but I didn't have to have any other medications – the only thing in my IV was fluids. I was given all the space and time I needed to make the decisions that were right for

me, my baby, and my family. Looking back, and looking at the thread of experiences that weaves through the stories in this collection, I think that the question of models of care and of smooth or fractured articulations is the key. Certainly there are people for whom giving birth at home is the ultimate goal, but I can't help but wonder if it would be so important if they could be sure they'd be treated with the same respect and assumption of competence that comes with the midwifery model of care. What if everyone who gave birth in the hospital had all the information about every intervention or medicine they were going to have before it was administered? What if individuals didn't go into the hospital with the expectation that they had to be aggressive to be taken seriously, if they could instead assume that their wishes would be respected and followed to the extent possible? What if there weren't 'home birthers' and 'hospital birthers,' but instead just people trying to birth in the safest and gentlest way possible, whatever that looked like to them? My birth, if nothing else, illustrates that it is not location that supports a certain way of giving birth. You can have a home birth in the hospital. Home birth is not a place, it's a philosophy.You just have to have a provider that will support that, too.

After I slept for a few hours, Jess came in to check my dilation. I was fully dilated, meaning I was ready to push! The midwives and Amira came back in, and I got to work. Amira offered to put on the playlist I had made several weeks earlier, with songs like Salt'N'Pepa's *Push It,* Survivor's *Eye of the Tiger,* and of course, Johnny Cash's *Ring of Fire.* I laughed and declined, though in retrospect I wish I were able to say I'd pushed my baby out to the theme from "2001: A Space Odyssey," *The Final Countdown.* The nurses brought a mirror in so I could see the progress I made as I pushed; this turned out to be especially useful not only because it was exciting to have those first glimpses of my baby's head, but because the epidural made it

hard to know what was most effective. I couldn't feel much more than pressure – which was gratifying earlier, but was now a little frustrating – so I used the Nurse's method of pushing. I thought to myself, "What would it feel like if I were engaging these muscles? Where should I be directing my pushing?" It was delightfully effective. I visualized a flashing arrow pointing the way over my sacrum and out into the world, a beacon for the baby. After less than ninety minutes of pushing, the baby I had worked so hard for followed the arrows and made her appearance.

I can close my eyes and remember being surrounded by people, though I would be hard-pressed to say who was where. I know Amira was holding one leg, and my dear friend the Nurse was at my other side, having come off shift just as I was pushing, and she was whispering "You're so strong! You're a warrior! You're amazing!" during every contraction, every push. I was surrounded by Jess, who I later learned had given birth at home; one pregnant midwife who had just come on shift; three home birth midwives; a doula and best friend; and at least two women who had experienced transfer before me – my partner and the Nurse. When the Economist said to surround yourself with people you trust, I think this must be what she meant.

I remember two things about the immediate postpartum period: I felt her slip out and I laughed at the intense feeling of relief at having that eight-pound-thirteen-ounce baby out of my belly; then someone said "You can pick up your baby!" and as I lifted up that slippery, squishy body, I promptly burst in to tears. She had spent quite a bit of time in the birth canal, and had quite the cone head. We had hoped to do oral vitamin K rather than an injection, but she was a bit bruised and had spent enough time working to get out that we thought the injection was warranted. We declined the other common postpartum medications, and

negotiated an early release after only twelve hours observation. The Nurse got to do our discharge paperwork with us, allowing us smooth articulations on our way out as well as those we experienced on the way in. Not everything happened the way I had planned it, not by a long shot. I think in the end, though, I had a version of the birth I wanted. I had a home birth in the hospital.

Commentary

The Graduate Student's Tale offers readers the chance to bring elements of the other tales together, as I, the Student, was the only one who knew all of the other storytellers' narratives before giving birth. This position allowed me to take the lessons I had learned from each into my own experience and use that knowledge to help me craft my own transfer even as it happened. Like the Birth Worker, I had years of experience attending births in addition to the multiple degrees I had attained before giving birth myself, and I was able to use that to inform my decision-making as well as how I labored. Like the Nurse, I had some medical complications, however minor mine may have been in comparison to hers. Yet, unlike her, I was given the space and time to consider my options, to attempt to labor at home, and to fully consent to each intervention before it happened. Like the Economist, I approached my experience with a sense of choosing what risk to take and with great forethought into how much of any given risk was acceptable. None of us went into labor without having given significant thought to all of our options, resources, values, and health care needs.

As stated earlier, the majority of people planning home births in the United States hold post-secondary degrees (Cheyney et al. 2014); this suggests a level of research literacy, health literacy, and critical thought that may be higher than in the general population. While none of

these factors guarantee any specific health behavior, they may point to an ability to find and understand relevant information and the skill to apply that knowledge to their own contexts and decisions. In our cases, we were each adequately prepared to take that responsibility for our care and to become vested stakeholders in our medical and health experiences by making the best decisions we could based on the best information that was available to us.

Although each story is unique and each storyteller had her own wishes and needs going in, there are some striking similarities, even beyond the fact that every baby in this collection was asynclitic. Every one of us wanted to feel like we had some control over the situation. Childbirth is an extremely vulnerable time, both physically and emotionally, and as such it is a difficult time to be making large changes or spending intimate moments with people who may be near-strangers. When a birthing person transfers to an unplanned birth setting, we need to be given as much autonomy and control as is possible. We need to be told about each proposed intervention, its risks and its benefits, and why it is being recommended, so that we can make truly informed decisions and give informed consent. This is true even of emergency procedures, to the extent possible. I can imagine nothing scarier than experiencing an emergency during birth and not having all the information possible about what was happening with my baby and my body.

Kleinman and Benson's guide on how to elicit explanatory models (Kleinman and Benson 2006) can be useful in these situations, when a patient's expectations and needs for treatment may not only differ from that of the clinician, but also may not be readily apparent. Howard Brody, physician and bioethicist, states that: "In the case of illness, the patient's history is the major source of data, since one cannot really perform an appropriate physical exam, or

order the appropriate laboratory tests and x-rays, unless one has been guided by the patient's descriptions of his own symptoms" (Brody 1994, 80). Further, he goes on to write that "the agreement between physician and patient about the nature of the presenting problem is closely linked to a good outcome" (Brody 1994, 82). In other words, smooth articulations, where the birthing person and their birth team are not only received but are listened to and treated as equal partners, have a demonstrable effect on outcomes. Although the elicitation of a full illness narrative is not always practical or expedient, the basics can be shared and a plan for treatment negotiated so that the knowledge and priorities of all parties can be honored.

Another similarity among the stories is that each of us wanted to avoid unnecessary interventions. Whether that was because we wanted to avoid the effects on our babies, because we thought the risks were unwarranted, or because we knew that higher rates of technological intervention are associated with higher rates of postpartum depression, we each wanted to give birth without any more technology or medication than was absolutely necessary. Mary-Jo DelVecchio Good (2007) coined the term "the biotechnical embrace" to describe the way that new technologies, medical tests, or treatments are greeted with near-limitless enthusiasm for the promise of better health, decreased suffering, or longer life (DelVecchio Good 2007). Cheyney referenced this concept when she wrote that "While home birth clients are often up for a biotechnical handshake, many would eschew the full embrace" (Cheyney 2015, 37); this was certainly true of the four of us whose stories are shared here. We were able to recognize the benefits of having technology available, but we were not interested in technology for technology's sake.

Although each of us went into our pregnancies, and some of us into our labors, with the desire and expectation of avoiding technological and medical intervention, we each also recognized that we were transferring because those interventions are tools that do have an appropriate time and place for use. Most people do not transfer to the hospital with the plan to refuse any and all treatment; that would defeat the purpose of transfer. What we do expect, however, is to have the spirit of our plan honored, even if the letter of it cannot be fulfilled.

Obstetricians and nurses, on the other hand, often hold an expectation or assumption that transfer patients will refuse or resist interventions (Cheyney, Everson, and Burcher 2014). Whether this is due to cases they have heard or read about or simply an internalization of the trope of the 'home birther,' this expectation may create anxiety and tension that can then affect the articulations when a transfer of care actually occurs. When stereotypes are recirculated and perpetuated, the assumption continues and leads to fractured articulations where none of the parties involved feel satisfied with the outcome, regardless of clinical measures of safety such as a live and uninfected mother and baby. The stories in this collection emphasize the view that medical and technological intervention is not seen by all community birthers as inherently evil or even as unwanted; many of us simply see it as not always necessary. All of the storytellers here noted that, although they struggled to make sense of the implications of each intervention during a fraught and vulnerable time, they recognized that these were the situations in which intervention was warranted.

Obstetricians, nurses, and Certified Nurse Midwives who receive home-to-hospital transfers might benefit from understanding that planning a home birth does not represent a rejection of modern medicine or the training and care that these clinicians strive so hard to

provide. Instead, it simply signifies a perception that birth does not always need medical intervention, alongside a desire to avoid the medicalization of the process *until a higher level of care becomes needed*. The rejection of the biomedical model and the obstetric "gaze" (Foucault and Sheridan 1994), a socially-constructed view of the birthing body as fundamentally in need of management and repair, is not synonymous with a rejection of all medical intervention. Once a transfer has been initiated, the patient and her care team have determined that more care is warranted, thus rendering baseless the perception of the transfer patient as anti-technology or anti-intervention. This is further reified in the acknowledgment that, while obstetricians can very easily do their jobs without midwives, community midwives "cannot provide safe, effective care without a reliable system of medical backup" (Cheyney, Everson, and Burcher 2014, 449). Community midwives know that they cannot treat every complication; unlike the medical model or the biomedical gaze, however, they do not see pregnancy and birth as complications in themselves.

One final place of overlap between the storytellers is that although we occupied different social locations, we all held an amount of social privilege that likely had an impact on the way our stories played out and how we approached each situation. We all had stable housing and knew where to expect our next meal. Given that the largest demographic of people planning home births in the United States is white, middle and upper class women with college degrees (Cheyney et al. 2014; Boucher et al. 2009) it is perhaps unsurprising that this collection of stories largely represents that group. However, it is important to remember that these stories are not intended to represent the stories of any group at large, and will certainly

differ from the stories of more socially marginalized people who plan a home birth but then choose or require a higher level of care.

I found out only recently that the Economist's birth had an impact on mine even more directly than the simple influence of her story on my own thinking. The obstetricians who were involved in the Economist's story were the last two holdouts standing against the implementation of a partnership between the local community midwives and the hospital, which would improve the integration of midwives into the system by offering the midwife-to-midwife transfer that I experienced and facilitating those smooth articulations that are so important to quality care. After those physicians had the opportunity to be a part of a transfer themselves and saw how simple the needs were in most cases – an epidural and some Pitocin, things that are nearly ubiquitous in vaginal births in the hospital! – they realized that blocking the policy was not protecting anyone. They changed their stance, and shortly thereafter the hospital adopted the midwife-to-midwife transfer plan that allows non-emergency transfers to be received by CNMs instead of obstetricians. The agreement stipulates that those planning a home birth establish care with the hospital midwifery practice at a single visit in the third trimester. The practice is then on call for the client if they are needed for any reason.

The Birth Worker was aware of the socio-political implications of her transfer, but the direct impact that the Economist's birth had on all local transfers that came after hers suggests that every transfer has the potential to be a political act in ways that may not be predicted or even understood until long after the fact. Although transfer can be difficult, even traumatic, to someone who identifies strongly with home birthers as their community, it is only by crossing those ideological borders that bridges between the factions can be built.

Conclusion

I collected these stories in the winter of 2016, when I was about four months pregnant and halfway through my first year of a graduate program. My partner had given birth to our oldest just over a year earlier – a planned home birth that ended in a transfer to the hospital. As I had been studying birth, and home birth specifically, for several years by then, I knew that home birth is a safe and reasonable option for individuals with healthy, medically uncomplicated pregnancies (Cheyney et al. 2014), but also knew that given my medical history and physical fitness, I was at moderate rather than low risk. I still wanted to plan a home birth, but also recognized that transfer was a very real possibility. Working on this project was not only an academic exercise, but also a step towards finding resolution between the birth that I wanted and planned, and the birth that I suspected was in store. Included in these mental exercises were deliberations on cost to my family and to my global and local communities, evaluations of risk to the immediate and long-term health of myself and my baby, and considerations of the emotional wellbeing of my older child. One piece often left out of Petersen's responsible health care consumer archetype is that we each hold a responsibility to ourselves, not simply to the institutions in which we are invested. Stakeholders are invested in a company only insofar as it is profitable, whether financially or through some personal satisfaction. Why then should health care consumers be expected to negate their personal wants, needs, and values in favor of the policies and practices of the dominant medical institution?

Petersen writes:

> "The neoliberal strategy is to compel actors to express their agency in line with official goals and to subject actors to penalties for error or for failure to comply. Individuals are compelled to choose among an array of options, which present constrained possibilities for action… Those who seek to operate outside of predetermined lines of action risk being labelled irresponsible or as troublemakers and suffering financial penalty of some kind or being denied access to services or advice. In other words, the range of possible ethical actions is always circumscribed (although not determined) by the imperatives of rule" (Petersen 2003, 195).

To lift up one set of actions, behaviors, or beliefs as valid, right, and true, while simultaneously sweeping all others to the margins and labelling them 'crazy,' 'unsafe,' or 'fringe' is a powerful form of social control; it is also highly socially constructed and the 'rules' for what is normative versus deviant vary based on gender, race, and other social identities (Thompson 2010; Jetten and Hornsey 2013; Blanton, Stuart, and Van den Eijnden 2001). Philosopher and Marxist thinker Antonio Gramsci conceptualized hegemony as "a system of legitimization in which individuals' actions are framed within those preordained forms of conduct permitted by the powers that be" (Filippini 2016, 18). In other words, it is a system of control that works by defining cultural and societal norms to the point that they become common sense and require no explanation or defense; indeed, to opt out of those norms is considered deviant.

The specific reasons that some behaviors are considered valid and others absurd matter less than the sheer efficacy of hegemony; once a critical mass has been persuaded, rule by cultural consent has been achieved and all others must either comply or face the social and cultural consequences (Eidelman and Biernat 2003; Petersen 2003). Likewise, the reasons for uplifting hospital birth under the supervision of a trained surgeon, while ostracizing those who instead opt to maintain their sense of control and agency by choosing to birth outside of the "constrained possibilities for action" (Petersen 2003, 195) are perhaps less important than the

fact that the choice to plan to give birth outside of the hospital is indeed seen as odd or at least unusual, if not outright dangerous and ill-informed, despite the fact that it was the dominant method of birth for the majority of Western history (Feldhusen 2000).

It is this broad marginalization of a given choice, regardless of the conditions under which it is chosen, that leads to that drive for home birthers to identify as such. Rather than hiding in shame or being browbeaten into compliance with the 'norm,' home birthers join forces in order to feel that they have power as part of a community. Salazar and Abrams (2005) write that "members of in-groups tend to identify strongly with other members of their own group while separating themselves from others" and go on to describe the "anger, often expressed outwardly, against injustice perpetrated against self and members of one's own group" (Salazar and Salazar 2005, 49–52) that is often expressed by members of marginalized groups. This anger and defensive separation then can be problematic when the time comes to make the shift from home to hospital before or during childbirth, as it adds an extra layer of psychological and emotional turmoil to be overcome during an already difficult and vulnerable time.

Just as the choice to plan a home birth is marginalized, as are the home birthers themselves, so too can they be normalized and re-centered. As stories of planned home birth circulate, whether completed in the home or ending at the hospital after a transfer of care, they can begin to lose their shock factor and sensational thrill and become mundane. As real faces are put to the tropes of the hippie home birther or the Type A parent who refuses to submit to a doctor, the stereotypes may begin melting away to reveal the next door neighbor, the straight-laced economist you know, or the graduate student you met on campus, thus re-

opening the possibility of planned community birth as a reasonable and legitimate option. This can only happen, however, if the divide between 'home birthers' and 'hospital birthers' is softened. As long as the decision to plan a home birth or a hospital birth is internalized as a strict either/or binary, it will be difficult to find the common ground needed to see that these are simply choices made, not once and forever but continuously as contexts change, rather than inherent differences that stand between individuals or communities. This is, ultimately, the lesson that comes from this project: Not that providers should perform a certain series of actions or espouse one model of care over another, but simply that the binaries do not hold up in practice and, in fact, cause more harm than good.

The stories shared here are all true, but do not claim to hold any truth beyond that of the lives they explore. Yet what else is Anthropology as a field than the exploration of human lives? The American Anthropological Association states:

> "Anthropologists want to listen to all voices and viewpoints in order to understand how societies vary and what they have in common… They try to understand the perspectives, practices, and social organization of other groups whose values and lifeways may be very different from their own. The knowledge they gain can enrich human understanding on a broader level" ("What Is Anthropology? - Advance Your Career" n.d.).

Brody writes that the purpose of the medical humanities is "to make a difference in the world of practice, and to do so guided by wisdom and virtue" (Brody 2011, 6). He goes on to write that "narratives remind us that the conceptions of the humanities are linked to ways of living our lives and of addressing problems in the real world" (Brody 2011, 7). These stories, then, are an attempt to help the reader understand these lives, and perhaps by extension, the thoughts, feelings, and decision-making processes of others who transfer to the hospital from a planned home birth. In doing so, we may then begin to better comprehend the problems of

fractured articulations and the great divide between ‘home birthers’ and ‘hospital birthers’ not as two opposing sides, but as people trying to make the best decisions for themselves and their families given the information and resources they have available. Transfers blur the lines between home birth and hospital birth and between technocractic and holistic models of care, offering a way to see a bridge where once there was a wall.

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