Homebirth Transfers in the United States: Narratives of Risk, Fear, and Mutual Accommodation

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Abstract

The purpose of this study was to explore the contested space of home-to-hospital transfers that occur during labor or in the immediate postpartum period, as a means of identifying the mechanisms that maintain philosophical and practice divides between homebirth midwives and hospital-based clinicians in the United States. Using data collected from open-ended, semistructured interviews, participant observation, and reciprocal ethnography, we identified six key themes—three from each provider type. Collectively, providers’ narratives illuminate the central stressors that characterize home-to-hospital transfers, and from these, we identify three larger sociopolitical mechanisms that we argue are functioning to maintain fractured articulations at the time of transfer. These mechanisms impede efficient and mutually respectful interactions and can result in costly delays. However, they also contain the seeds of possible solutions, and thus are important starting points for developing an integrated maternity system premised on mutual accommodation and seamless articulations across all delivery locations.

Keywords

America, North; childbirth; health care, interprofessional; midwifery; perinatal health; risk

For Mother’s Day 2011, Amnesty International released a report entitled “Deadly Delivery: The Maternal Health Care Crisis in the USA—One Year Update,” designed to call global attention to the dangers of giving birth in the wealthiest country on earth (Amnesty International, 2011). Although the United States spends more than any other nation on health care (almost half of all of the world’s health care dollars), with one of the largest portions of that spending ($98 billion) going toward the provision of maternity care, the United States currently ranks 47th in the world for maternal mortality and 51st for deaths occurring during the first year of life (Central Intelligence Agency [CIA], 2012; World Health Organization [WHO], 2012). Critics differentially blame maternal obesity (Vinayagam & Chandrakaran, 2012), poverty (Nagahawatte & Goldenberg, 2008), institutionalized racism (Domínguez, 2008), prematurity (Callaghan, MacDorman, Rasmussen, Qin, & Lackritz, 2006), advanced maternal age (Delbaere et al., 2007), rising rates of cesarean section, and other, often unnecessary and invasive medical procedures (Blanchette, 2011) for high costs and poorer-than-expected outcomes.

At the heart of discussions over how best to improve maternal and infant health in the United States stands the place-of-birth debate (Sandall, McCandish, & Brick, 2012)—a series of highly contentious discourses about the relative safety of home, birth center, and hospital delivery; the efficacy of obstetricians and midwives as primary maternity providers; and the ethics of a woman’s right to choose where and with whom she gives birth (Bogdan-Lovis, de Vries, & de Vries, 2013; Kingma, 2011). Although several high-income nations, including the Netherlands, Great Britain, New Zealand, Australia, and Canada (Malott, Murray Davis, McDonald, & Hutton, 2009), have embraced home and birth center delivery with midwives as a strategy for increasing access to care, improving outcomes, and reducing costs, clinicians and researchers in the United States remain divided, and particularly so around birth at home.

MacDorman, Declercq, and Mathews (2013) reported that in the United States, approximately 1% of all births occur outside of the hospital in women’s homes and in birth centers that are not affiliated with hospitals, and that these births are attended primarily by direct-entry midwives (DEMs), described in more detail below. Of the

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1.18% of U.S. births occurring outside of the hospital in 2010, approximately 66% (31,500) were home births. Although a small proportion of total births in the United States, home births are on the rise. After a steady decline between 1990 and 2004, home births increased by 41% between 2004 and 2010, up from 0.56% to 0.79%, with 10% of this increase occurring between 2009 and 2010 (MacDorman, Decerlcq, & Mathews, 2013). By comparison, in Great Britain and the Netherlands, 8% and 29% of women, respectively, give birth outside of an obstetric unit (Brocklehurst et al., 2011; Hendrix, Evers, Basten, Nijhuis, & Severens, 2009).

The U.S. trend in home delivery has increased the need for collaboration between obstetricians and homebirth midwives, as studies indicate that between 10% and 40% of women who go into labor intending to deliver at home will end up transferring to the hospital as a result of complications that arise in labor or in the immediate postpartum period (Cheyney et al., 2014; Olsen & Clausen, 2012). Compulsory interprofessional interactions that occur during intra- and postpartum transfers from home to hospital bring ascendant, biomedical knowledge systems into contact with the contested and marginalized knowledge systems of out-of-hospital midwifery. The interactions that result can function either to entrench divisions between provider types and models of care, or to provide the opportunity for what anthropologist Bridgette Jordan (1993) called mutual accommodation—a form of interprofessional and cross-cultural collaboration characterized by negotiation and shared respect between practitioners and their respective epistemologies.

The purpose of this study was to explore the contested space of home-to-hospital transfers that occur during labor or in the immediate postpartum period as a means of identifying the mechanisms that maintain philosophical and practice divisions between provider types, as well as those that might improve interprofessional communication across differences in worldviews and approaches. Using data collected from open-ended semistructured interviews, extensive participant observation, and reciprocal ethnography, we examined physicians’ and midwives’ transfer narratives and analyzed them for recurring themes. We used a modified grounded theory approach (Charmaz, 2006) to interpret the perspectives of home- and hospital-based providers and to identify three key mechanisms that we argue are functioning to perpetuate the chasm between midwifery and more medicalized models of birthing care.

**Study Background: The Place-of-Birth Debate in the United States**

In the United States there are two general categories of midwives. The first, certified nurse-midwives (CNMs), are registered nurses who have completed additional educational requirements and clinical training specific to midwifery. They are legal practitioners in all 50 states and attend approximately 7% of all births in the United States (American College of Nurse Midwives [ACNM], 2011; Martin et al., 2012). CNMs practice almost exclusively in hospitals and birth centers, although a small percentage (3.7% to 6.4%) also attend home deliveries when their malpractice insurance providers and hospital/physician backups do not strictly prohibit births outside of the hospital (ACNM, 2012; Vedam, 2009).

A second category of midwives, direct-entry midwives, choose to bypass nursing school and enter directly into midwifery training through one or more of several educational routes. Training options include accredited or unaccredited schools, many with distance-learning programs, apprenticeships with senior midwives, and internships at high-volume birth centers (Cheyney, 2008). Direct-entry midwifery is premised on the belief that low-risk births are generally not medical events, and many proponents see nursing training as irrelevant to home or birth center practice at best, and as a potential method of medical indoctrination at worst (Cheyney, 2011).

Direct-entry midwives work at home and in freestanding birth centers and do not, as a rule, have hospital privileges in the United States. As a result, they occupy a highly marginalized position vis-à-vis the obstetric hierarchy and are not acknowledged as legitimate providers by the American College of Obstetricians and Gynecologists (ACOG, 2011; Declercq, Devries, Viisainen, Salvesen, & Wrede, 2001).

DEMs do not practice under the supervision of a physician in most states, nor do they typically have formalized, back-up relationships with obstetricians who are willing to assist them with home-to-hospital transfers or with prenatal consultations (Cheyney, 2010). When DEMs transfer care because a previously low-risk client is developing complications, they commonly transport to whoever is on call for “undoctored” patients, or those individuals who arrive at the hospital with no record of prenatal care.

Direct-entry midwives, formerly referred to as “lay” midwives, began the process of professionalization in the 1980s and may now become certified professional midwives (CPMs) via the North American Registry of Midwives’ (NARM) examination: “The Certified Professional Midwife credential, issued by NARM, is accredited by the National Commission for Certifying Agencies (NCCA), the accrediting body of the Institute for Credentialing Excellence (ICE, formerly NOCA)” (NARM, 2012). However, even with this credential, certified DEMs continue to occupy a controversial space relative to culturally sanctioned obstetrics in the United States. In 27 states, CPMs are legally recognized or licensed (NARM). In the remaining 23 states plus the
District of Columbia, CPMs are not legally protected; penalties for practice range from misdemeanor to Class C felony (NARM).

In 2001, the American Public Health Association (APHA) called for increased access to out-of-hospital maternity care services using legally regulated and nationally certified DEMs (APHA, 2001). The WHO, ACNM, and the National Perinatal Association also support home and birth center deliveries for low-risk women (MacDorman, Declercq, & Mathews, 2011). However, at the time of this writing, ACOG remains opposed to homebirth and especially to those attended by CPMs. ACOG’s 2011 committee opinion on planned homebirth (ACOG, 2011) concludes that because of insufficient research and variability in CPM training, education, and legal status, they do not support the provision of care by “lay” or certified professional midwives—the midwives who are currently attending the highest percentage of home deliveries in the United States (MacDorman, Mathews, & Declercq, 2012). At the same time, the ACOG committee opinion acknowledges that women have the right to make medically informed decisions about place of delivery and that safety is tied to the availability of timely transfer and an existing arrangement with a hospital for such transfers.

Herein lies the conundrum that motivated this research: How do individual obstetricians and midwives negotiate home-to-hospital transfers against a political and cultural backdrop that upholds a woman’s right to choose homebirth and acknowledges the need for coordinated home-to-hospital transfers, while simultaneously condemning the practice and its primary practitioners? We began this study, thus, not with the question of whether women should be allowed to give birth at home with midwives, but rather with the following: Given that home and birth center births with certified or licensed DEMs are legal and increasingly popular options in many states, how can the tools of medical anthropology and interprofessional communication be applied to help smooth articulations across a spectrum of care providers whose approaches to maternity care are acknowledged to be quite different?

**Methods**

To examine this question, we employed a multisite ethnographic approach in hopes of capturing any cross-county or cross-hospital variation in working relationships between midwives and physicians. We began by attending mixed stakeholder meetings in three research counties in the Pacific Northwest of the United States as a means of identifying the central questions and key concerns marking home-to-hospital transfers. We selected this region of the United States because of the long history of legal practice for DEMs and the relatively broad scope of practice supported by state administrative rules. In addition, our positions as a medical anthropologist and CPM (Cheyney), medical anthropologist and birth doula (Everson), and collaborating obstetrician and medical ethicist (Burcher) facilitated unprecedented access to midwife–physician interactions, allowing for direct observation of more than 50 home-to-hospital transfers in four different hospitals.

Our approach included participant observation (DeWalt & DeWalt, 2011) at actual deliveries as well as participation in community meetings, and thus we often had the opportunity to attend a delivery as midwife, doula, or doctor and as researcher, and then later, during postpartum visits or mixed provider gatherings, to listen to the retellings and ongoing interpretations of transfer experiences. This methodology enabled us to observe the construction of what Wirtz (2007) has called “telling moments”—a form of reflective discourse that includes both the noteworthy moments of the experiences themselves and the “reflective discourses” that come later as participants evaluate, critique, compare, and think through their experiences. The “processing” of transfer narratives as telling moments, combined with participant observation, enabled us to see not only how transfers were experienced in the moment, but also how subsequent narrations played a role in ongoing and dynamic meaning making for providers. Collectively, this experiential and observational phase allowed us to identify some preliminary analytic categories that could be explored in more detail during interviews.

After receiving institutional review board approval for the ethical and noncoercive treatment of participants, we sent recruitment letters to all practicing midwives and physicians in the research counties, informing them of the study and requesting participation in semistructured, open-ended interviews (Creswell, 1998). A voluntary sample of homebirth midwives (n = 24) and hospital-based practitioners (obstetricians, CNMs, perinatologists, and general practitioner; n = 16) agreed to be interviewed between 2007 and 2012. After describing the aims of the project and ensuring that informed consent was obtained, we began interviews by asking participants to tell us the story of one of their more memorable transfers, encouraging them to elaborate on how effectively or ineffectively they felt they were able to communicate with the collaborating provider. We also asked them to situate their experiences relative to the range of their interactions working with midwives or physicians, and prompted them to identify the characteristics of positive or collaborative transfers as opposed to those characterized by animosity or disrespect. We concluded interviews by asking midwives and physicians what they needed most from their referring or receiving provider during home-to-hospital transfers.

Participant observation notes and audiorecorded interview texts were then transcribed into Word documents.
and analyzed independently for recurring themes/analytic categories by the first and second authors. This process involved inductive or open coding—an approach to data analysis common to grounded theory whereby en vivo codes or emic themes are allowed to “emerge” via a close study of interview transcripts as texts (Charmaz, 2006; Creswell, 1998; Glaser & Strauss, 1967). To evaluate intercoder reliability (Bernard, 2006), the first and second authors generated and compared lists of common theoretical categories and then discussed and refined these during a collective process of memo writing that identified relationships among themes (Glaser & Strauss; Strauss & Corbin, 1990). During this process, we continually returned to the data to check models against narrative content, paying close attention to counterexamples or negative cases where a transfer narrative diverged from a common model or theme.

Because midwives were far more likely to volunteer for interviews, we quickly achieved concept saturation via theoretical sampling (Charmaz, 2006; Glaser, 2001). Although the individual details of each transfer narrative were highly varied and client- or patient specific, larger, recurring, conceptual themes, such as those related to the power dynamics of transfers, were considered “saturated” when no new data informing the preliminary analytic categories were emerging despite continued interviewing. Conversely, although dozens of physicians were willing to share transfer narratives over the course of everyday professional interactions, far fewer responded to requests for formal, audiorecorded interviews. Although informal conversations with a variety of providers certainly influenced our interpretations, we quote only individuals who agreed to formal interviews and signed consent documents. Concept saturation for hospital providers’ perspectives was not achieved until the reciprocal ethnography phase of this study, when many more providers were willing to critique our work. Six recurring themes emerged from home- and hospital-based provider narratives and were refined via consultation with the third author.

The final stage of the project involved making a summary of findings available to perinatal task force and study participants and inviting feedback; more than 50 individuals (split roughly evenly between provider groups) provided us with comments and critiques. This process of member checking (Charmaz, 2006), or reciprocal ethnography (Lawless, 1992), led to further elaboration and refinement of key themes initially identified during interviews. Perhaps most importantly, during this phase of the project, participants elaborated on how differences in practice styles and birthing perspectives between provider types might be bridged. In the pages that follow, we elaborate on the six interview themes that emerged (three from physicians, three from midwives) and provide a discussion of three key sociopolitical mechanisms that we argue are functioning to prevent smooth articulations between home- and hospital-based maternity providers. We conclude with four specific recommendations (two from physicians, two from midwives) for improving collaboration across the spectrum of maternity providers.

**Results: Providing Care Across the Home/Hospital Divide**

Qualitative analysis of interview and participant observation data indicates that as the cultural opposites of home and hospital care sustain intimate and often emotionally charged contact with one another during intra- and postpartum transfers, the potential for open hostility, uneasy tolerance, or collaborative acceptance is generated. The themes that emerged from care providers’ narratives indicate deeply conflicting perceptions of risk and of the larger models of birthing care that inform risk designations. These, we argue, are essential for understanding, and eventually transcending, the home/hospital divide (DeVries, Benoit, van Teijlingen, & Wrede, 2001).

**Hospital-Based Providers’ Narratives**

Interviews with hospital-based providers revealed three key themes that differed qualitatively from those emerging from midwives’ narratives: (a) the belief that home delivery is substantially more dangerous than current studies suggest; (b) the experiences of fear and frustration generated when physicians are forced to assume the risk of caring for another provider’s patient; and (c) challenges related to charting and interprofessional communication.

**Homebirth as dangerous.** The first theme—the belief that home delivery is more dangerous than studies indicate—was widely shared by hospital-based practitioners who, with few exceptions, expressed the view that birth is safest when it unfolds in the hospital. Specifically, physicians described the dangers of homebirth as emanating from two main sources: midwives attempting too many “high-risk” births at home and substandard educational requirements for DEMs. For example, whereas one physician argued that low-risk women should be able to choose a home delivery with a well-trained midwife, he was careful to stress his concern that local midwives were caring for too many high-risk patients:

My point is not so much that high-risk women can’t ever have homebirths, but I’m concerned that midwives might not be giving the appropriate extra care. Like for some VBACs [vaginal births after cesarean]. In order to reduce
the risk of a uterine rupture, some assessment of fetal size such as an ultrasound might be appropriate. It doesn’t seem like all midwives are doing that."

The perceived prevalence and mismanagement of higher-risk patients, he argued, fuels discord between midwives and doctors and makes hospital practitioners skeptical of the data on home delivery. He said of his colleagues, “When they hear that homebirth is relatively safe, they just don’t believe it because they all know of cases where a mother or baby has transported and they were in danger.” The findings just don’t fit with their experiences.” Although all of the hospital providers who participated in the interviews and reciprocal ethnography phases agreed that the vast majority of home-to-hospital transfers were nonemergent, they remained deeply influenced and angered by the few emergencies they had either experienced or heard of through the “hospital grapevine.” Being forced to take over these cases, or even thinking about having to do so, produced a fear and animosity that was not easily assuaged, even by a positive outcome.

Another physician, in discussing his belief that midwives assist too many high-risk women at home, argued, “How can obstetricians be expected to be nice and respectful to homebirth midwives when they are forced to clean up their messes, when they have to take care of a mother and the baby dies?” Even when deaths do not occur and the ultimate outcomes are positive, concerns are still evident. One hospital-based certified nurse-midwife asserted,

> It is true that few transports are emergencies, but what really frustrates me is what I would call mismanagement. You know, the water has been broken for three days, or she’s been dilated to six centimeters for twelve hours. That’s not an emergency, but it’s also not good care! Why gamble with high-risk situations?

Echoing the concerns of her colleague, she continued,

> It is just impossible for us to believe that homebirth is safe because we have seen all the times when it has not been. It makes us skeptical of the literature. We’re living it, and we don’t see it as safe.

Because perinatal deaths were very uncommon at the three research sites, we were able to talk to only two individuals who had personally attended a transfer that resulted in the death or severe compromise of a baby. Nonetheless, all hospital-based practitioners discussed this as their primary concern related to collaboration, and several tied their perception of homebirth as excessively dangerous to what we have called the “you-never-know-what-you-are-going-to-get” argument. Physicians commonly discussed their range of experiences over the years from “homebirth midwives who are very experienced and well trained and feel no different from our CNM colleagues” to those who had “no formal training and are clearly incompetent.” As one physician described it,

> I acknowledge that there are also bad doctors; however, because we work within institutions with quality assurance and quality improvement protocols and clear standards around peer review, providers with poor outcomes are held accountable. I don’t see that kind of accountability within the community of homebirth midwives here. Poorly trained midwives keep practicing and keep transporting to us. Also because our education is more standardized, you are less likely to see the wide range in skills and training in an OB [obstetrician] or CNM that I have seen in CPMs. . . . We are skeptical about collaboration and see homebirth as dangerous because we never know what we are going to get during a transport.

These concerns echo ACOG’s position statement, which links their opposition to homebirth to the “tremendous” variability in educational and regulatory standards for CPMs and lay midwives across the United States (ACOG, 2011). Similarly, DiVenere (2012) argued that collaboration between home and hospital providers is currently too risky because “many CPMs have no formal academic education or medical training, and their requirements fall short of internationally established standards for midwives and traditional birth attendants” (p. 25). Although this final point is debatable (NARM, 2012), it nonetheless rather succinctly captures a recurring sentiment: Regardless of what large-scale studies suggest regarding perinatal outcomes, homebirth, as hospital providers are compelled to engage it, feels dangerous.

**Fear of assuming care.** The second theme—fear of inheriting a patient with a serious or life-threatening complication and of the associated transfer of risk to the physician—was discussed in all hospital practitioners’ interviews. Fear of assuming care was also evident in many of the transfers that the study team participated in. Physicians expressed concern over what they worried were preventable deaths in high-risk homebirth clientele and bemoaned the risk they were forced to assume when midwives transported what were commonly called “train wreck” births. One obstetrician said, “I’m getting older, and I can’t retire because I’m worried about these home-borne babies. Who is going to be there to help these babies?” Another physician explained,

> Imagine our perspective. This woman comes in with her midwife after a failed homebirth. We’re out in the hall arguing about who is going to go in there. There is a lot of risk involved for us. Plus, we know we are likely to have a
hostile interaction or a noncompliant patient. It’s not something we’re going to look forward to.

All of the DEMs who participated in interviews cited this problem as well, and offered empathy for how physicians might experience transfers. One said,

During a transport, you can tell they [the doctors] are really fearful. They’re afraid because no one knows what’s going on, and they always have litigation hanging over their heads like a dark cloud. . . . There isn’t any mal-intent. They are just so out of their comfort zones, and they’re scared that homebirthers are going to refuse procedures because they’re so “pro natural birth.”

Another DEM explained, “We wouldn’t want that either, to have to care for someone we’ve never met who may or may not be in crisis, knowing the family doesn’t want to be there [the hospital].” Both sides openly recognized that transfers place midwives and physicians in vulnerable positions precisely when working together and communicating across differences are essential to positive outcomes. Short of a complete overhaul of the United States medicolegal system, however, there was little agreement on how best to rectify this specific problem.

During the reciprocal ethnography phase, several hospital-based providers elaborated on this theme, describing the source of fear as only partially related to liability. One hospital-based CNM said,

The biggest fear is that something bad will happen to a mother or baby and you will have to carry that. . . . During a transport, we get exposed to practices we are not comfortable with, like women declining antibiotics for group B strep or not wanting a baby to have vitamin K administered. In our typical patient base, these things are declined relatively infrequently. What we are used to is what we are most comfortable with. It is scary to work outside our comfort zone.

Another asserted, “Yes, liability is always an underlying concern. But really, in practice, we are more afraid of peer review.” These points are important, because many of the homebirth participants assumed that all fear encountered in the hospital stemmed from concerns about being sued. Receiving providers were careful to note that fear of a bad outcome and accountability to one’s peers were actually larger, day-to-day concerns.

Charting and interprofessional communication challenges. To complicate the fears cited in the second theme, hospital-based providers discussed a third concern: poor charting and “argumentative” or “contentious” personalities that combine to increase risk by exacerbating already tense situations. All hospital-based participants stressed the difficulty they had working with some homebirth midwives, citing confusing or poor charting that included “a whole bunch of psychosocial stuff that we don’t care about, like her diet in the first trimester or how the women in her family have given birth.” Another physician said, “Everyone uses different charts and we’re getting so used to electronic charting now, you can’t find anything that makes sense to you, and meanwhile this mother and baby need help. It’s frustrating.” A hospital-based CNM who also had experience working in a birth center added, “When you have to jump through forty pages of nonmedical information to get to pertinent clinical details, it really increases the stress level.”

Participants described this challenge around charting as connected to larger communication problems that stemmed from cultural differences that included dissimilarities in terminology, valuing of psychosocial information, charting techniques, and ways of debriefing about the history of care up until the point of transport. Add to this the “difficult,” “defensive,” or “antagonistic” personalities of some midwives, as perceived by some physicians, and it is not surprising that many hospital providers were anxious about assisting with transfers. As midwives advocated for options for their clients, physicians reported feeling “put on the defensive” and “attacked.” One doctor explained:

They come in for our help and then they act like they are trying to protect the patient from us. That is insulting! We’re there to help, and they act like we’re out to [cesarean] section every woman just to make our lives easier.

Another said in reference to homebirth providers in his community,

The simplest question can be interpreted as an insult. Many are fine and collegial during a transport, but we are afraid of those few that have a reputation for challenging you on every point and encouraging their clients to decline procedures. There are some midwives that no one wants to work with.

This distinguishing between “good” and “bad” midwives was a common theme, and during the reciprocal ethnography phase, one CNM observed,

The “good” midwife “bad” midwife thing really makes a difference because the “good” midwives tend to be treated with respect, and that generates more respectful and collaborative interactions. A “bad” midwife has one negative transport and that is everything. Her reputation precedes her, and all future interactions begin on the defensive. It can become a vicious cycle.

When asked if they had ever participated in a positive home-to-hospital transfer, all of the hospital providers
stated that, in fact, most were positive and that many midwives were excellent charters and communicators. They appreciated that some also did “an excellent job of preparing their patients for the hospital,” which helped to “make mothers more compliant.” Although hospital-based participants agreed that the majority of transports were amicable and nonemergent, all were heavily influenced by those they perceived as hostile or frightening and, unless specifically prompted, were significantly more likely to discuss negative experiences with DEMs. This was true even when a provider had never personally experienced a hostile transfer. Even the possibility that they could “get blamed for someone else’s bad decisions” was enough to generate fear, frustration, and discourses of mistrust or outrage aimed at DEMs and at homebirth as a legal option.

Conversely, midwives asserted that during transfers, most interactions with medical staff were friendly and supportive, even citing instances in which physicians allowed them to continue to participate in a client’s care after transport. Although all also shared stories of “difficult,” “bad,” or “humiliating” transfers, when physicians insulted or mocked them in front of their clients, midwives were much more likely to stress the collaborative model of care they strove for and sometimes achieved. This might be borne of necessity; although most obstetricians in the United States can envision a system without homebirth midwives, DEMs cannot provide safe, effective care without a reliable system of medical backup.

**Homebirth Midwives’ Narratives**

Midwives’ discussions of risk assessment and transfer power dynamics revolved around three key themes reflecting views of pregnancy and risk that differed from their hospital colleagues: (a) the defense of more holistic and conegotiated constructs of risk in midwifery models of care; (b) physicians’ tendencies to judge DEMs by “the exception, rather than the rule”; and (c) the failure of physicians to take responsibility for their roles in poor state and national maternal–child health outcomes.

**Holistic and conegotiated risk assessment.** The first theme—the defense of holistic and conegotiated risk assessment—was discussed by every DEM interviewed as one of the core values of the midwifery model of care (Rooks, 1999). One participant said,

> The midwifery model of care is about acknowledging more than just clinical risk. It’s about the whole person. . . . There are other kinds of risk. There is psychosocial risk, the risk of unnecessary procedures, the risk of having to parent from a position of victimization and regret. Does that matter? We think it should.

Several midwives discussed this theme specifically in relationship to vaginal birth after cesarean (VBAC), explaining that the risk of uterine rupture is not the only risk that women negotiate when choosing a delivery place for an attempted VBAC. One midwife described what she called “holistic risk identification” this way:

> Imagine the doctor keeps saying, “You have a one in two hundred chance of [uterine] rupture.” They are thinking this mom cannot go for a homebirth because her uterus could rupture. Period. Decision made. But the mom is thinking, “Yes, I could rupture. But if I go to the hospital, I could get another cesarean, and what I really need is someone who believes in me and is invested in giving me the best possible chance for a successful VBAC, because I felt really traumatized last time.”

Midwives also discussed how differences in the clientele they serve fuel the need for shared decision making, power sharing, and more holistic risk assessment. One DEM said,

> You know homebirthers. They are not typically people who are just told what to do. They are people who wear shirts that say, “Birth: Have it your way.” . . . They want information so they can filter that information through their own values and needs and come up with their own decisions. We don’t have full power over them.

Another DEM elaborated,

> Some women will choose a higher-risk birth at home before agreeing to go in because they know a trip to the hospital or just starting the birth there, like for a breech baby or a greater-than-four thousand-gram baby, will likely mean a cesarean. Do you see how this is a problem? The hospital gives women fewer options, which makes some women choose a higher-risk birth at home, and then if we have to go in for the safety of mother or baby, we get berated. So it feels like a vicious cycle.

Midwives also argued that, because of selection bias, they tended to see more women who “have issues with the hospital.” Homebirth clientele, they asserted, draw the “risk line in the sand” in different places because of unique values, life contexts, and personal histories. As one midwife explained,

> Take someone who feels like her first cesarean was unnecessary, and she had a tough postpartum period as a result. Can you see how she might push staying at home longer than someone who feels like going to the hospital is really no big deal? I can give them information, but I can’t always decide what is best for them. At most, I can decline to offer them care if it goes too far outside my comfort zone, but you have to know, too, that a small percentage of these...
women will just go and do an unassisted birth then. It’s a hard line to draw, because I’m not the only one involved in drawing it.

In discussing this theme of conegotiated risk assessment, midwives expressed concern over the focus on “the small minority of planned home deliveries that are for higher-risk clients” and were careful to stress that the vast majority of their clients were indeed healthy, low risk, and deeply committed to their baby’s health. One said,

“It makes me really mad when you end up transporting someone who is higher risk and the doctor is giving you this nasty look and yelling at you in the hall and acting like it’s your ignorance that has brought this on. . . . I always say, “Listen, you know how you have people who want an elective c-section, and it’s a small percentage, like two to three percent, but you have them, and they are really set against having a vaginal birth? Well we’re dealing with the opposite end of the spectrum. So, try to understand. We are serving moms who are hoping to avoid much of what you have to offer her, and that means I am serving a really different clientele. It’s not fair for you to judge me by your hospital’s standards of care and not by the midwifery model that guides my work.”

Judged by the exception, not the rule. Midwives also discussed a second and related theme—feeling judged “by the exception and not the rule”—which they asserted leads to deep misunderstandings between DEMs and their medical colleagues. In addition to feeling blamed for the infrequent, higher-risk client, midwives expressed frustration with physicians doubting or simply not knowing about the literature on home delivery’s safety. One said,

What they see are our transports, and then out of that, they seem to only remember the more emergent ones. They have no idea how many births we do that go beautifully at home because they, of course, never see those.

Another midwife said, “From their perspective, every homebirth is a transport, otherwise how would they know about it? So they are thinking about our transfer rate or even our mortality rate, but they don’t have any idea what the denominator is.” She continued, “We have these big scientific studies that show we are safe, but docs [doctors] can’t believe them. Why? Because they don’t fit with their experiences. So here we are at a total impasse.”

The sense that they were being judged by the exception and not the rule is an important point given the difficulty of tracking homebirth outcomes through vital statistics in the United States (Martin et al., 2013). This surveillance limitation allows physicians to form opinions on the safety, and thus the acceptability, of home delivery based on anecdotal data and perception rather than on scientific evidence gathered in their own communities. One midwife called this way of thinking “medicine-based evidence, instead of evidence-based medicine.”

Furthermore, it is clear that DEMs often engaged in the same process of internalizing highly biased information on more medicalized deliveries. Because DEMs developed their perceptions of hospital staff and practices during defensive and occasionally openly hostile transfer situations, as well as through clients who came to them after “traumatic hospital births,” many of their views were equally prejudiced, because they were exposed to the extremes of experience. This further fuels the discord that develops between medical and midwifery models of care and between home- and hospital-based providers. Any potential overlap in values or practice tends to be overlooked in a manner that functions to reinforce the midwifery/obstetric divide and an “us vs. them” mentality.

Failure to take responsibility. The third theme from midwives’ narratives—the belief that physicians fail to take responsibility for their roles in poor state and national maternal–child health outcomes—stemmed from the frustration inherent in the first two themes. Midwife participants resented the negative focus and perception of blame “laid at our feet by the medical establishment.” One midwife, in critiquing physicians who oppose homebirth, said,

We do one percent of all births in this country; ninety-nine percent occur in the hospital, and ninety percent are physician-attended. So hospitals are doing the vast majority of the births in this country, and where does the United States rank in terms of maternal and infant health? Are we the best? No. We are toward the bottom. We have some of the worst outcomes in the developed world. When are they going to own up to that and start saying, “What can we do to make birth safer and to improve access to care for mothers and babies?” instead of saying, “Let’s try to get rid of homebirth altogether”?

Another DEM tied this argument to rates of preterm birth:

I don’t like being treated as the enemy, like women need to be protected from us, like we are forcing them to give birth at home. My phone is ringing off the hook with women looking for another option. Homebirth is not killing babies. . . . Preterm birth is! If doctors want to save babies, we need to figure out how to reduce prematurity.

Midwives were concerned that the long history of blame and misunderstanding that has developed between obstetricians and homebirth midwives in their communities was “so entrenched that it could be insurmountable.” One
participant compared physician–midwife relationships at her local hospital to the Arab–Israel conflict.

Discussion: Sociopolitical Mechanisms Maintaining the Home/Hospital Divide

Davis-Floyd (2003), in her examination of the home/hospital divide, proposed four possible outcomes of interactions between what she argued are often disparate cultural domains. Disarticulations of knowledge systems occur when there is no overlap in or correspondence of information or worldview between the midwife and the hospital staff. Fractured articulations of systems result from partial or incomplete correspondence; smooth articulations of systems result when the interactions between midwife and medical personnel are characterized by mutual accommodation. Davis-Floyd argued that the fourth outcome, seamless articulation, occurs when health care systems fully support birth in all settings, facilitating ease of choice and continuity of care across place and provider type.

As Davis and Walker (2010) noted in their work on the corporeal, the social, and space/place in midwife–obstetrician interactions in New Zealand, these articulations do not occur in a power vacuum. The hospital, the space and place of transfers, along with the pregnant and birthing body itself, are discursive fields inscribed and constructed by discourses that shape ways of thinking and acting to meet particular socially and politically situated ends within webs of power/knowledge (Foucault, 1980). The transported birthing body (understood as a discursive construct rather than as an essential or biological truth) becomes a symbolic battleground where competing epistemologies and claims to ascendancy are disputed. This was evident in narrative content as well as in the dynamics of physician–midwife interactions we observed during transfers.

The obstetric or biomedical “gaze” (Foucault, 1963/1973) constructs the maternal body and childbirth itself in particular ways—as risky and therefore in need of intensive medical management—whereas the midwifery “gaze” (which is equally socially constructed) is premised on a challenge to, and a contestation of, the power and authority of obstetric norms (Cheyney, 2008; Davis & Walker, 2010). What results is indeed a contested space where the very nature of birthing bodies and the locus of power and authority are being negotiated as subtext, even as the clinical “facts” of the particular mother–baby transfer are being negotiated as text. We are struck not by how quickly and profoundly interprofessional interactions can disintegrate, but by how they are ever smoothly articulated at all.

In addition to Foucauldian systems of power/knowledge and hierarchies of the obstetric gaze, providers’ narratives also illuminate some of the central, everyday stressors that characterize home-to-hospital transfers. From these, we have identified three overarching sociopolitical mechanisms that we argue are functioning to produce and maintain fractured articulations against a backdrop of unequal relations of power. These mechanisms create impasses or “vicious cycles” that impede efficient and mutually respectful interactions.

Mechanism #1: The Sociopolitical-Climate-vs.-Ethical–Legal-Realities Conundrum

We see this first mechanism as the most foundational to the structural limitations preventing smooth articulations between systems of care. As summarized at the beginning of this article, ACOG (2011) openly opposes homebirth, stating very clearly in a series of progressively more public statements over the last decade that it does not support the care provided by DEMs. Yet many physicians, in talking about their transfer experiences, were all too aware of the concurrent, practical reality: that hospital-based practitioners cannot legally or ethically refuse to care for patients who are transferring from any environment, including an intended home or birth center birth. This conundrum seemed easiest to negotiate during an emergent intrapartum transport, and many physicians we spoke with simply felt that in the moment of need, ACOG’s position had no relevance. Others, however, worried about “going against our own professional organization’s recommendations.”

What is much less clear in relationship to this conundrum is whether an obstetrician can or should help a homebirth midwife before a clear emergency develops, as in the case when a midwife seeks a prenatal consult because she is unsure if a client is a good candidate for a home delivery. Arguably, timely consult and a resulting collaborative care plan could improve outcomes for mothers and babies in this situation, and yet all study participants were decidedly unclear about whether this was acceptable and/or allowable. An institutionalized sociopolitical climate that allows for this level of ambiguity muddies already clouded transfer waters, increasing the likelihood that articulations will be fractured rather than smooth.

Mechanism #2: The CPM Education, Regulation, and Accountability Glass Ceiling

Hospital-based participants in this study echoed many of ACOG’s concerns about perceived inadequacies in education, regulation, and accountability of DEMs who hold
the CPM credential. Critics of the CPM call for higher educational standards, tighter regulation, and greater accountability, while simultaneously citing a lack of reliable research on safety as their primary reason for withholding support (ACOG, 2011; DiVenere, 2012). Yet to date, there has been no formal analysis of the primary routes to the CPM credential and their respective relationships to safety or perinatal outcomes.

This call for higher standards in education and accountability (whether justified or not) is precluded by the legal status of DEMs in nearly half of all states in the United States. Midwives in states without legal recognition of the CPM credential face extraordinary difficulties getting trained and acquiring routine tests like ultrasounds and blood work (Cheyney, 2010). Similarly, it is impossible for states without legal recognition, and therefore no regulatory agency oversight, to require mandatory reporting of outcomes, peer review, or continuing education. Add to this the fact that very few states accurately collect data on intended place of delivery on the birth certificate, and this second mechanism crystalizes (Martin et al., 2013).

How can training and educational standards be increased for CPMs, and reliable data collected on outcomes, in the absence of the legal recognition that is the necessary precursor to the regulatory power to require these? A legislative glass ceiling results that hinders CPMs from doing just what their critics are requesting—improving educational standards and providing transparency around outcomes. One of the unfortunate results of the education/regulation/ accountability glass ceiling is that anecdotal data and media headlines that often promote fear and mistrust between provider types take precedence over evidence-based protocols, thereby setting the stage for fractured rather than smooth articulations during transfers.

**Mechanism #3: The Fear-of-Liability-and-Bad-Outcomes Vicious Cycle**

Our results indicate a culture of fear around transfers: for midwives, fear of being treated poorly or having a client treated poorly during a transport, and for hospital-based providers, fear of inheriting risks associated with a bad outcome. Unfortunately, we have had ample opportunity to observe fear and communication-related delays in practice, and it seems clear to us that they do not serve anyone, least of all the mothers and babies in need of assistance. When fractured rather than smooth articulations occur, treatment after transport might be delayed because of ineffective communication and contentious interactions (Washington State Perinatal Advisory Committee, 2011). Because delays can actually increase the likelihood of the poor outcomes that precipitate fears, this mechanism often functions like a self-fulfilling prophecy—a vicious cycle that might also further strain interprofessional relationships, ensuring fractured rather than smooth articulations.

Furthermore, these three mechanisms do not function in isolation. They are intertwined in complex and regionally specific ways. Fear of liability and poor outcomes maintain fractured articulations, making it difficult for mixed stakeholder groups to come together to develop and test standardized transport protocols aimed at maximizing smooth articulations. Without smooth articulations during transfer, delays in treatment and related negative outcomes might be increased, which in turn increases the potential for litigation and confirms physicians’ “worst fears” about working with midwives. This scenario ultimately ensures that fractured articulations are produced and reproduced to the extent that some physicians feel compelled to attempt to block the very legislation that would allow for the improved education, regulation, and data collection that their colleagues are calling for. Together, these impasses prevent an integrated system of seamless collaboration that best serves child-bearing families, regardless of their choice of where and with whom to give birth. However, they also contain the seeds for creating and assessing national protocols for the management of home-to-hospital transfers.

**Clinical Implications: Recommendations for Smoothing Interprofessional Collaboration**

Collectively, study participants offered four suggestions that they believed might help to decrease fractured and disarticulated interactions; two came from midwives and two from hospital-based practitioners. First, midwives requested that they be treated as respected colleagues during transports and included in dialogues about the best course of action following a transfer. Midwives asserted that they often have access to intimate knowledge of the mother, her pregnancy, and her labor that is essential to the development of a diagnosis and treatment plan. Respectful communication increases the likelihood that this information can be shared and used beneficially. In addition, as the client finds herself in a new and unfamiliar environment during transport, facing unknown interventions, she will almost inevitably look to her midwife for support and guidance. Any perceived devaluing of the midwife by hospital personnel can be internalized as a criticism of the mother’s choice to attempt a home or birth center birth. This means that no matter how supportive the staff is of the patient, if they are dismissive, judgmental, or condescending toward the midwife, the mother might feel alienated. Conversely, collegial interactions with the midwife communicate respect for the mother’s
autonomy and right to choose a provider and place for delivery. Any questioning of the midwife’s skill or pretransport management, along with any displays of frustration, explicit or implied, should not occur in the client’s presence.

Second, midwives cautioned hospital staff against assuming that if someone has chosen to attempt a home delivery she will necessarily decline hospital procedures. Homebirth clientele run the gamut from families who decline all prenatal testing, including routine ultrasounds, to those that request every test available under biomedical models of care (Cheyney, 2010). In addition, even when an unmedicated home delivery is their ideal, the decision to transport is almost always a tacit acknowledgment of the need for interventions available only in the hospital. Midwives suggest that physicians give an assessment of the situation, avoid scare tactics, and offer their recommendations knowing that although homebirth clients are likely to ask numerous questions and require extensive explanation, this does not necessarily mean that they intend to decline a procedure. Homebirth clients have simply internalized a model of care that involves detailed discussion of options and valuing of client input during shared decision making when time permits.

Hospital practitioners offered a third recommendation, stressing the need for “timely transport with clear charting,” along with a desire to assist with “complications rather than crises.” Acknowledging that rare and unforeseen emergencies can occur, physicians requested that midwives make it a priority to allow adequate time to talk prior to meeting the patient and assuming responsibility for care. Calm, informative discussion that familiarizes the receiving provider with the complications precipitating transport, along with the effort required to read through the patient’s chart, all require substantial time. Midwives are encouraged to keep this in mind and to discuss this with their clients prior to the onset of a planned home delivery. Hospital-based providers also suggested that a standard transport form be developed that includes all of the key information that physicians and nurses require to make their initial assessments during an intran or postpartum transfer. In addition, if midwives and physicians can confer over a particular woman’s history and circumstances in the hall and enter the room together with a plan to discuss with the client/patient, then a sense of collaboration and camaraderie might be effectively communicated to the family. This could, in turn, reduce the client’s fear of being judged and further facilitate smooth articulations and mutual accommodation.

The fourth and final recommendation came from physicians who requested that midwives make a greater effort to prepare all clients for the possibility of transfer, with the expressed intent of demystifying and “devilifying” interventions such as epidural pain relief, synthetic oxytocin augmentation, and cesarean section in certain contexts. Many homebirthers elect to deliver outside of the hospital precisely because they wish to avoid these procedures, seeing them as overused and riskier than a “natural” vaginal delivery. Women planning home or birth center deliveries must be able to transition from a critique of interventions to understanding them as necessary in some higher-risk situations or when attempts at an unmedicated delivery at home have not been successful. This can be especially difficult after a pregnancy spent defending the decision to deliver at home. Preparing clients for potential transfer is essential to smooth articulations.

Conclusion: Speaking Across the Home/Hospital Divide

In conclusion, we have identified three key themes from hospital-based providers’ transfer narratives that differed qualitatively from those emerging from midwives’ narratives: (a) the belief that home delivery is substantially more dangerous than current studies suggest; (b) the experiences of fear and frustration generated when physicians are forced to assume the risk of caring for another provider’s patient; and (c) challenges related to charting and interprofessional communication. Midwives’ discussions, alternatively, revolved around three themes reflecting views of pregnancy and risk that differed from their hospital colleagues: (a) the defense of more holistic and conegotiated constructs of risk in midwifery models of care; (b) physicians’ tendency to judge DEMs by “the exception, rather than the rule”; and (c) the failure of physicians to take responsibility for their roles in poor state and national maternity outcomes. Taken together, these themes are potent reminders of the fact that every clinical encounter is a cross-cultural interaction.

Embedded within physicians’ and midwives’ narratives were also three larger sociopolitical mechanisms that we have argued are functioning to produce and maintain fractured articulations at the time of transfer: (a) the sociopolitical-climate-vs.-ethical—legal-realities conundrum; (b) the CPM education/ regulation/accountability glass ceiling; and (c) the fear-of-liability-and-bad-outcomes vicious cycle. These mechanisms impede efficient and mutually respectful interactions and can result in costly delays; however, they also contain the seeds of possible solutions.

Midwives requested that the hospital staff show respect for them during transports and in dialogues over the best course of treatment, while also cautioning hospital staff against assuming that someone who has attempted a home delivery will necessarily decline hospital procedures. Hospital-based providers expressed the need for timely transports with clear charting. In addition, they
requested that midwives make a greater effort to prepare all clients prenatally for the possibility of transport. These are important starting points for developing an integrated maternity system premised on mutual accommodation and smooth articulations across provider types and places of delivery.

Finally, although our findings lay a foundation for beginning to understand midwives’ and physicians’ views and experiences, we recognize that these clinicians are not the only stakeholders who stand to benefit from smooth or seamless articulation and mutual accommodation during a transfer. The perspectives of labor and delivery nurses, mothers, and fathers/partners are conspicuous in their absence. Only with the inclusion of these voices will we be able to establish a more complete picture of the sociocultural and clinical dynamics of home-to-hospital transfers and the associated need for interprofessional collaboration.

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Notes

1. New York, New Jersey, Delaware, Rhode Island, and Missouri acknowledge a credential called the certified midwife (CM), a form of direct-entry midwifery requiring passage of the American Midwifery Certification Board’s certification examination. Some CMs have hospital privileges in these states, and CMs are acknowledged by the American College of Obstetricians and Gynecologists.

2. Midwives in this study used clients to refer to the women they cared for, whereas hospital providers used the term patients. We have preserved this distinction throughout.

3. To protect the confidentiality of participants, we have not identified the state or counties where data were collected.

4. Because of the communities’ small size and requests for maximum anonymity and confidentiality, we use a minimum of identifiers.

5. A note on terminology: Both home- and hospital-based providers tended to utilize the terms transfer and transport interchangeably to refer to the movement of a woman from home or birth center to the hospital. We use the term transport throughout the article because it is more commonly used in the clinical literature; however, we have retained the use of the term transport when it appears in a direct quote.

References


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