

# Narratives of Risk

## Speaking Across the Hospital/Homebirth Divide

MELISSA CHEYNEY  
OREGON STATE U

COURTNEY EVERSON  
OREGON STATE U

In this article, we discuss findings from a community-based participatory research (CBPR) project designed to assess the contribution of midwife-attended home deliveries to elevated rates of poor birth outcomes reported in one Southern Oregon county for a six-year study period between 1998 and 2003. We found no intrapartum or perinatal deaths in the completed home delivery sample (n=330). Records from one local hospital were also examined for cases in order to assess whether women who went into labor intending to deliver at home, but ended up transporting to the hospital for complications during labor or delivery, were contributing to the county's increased mortality rate. No deaths or low five-minute Apgar scores (a common indicator of perinatal morbidity) were found (n=33). The other two hospitals in the research county did not keep records on home-to-hospital transports—one of many methodological constraints associated with tracking homebirth outcomes.

These findings were surprising to members of the county's perinatal task force, as most openly expected to discover that births occurring at home were substantially riskier than hospital deliveries (ie, associated with elevated mortality and morbidity). Antagonism between hospital and home providers was consid-

emerged from open-ended, semi-structured interviews and focus group discussions with a volunteer sample of hospital-based practitioners and homebirth midwives that helped to delineate the disparate constructs of child-bearing risk that form the foundation for (mis)communication between midwives and obstetricians during home-to-hospital transports in this community.

### Hospital-Based Practitioners

As the cultural opposites of home and hospital care sustain intimate contact with each other during transfers of care, the potential for open hostility, uneasy tolerance or collaborative acceptance is generated. Emerging narrative themes indicate deeply conflicting perceptions, not only of risk, but also of the larger models of birthing care that inform risk designations. Hospital-based midwives and physicians discussed three key themes that differed substantially from those that emerged from homebirth midwives' narratives: (1) the belief that home delivery is substantially more dangerous than current studies indicate; (2) fear and frustration generated when physicians are forced to assume the risk of caring for another provider's patient; and (3) the belief that midwives make high-risk situations more dangerous by being difficult to work with due to poor charting and defensive personalities.

The belief that home delivery is substantially more dangerous than current studies indicate was widely shared by hospital-based participants. Medical model practitioners, with one exception,

homebirthers, 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

providers discussed a third concern, that poor charting and difficult personalities combine to increase risk by exacerbating already tense situations. All hospital-based participants stressed the difficulty they have had working with some homebirth midwives, citing confusing or poor charting that includes "a whole bunch of psychosocial stuff that we don't care about like her diet in the first trimester or how the woman feels about giving birth." As midwives advocate for options for their clients, physicians report feeling "put on the defensive" and "attacked." One doctor said: "So they come in for our help and then they act like they are trying to protect the patient from us."

### Homebirth Practitioners

Homebirth midwives' discussions of risk assessment and the power dynamics of transport revolved around three themes that reflect views of pregnancy and clientele risk that differ substantially from those shared by their hospital colleagues: (1) the defense of more holistic and co-negotiated constructs of risk in midwifery models of care; (2) accusations that physicians tend to judge them by the exception, rather than the rule; and (3) the failure of physicians to take responsibility for their roles in poor state- and national-level maternal-child health outcomes.

The first theme—defense of holistic and co-negotiated risk constructs—was discussed by every homebirth midwife interviewed as one of the core values characterizing the midwifery model of care. As one midwife explained: "We don't just say 'look you're high-risk, you can't have a homebirth.' We explain the increased risk associated with their complication ... and then we work through it with them until we all feel like we've come to an informed decision about what they want to do." Another homebirth midwife elaborated: "For me, the midwifery model of care is about acknowledging more than just clinical risk. It's about the whole person."

Homebirth midwives also discussed feeling judged "by the

---

Homebirth  
midwives also  
discussed feeling  
judged "by the  
exception and not  
the rule"—that is,  
by the occasional  
hospital transport  
for a complication  
rather than the  
far more common  
successful home  
delivery.

were in danger. The findings just don't fit with their experiences."

The second theme—fear of inheriting a patient with a serious complication and the associated transfer of risk to the physician—was brought up in all hospital practitioner interviews and informal discussion with perinatal task force members. One 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 and/or a noncompliant patient. It's not something we're going to look forward to."

To complicate the fears cited in the second theme, hospital-based

### COMMENTARY

erably amplified by the presentation of these findings, leading us to question how our CBPR project might be redirected to help improve communication between home and hospital-based birth practitioners, especially during the compulsory interactions that occur through intrapartum hospital transports. Below we summarize the themes that

expressed the view that birth *must* occur in the hospital to be safe. Although one physician argued that low-risk women should be able to choose a home delivery with a well-trained midwife, he was also careful to stress his concern that midwives in his community were caring for too many "high-risk" patients. This perceived prevalence of high-risk

See *Risk Narratives* on page 8

## Risk Narratives

continued from page 7

exception and not the rule”—that is, by the occasional hospital transport for a complication rather than the far more common successful home delivery. Midwives explained their frustrations with physicians doubting or simply not knowing about the literature on the safety of home delivery. As one home-birth midwife explained: “From their perspective, every home-birth 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.” This leads physicians to form opinions on the safety and acceptability of home delivery based on anecdotal data and perception, rather than on scientific evidence. One midwife called this way of thinking “medicine-based evidence, instead of evidence-based medicine.”

The third theme—the belief that physicians fail to take responsibility for their roles in poor state- and national-level maternal-child health outcomes—grows out of the frustration inherent in the first two themes. Homebirth midwives resented the negative focus and perception of blame “laid at our feet by the medical establishment.” One explained: “So, they are all about ‘home-birth is dangerous, we have to protect mothers and babies.’ Here is what I say to that. We do 1% of all births in this country. 99% occur in the hospital, and 90% are physician-attended. So hospitals are doing the vast majority of the births in this country, and where does the US rank in terms of maternal and infant health? Are we the best? No. We are on the bottom.” The 2008 CIA World Factbook lists the US infant mortality rate as 6.30/1000, or 180 out of 221 countries ranked for infant mortality.

### Bridging the Gap

Clashes of worldviews and value systems contribute to the fractured working relationships reported by participants in this and other studies on home-to-hospital transports (see Johnson

and Davis-Floyd’s chapter in *Mainstreaming Midwives*). The compulsory interactions that happen around transport, prenatal consultation and perinatal task force participation bring the ascendant knowledge systems of biomedicine into contact with the devalued and marginalized knowledge systems of homebirth midwifery. This contact can function either to entrench and solidify divisions or to begin to bridge the gap.

Regrettably, we conclude this CBPR project with the sense that current articulations between providers are more fractured than smooth, though we remain hopeful that a model of mutual accommodation may eventually be achieved through continued contact and cooperation. We urge physicians and midwives to view transports, consults and perinatal task force meetings as opportunities for collaboration and the development of cultural sensitivity around alternative perspectives and experiences. In this way, practitioners representing the spectrum of birthing options can begin to work together to achieve comprehensive, supportive and effective maternity care that transcends the home/hospital divide. The experiences and safety of birthing families depend upon it.

*Melissa Cheyney is an assistant professor of medical anthropology and reproductive biology at Oregon State University. She received her doctorate from University of Oregon in 2005, where her research examined the US homebirth movement and midwifery models of care. Cheyney is also a practicing certified professional midwife licensed by the State of Oregon. She serves on several task forces and the governor-appointed State Board of Direct Entry Midwifery.*

*Courtney Everson is a doctoral student in biocultural medical anthropology at Oregon State University. She received her master’s degree in 2008, where her research examined reproductive decision-making in young women breast cancer survivors. Her dissertation research examines the maternal-infant health outcomes and lived experiences of doula-supported teen mothers. She is also a practicing birth doula and student midwife. ☐*

## Midwives Unite in the Brazilian Amazon

SORAYA FLEISCHER  
U BRASÍLIA

According to the national census in Brazil, around 95% of births take place in hospitals. But in regions with lower population and biomedical density, births are usually home-based and assisted by a midwife. Amazonian midwives, as seen standing in front of their club in the below photo, are women who have learned by practice, coming to midwifery through necessity or “divine calling.” In many places, they are the sole care provider available to help women in need, such as pregnant women giving birth, new mothers seeking a cure for a newborn with *quebranto* (similar to “evil eye”), or victims of spousal abuse. *Parteiras*—as such caregivers are locally known—are typically senior women who have raised their own children, been married at least once and are usually available to help other women. A substantial part of their income derives from attending deliveries and offering *puxações* (abdominal massages) to pregnant and post-partum women.



Photo courtesy Soraya Fleischer

The city of Melgaço, in the northern part of the State of Pará, has around 4,000 residents and depends on 22 midwives with diverse life histories, levels of experience and styles of practice. Together they are responsible for 60% of births in the city. Although Melgaço maintains three hospital facilities, women seem to prefer being assisted by a parteira of their immediate social circle, known by them since childhood and present at every health situation witnessed in their homes. National health policies have begun to recognize the important role that these women play in their communities by offering hygiene courses (though they are short and sporadic) and by stimulating the organization of *associações* (professional clubs) for parteiras, so that they might unify and “demand collectively for their rights.” Each club takes on multiple roles as a meeting space and a visible local symbol of wealth and influence.

*Soraya Fleischer (sorayafleischer@hotmail.com) is an anthropology professor at the University of Brasília. Her PhD research, through the State University of Rio Grande do Sul, was on reproductive health delivered by midwives in the Amazon region, and can be downloaded at [www.bibliotecadigital.ufgrs.br/da.php?nrb=000591725&loc=2007&l=992f7c8a269d2a10](http://www.bibliotecadigital.ufgrs.br/da.php?nrb=000591725&loc=2007&l=992f7c8a269d2a10). ☐*