Shouldn't it be "Midhusband?"

The Dynamics of Masculinity and Structural Femininity in American Midwifery

A Senior Honors Thesis for the Department of Sociology

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Table of Contents

Abstract

Midwifery today has been recontextualized as subversive within the American medical system. This is in large part due to the gendered, clinical takeover of birth care by the new man-midwives/obstetricians during the 18th and 19th centuries. Reentering the medical system in the early 1900s, midwifery subverted the obstetric conception of the normal, pathological birth, and established a women-centered approach to birth care. In the face of this history, this study asks what happens in the clinical and professional spaces of midwifery when cis-masculine and masculine-of-center folk become midwives. Utilizing mixed purposive and snow-ball sampling strategies, semi-structured, in-depth interviews were conducted with a group of six cis-feminine mothers, and nine midwives (six of whom identified as cis-masculine, and three of whom identified as trans-masculine and/or genderqueer-masculine-of-center). The mothers in this study experienced their pregnancies as inseparable from their identities as cis-women; this translated into their expectations of midwifery care, and their relationships to masculine clinical providers. The mothers experienced a relationship arc with their personal masculine midwifery providers characterized by a positive shift in their perspective on the masculinity of said providers that did not correlate to a global shift in their perception of cis-masculine providers. Midwifery was found to be a hyperfeminized profession that, in some ways, was able to push back against the presence of masculinity unlike other feminine professions. It did not remove the affect of the privilege of masculinity, but the masculine midwives of this study did experience a significant push back against their presence. The trans-masculine and genderqueer-masculine-of-center midwives experienced a transphobia characterized by invisibility and isolation within the midwifery community, and blatant exclusion from and by their cis-feminine counterparts. Unlike the cis-masculine midwives, the queer midwives in this study voiced a distinct desire to create space for, and to support queer and trans patients through midwifery. These results help to define the concept of a "hyperfeminized profession" wherein agents and recipients of midwifery care adhere to structural femininity in recognition of the gendered power dynamic in clinical pregnancy and birth care created by the history of the profession. The study showed that the dynamic of hyperfemininity in midwifery required masculine identified agents to conform and uphold the standard of femininity defined by the profession.

Introduction

I sobbed at every single birth in the BBC's *Call the Midwife.* After five seasons of sobbing, I thought it time to reflect on my emotional state, and its apparent relationship to childbirth. This led me to research the prospects of becoming a midwife in the US. Two years ago, I didn't even know the US still had practicing midwives, let alone that they were fully integrated into the American medical system. Through my research and self-reflection (and only a few more tears as I rewatched all of *Call the Midwife* in preparation for season six), I decided to pursue midwifery.

In the US, midwifery experienced a gendered takeover by male physicians that has defined its practice up to today. Prior to the late 1700s, women in the US experienced a social childbirth characterized by its embedment in communities of women. When anatomical sciences began advancing in Europe, however, newly invented, birth technologies were brought to US birthing rooms by American physicians that had studied in European medical schools. Armed with these knew technologies and the latest anatomical knowledge, male physicians began a campaign to take complete economic and scientific control of birth in the US. Over the next 250 years, physicians would campaign against the American midwife on grounds of her incompetence, unintelligence, and lack of the wherewithal to work with such a strenuous experience as birth due to her gender. Meanwhile, physicians would begin a process of medicalizing birth by making medical intervention the norm and redefining birth as pathological, all while spreading disease and physical damage as a result of their unskilled and dirty care.

In the first quarter of the 20th century, the new American midwife came onto the scene. The Nurse-Midwife, soon to be followed by the Professional Midwife, attempted

to regain lost footing for women in the realm of childbirth. The new midwives reestablished the professions as both subversive, and distinctly feminine. The proportion of men in the profession is now less than two percent. So in the face of this history, I ask if my pursuit of midwifery would be an appropriation of an already coopted profession. What happens in the clinical and professional spaces of midwifery when cis-masculine and masculine-of-center folk become midwives? And, specifically, how do masculine identified midwives navigate the hyperfeminine profession, and how does their gender influence their clients' experiences of clinical pregnancy and birth care?

In order to attempt to answer these questions, a qualitative study was designed that utilized semi-structured, in-depth interviews to access peoples lived experiences of birth, pregnancy, and its associated attendance. This study was initially proposed to the Tufts University Summer Scholars Program, and subsequently received funding from the program. Following the receipt of this Summer Scholars grant, this project's methods were approved in their entirety by the Tufts University Social, Behavioral & Educational Research Institutional Review Board (SBER IRB) for abiding by the ethical standards for human subjects research.

Mixed purposive and snowball sampling techniques were utilized in order to find participants for the study. To begin, emails were sent to many MSN/DNP midwifery program in the US requesting to be connected with known male or masculine midwives from the academic communities. The most effective way of finding midwife participants was telling friends and family about this project. These friends connected me with the initial two midwives who agreed to participate. Upon contact, those two midwives extended my invitation to participate in an interview to their fellow masculine midwives.

All of those contacts were Certified Nurse Midwives (CNM). One participating mother connected me to her Certified Professional Midwife (CPM) who subsequently connected me to the other CPM in this study.

Initially, I framed this study around "male-midwives." very quickly, however, I found that the term "male" limited the scope of the experience of masculinity within the space of midwifery. "Male" defines a biological sex category, but I was using it to define a gender identity. This was both inaccurate in capturing the experiences of many midwives (and people generally), and, had I continued using it, would have denied me access to the manifestations of masculinity as a structural component of midwifery/the medical system. This term was thus expanded to "masculine-of-center midwives" in order to include any midwife who identified their gender with binary and non-binary masculinity more than femininity.

Overall, eight midwives and one midwifery student eventually agreed to participate in this study. This cohort was comprised of seven CNMs and two CPMs. One midwife was located in Washington, DC; another was in Chicago, IL; five midwives were located in Seattle, WA; and, lastly, two midwives were located in San Francisco, CA (refer to Table A: Midwives for list of full demographic information). Funding provided by Tufts Summer Scholars allowed me to travel to each of the above locations (except Chicago) to do in-person interviews with all but the one midwife in Chicago. Interviews with midwives averaged around an hour and a half, and ranged from one hour to two and a half hours.

Clients of male and masculine midwives were more difficult to find. I initially attempted asking the masculine midwives if they would be interested in sharing the

contact info of a client of theirs with me. But due to confidentiality and/or personal discomfort issues, this only actually happened in three cases – only one of which successfully resulted in an interview. I was connected to the first of six respondents, however, via a family friend. For subsequent participants, postings that requested interviews were placed on community message boards on Facebook and new-mom blog forums. Very few people responded, but ultimately four women were sourced via this method. One mother was based in Los Angeles, CA; one was located in Connecticut; one in San Francisco, CA; one was in New York City, NY; and two were located in Seattle, WA (refer to Table B: Clients for full demographic information). Two interviews (one in Seattle and one in SF) were conducted face-to-face, and four interviews were conducted over Skype video calling software. Interviews with mothers averaged around one hour, with a range from thirty minutes to on and one and a half hours.

All interviews with both mothers and midwives were recorded in full with my participants' consent. I used Callnote software to record Skype interviews via my computer's built in speakers and microphone. I used the built-in recording software, "Voice Memos," on my iPhone 6s to record the in-person interviews in full. All interviews were then transcribed in full in order to be analyzed. I then analyzed those written texts.

In keeping with sociological grounded theory methods, I utilized an inductive coding scheme to analyze the data. I pulled from a combination of traditional coding methods and creative analytic practice as described by Happel-Parkins and Azim (Happel-Parkins and Azim 2017). Their methodology involved the conglomeration of

interview data into a narrative poem with the intent to lyrically present their findings (Happel-Parkins and Azim 2017). I used this idea of a narrative analysis to develop a grounded theory from my data. First, transcripts were coded using descriptive open codes that framed a working understanding of what the individual respondent discussed throughout their interview, so someone could read solely the codes without referencing the original text. These descriptive codes were then organized thematically within each individual interview. I then compared the themes, or focus codes, amongst all the interviews (separately for midwives and clients) to develop larger, cohort-complete themes. I found this method of coding allowed for the final themes to read as a cohesive, communal narrative while simultaneously allowing each individual story to shine.

Chapter two will discuss the experiences of the mothers who participated in this study. Universally, the women considered their motherhood as an essential representation of their femininity. As such, they considered pregnancy and birth as entirely normal. This gendered understanding of their pregnancies as normal acted as the impetus to searching for the birth care they felt best supported that conception. In most cases, this was midwifery, and was associated with natural care. It was also associated with the assumption that the midwifery provider would be a woman. The fact of their providers' masculine identities, however, prompted a confrontation of expectations that began the defining relationship arc between client and midwife. Following the confrontation, clients experienced a period of gestation in the relationship characterized by receiving the same type of supportive, nurturing, and empathetic care that they initially had desired to come from women. Gay sexualities in many cases mitigated the masculinity of their providers, and allowed for the mothers to feel comfortable faster.

The birth transformed the relationship, acting as a sort of gateway beyond which the gender of their masculine provider no longer mattered.

Chapter three will discuss the ways masculinity functions within American midwifery. The masculine midwives who participated in this study discussed their engagement with clients in the clinical space. They especially outlined empathy and empowerment as central to midwifery care, and as distinct from obstetrics. Subsequently, I will walk through the ways in which the midwives discussed the structural, gendered conflict in midwifery that creates a dynamic of both discrimination and support for masculine folk in the practice. The discussion of gayness will then be echoed in this chapter for the same reasons it was discussed by the mothers in the chapter before. And lastly, the chapter on masculine midwives will outline the ways in which the midwives still experience privilege in the feminine profession.

Chapter four will dissect the discussions about queer masculinity in midwifery practice. I will show how the gendered barriers and discrimination experienced by all the masculine midwives was broadened to incorporate transphobia as a mechanism for reinforcing the femininity of the profession. Subsequently, I will discuss the privileges of queer masculinity in midwifery. I will then analyze the queer midwives' desire to utilize midwifery as a space to care for queer folk, and outline the ways they adapted the protocols of midwifery to create a clinical precedent for caring for queer clients.

Over the course of this thesis, I explore the gendered power dynamic that exists in midwifery. I show how femininity is a system within midwifery that is both recreated by the social actors in the space, and asserted over the behaviors/beliefs/experiences of those actors. I argue that the ways in which masculinity was enacted and received in the

experiences of both mothers and midwives indicates the requirement for its conformity to the feminine standards of the profession. These two intertwining arguments ground my definition of midwifery as a hyperfeminine profession. Ultimately, I claim that the history of American midwifery – its gendered takeover by male physicians, and reestablishment by revolutionary women – constructs the profession as uniquely hyperfeminine, and defines both the experiences within, and practice of American midwifery.

American Midwifery: A Discourse and History

The literature on birth, and especially on birth care, is a multifaceted literary canon spanning, at the very least, the five academic disciplines of sociology, anthropology, midwifery/nursing, obstetrics, and history. It therefore exists at the intersection of the discussions about medicine, gender, race, power, and culture, and concerns itself with everything from culturally gendered processes of power to the risks of medical intervention in parturition. Midwifery and its discourse sit within this literary cannon, and are as much consequences of this breadth of systems and structures as they are the producers. As such, I approach the discussion of the literature with two objectives. In drafting a genealogy of midwifery, I will first define and then deconstruct the intertwining power dynamics that amount to our established dispositif on birth and the work of birth care (Garland 2014). I will then make this problematization "less puzzling" as I craft a history of the present of midwifery and birth in the US (Garland 2014). In doing so the historical shifts will be presented as contributing factors to the consequences of today's paradigm (Garland 2014).

In the United States, birth and pregnancy are highly medicalized. According to the CDC, 98% of all birth in the US in 2015 occurred in a hospital, where almost 90% of births were attended by an obstetrician (HHS 2015). Even the midwife, which in many cultures is considered a traditional birth attendant, has become integrated into the medical context. Nurse-midwives now exist as the American version of this profession; while professional midwives (non-nurses) and nurse midwives can both care for individuals in their pregnancy and birth outside of the hospital, only those Registered Nurses (RNs) who have received academic postgraduate degrees in the advanced practice nursing

specialty of Nurse-Midwifery can practice in hospital. This suggests that the story of American obstetrics is a story of control and domination that begins within the ideological structuring of the care of pregnant people. This structuring is inherently masculine. It is the result of a male take-over of both medical and birth space during the eighteenth and nineteenth centuries in the US. In the course of this chapter, I will walk through the ways in which masculinity has coopted the childbirth space. I will discus the establishment of culturally sanctioned authoritative knowledge and the use of violence as control. I will then give a historical account of how men took control over obstetrics, framing the history of the medicalization of birth and pregnancy as a history of masculine control over femininity. Finally, I will discuss what we know happens when men enter feminized professions.

I – Authoritative Knowledge and the Social Construction of Birth Practices:

Brigitte Jordan, in her cross-cultural ethnography of birth practices *Birth in Four Cultures*, investigates the dynamic implementation of obstetric knowledge in the US, Holland, Sweden, and Yucatán. Working in the 1970s, Jordan's comparative approach problematizes each of the four birth practices simply by putting them in context with the others. The juxtaposition was so powerful because the different birthing systems inherently contradicted the others' "internally consistent and mutually dependent practices and beliefs" about birth (Jordan 1992:4). Jordan asserts "that birth is universally treated as a marked life crisis event," therefore existing as a prime "candidate for…social patterning" which inevitably results in a culturally specific approach to birth that amounts to "*the* way to bring a child into the world" (Jordan 1992:3–4). Her

ethnographic findings support this argument, and her comparative, cross-cultural approach is the foundation for Jordan's most salient contribution to the anthropological literature: the theory of authoritative knowledge (Jordan 1992).

Authoritative knowledge is the established, reified, mutually agreed upon knowledge base that holds the most power within a given society. Jordan defines authoritative knowledge as the result of a continuous symbolic process wherein the interactions between individuals within a given society or culture serve to assign more meaning and importance to certain understandings/knowledge bases (Jordan 1992). This theory seamlessly arises from and lends itself to cross-cultural analyses because it asserts that knowledge functions in two distinct and interacting patterns. The first defines knowledge as separate from fact, and therefore as a major impetus for behavior. And the second asserts that knowledge is wholly defined within specific cultural milieus. So the Yucatán midwife knows not to insert her hand inside of a birthing woman's vagina; she knows because the empirical training she received from her predecessor taught her that to do so would cause infection and damage the woman's modesty (Jordan 1992). Although assumed as fact, her knowledge was constructed by the highly esteemed midwives who came before her. The power imbued within this knowledge by the culturally specific birth practitioners of the Yucatán was hindrance to vaginal checks. Furthermore, the midwife's knowledge was confirmed by the numerous knowledgeable familial birth attendants present with her who would undoubtedly sanction any behavior deemed illegitimate (these attendants are knowledgeable because knowledge of birth practice is disseminated within Yucatan culture) (Jordan 1992).

Jordan's pioneering work and theory paved the way for researchers to enter the birthing room, giving validity to the pursuit of knowledge about a space deemed private, impenetrable, and exclusively feminine. This to end, the earliest researchers were all women as they, like Jordan, faced no symbolic barriers placed against the presence of men in birthing spaces. In 1987, Emily Martin published *The Woman in the Body: A Cultural Analysis of Reproduction,* wherein she interviewed women in the US to better understand the ways they experienced the medical profession's treatment of them. Martin found that women experienced a technologization of their bodies (Martin 1987). Martin's analysis of the obstetric literature found that the medical field considered birth follow almost a mechanical progression, associating the physician with mechanic, and focusing on that which could breakdown during birth and labor requiring the mechanic's intervention (Martin 1987). She found that the progression of obstetrics follows more closely the production, labor management, and repair functions of men in factory work than of a space dedicated to the highly gendered, embodied experienced of birth most women report (Martin 1987). Furthermore, Martin's findings were reinforced by the presence of stark distaste for, and a growing rebellion against the practices of western, mechanized birth care by the women on whom it practiced (Martin 1987). The knowledge about birth in Martin's findings had been constructed in a decidedly mechanical mode, actively produced by and for men, with the intention of creating capable mechanics of the bodily process.

Robby Davis-Floyd was further integral in progressing the literature on birth and pregnancy, focusing on the lived experiences of pregnancy and birth by women under the care of the American medical establishment. Following Jordan and Martin, Davis-Floyd

argued that pregnancy and birth were treated without exception in the US as a rite of passage with culturally specific stages and required actions (Davis-Floyd 2004). In her qualitative, interview based study Davis-Floyd found very similar experienced and mutual understandings of pregnancy and birth care as did Martin, however Davis-Floyd's findings developed the technocratic ideation of pregnancy and birth into a ritual of change (Davis-Floyd 2004). Her model followed the same stages as developed by Turner of Separation from the society, transition rites of passage, and reintegration into society with the new status of having experience the ritual (Davis-Floyd 2004). Within this American conception of birth, Davis-Floyd found that most women experienced a series of "standard procedures" developed by the medical establishment that effectively diminished their agency in the embodied experience of birth, and required a set and uniform series of biological processes that – should nature be insufficient in their production – could be mechanically and pharmacologically induced (Davis-Floyd 2004).

The constructed ritual of American birth is reified within a context where the knowledge based about birth and pregnancy sits in the medical establishment, allowing it to be shaped and structured by said establishment. In other words, pregnancy and birth are structured, world over, by individual cultures because of Jordan's first assertion that the biological "crisis" of birth is important enough to necessitate "social patterning" (Jordan 1992:3–4). The American construction of this biosocial event defines it as a bodily and, therefore, medical event to exist within the realm of technological expertise (Davis-Floyd 2004; Martin 1987). The medical establishment can therefore outline the specific actions and behaviors that must happen in order for the transitional rite of birth to be considered successful (Davis-Floyd 2004). All of this is to say that birth and

pregnancy are biological events marked by socially constructed behavior. This is not to say that the behavior doesn't hold immense power within any given society; rather this is to say that the behavioral components of the biosocial event can – and do – shift over time (all three authors alluded to the rising rebellion amongst women in the natural childbirth community during the 1960s-1980s) (Davis-Floyd 2004; Jordan 1992; Martin 1987). The definition of pregnancy and birth as socially constructed experiences is a relatively novel understanding that arose at the end of a 200-year shift beginning in the mid-1700s to the present where birth left the hands of women and entered the control of men. This shift will be discussed in the following chapter, and will be presented as lineage for the above findings.

II – Scientific Response to Science:

We see, then, that modern American obstetrics functions as the culturally specific manifestation of authoritative knowledge about birth and pregnancy. It is, therefore, within this theoretical framework that we can approach the discourse about midwifery in the US. This literature, at its core, refutes the definition of birth as inherently pathological. As shown in the discussion above, scholars have argued that this conception was developed within the process of medicalizing birth. The following literature furthers this argument, stating that birth has and will always exist as a normal physiological experience with some associated risk. This stance establishes the basis for the midwifery research into birth and pregnancy as dichotomous to obstetric research. This research, especially – but not exclusively – put forth by the nursing and midwifery research communities, engages in the rhetoric stance I am terming the Scientific

Response to Science. Where much of the early research onto this topic discussed in the previous section relied on social constructivism to explain the development of pregnancy and birth practices in the US, a newer stance from researchers has been to engage in specific scientific methodologies to argue against the technocratic model for pregnancy and birth.

For example, Bria Dunham explains in her article "Home Birth Midwifery in the United States: Evolutionary Origins and Modern Challenges" that the relative difficulties of human birth seem to have coevolved with social birth practices, including physically assisted birth (Dunham 2016). She emphasizes the fact that social birth almost never occurs in non-human mammalian species, and almost universally occurs across human cultures (Dunham 2016). Dunham's analysis contrasts midwifery and obstetric care within the context of an evolutionary lens on human birth. She praises the advances that obstetrics has made in the specific care of high risk or emergency birth, while critiquing its liberal and unnecessary implementation of that care, showing how the obstetric model of care isolates women, and conceives of many protocols that seem to have no scientific foundation or evolutionary necessity (Dunham 2016). In response to this outlining of the obstetric model, Dunham lauds midwife-attended, home birth as a viable and safe option for low-risk pregnancies, showing that it can function as a return to evolutionarily beneficial birth practices like freedom of movement during labor and having a support system/social birth (Dunham 2016). She does, however, recognize many difficulties with home birth in contemporary America due to the clash between the opposing models of care that result in a possible "trade-off" of losing access to medical intervention if deemed necessary due to difficulties with hospital transfers (Dunham 2016). In

conclusion, Dunham advocates for a "humanized childbirth model" that integrates the modern, specialist obstetric model and technologies with the ancestral and evolutionarily based model of normal birth care (Dunham 2016).

Dunham argues specifically for a naturalistic/holistic stance on pregnancy when the pregnancy is uncomplicated/normal. Interestingly, however, her bio-anthropological approach allows Dunham to claim authority over the realm of reproductive science. In other words, Dunham adapts a very specific, scientific presentation of ideas/structuring of argument to build her own authority, as she is conscious of the power held by the institution of obstetric science. In forgoing the social constructivist approach of the canonical research in her discipline, Dunham is making a choice that she hopes will ultimately serve to advance the stance against obstetric science's medicalization of pregnancy and birth. She is fighting fire with fire.

This same approach is most commonly utilized by the nursing and nurse-midwifery research communities. However, where Dunham utilizes evolutionary science, these researchers utilize statistical and medical methodologies to argue against the medical paradigm of pregnancy and birth. In once such piece, Jeanne Raisler reviews 140 studies from the period of 1984-1998 on the subject of midwifery care in America. She finds numerous evocations of the scientific response to science from the community of midwife academics and researchers, not least evoking this response paradigm in her own call for further research utilizing the specific methods of scientific/medical research (Raisler 2000). In order to grasp the scope and success of the studies conducted during the review period, Raisler raised five critical questions concerned with the topics, methods, results, and broader applications of midwifery care research, as well as the

negative space of topics insufficiently explored; in continuing this work after Joyce E. Thompson, Raisler was particularly concerned with exploring a possible response to Thompson's questions as to having research that presents direct benefits of midwifery care, develops conceptual/theoretical frameworks to approach this area of research, and directly tests hypotheses (2000). The 140 studies analyzed in this review were categorized into six topical areas: midwifery management of care, structural issues, midwifery practice, comparisons of midwife and physician care, place of birth, and care of vulnerable populations (Raisler 2000).

Raisler's review found a mixture of promising new results about the midwifery model of care, and a lacking in some of the more rigorous methodologies necessary for strength in empirical analysis. The primary finding in support of the midwifery model was that reduced use of technological interventions during birth resulted in a higher rate of spontaneous vaginal birth, and an equivalent positive health outcome in mothers and neonates as those cared for by an obstetric model (Raisler 2000). She did find that some of the concerns Thompson had raised continued to go unresolved through the current literature. Raisler suggests again that future studies must grow in sample size and random sampling/clinical techniques, and that a conceptual study framework needs to be developed (2000). Raisler further urges for more in depth collection of national data on midwifery care, and created an outline fore the areas of midwifery research she deemed lacking. But overall, Raisler finds that midwifery care is as, if not more, successful as obstetric care for low-risk reproductive health care, and that even in spite of risk status, midwifery care often achieves positive outcomes (2000). In her review, Raisler not only presents an array of research findings that support midwifery care and non-invasive/non-

medicalized procedural approaches to reproductive health care, but also calls to action the academic world of midwifery for the production of more rigorously scientific research on birth and reproductive health care. In stating the need for larger sample sizes and random sampling techniques, Raisler is stating a desire for the academic community of midwifery to conform to normative medical and scientific research methods.

This call to action is echoed by Leah Albers and Kay Sedler in their analysis of the clinical barriers and incentives to participating in research as clinical Certified Nurse Midwives (CNMs) in the US. The pair advocates for joint endeavors from academic researchers and practicing midwives as a specific manner of advancing midwifery/normal-birth research in the US (Albers and Sedler 2004). In their qualitative analysis of narrative discussions of care by American midwives, Holly Powell Kennedy and Maureen T. Shannon find that midwives engage in birth care with the specific ideological approach of caring for normalcy, therefore engaging un-invasively with birthing women (2004). The authors call for a scientific defining of normal birth because they believe that midwifery care will benefit in success and uniformity by having an established scope of what normal birth looks like (Kennedy and Shannon 2004). These authors, in their advocacy for further clinical, biological, and physiological research, are acknowledging the need for the midwife community to claim authority of the knowledge on normal childbirth. In fact, Albers and Sedler stake the claim for midwives as "experts on normal childbearing" in a declaration of authority on the subject when it comes to research and practice (2004:47). Midwifery care researchers claim authority by utilizing the methods set forth by obstetricians and reproductive health researchers, thereby attempting to situate themselves as equal in quality and power to said researchers. This

scientific response to science indicates an inquietude in the, obviously self-conscious, knowledge system about birth and pregnancy that exists in the US.

III – Obstetric Violence:

The scientific response to science is a research paradigm advanced by the scientific and clinical community in self-critique. However another paradigm of research raises the voices of those recipients of obstetric care in order to present different lived experiences of the midwifery and obstetric models of care. In her article "Making Loud Bodies "Feminine": A Feminist-Phenomenological Analysis of Obstetric Violence" Sara Cohen Shabot begins with her own experience of a medicalized childbirth in order to situate her readers in both an empathetic and empathetically critical role towards women's experience of birth and their obstetric care, respectively. In engaging a feminist-phenomenological perspective, Shabot depicts the embodied process of birth through which doctors and medical professionals engage in a process of corporeal objectification wherein they violate the liberated femininity held within a laboring woman's body; a process about which Shabot establishes an argument to describe obstetric violence as "birth rape" (Shabot 2016). She does so by drawing a parallel between the process of birth and feminine sexuality, describing a continuum of penetrative sex, physical sexual changes of pregnancy, and genitalia involved birth (when caesarian sections are avoided) (Shabot 2016). This description of birth as inherently sexual allows for obstetric violence to be categorized as patriarchal and gendered, and therefore as a sort of discriminatory gender violence similar to sexual assault or harassment (Shabot 2016).

Alison Happel-Parkins and Katharina A. Azim further this phenomenological and embodied experience perspective on obstetric violence in their analysis of the narratives of pregnancy and childbirth of women who had planned for natural childbirth. Their study, utilizing a novel qualitative methodology called "creative analytic practice (CAP)," organized the interview data from six women into a thematic poem on the experience of childbirth (Happel-Parkins and Azim 2017). This poetic structuring of the data enabled the researchers to describe narratives of both experienced and desired childbirth, thereby effectively characterizing the emotional experiences of the women in their study (Happel-Parkins and Azim 2017). Happel-Parkins and Azim find that when the women in their study attempted to experience natural childbirth within an institutional setting, their desires were often overridden by the highly technological approach to birth to which these settings and the obstetric practitioners therein subscribed (2017). The researchers conclude that, as the procedures of obstetric technological birth in these settings overrode the wishes and intentions of the women, the women therefore were treated without consent by the physicians and institutions, amounting to an experience of obstetric violence that fits within the definition posed above (Happel-Parkins and Azim 2017; Shabot 2016).

The findings of the two articles immediately described are heavily substantiated by the socio-legal analysis of obstetric violence by Farah Diaz-Tello. Her article utilizes three case studies of explicitly non-consensual or threatened non-consensual medical intervention in birth; two cases resulted in physiologically and psychologically scarring cesarean sections against the will of the individual women, and one required the intervention of a national advocacy organization with the hospital's legal team in order to

stop the practitioners from carrying out their threat of having law enforcement forcibly drag the woman to the hospital for a cesarean (Diaz-Tello 2016). According to Diaz-Tello, obstetricians in the US have a divided concept of their patient wherein the mother constitutes one portion, and the unborn fetus constitutes the other (2016). The dichotomization of woman and fetus, due to the potential liability associated with corporeal harm to the fetus resulting in legal action taken by the mother, results in the nullification of that same mother's autonomy, as physicians know that the "juries are susceptible to the very biases that lead to obstetric violence in the first place" (Diaz-Tello 2016:59). Those biases assume authority of knowledge about reproductive health sits solely with the physician, and asserts the cultural requirement of American women to rank "having a healthy baby" over "their health and dignity, and even potentially their lives" (Diaz-Tello 2016:61). Diaz-Tello's analysis establishes a legal-theoretical basis for obstetric violence as a form of discriminatory gender violence because the assumed gender of the birthing individual allows medical professionals to supersede the individual's directives and intentions due to the ascription of an American gendered ideology about the duties and desires of motherhood. If the case studies presented by Diaz-Tello described a case of forced surgery on a man's body, regardless of extenuating circumstance, the legal cases brought against the surgeon would first be viable, and then more-than-likely won by the victim.

Midwifery practice is, for the most part, engaged in the explicit empowerment of the midwife's client. It holds, as central, an opposition to the non-consensual structuring of obstetric violence because, part and parcel with the notion of empowerment, personal autonomy and client choice are paramount features of midwifery care. Yet, Katharine

McCabe makes a compelling argument against readily absolving midwives of their potential involvement in obstetric violence. In her article, McCabe defines a process she calls "mothercraft," wherein birth attendants shape the experience of birth for their clients with the explicit or implicit intention of "ushering women into motherhood" (McCabe 2016). In her qualitative study of in-depth interviews with traditional birth attendants like midwives and doulas, McCabe found that these practitioners believed that their role, beyond catching and caring for the infant and mother, was to create birth experiences cemented in compassion and empowerment in order to create positive social change in the mother, the infant, and the community around the mother (McCabe 2016). Mothercrafting, according to this study, has become a neoliberal endeavor that begins with the conscious indexing of clients into two groups: those who can be affiliated with the process of birth "empowerment," and those who, by nature of their lacking "cultural health capital," are incapable of being affiliated to the empowerment process (McCabe 2016). The second stage of the neoliberal mothercraft stems from the model of empowerment and autonomy within midwifery care that preferentially supports women who have the cultural capital and financial capital to care for and shape their own health, pregnancies, and births; women who may not have a knowledge of "empowered" birth, who lack the financial capital, who rely on expert coordination/authority are disadvantaged within this space because they cannot afford (literally in money) to learn to care for their own pregnancies and births, and are therefore treated as passive, ignorant, and powerless by midwives (McCabe 2016).

McCabe's research complicates midwifery care. Her findings explicitly state that the broader American medical system's neoliberal economic approach to health care have

become embedded in midwifery practice via the perceived good of empowerment. But this economic approach is, perhaps, creating a differential in the implementation and outcome of midwifery care depending on the category of autonomy level achieved by the woman under care. This categorical difference increases clinician authority in cases of little to no self-driven investment in one's own reproductive health care. This, therefore, increases the potential for practitioners to make the clinical decisions for their clients, which potentially results in non-consensual obstetric interventions – in other words, obstetric violence. This cascade is specifically associated with women of lower socioeconomic classes, immigrant women, and women with lower levels of education (McCabe 2016). Neoliberal mothercraft, like most neoliberal behavior, therefore more effectively empowers upper class, white women, privileging them to midwifery care, a model purported by clinicians and advocates as a more cost-effective alternative for all women.

IV – A History of the Present

The two above sections on the scientific response to science and obstetric violence describe the current, American social moment in birth care and work. In returning to the concepts established by Davis-Floyd, Martin, and Jordan as described in the first section of this chapter, the shape of birth care in this moment in America is socially constructed by a legacy of power, customs, rituals, and knowledge systems about birth that were defined throughout the nation's culturally specific history. We know that birth care looks different all over the world whether by the simple marker of the massive global variation in the Maternal Mortality Ratio (MMR), or by the more complex

analyses and studies conducted about the policies concerning and health of birthing women in different nations and contexts. So in order to study a specific phenomenon of this modern shape of American birth care, we must ask how America's birth culture has been shaped. I argue that the current state of American birth care is the result of a gendered process of medicalization wherein male doctors wrestled the profession associated with birth away from the control of women, redefining the physiological process of birth as pathological, and re-contextualizing birth as an in-hospital activity.

Considering the history of the present of midwifery requires approaching said history with the conundrum of the present. If midwifery in the US is an incorporated, scientifically/evidence based nursing practice, why then does midwifery research, both from and about the community, make a clear attempt to continuously establish itself as valid science? To answer this question, we have to look back to the midwifery paradigm in the mid to late 18th century. For the first 250 years of American history (beginning with the introduction of Europeans to North America), pregnancy and birth were held exclusively within the purview of women. Birth for this time period did not greatly change or evolve. Colonial and early American women, for the most part, experienced a "social childbirth;" a paradigm of childbirth that enmeshed each woman within the broader female network of her community (Leavitt 1988; Wertz and Wertz 1977). The women in the community would be present for support of the laboring mother, while a midwife would preside over the scene (Leavitt 1988; Wertz and Wertz 1977).

The midwife of this period was a woman of *experience*; she was typically an older woman who had had her own children successfully, had been at numerous community births, and was – potentially – empirically trained by other local midwives in the art of

caring for birthing women (Ettinger 2006; Leavitt 1988; Wertz and Wertz 1977). The paradigm of social childbirth was predicated on community. Similar to the Yucatán customs as described above, the midwife was a single person in the group of caregivers, and shared in the communal knowledge of the rest of the women present. Following the birth, the women of the community would continue to support the new mother for weeks, sometimes months, creating a much needed respite for the new mother from caring for her family in the 24/7 style of the colonial wife (Wertz and Wertz 1977). Food, childcare, and housework would all be provided simply under the premise that the favors would be returned for each neighbor during their pregnancy and birth. This social birth practice was, for all that we know, vital to the survival of the women in the colonial era.

Men of this time period had no place in the birthing room. In fact, it was generally seen as improper and vulgar for a man to be in the birthing room unless no women were available to support the one giving birth (Leavitt 1988; Wertz and Wertz 1977). This social rule included the exclusion of male doctors unless their presence seemed necessary to save the mother's life (Leavitt 1988). "To save the mother's life" is an extremely important distinction because the earliest role of male doctors in the birthing room was to break the baby's skull in utero, remove the brain, then dismember and – piece by piece – extract the baby to violently save a mother's life (Leavitt 1988). This was always a last ditch effort, and served to reinforce the discomfort with men in the birthing room by directly associating male doctors with the violence they brought to the birth (Leavitt 1988). In the middle of the 18th century, when men started to make their earliest attempts at entering the birthing room to assist in successful parturition (as opposed to fetal dismemberment), they had to compensate for their gender in some

capacity. One of the most famous images of man-midwives, as they were called, was a satirical cartoon of a person split down the middle, with a man and his instruments on the left, and a woman in traditional garb on the right. And while this image poked fun at the presence of men in the birthing room, what it depicted was not far off from reality. William Smellie, one of Britain's earliest man-midwives/obstetricians would often dress up in a woman's smock in order to avoiding distressing his patients, and to gain access to many more birthing rooms (Leavitt 1988; Wertz and Wertz 1977). Once he had compensated for his gender to gain access to the birthing room, Smellie could experiment with the use of his invention: the forceps (Leavitt 1988; Wertz and Wertz 1977).

These tools were intended for use during pregnancy only for the extraction of a fetus during a protracted (prolonged) labor (Leavitt 1988; Wertz and Wertz 1977). The forceps found their way into American medical practice during the 18th and early 19th centuries' advancement in European anatomical sciences. American physicians would frequently study at European universities for their medical training, and would return to the U.S. with the knowledge of the new tools of fetal extraction. The coinciding introduction of forceps to American medical practice with the growing interest in new medical/anatomical research pushed for the growth of knowledge about birth and pregnancy because it was seen as so vital to the continuation of the society/nation (Leavitt 1988; Wertz and Wertz 1977). At this time, and for the same reason, midwifery science was seen as the "keystone" to medical sciences, and was the first discipline founded at many of the American medical universities (Wertz and Wertz 1977:50). Furthermore, attaining the most up to date knowledge on birth and pregnancy was considered a good economic investment for all physicians since all women at the time

were expected to give birth (Leavitt 1988; Wertz and Wertz 1977). So as American society continued its development, towns and cities more commonly would have their own physicians who, in turn, felt the need to, and/or were obligated to, learn the science of man-midwifery (Leavitt 1988; Wertz and Wertz 1977). As "midwifery" was considered a feminine art, "man-midwifery" needed to establish itself opposed to "midwifery," both practically and politically.

A central tenet to the development of this new medical science was the use of forceps in delivery. As stated, the original intention of these tools was for the manual advancement of a protracted labor. But their use became extremely common for a variety of social factors. First, doctors received little to no practical training in the use of forceps or other man-midwife techniques/tools. Midwifery lectures in medical schools were almost entirely theoretical, with the possible exception of a handful of courses that employed a female prostitute for one lecture where students only observed a gynecological examination, or potentially (and even more rarely) an actual birth (Leavitt 1988; Wertz and Wertz 1977). So new doctors were unskilled in the use of forceps, not to mention their lacking ability to tell whether a labor was protracted, or simply a longer labor. Secondly, doctors, both new and experienced, felt out of place in the birthing room during non-emergency periods when surrounded by women. The male doctors' frequent and unnecessary use of forceps was prompted by the inactivity associated with sitting with a pregnant woman as she labored through to parturition, and their resulting sense of uselessness (Leavitt 1988; Wertz and Wertz 1977). And lastly was a complicated interactive prompting by the doctors and the women who surrounded them. The more doctors used forceps out of inactivity, the more they associated their use with

masculine science (Leavitt 1988; Wertz and Wertz 1977). For upper-class women, this translated forceps-assisted birth into an assistive procedure of prestige, and the promise of a swift birth (Leavitt 1988; Wertz and Wertz 1977). There were many women who held the opposite belief that the associated perils of infection and death with forceps made the procedure, and inviting a man-midwife into the birthing room, a last ditch effort (Ettinger 2006; Leavitt 1988). In the end, however, the hegemony of masculinity and scientific knowledge won out, making the use of forceps a wide and well-regarded practice (Ettinger 2006; Leavitt 1988; Wertz and Wertz 1977).

As with most of the shifts in the history of midwifery and birth care in the U.S., the prestige associated with the medical science, and ensuing support of upper class women for man-midwives lead to the overall favoring of doctors and their practices. This expanded both the economic opportunities for doctors in the mid-19th century, and their dominance over the science and knowledge of medicine (Leavitt 1988; Wertz and Wertz 1977). The economic opportunities created professional competition between the man-midwives and traditional midwives of the period. So male doctors launched a campaign against the midwife (D. Bonaparte 2015; Ettinger 2006; Fraser 1998; Leavitt 1988; Wertz and Wertz 1977). Doctors argued that midwives were dirty, incompetent, untrained, and unsafe, and that their gender and associated bio-physiological make-up left them constitutionally lacking in the wherewithal to accomplish the task of assisting at births (Ettinger 2006; Fraser 1998; Leavitt 1988; Wertz and Wertz 1977). In contrast, doctors lauded science and medicine as both safer and faster, appealing to the women's fear of the risks that came with birth, and to their desire for a painless birth (Ettinger 2006; Leavitt 1988; Wertz and Wertz 1977). In truth, the science of man-midwifery was

minimal/ineffective as it was predicated on guessing and trial and error rather than a true scientific method (Leavitt 1988; Wertz and Wertz 1977). The science was further constrained by the Victorian ideals of the time. Man-midwives were not allowed, by social convention, to ever visually examine their clients; in fact, all obstetric care was done beneath the woman's gown or blankets by touch alone, with major medical knowledge at the time saying that a good physician should have no need to ever look at his patients body/genitalia in order to effectively care for her (Leavitt 1988).

Regardless of these limitations to the effective and safe practice of man-midwifery, male doctors felt the incessant need to reinforce their base in the most up to date science of the time. In 1828, "man-midwives" – in what I see as one of the most important acts by doctors of the period to dominate the practice of midwifery, and reinforce their "basis" in science – decided to rename themselves as "obstetricians" because "it had the advantage of sounding like other honorable professions, such as 'electrician' or 'geometrician,' in which men variously understood and dominated nature" (Wertz and Wertz 1977:66). This decision makes the intention of male obstetricians (I will from here on out refer to "man-midwives" as obstetricians to reflect this major shift in the history of birth care) clear: to dominate the space of birth by a) ruling over nature with science, b) professionalizing their discipline in opposition to midwifery, and c) creating a precedent for men to dominate women even in, what was seen as, the most basic of feminine acts.

However, this reframing of obstetrics as a medical science reinforced the doctors' propensity for unnecessary intervention during parturition. Thus, birth at the time brought with it much pain and physical damage. The improper use of intervention

frequently led to vesicovaginal fistulae that created immense pain and imprisoned women afflicted away from "polite" society (Leavitt 1988; Wertz and Wertz 1977). But these interventions were seen as an unfortunate necessity because, the more doctors intervened, the more they rationalized their interventions in a self-fulfilling cycle of pathologization that found other support in their patients' birth experiences (Leavitt 1988; Wertz and Wertz 1977). For instance, doctors believed that pain in childbirth was a sign of pathology for upper class women, whereas the poor and lower class were of constitutions where the pain was associated with normal birth (Wertz and Wertz 1977). This scientific belief came from the more frequent complications obstetricians saw in upper class births (it is unknown as to whether this was a true or perceived statistic for a lack of birth data of the period) (Leavitt 1988; Wertz and Wertz 1977). Doctors, however, failed to see the complications as the result of upper class young women wearing corsets that permanently deformed their ribcages resulting in more difficult births (Wertz and Wertz 1977). This classed pathologization eventually became more universal, with some doctors stating that all birth was pathological in its very nature (Leavitt 1988; Wertz and Wertz 1977).

In the late 1800s, upper class women pushed for the creation of "lying-in" hospitals to care for the poor and "undesirable" women of the time (Ettinger 2006; Leavitt 1988; Wertz and Wertz 1977). Hospitals were simultaneously a place to solve the problem of impoverished birth, and to experiment on the poor to advance obstetric knowledge (Wertz and Wertz 1977). The hospital was, as well, a place of disease and infection. Until the widely held practice of sanitization was introduced to the American hospital, the use of medical intervention and the quick transitions between the sick/dead and birthing patients lead to the rampant spread of puerperal fever and other infections,

making hospitals some of the most dangerous places to give birth at the time (Leavitt 1988; Wertz and Wertz 1977). However, hospital birth was vital to the continuation and advancement of obstetric knowledge, so although the rates of mortality and morbidity were astronomical in hospitals, obstetricians continued to drive the point that hospitals were the safest place to give birth (Leavitt 1988; Wertz and Wertz 1977). This spurred the transition of hospitals as solely a place for poor birthing women, to institutions that served both the poor and the rich white upper class women wanting the best care for their births (Leavitt 1988; Wertz and Wertz 1977).

Hospital birth gave doctors an extreme level of control over birth, so they were able to implement protocols of birth that were invasive like the routine use of intra-uterine forceps, episiotomies, and cesarean sections; these interventions had the added consequence of higher rates of infection and mortality (Davis-Floyd 2004; Leavitt 1988; Wertz and Wertz 1977). The hospital served to finally cement the concept of the pathologically normal birth because it placed birth within the context of technological intervention of the sort typically used to treat sick/ill/diseased/damaged patients (Leavitt 1988; Wertz and Wertz 1977). The institutions also finalized the male cooption of the birth space, and control over women's body – a legacy that has continued into today with 98% of births occurring in hospital – by placing birthing women entirely within the sole and explicit care of male obstetricians and its accompanying male science (better read as simply a masculine approach to doing birth) (HHS 2015; Leavitt 1988; Wertz and Wertz 1977).

At this time, women starting asking for pain-free childbirth, stating that, if medical science was advanced enough to move childbirth into the hospital and intervene

in so many ways, then it should be capable of removing the pain of childbirth (Leavitt 1988; Wertz and Wertz 1977). This resulted in many different pain reduction strategies including the use of chloroform gas masks (Wertz and Wertz 1977). Eventually, the technique developed in Germany called "twilight sleep" was brought to the U.S.; it involved the injection of women with morphine and scopolamine, followed by chloroform administration at the birth of the head (Wertz and Wertz 1977). The use of scopolamine caused women to hallucinate during their births, and the morphine slightly subdued them because the state of altered consciousness together with the pain of birth often made the woman thrash about during her labor and delivery (Leavitt 1988; Wertz and Wertz 1977). Often, women were caged in labor cribs during their labors to stop them from falling and hurting themselves while dosed, and were then tied down for their births while their babies were extracted with forceps (Leavitt 1988; Wertz and Wertz 1977). The twilight sleep cocktail had the effect of removing all memory of the birth, with women waking up to an infant, also groggy from the effect of the cocktail, placed in their arms (Leavitt 1988; Wertz and Wertz 1977). The practice of twilight sleep was, for the most part, lauded by both the obstetricians and the mothers because doctors could have full control over their patients, and women did experience the removal of pain.

Eventually, however, women began to push back against the routine use of twilight sleep because they felt robbed of the experience of childbirth, and called for more "natural" childbirth (Leavitt 1988; Wertz and Wertz 1977). The natural childbirth movement of the 1960s called for a reduction in the medical interventions used during childbirth, and pushed back against hospitals "standard procedures for normal birth" (Davis-Floyd 2004; Leavitt 1988; Wertz and Wertz 1977). This prompted many different

responses from the medical community. On the one hand, obstetricians attempted to reframe the public discourse on hospital birth to one that redefined "natural" birth as basically anything that wasn't a cesarean section so that they could maintain control over birth in hospital (Leavitt 1988; Wertz and Wertz 1977). Other doctors responded by creating new methods of pain relief that were non-interventionist, but still intended to keep birth in hospital and under the control of physicians. The most famous of these were the Lamaze techniques developed by Dr. Fernand Lamaze, the husband-coached childbirth method by Dr. Robert A. Bradley, and Dr. Michel Odent's *Birth Reborn* (Leavitt 1988; Martin 1987; Wertz and Wertz 1977).

The Lamaze and Bradley techniques involved educating women about the physiological, biological, and emotional processes of birth, and teaching these women different methods to help reduce pain and birth naturally; the most iconic image being of Lamaze trained women fast-breathing in "he-he-hoo, he-he-hoo" staccato rhythms (Leavitt 1988; Wertz and Wertz 1977). The Odent method took this a step even further and allowed women to control basically their entire experience from start to finish, deciding when to stand, walk, crouch, push, get into a birthing tub, etc. etc. (Martin 1987). All of these methods, however, have consequences at the expense of the women they were intended to help. The Lamaze and Bradley methods served to give clinicians another method of controlling women in the hospital. Jordan describes a scene in an American hospital of a distressed mother, feeling the need to push, being told to do her breathing and stop the urge until the doctor showed up to preside over the pushing (Jordan 1992). In his writings about the births he has attended, Dr. Odent describes women in labor and parturition to be in an "animal-like, unselfconscious state…part of

nature, not of culture" (Martin 1987:164). He reduces their womanhood to non-human status, as opposed to, as Martin states, a "higher-order activity…the kinds of integration of body and mind…engaged in what may be the only form of truly unalienated labor" (Martin 1987:164).

Up to this point I've described the reasons for, and mechanisms by which obstetricians took control of birth in the US. I've explored the history of obstetrics, delineating the origins of the masculine structuring of American birth that lead to its scientific reconceptualization, and established its predisposition towards gendered violence. But I have yet to discuss the ways in which the context of American birth, as constructed by said obstetricians, shaped the regrowth of midwifery into its current state. Returning briefly then to the ways in which obstetricians campaigned to remove midwives from birth, we have to consider the image obstetricians painted of the midwives they slandered. As I said above, obstetricians argued that midwives were dirty, incompetent, unintelligent, unscientific, unsafe, and weak by their feminine nature (Ettinger 2006; Leavitt 1988; Wertz and Wertz 1977). More importantly, however, the image of the incapable midwife was tied directly and purposefully to the image of undesirable populations in the US throughout the obstetric transference of power (D. Bonaparte 2015; Ettinger 2006; Fraser 1998; Leavitt 1988; Wertz and Wertz 1977). In the North, midwives were contextualized as immigrants who did the work of the old country; obstetricians played on northerner's sense of xenophobia with threats of disease and death coming in through the hands of these foreign midwives (Leavitt 1988; Wertz and Wertz 1977). At the same time, the southern midwife was made out to be a homegrown threat. Black midwives, termed "granny" midwives, were painted as

dangerous practitioners of old/traditional magic, and bringers of sickness and disease through their lack of aseptic technique and natural tendency towards uncleanliness (D. Bonaparte 2015; Fraser 1998; Leavitt 1988; Wertz and Wertz 1977).

In her article "Physicians' Discourse for Establishing Authoritative Knowledge in Birthing Work and Reducing the Presence of the Granny Midwife," Alicia D. Bonaparte sets out to analyze the writings of physicians in the Journal of the American Medical Association (JAMA) and the Journal of the South Carolina Medical Association (JSCMA) during the first forty years of the 20th century to see how physicians utilized academic and professional communication and dialogue to the end of disenfranchising, ostracizing, and, ultimately, eliminating granny midwives in the South. She finds three main mechanisms discussed by physicians with the intention of eliminating the "midwife problem": educational propaganda against midwives, education as a tool of abrogation, and supervision as an abrogation effort (D. Bonaparte 2015). Bonaparte's findings illustrate the blatant racism southern physicians were able to pass as 'scientifically based'; "those [negro] midwives were not only ignorant, conceited, dirty, but very superstitious, and that more stringent laws should govern them" (D. Bonaparte 2015).

Those same midwives that were so dirty and insidious, however, did serve some purpose for the physicians and wider American society. With the turn of the century came a new interest in social welfare, especially with a focus on infant and child health (Leavitt 1988; Wertz and Wertz 1977). By this point the transition of birth into the hospital had been well underway, meaning that medically attended parturition was, as well, an established tenet of obstetric sciences. Traditional/empirical midwives offered physicians an out from having to work with the populations they so disliked – the very

populations that gave rise to the midwives so abhorred – and were encouraged to care for the populations until a 'better' solution could be found that did not involve midwives (Ettinger 2006; Leavitt 1988; Wertz and Wertz 1977). So empirical "granny midwives" and immigrant crone midwives were given meager training in "proper" birth care that encouraged these practitioners to leave behind their traditional/non-medical practices, placed the midwives on registries by licensing them, and thus allowed state medical and social welfare officials to remove a midwife from practice if she failed to comply with the regulations set out by her meager training (Fraser 1998).

The medical disdain for the populations from which the traditional midwives came produced a context in which the modern American midwife was able to take shape. In 1925, Mary Breckinridge, an American nurse trained as a midwife in Britain, opened the doors to the Frontier Nursing Service (FNS), an organization that served poor, white women of the Eastern Kentucky Appalachian Mountains (Ettinger 2006). These "mythical," "horseback-riding, mountain-mother-serving nurse-midwives" created a practical bridge between American public health nursing and European midwifery in order to serve a population deemed undesirable in the eye of the medical community at the time (Ettinger 2006:33). Furthermore, this group of nurse midwives not only held up the medical establishment's disdain for "granny midwives," but also actively promoted the idea that their cause was one to save fine, forgotten, American White-Anglo-Saxon-Protestants in rural Kentucky (Ettinger 2006).

Seven years later, the Maternity Center Association (MCA) of New York City opened the Lobenstine School of Midwifery; this school trained public health nurses in midwifery practice to supply competent medical attendance at births of the undesirable

black, European, and Puerto Rican immigrant populations (Ettinger 2006). Both of these schools (FNS eventually opened a school of midwifery in the Appalachians) served to place Nursing Midwifery on the map of medical professions with graduates moving on to establish Nurse-midwife practices all along the eastern seaboard, southern US, and even out west (Ettinger 2006). Sister Theophane Shoemaker, graduate of the MCA Lobenstine School, founded the Catholic Maternity Institute (CMI) in Santa Fe, New Mexico to care for the poor, Native American, and Mexican immigrant populations under the auspices of the Catholic Church (Ettinger 2006). Wherever Nurse-Midwives began to practice in the US, a pattern, sourced in their profession's founding, followed that relegated them to care for those patients deemed undesirable or untouchable by doctors. This fact, however, founded the argument by which Nurse-Midwives ensured the preservation of their profession.

The argument was trifold. First, as stated above, nurse-midwives engaged almost exclusively with undesirable populations (or in the FNS case, desirable but forgotten/inaccessible). The second foundation was a strict adherence to western medicine's obstetric guidance. The nurse-midwives of FNS, MCA, and CMI were all only trained in the care of normal pregnancy and birth, and they stuck to that delineation; if at any point pregnancies were considered beyond their scope of knowledge, the care of their patients was passed to obstetricians (Ettinger 2006). In many instances, if the nurse-midwives were practicing in hospitals where obstetricians normally cared for all births, the nurse-midwives took the role of assisting labor and delivery or ward nurses (Ettinger 2006). Thus, the nurse-midwives were able to fit within the American paradigm of clinical parturient care, avoiding a complete association with empirical/traditional

midwives. The third, and perhaps the most important foundation, placed nurse-midwives in every situation – be it in hospital, rural home, or non-hospital birth center – intentionally subordinate to doctors (Ettinger 2006). This professional standing was often specifically used to argue for the relevance, importance, and unobtrusiveness of nurse-midwives in the medical community (Ettinger 2006).

Once established as relevant in the medical community, nurse-midwives were able to cement themselves. The new nursing specialty eventually gained the right to be considered at the level of the newly coined "Nurse-Practitioner" or Advance Practice Registered Nurse (APRN), gaining privileges of practice and prescriptive authority over their own client base (Ettinger 2006). This new status allowed nurse-midwives to preside entirely over patients with normal pregnancies and births. Furthermore, the profession gradually built up their scope of practice to include well-woman/gynecological care, and sexual and reproductive health care, and has maintained their relation to public health nursing and education (Ettinger 2006). Nurse-midwives went on to establish the American College of Nurse Midwives (ACNM) as a professional organization to support the profession within the medical community (Ettinger 2006). The organization publishes a journal of research intended to advance the nursing specialty in an attempt to establish better care for pregnant and birthing women (Ettinger 2006). But the question remains as to whether or not nursing-midwifery has stepped away from a subordinate existence to obstetrics. As a specialty that is *currently* intended to be "with women, for a lifetime," what are the remnants of its gendered, classist, and racist beginnings? Does the specialty fit within a system of paternalistic and patriarchal care, or has it thrown off the masculinity associated with obstetrics? These questions are particularly potent when

discussing the presence of men in the practice of nursing-midwifery. The following section will attempt to tease apart these last couple questions to establish a framework for this study.

V – Men & Masculinity in Midwifery:

Obstetric violence and the medicalization of American birth result, for the most part, from the gendered hierarchy where masculinity holds the power and authority to control those spaces and ideas deemed feminine. So, the question arises, what happens when men and masculinity enter Midwifery – a hyper-feminized profession. In some capacities, the inclusion of men within feminized occupations is simply beneficial. In their research, Evelyn J. Hsieh, Patricia J. García, and Sayda La Rosa Roca analyzed the data produced by a Peruvian study of midwives in ten cities outside of Lima that specifically asked after "provider management of STIs" (2008). The research team found that all midwives routinely cared for both male and female clients on STI consultations, but that male midwives saw twice as many male clients per month than female midwives (Hsieh et al. 2008). The group, therefore, concluded that the cultivation of a force of male midwives – especially because of the integrated support by and for midwives within rural communities – may be a substantiated goal in order to more readily screen and treat male clients with STI's (Hsieh et al. 2008).

In the case of midwives within the indigenous community of the Semelai of Malaysia, the knowledge associated with birth care – of massage during labor and incantations for difficult pregnancies – had been associated with the midwife's bravery, regardless of their gender (Gianno 2004). Rosemary Gianno, however, catalogues a shift

to the presence of solely male midwives because "[women] were not brave enough;" she finds that the powerful insertion of the national Malaysian culture of biomedical childbirth created a secondary fear associated with childbirth (secondary because the Semelai already fear childbirth, hence the midwife's need for bravery) that established a masculinized need for bravery in the birth attendant (2004:33). This rapid shift occurring over the ten years from the 1980s to the 1990s is indicative of a power differential that, while unable to remove traditional birth knowledge, asserts a new category of knowledge whose authority demands a responsive adaptation within the traditional knowledge paradigm. Furthermore, this presents a case wherein masculinity is not only beneficial within the context of "women's work," but is also culturally necessary. In the case of the Semelai, midwifery is not defined as feminine or masculine, it is defined as necessitating bravery.

However, when men in the western paradigm deviate from masculinity by doing "women's work," they complicate and question the west's hegemony of gendered roles in society. In her landmark study of men who do "women's work," Christine Williams sought to understand the ways in which men both experience and navigate the challenges of working in the feminized professions of nursing, librarianship, social work, and elementary-school teaching. In this qualitative, interview based study, Williams found that the majority of men experienced some sort of othering in the respective jobs (Williams 1995). However, this process of "tokenization," a process that has been found to negatively affect the minority population in a given social space, was discovered to positively affect men in their positions within feminine professions (Williams 1995). Masculinity functioned as a signifier of expertise and skill, as well as a trait associated

with managerial/leadership capabilities, and more often than not allowed men an easier time to make friends and social connections among their coworkers; these traits all compounded to allow men to move up the professional hierarchy much faster, and, in some cases, at the expense of, women in the same profession (Williams 1995).

Williams coined this social process the "glass escalator" to describe the invisible mechanisms that propel men in feminized professions to higher paid, higher responsibility, and more technological positions within their professions (1995). As a consequence of this gendered differential in the hierarchy, Williams found that men often contributed to their own successes by creating vertical relationships among the men in the profession; so men newly joining the profession would inevitably become good friends with the men already in leadership professions, and would thus place themselves at the ready to be promoted (1995). Furthermore, she found that men were often, regardless of their relationship to their superiors, funneled into more technical/appropriately masculine sectors of the professions and/or to higher level positions by their superiors (Williams 1995). Williams therefore concludes inconclusively; she finds that masculinity in feminine professions can serve to forward gender equality and support more positive roles for men, but she also finds that it pushes women out of leadership and high-tech roles in their own professions (Williams 1995). This therefore raises the question as to whether or not masculinity plays a similar role in midwifery as other feminized professions, given the argument presented in this paper that midwifery has been socially defined as hyper-feminine, thus excluding all conception of the masculine.

Birth, as well, provides an interesting professional space within which to study the role of masculinity because the bio-physiological source of the profession so inherently

rests in a society's definition of femininity/womanhood. This differs greatly from professions like nursing, elementary school teaching, social work, cosmetology, and secretary work because the femininity of these professions has been defined by their establishment/creation by women. So, men in birth work have had to create their own right to be involved, and the role within which they can practice. In obstetrics, this process has often been experienced, as described above, as a form of gender based, structural violence; obstetric violence. In a study on clients' gender preference for provider, researchers in the UK found that many male student OB/GYNs felt that patients were uncomfortable with their gender, preferring female students OB/GYNS as during shadow training (Makam, Saroja, and Edwards 2010). Makam et. al. therefore state that, "the inadequate practical training in obstetrics and gynaecology that many male students receive because of refused consent from patients and relative requires that patients and relative appreciate the importance of education to all medical students, male and female, if they are to become effective safe and competent doctors." The devaluation of female patients' desires about their medical care suggests a blatant dehumanization of said patients by the field of obstetrics. It establishes a hierarchy wherein training male obstetricians is more important than the clients' consent and desires. This marks one way in which masculinity defines its own role and space within birth professions, in this case reinforcing the "expert" role.

Masculinity has been shown to take control of the feminine professions it enters. Thus, the entry of men into midwifery raises multiple concerns in the face of the hyper-feminization and self-contextualization as by women, for women. The natural question about men in the profession today is whether or not they experience a "glass escalator"

effect that pushes them to the top of the profession, and therefore assert a level of gendered control onto the care of birthing women. This would be a subversively appropriative role counter to the conception of midwifery itself. In the only American study on men in the profession, midwives Ira Katrowitz-Gordon, Simon Adriane Ellis, and Ann McFarlane attempted to understand this counterintuitive role. They did so by conducting a qualitative, internet-based survey sent to the entire constituency of the American College of Nurse-Midwives. This returned only 31 responses from male midwives, which is potentially a large percentage of the overall masculine proportion of midwives since the ACNM states that fewer than 2% of midwives make up this segment of the constituency (Kantrowitz-Gordon, Adriane Ellis, and McFarlane 2014). Kantrowitz-Gordon et. al. first situated the concept of men in midwifery within the available literature about gender diversity within the nursing profession, as there is lacking available literature on the gendered nature of midwifery. In doing so they explain, in agreement with Williams above, that men in the nursing profession often paradoxically experience discrimination and privilege because of their gender: they may receive discouraging and discriminatory remarks from their professors, colleagues, and friends, but they often are pushed towards the more technical and leadership roles more quickly and often instead of their feminine counterparts.

Their findings expand on those discussed above with five thematic experiences of the men in the study: Singled Out, Social Support, Exclusion, Pride in Work, and the Paradox of Man as a Minority (Kantrowitz-Gordon et al. 2014). The authors found that the respondents frequently described their experience of being demarcated as the man in the room, never being allowed to simply be another midwife. Social support described

the dichotomous relationship these midwives had to their social circles where some sources were hugely supportive and others were altogether discouraging. Exclusion functioned as more of a professional limitation in that the exclusionary beings were clinical sites and schools. But the participants were, despite the challenges, extremely prideful in the work they did with women. Furthermore, the men, for the most, part did not consider themselves as a true minority because of the privilege their masculinity still brought them substantial privilege. In their conclusion, Kantrowitz-Gordon et. al. emphasize the substantial percentage of participants who experienced challenges as a result of their gender, and point to the need for further research on this finding and on that of the discrimination experienced by trans-masculine midwives (2014).

However, the study of men in midwifery is not so limited in countries besides the US. In France, where midwifery has a longer, more cemented history of accepted medical merit (like most of Europe), multiple studies have been conducted on the role of men in the profession (Charrier 2011). In his robust, mixed method, interview and survey based study of male midwives in France, Philippe Charrier provides an excellent analysis of the masculinity developed and performed by these men. The masculinity presented in this study plays a surprising role not seen in much of the work on men who do women's work. Most surprising is the finding that the male midwives seemed not to ride the glass escalator to the top of their profession (Charrier 2011). Rather they felt quite content in their role in the profession without any need to move up the hierarchy, nor were they actively funneled up the ladder; in fact, the men professed a desire to be seen and to act as no different from any of their female counterparts (Charrier 2011). Charrier states that this finding may be a result of the positive conception of midwifery in

France which is "generally considered a prestigious field" (Charrier 2011). The prestige described may counteract the men's desire to work towards an achievement of a higher status in the profession in order to compensate for their masculinity in a feminized space (Charrier 2011).

This said, men may not feel the need to compensate for the masculinity at all in the midwifery profession in France. Charrier reports on the counterintuitive ways that men in this profession attempted to overcome the gendered boundaries to achieving a traditionally feminine trait: empathy (2011). The men in this study displayed empathetic characteristics by actively engaging in their clients feelings/experiences, emphasizing the professional and learned capacity for empathy, and confronting their masculinity head-on by establishing a "link" with their clients via a direct introduction of themselves as men (Charrier 2011). Charrier argues that the combination of an intentional attainment of empathy and the avoidance of masculine compensation in the feminized space leads to different paradigm of masculinity; respectful masculinity (Charrier 2011). Charrier does, however, allow for the caveat of a structural limit to the advancement of masculinity in the profession due to the distinctly non-hierarchical structure of French midwifery (2011). Thus, Charrier's "respectful masculinity" is not necessarily a negation of hegemonic masculinity; rather it is an attempt by men not to outcompete, coopt, or control the femininity of midwifery. The findings of this study present a novel adaptation of masculinity within the context of a feminized profession, specifically as a result of the sociocultural and structural qualities of the profession itself. Charrier's findings are an important empirical basis for my own study as they present one of the few analyses of masculinity as it is performed specifically within midwifery.

VI – Conclusion:

In this chapter, I have discussed the current sociological, anthropological, and nursing literature on midwifery and childbirth. The above first outlines the ways in which midwifery and childbirth are both socioculturally and biologically defined, and therefore practiced differently in various cultures. This contributes to the manner in which knowledge about birth is constructed, so that it is established along structures of power within, and differences between cultures. In the western context, the medicalization of birth that occurred over the eighteenth, nineteenth, and twentieth centuries lead to the construction of western obstetrics as a specifically scientific – and thus powerful – knowledge base. Furthermore, the power dynamic of this obstetric restructuring of midwifery placed male dominance over a field that had been, for centuries, an exclusively feminine space. The current discourse within midwifery research is therefore structured as a scientific response to science in an attempt to effectively counteract and subvert the authority of knowledge held by obstetrics. The scientific response to science is, I argue, structured as such to give backbone both to the methodology of midwifery, and in support of the women the profession serves. This model of professional support contrasts that which has been experienced by women within an obstetric context. Obstetric violence, as described by the literature, is a systematic form of gender-based violence wherein the autonomy and agency of pregnant/birthing women is requisitioned sans-consent. This raises, then, the question as to what role men may be able to play within the profession. With very little literature existing on the role of men in midwifery, I turned to the general literature on men in

feminized professions to analyze the role masculinity plays in a feminized context. While the limitations in the quantity of studies on this specific profession with regards to masculinity leave much space for inquiry, the current research does suggest a difference in the way that masculinity is enacted within midwifery in that it may be more respectful than authoritative. Furthermore, men in midwifery may be tokenized in a more discriminatory capacity than has been observed in men of other professions.

Motherhood and the Midwifery Relationship

I – Gendered Contexts

The mothers in this study did not enter into midwifery care from a social vacuum. Personal histories of clinical trauma from obstetrics and gynecological care both contradicted their self-conceptions, and informed the ways in which the women approached their clinical birth and pregnancy care. In contrast to this medicalized treatment, the women conceptualized their motherhood identities as essentially defined by their own femininities. The essentialism with which the women considered their pregnancies lead the women to choose the care they felt would best support a normal pregnancy and birth experience. These contexts create a gendered foundation to the relationships the women would eventually build with their masculine midwives.

Obstetric Trauma

The obstetric model of care authoritatively controls the female body, and has been doing so since its conception by male doctors. "I had some doctor tell me I had the educated woman's disease." By this, the doctor meant that Meredith, a mother of four from Connecticut, would eventually be unable to have children because she had spent too much time focusing on her education, and her window of conceptive-opportunity would surely shut. Framing it as a disease, the doctor pathologized her education, positioning it in direct opposition to her biological nature as a woman. This reduced Meredith to her 'productive' capabilities for surely if she were to have no children, Meredith would be personally ill and socially undesirable. Meredith received this care during the 1970s' period of social unrest wherein women were rebelling against the medicalized conception

of childbirth. Meredith's medicalized experience of childbirth created a basis to compare the other modern birth experiences of this study.

The respondents, however, did not discuss a shift in the medicalized treatment of pregnancy and birth in their interviews. Samantha, a mother of three from Seattle, experienced in vitro fertilization (IVF) treatment, and the repositioning of her partner's infertility onto her body over the course of a few years during the 2010s. Samantha and her husband knew that they would have difficulties conceiving because Samantha's husband had had testicular cancer at the age of twenty-one. Although their "infertility never had anything to do with [Samantha], it was a male factor issue…the whole process of trying to get pregnant, the focus was on [Samantha], and all the treatments were on [Samantha], and it was [Samantha] doing all these injections." For Samantha, the medical community situated her partner's inability to conceive as a pathology of her body, and a question of her productivity as a woman.

Every woman interviewed in this study recounted some manner in which their choice was overlooked, their experience was undervalued, or there lacked an infrastructure/procedural norm to incorporate her desires regarding her pregnancy and birth. These women each felt that, in some way, obstetrics had failed them. According to her OB/GYN, "if [Sophie couldn't] manage… just morning sickness," the only option was to terminate the pregnancy. This "solution" came only after multiple visits to the OB/GYN that minimized and/or ignored Sophie's experience of extreme nausea, vomiting, loss of appetite, inability to eat, pain, weight loss, and generalized discomfort. Her midwife later diagnosed this series of symptoms as Hyperemesis gravidarum –a manageable condition. Sophie, a mother of two from San Francisco, needed some

serious "handholding" to be able to work through the extreme symptoms of her condition. Her obstetrician lacked the ability to support Sophie in the validating, empathetic, and individualized way that she needed. The ultimatum of an abortion countered her essential conception of herself as a mother.

Motherhood as Femininity

Motherhood was, by all accounts, a normal, expected, essential identity marker. For Meredith, her innate desire to be a mother was tied to the idea of family and culture. Family was an assumed eventuality because "family is really important in Greek culture…it's all about family…families take care of each other…those are the people you can trust." In order to fulfill the filial/cultural obligation of family placed on Meredith by Greek tradition, she had to achieve the status of motherhood. Importantly, this was not a burdensome obligation for her. Meredith never "even considered an option of not having children," suggesting that there wasn't an alternative option to begin with, therefore no struggle.

The women in this study upheld motherhood as both central representations of, and a force for constructing their identities as women. Lynda, a pregnant woman living in New York City, conceptualized motherhood as indicative of her womanhood; "I feel like becoming a mom is central to who I am as a person and my identity as a woman…I think it's so global and so deep-rooted in who I am." Lynda's gender built the foundation for her motherhood identity, which subsequently defined the basis for her professional endeavors (early childhood education) and her decision to foster children.

Retrospectively, motherhood functioned more often as a representation of the respondent's womanhood. Therese, a mother of three from Los Angeles, stated;

> *"I always imagined myself being a mother…I always loved kids, I worked with kids, I babysat, and I always imagined myself being a mother…it felt very natural, it wasn't even anything that I felt really conscious about - it was like, we were gonna get married, and we were gonna have children."*

Therese describes a continuous assumption about her identity, and associates that assumption with actions that were childhood mimics of motherhood. The women discussed childhood as a period of fostering motherhood. Like Therese, Samantha described herself as "the little mommy… always playing with baby dolls and always kind of a little nurturer." She went on to say that motherhood was always "in [her] personality," or a constant in the way she interacted with the world. Samantha held motherhood as both innate to her self-image, and defining of her behavior.

However, not all the women felt that motherhood had been a present identity throughout their lives. Neither Monica, a mother of three from Seattle, nor her husband had wanted children. But one day, Monica changed her mind, and decided that she wanted to start a family with her then boyfriend; "I don't know if something flipped in me, or whatever, but then I was like 'so if you don't want that, let's break up.'" This instantaneous transition was, according to her memory of the switch, something over which she had no control. It was innate to her personhood, to her identity – motherhood became her identity. So even though Monica didn't discuss any indications of a motherhood identity in her childhood or life decisions, she still experienced motherhood as essential, internal, and intrinsic. Motherhood was a universal symbol of self in this pool of respondents.

Natural and Normal Childbirth

Motherhood was as much an identity in and of itself as a bridge to a femininely defined birth experience. For Lynda, this birth experience was situated in a belief about the strength and capabilities of her body. She discussed wanting "to feel holistically supported in having a natural experience…grounded in a really deep belief…it's what [her] body is capable of." This capability, this belief in the strength of her body was linked to the belief that she could give birth naturally. By this very nature, her strength and capability were wrapped within the idea of the feminine. In many respects, the discussion of natural childbirth by the women in this study was a discussion of validating their bodies' and their essential identities as mothers and women. For Samantha, the midwifery care she received was a "conscious choice" in an effort "to move onto feeling like a normal pregnant person" after "such a medicalized process to get pregnant." The "nurturing" and natural care she received from her midwife was part of her own normalization process to remove the sense of being "like a lab rat." Being a "normal pregnant person," for Samantha, meant being able to choose a more natural course of care, one that emphasized her connection to femininity. Samantha described having midwifery care "like having your mother or your aunt or your sister there with you at your birth." Natural childbirth and birth care was, for Samantha, a link to a community both filial and feminine in nature. They were synonymous in that every time Samantha discussed a desire to be nurtured in her care, she associated that nurturing with women. Finding a community in natural childbirth supporters seems to have been more or less common amongst the respondents.

For Meredith natural childbirth was very much so a rebellion. In the 1970s when she was giving birth to her first two children, Meredith's only option was obstetrician attended, hospital births. Despite this limitation, Meredith constantly fought to achieve as natural a birth experience as was possible. The limitations of control and agency imposed by the medical establishment at the time meant that Meredith "was very conscious of wanting to be in charge of how [her birth] happened." And she wasn't alone in her natural endeavors; Meredith built up her own agency by "finding other women to hang out with that felt the same way." She engaged in an activist community of women seeking natural childbirth who gave each other advice on how best to rebel against the system, organized protests, and supported each other in their endeavors. This desire for natural birth care was predicated on family beliefs and experiences; it was predicated on Meredith's conception of normal as constructed by her family history. In discussing her family's birth history, Meredith recounted, "my sisters were all born at home…my father's family all, everybody was born at home in those days…and my mother, of course, breastfed." So while the context of medical care at the time of her pregnancies required Meredith to engage in a rebellious search for natural birth care, the reasoning behind her search for said care was based in a concept of normality in birth.

The women in this group of respondents who actively searched out midwifery care seem to have had more of a specific desire or relationship for natural healthcare in general. Monica, for instance, "[loves] naturopaths, because [she feels] like they are more holistic and more well-rounded" in their care styles, and incorporate both western and homeopathic/holistic perspectives of healthcare. The naturalistic healthcare Monica experienced didn't negate western medicine. Rather she uses homeopathic health care

because she believes it acknowledges the validity of western medicine, but considers it incomplete. This sentiment was echoes by Samantha who "chose midwives [because] this person who's medically trained…and helping you give birth" is also a "nurturing" and "motherly" figure.

The combination of western and natural health care pedagogies augments the sense of safety and support that the women received from their natural healthcare. Samantha, also a naturopathic doctor, knows "from [her] own medical background…that being in a hospital [for birth] is not necessarily really the most safe place to be." Notice that this is not a negation of hospital safety. It's a statement that allows a hospital to be safe in certain cases, but also allows for safety in non-hospital settings. This effort not to negate western medicine through a preference toward natural healthcare was clear throughout the interviews. Lynda, in fact, would have been perfectly okay with having an in-hospital birth in New York City, but she found that the infrastructure of midwife supported, in-hospital birth was, at the time, overcrowded due to the closing of an in-hospital midwife clinic.

However, this sentiment of natural health care as a completion of western medicine did not come without its critiques of western medicine. At the time of Meredith's first two births, hospital-based, labor and delivery practitioners would "give you sugar water to give to your baby." But Meredith's familial understanding of a natural and normal childbirth, and participation in the natural birth activism community told her to "nod [her] head and say yes, and then…dump it out, and then lie to them and tell them that [she] fed the baby sugar water." While this action was in opposition to the medical recommendations of the time, it was not a critique or negation of the entire

system. Importantly, however, it was a critique of the de-feminization and alienation of mother and baby in the hospital (a legacy brought over from the days of early hospital maternity care, and the twilight sleep era). To give birth is to become a mother – assuming all of the rights and responsibilities of being a mother includes the right to breastfeed your baby. So Meredith's actions were embedded within her feminist activism, engaging directly with medical ideas that stripped the femininity from the birth experience.

Another common critique of the medical system discussed the ways in which the healthcare was potentially dangerous. Monica, for instance, denied frequent ultrasounds of her baby because she "[feels] like there's evidence out that they don't know enough about them, about how much they're affecting the bay in utero." This concern is built upon a belief that "OB practices and gynecological care in the United States…[doesn't] have the best intentions." She holds this belief because she knows the maternal/fetal statistics on the US, and recognizes that "we're so poorly rated compared to other people who are a little bit more hands off." This concern, like Meredith's above, worries that the medical interventions of modern obstetrics are potentially, or proven to be harmful. These concerns have clear links to the transition from social, feminine childbirth to a male dominated, violent obstetrics because they call into question the objectives and morals of said medical practice.

The context presented in the findings above creates a starting point to work through the trajectory of the relationships the women in the study had with their respective cis-masculine midwives. To this point, we can see that the women who participated in this study all shared similar experiences of pathologization and/or

dehumanization when is came to their obstetric care. They felt that their births and pregnancies were treated as abnormal, medicalized experiences. This was contrasted by the way the women identified with motherhood and its associated femininity. The general consensus among the the different interviews regarding the identity of motherhood was the normality and essentialism of the identity. Furthermore, motherhood acted, not just as a literal representation of womanliness, but as a bridge to natural healthcare. Structurally, the women began as women. Their identity was of the feminine gender, and encompassed in that identity was an essential, innate desire to be a mother. In order to achieve this identity, women chose a path towards natural health and birth care because they didn't have a personal conception of birth as pathological. The only two mothers who did not search out natural birth care from the beginning didn't hold any issue with natural birth care, they simply followed what they knew to be normal birth care: obstetrics. Importantly, this naturalistic birth care was not a negation of western medical obstetrics, but in many ways it was a critique of the overly medicalized and pathological ideation of birth held by the field. It is with this context that we enter the discussion about the relationship clients had with their midwives, and watch the transitions that occurred.

II – The Relationship Arc

The mothers in this study experienced a relationship arc with their cis-masculine midwifery providers. The arc began in a confrontation between clients' expectations of their midwives' gender, and their personal and intertwined identities of mother and woman. As the arc progressed, it became clear that the model of midwifery care the

women received mitigated the masculine gender identities of their midwives, allowing them to bond with their practitioners, and experience empathetic and empowering care. These shared experiences, however, did not entirely recalibrate each woman's preconceived belief about masculinity; rather the mitigation was specific to the single cis-masculine practitioner administering midwifery care.

The Confrontation

This first stage in the relationship arc is characterized by a confrontation between the clients' assumptions about their male practitioners and their expectations of midwifery care, coupled with some factor that allowed the women to receive care from these men. In some cases, the confrontation created a sense of fear in being cared for by men. Monica had a history of sexual abuse, and was nervous that having a male practitioner would mean a birth experience that lacked in empathy; "So it was a team. It was a team of two - one was a woman and one was a man…I actually had reservations because I REALLY liked her, but then I was uneasy about having a man as my midwife." She had never had a male OB/GYN, and didn't know what to expect from having a male practitioner. But Monica was very comfortable with the female midwife, and felt that the "team [fit her] philosophy," so she decided to hire the male/female team despite her discomfort. Monica confronted the gender of her midwife with a strong sense of discomfort because she had a traumatic history of sexual abuse. Her expectation of midwifery care was situated in the idea that she would be supported during her pregnancy and birth in a way that best suited her individual needs. The presence of the cis-feminine

midwife assuaged her fears that the masculine midwife would be incapable of providing the empathetic care she wanted because he wouldn't be the only one providing care.

The confrontation, however, didn't exclusively imply a negative interaction between clients and their practitioner's gender. In Therese's case, the midwife created an opportunity to acknowledge the potential discomfort of his client; "I would love to assist you with this birth, but I know I'm a man, so how do you feel about it?" This statement indicates that the midwife was aware that his gender could have been a problem for some of his clients (presumably mostly women), and was making space for any confrontation that needed to arise. Therese's responded with happiness; "I was happy that there was someone who cared and wanted to, you know, be there as part of the birthing process." From Therese's perspective, this midwife who entered her room to assist was vastly different from her male obstetrician who showed up only to preside over the pushing. In this context, it's no surprise that she was comfortable receiving support and assistance from anybody who offered. Similarly, Sophie was placed in the care of her midwife by her OB/GYN who was unable to diagnose her hyperemesis gravidarum. The transfer of care happened at the peak of Sophie's symptoms – her midwife "walked in, he was serious, but smile on his face…[he] recognized the seriousness of the situation." And in that moment, her midwife diagnosed her disease, and set her on a course of treatment that would allow her to carry to term. For Sophie, there was no emotive confrontation, rather she was validated instantly, and so accepted the care she was given. The confrontation was this moment of being validated.

This initial confrontation stage aligns with the ways the women described their beliefs and understanding about gender. Most notably, regardless of a positive or

negative confrontation with the gender of their midwife, women tended to have essentialist notions about gender and gender relations. This was discussed above in the way my respondents perceived themselves as women and therefore mothers. But these notions of gender as essential and normative extended to men. For Sophie, whose confrontation consisted of a validation, "straight male healthcare providers tend not to be as caring, soft, personable…they're like tough and macho." This belief comes from, first, an assumption that "doctor equals male" because "a *lot* of [her] family members…were doctors, and everybody was [male]," and from personal experiences with men that taught Sophie that "generally men tend to view women as whiny and weaker." Samantha, who confronted the gender of her midwife with discomfort, felt that male midwives would have "that barrier there that makes it harder for them to connect with their female patients" because she believes that "women are looking for that kind of motherly sisterly feeling of being cared for by another woman."

When Lynda first met her midwife, she and her husband briefly confronted his gender with a moment of surprise. Again, this makes sense because in Lynda's mind, a male obstetrician or birth clinician is "gonna come and be all up in [her] grill, and try to support [her] through an experience that he hasn't had and…has been prepared for in a very medical, clinical way." So to be approached by a male midwife when her expectation was to receive care from female providers would be, at the very least, surprising. However, these essentialist beliefs of "male clinician ≠ caring/nurturing" were not universally professed by my respondents. Therese, for instance, felt that "gender was not the issue." Instead, she felt that it was important to consider if the clinician can "build the relationship…make you feel comfortable…make you feel like

they know what they're doing so that you feel like 'ok, this is a confident individual who can really take care of me.'" And this conception of gender fits with Therese's reaction to the gender of her midwife. As stated above, Therese reacted with happiness because someone with clinical skills was present and wanted to support her through her birth. Each of these conceptions of gender mapped onto the reactions the respondents had to their male midwives. The women in my cohort of respondents were bringing in their assumptions and experiences of masculinity into the clinical space, and initiating their clinical relationship with a pre-conception about the type of care their masculine midwives would provide.

Gestation

The care the mothers received during the gestational period in the relationship arc engendered a deeper comfort in their clients in spite of the midwives' masculine identities. Following the gender confrontation, clients received care that ranged from the full nine months of pregnancy up to just assisting at labor. And in all cases, this period of prenatal care established a precedent for the clinical relationship that worked to, in some cases, partly quell the nerves associated with the practitioner's gender, and, in all cases, provide visibility, autonomy, and individuality in care. Visibility was a two-pronged element of the clinician-client relationship discussed in the interviews; it was comprised of validation and communication. In choosing midwives for her homebirth care, Monica "felt like a woman might just be a little bit calmer…[she'd be] be more comfortable just being [herself] in front of a woman." She wanted someone to support her discomfort with medicalized obstetrics in the US who could also utilize medical science and

knowledge. Furthermore, her history of sexual abuse trauma made the gender of her practitioner particularly charged; the idea of a male practitioner just "wasn't as comforting to [her]," and she "felt like there'd be a lack of empathy." In the beginning of her care, Monica was mildly uncomfortable with the vaginal exams when they were – rarely – performed by her male midwife. But at every hour long appointment with the midwives, Monica would ask "1,000 question," and her male midwife would "do his research to find [the answer]. And [he'd] do it in front of you." Her midwives worked hard at "normalizing everything" in her pregnancy. She could email her midwives any time, and she found that her male midwife was "super quick on email." And eventually "he really ended up being [Monica's] primary."

Therese expected to receive classic obstetric care, and instead received a model of care from a masculine midwife that was predicted on listening and validating her experience during birth. When her midwife walked into the room and offered his services for labor support, Therese found him "warm and wonderful and communicative." Coming into this first birth, Therese "had a lot less knowledge," and really valued that "he was very 'on.'" Her midwife "shared a lot of information with her," and helped Therese process the new experience of labor and deliver; "you know, when we were talking about epidural, he was like 'this is why you may want one, this is why you won't want one.'" When the anesthesiologist place Monica's epidural incorrectly, her midwife trusted her, and confronted the defiant physician, saying, "'but the patient is right, you're not right." Very quickly (especially in comparison to the other clients in this study who had multiple months to build connections with their midwives) Monica's midwife became "*the* person…this nurse was *really* fabulous."

These two accounts present two entirely different timelines of clinical midwifery care. Yet they both follow a pattern of relationship building via prenatal care that was mirrored throughout the interviews. The two cases above are good examples of visibility in care. Whether over a nine-month period with Monica, or a few hours with Therese, both their midwives established a precedent of communication that was foundational to building a relationship of trust. Monica "liked the fact that [her midwife] wasn't like B.S-ing [her] about anything." She was able to trust his words and intentions because truth was the basis of how he shared knowledge. The frequent contact, and a style of natural clinical care that was predicated on "pulling more from the science mind" also shows how the midwife was able to reflect Monica's desires for scientific but non-medicalized care in his actual practice. This is, thus, a component of the validation Monica received. Therese's midwife worked at building up her knowledge about the labor and birth process. As described above, he didn't share information to persuade Therese to choose a specific course of care. Rather, her midwife communicated the positive and negatives around clinical decisions. He then supported her in whatever choice she made, as seen in his support in ensuring a well placed and functioning epidural, validating both her choice and her discomfort.

Visibility also took the form of communication. Prior to her pregnancy at the time of her interview, Lynda had experienced a miscarriage. Her "trust in [her] body had been challenged in that – how did [her] body not even know and let [her] know that [she] was miscarrying." In knowing her history, Lynda's midwife tailored his clinical approach to her comfort level;

> *"'When I'm doing the scan, I tend to make a lot of faces while I'm looking at the screen, and that is my way…of just analyzing what I'm seeing, don't*

read into my faces…I will tell you right away, verbally, if I see something that's concerning, I won't wait to tell you'"

This was a very simply, quickly mentioned statement that was integral to Lynda's experience of midwifery care. First, her midwife was communicative – he was communicative about being communicative. In other words, he engendered her trust by presenting his unique expressiveness as simply a style of practice, and assured Lynda that all information would be shared immediately. Secondly, her midwife validated Lynda's history and personal trauma as a result of her miscarriage. He knew that this scan, the same scan that she had found out she had miscarried the first time, would be particularly anxiety inducing for Lynda, and so he preemptively named her anxiety, gave it space in the clinical setting, and allowed his client to understand that he was paying particular attention to that anxiety. In this way, her midwife created generated visibility for Lynda.

In this same instance, Lynda's midwife also established an individualized course of care, fulfilling a second of the three tenets to the care the women in this study discussed. At the end of this appointment, Lynda's midwife formulated a preference guide for future appointments; "'I'm just gonna put a note in your chart that, when you're getting scans, this works really well for you…if somebody else is working with you, [they will know] the preferences that you have that make you feel more comfortable and at ease." This individuality was paramount to Lynda's clinical experience, so much so that she "always would have preferred to see him, even to have [her] messages returned by him." In Lynda's case, visibility and individualized care completely assuaged her, self-described "cognitive dissonance" with the masculine gender of her clinician.

This individuality was also present in the care Sophie received during two very difficult pregnancies. Sophie's hyperemesis gravidarum required some rather intense

medical intervention. As described above, Sophie's OB was unable to diagnose her hyperemesis, and went so far as to invalidate the level to which Sophie was experiencing its symptoms, suggesting termination as the only solution. When Sophie was handed off to her midwife, she was validated both in her experience of the symptomology, and with a diagnosis. Once she was being treated for hyperemesis gravidarum, her midwife could tailor his care to fit to Sophie's specific situation. Her midwife would pay attention to Sophie's demeanor, "If it looked like [she] was having a bad day, he would just kinda quietly sit and be like 'how has the week been? Are you feeling any better/any worse?'" Her midwife made sure to make a lot of appointments for Sophie; "he said he wanted to make sure for [her] morale, he wanted [Sophie] to hear the baby's heartbeat as much as possible." This approach to care was centered in Sophie's experience of pregnancy. It focused on the fact that her pregnancy was difficult, and her OB experience may have made her question her ability to carry her baby to term. Allowing Sophie to listen to the baby's heartbeat reinforced its viability, and gave her something to hold onto, to focus on.

Meredith switched to midwifery care after two births under the care of obstetricians in order to gain the autonomy she desired in her birth experiences. Giving birth in the 1970s and 1980s, her hospital experiences were exceptionally medicalized. When she got pregnant a third time, she became aware of a newly registered CNM being used for homebirth care by a group of her friends in Connecticut. She had met this midwife before, and knew him as an acquaintance and as part of their community, so her confrontation was basically nonexistent. Meredith "didn't go out interviewing midwives, he was the only one that [she] called." The care that her midwife provided was starkly

different from the care she received in hospital. Meredith "was considered at [her third birth] to be a mother of advanced maternal age because [she] was 37…[she] knew how the medical establishment was gonna treat [her] in the hospital." She was aware that the hospital would be invasive, uncommunicative, and remove much of her independence. Her midwife, however, "did all of [her] prenatal care at his house or [Meredith's] house…was gentle, knowledgeable, cooperative in doing whatever [she] wanted to do." Meredith's midwife experience was characterized by an emphasis of individualized autonomy. The care was provided noninvasively in Meredith's own home; she "never had the ultrasounds. [Her midwife] did limited internal exams," but "he didn't take any chances…he followed [Meredith] very closely." Meredith's midwife was able to provide scientifically informed, competent, and advanced obstetric care to an pregnant woman, thus tailoring the medical care to fit with her desires for a normative and natural birth experience. As such, he also afforded Meredith the autonomy to decide how she wanted her care to look, where she wanted her care to take place, and who (of her family) she wanted present for check-ups and the birth – all characteristics that drastically contrasted the care she received in hospital by obstetricians. Meredith and the fellow women discussed in this section received prenatal midwifery care that was structurally based in the provider seeing and validating their clients, creating a course of individualized care, and allowing for a high degree of personal autonomy.

Let Him be Gay

Through their experience of prenatal and antepartum care, the majority of the women interviewed in this study reported a reconceptualization about the gender of their

male midwives. They felt cared for, supported, and validated, and thus had really positive experiences and relationships by the end of their pregnancies. But part of the feasibility of this reconceptualization was a theme regarding the assumed or desired gay sexuality of their male midwife. Sophie stated this as a specific and blatant desire. In discussing her ideal male clinician, she stated; "if it's gonna be a guy, I'd prefer that he be gay…In fact, I want him to be gay." Additionally, "when [she] started to feel better, and [she remembered] saying to [her] husband, 'um, [my midwife], is he gay?'" Her husband responded with the affirmative, and Sophie "[thinks she] would've felt differently if the answer was no. For sure [she] was relieved that the answer was yes." This desire for a gay clinician stems from a desire not to have "that whole opposite sex thing going on." Upon clarification, I understood that Sophie was worried she would be sexualized by a heterosexual clinician, and that a homosexual clinician entirely negates this possibility.

Lynda shared Sophie's desire for a homosexual clinician, but her desire was more complicated by gender perceptions. Lynda's perception of her midwife was that "he didn't exude masculinity…at all. [she] didn't get those vibes from him, if anything [she] got, you know, more feminine-like vibes from him." This femininity allowed her to feel more comfortable when her midwife was providing care. In addition, Lynda really valued the fact that her midwife was gay, but felt conflicted about the implications of her desire:

> *"I think part of that was his gayness, to be honest. Like I just really, loved, and adored, and appreciated - and I don't even know why, I feel like that's really maybe shitty of me to like love that and decide that it impacted the experience - so a lot of me sharing it with friends and pregnant friends was "I had this FABULOUS gay male midwife, let me tell you all about why."*

Something about her midwife's homosexuality added to her comfort in his presence, but Lynda was unable to articulate why gayness was a specific character trait that encouraged this comfort. From her discussion of this idea, especially of her description of the "FABULOUS gay male midwife" to her friends, it seems that her affinity for his homosexuality was related to a comment made by Sophie regarding homosexuality in gender. In discussing her comfort with gay male clinicians, Sophie made a general claim about gay men; "I mean gay men are like the best." Sophie's claim and Lynda's description allude to this idea that gay men exist as accessories for cis-heterosexual women to collect. This makes me believe that there may be some sort of sentiment about, not only the perceived harmlessness of gay men, but also some sense of ownership or – at the very least – cis-privilege at the core of this comfort with homosexual providers. Thus gayness and femininity observed in clinician seems to be something that outright negates the fact that the clinicians are male, and engenders comfort without the need to navigate discomfort.

The Birth

The birth defined the final stage of the relationship arc as a transformation. The physiological and emotional transformation that came with my respondents' births included a transformation about the beliefs the respondents held about their masculine midwives. Meredith's now adult son and his wife planned to have a homebirth with a midwife. This was unbeknownst to Meredith, but when she flew out to see her grandchildren, the midwife wanted to meet her. Meredith was told by that midwife that there was

> *"much love in [her] son, because he was the only father-to-be that she had ever had who had experienced home births. And he was so knowledgeable, and so gentle through the process with his wife, because he had been there for his siblings' births…It would turn out to be a good thing."*

Meredith attested this to the transformative experience of, not just experiencing his mother's homebirth, but participating in her care under the guidance of her midwife; "my son was only nine and a half, and he was chosen, of course, to sit at my head, and to feed me ice cubes." Meredith's midwife "explained to [her children] what was happening with [her] in terms of going through transition…he was able to not only keep track of me but also keep track of my children, who wanted to be part of the experience." He created a dynamic that was transformative for the entire family. In this last hours of his care, this midwife was able to create a legacy of a positive birth experience that Meredith was, thirty years later, able to see realized.

Monica "wanted another woman – in case [she had her midwife], [she] wanted another woman in the room…so [she] could have somebody who [would be hers]." Monica had hired a doula to support her during her birth, but she ended up relying on her male midwife more than the doula. Her midwife was "very reassuring and calming and knew what he was doing." He was so "awesome," that "during the birth, it was like – [she] couldn't give a shit" that he happened to be a man. Once the baby was born, Monica could continue seeing her midwife in his naturopathic capacity; "It was *so* seamless. Like I love the continuity of care, the community that it provided." Her birth experience, and the care that her midwife provided during that period finally shifted Monica's discomfort with her midwife's gender entirely. In reflecting on the care she received from her midwife, Monica said, "I *adore* this man now…I would look back and be like 'why did you ever have any hesitation?'"

The experience Monica and Meredith shared described a transformative experience. Their prenatal care, as discussed above, focused – beyond the clinical – on the development of a relationship. In essence, the care functioned as a transitional state between from initial gender confrontation, through the actions of the midwives that supported the women, and landing at a comfort and trust between client and clinician, setting a foundation for a positive and affirming birth experience. But the experiences of midwifery care during the women's births created the space for transformation. The transformation in each case was different, and predicated on the intentions of the women as they entered their midwifery care. Meredith intended to utilize midwifery care to achieve a personal and political goal of natural childbirth during a highly medicalized period in American obstetric history. In many ways she used midwifery care in the face of this medicine, especially as an older mother. As such, her own personal transformation was so apparent immediately after her homebirths. She succeeded in achieving an autonomous, midwife supported homebirth; that was a success, period. Her transformation was a legacy that Meredith and her midwife left in the future of her children. No only was her son "knowledgeable, and so gentle" with his with about homebirth, but her daughter went on to be a physician after she "helped in the delivery, she was eleven and a half, and assisted [the midwife] in the delivery…she held her sister's head as [the midwife] rotated the shoulders, and the baby slid into her arms." These experiences were profound, and left lifelong impressions on her children.

Monica's transformation was certainly much closer to home, and immediate. Whatever hesitation she had about her male midwife prior to her birth quickly dissipated. The experience transformed her midwife into her primary medical support. He became

her children's naturopathic pediatrician, and she decided not to move because she "'would lose [her midwife]' so that just shows you how much [the family respects] him." Needless to say, gender, with her midwife, became a complete non-issue for Monica ultimately because of the transformative experience of her birth. Sophie shared this immediate transformation that established a long-term relationship. In the end, Sophie's birth was a non-elective cesarean that was made incredibly relaxing and positive in stark contrast to her entire pregnancy. As soon as Sophie entered the hospital in early labor – a period of time when mothers may be sent home until they dilate further – her midwife secured her a place on the ward; "'Well [your midwife] has spoken, and apparently you have suffered enough. You are not leaving this hospital without a baby, so you're in.'" Furthermore, her midwife created a contrast to extremely uncomfortable pregnancy by allowing Sophie to "have whatever [she wants]," so Sophie "hung out, like 12-14 hours, not uncomfortable, totally fine" having had an epidural placed upon arrival to the hospital. In addition, Sophie was surprised to find her husband doing a poor job at supporting her through her birth, but her midwife "filled in some of the gaps where [Sophie's husband] was not good." Sophie's prenatal and intrapartum care founded a long lasting clinical relationship. This relationship soon developed, after the first birth, into a deep, important, non-clinical friendship; "look at my phone, he's my emergency contact…thanks to child #1, he's kinda one of the most important people in my life…He's one of my very best friends…He's kinda like a brother." This is surely an unusual outcome in a clinical setting, but it shows that Sophie's midwife was able to create a a clinical care space into something that allowed for empathy, vulnerability, and mutual respect – or the foundations to a friendship.

In as much as the women who gave birth with a midwife experienced a transformation of different sorts, this didn't necessarily create a universal change in the established conception of genders. Meredith, Lynda, Sophie, Monica, and Therese all received prenatal care from their midwives that structurally emphasized a sense of visibility – comprised of validation and communication – individuality, and autonomy. Samantha also experienced care that structurally mirrored that of the other women in this cohort. She split her appointments between the male midwife and the female midwife, spent "a lot more time" with them than she would have with an OB, spent "a lot more time on kind of addressing emotionally how [she was] doing in [her] pregnancy," and experienced a "really nurturing, caring environment" that "honored [her] experience of going through IVF and all that beforehand." Overall she felt that she had "not just a medical relationship, but also almost like a family relationship" with her midwives. During the birth, Samantha's male midwife "was nurturing," a quality she was nervous he would be lacking. She remembered "being really impressed with [her] male midwife and how he dealt with the baby…he was just really sweet and nurturing and lovely with [her] baby." In reflecting on her three birth, Samantha shared that "when you're in it, you kinda don't really care where you are or who's there." In fact, in Samantha's experience, the opposite becomes true, so "when you give birth with someone there…it's such an intense experience…the level of trust goes up a lot…so you always feel connected to them in a way." This reflection was specifically in considering her post-partum comfort with her male midwife.

All of this said, however, Samantha did not experience a transformation of beliefs. She had a newfound comfort with her specific male midwife, but Samantha's

core beliefs about gender didn't shift. Even after stating that she felt like her midwife was "nurturing" during the birth – a transformation in and of itself since, throughout her pregnancy, she felt that he was less nurturing and more clinical than her female midwife – Samantha felt that she "didn't get that super warm/cozy feeling from him." Furthermore, she felt that she'd be able to have just her male midwife present at a hypothetical future birth because she realized she didn't need the handholding and support that she thought she needed. Lastly, in discussing gender and masculine women's health professionals during her interview, Samantha stated a current belief in the barrier that exists between male clinicians and female clients established by the clinician's masculinity. This belief was echoed in Sophie's desire to have a gay clinician if he was to be a man. Their conceptions of masculinity were so foundational to their understanding of the clinical space that their own personal experiences did not have traction to overturn the preconceived beliefs. The rest of the mother's who experienced birth with masculine clinicians referred either to no preconceived belief about masculinity in the clinical fields, or referenced their discomfort with gender retrospectively. So while the experiences of pregnancy and birth, and their associated care were profound and transformative experiences for the women who participated in this study, they may not have created a paradigm shift about the conceptions the women held regarding gender and masculinity.

III – Conclusion:

Gender is inseparable from the world of midwifery, medicine, obstetrics, and parturient care. This was established well before the women who agreed to participate in

this study experienced midwifery care, and, in many cases, were even pregnant. Samantha felt like she had been transformed into a lab rat through her IVF treatment. Sophie's family of doctors created a precedent that "doctor = male." Monica experienced sexual abuse that made her uncomfortable in clinical situations with men. And Meredith experienced some of the most paternalistic, patriarchal, technocratic, dehumanizing, medicalized/pathologized birth care in this history of the US. Gender is even inseparable from the way these women conceptualized themselves. Their identities as mothers or mothers-to-be were essentially predicated on the conceptions of their gender identities. This natural, essential conception of themselves paralleled their desires for clinical experiences that sat in and validated pregnancy and birth as a normal process, rather than something medicalized and pathological.

These gendered beliefs were salient before and after the women experienced care with male midwives. This suggests that physicians and obstetrics are socially coded as masculine people and spaces. Regardless of the provider gender, there is an assumption that the experience of obstetrics care will be masculine in nature. The women expected not to receive empathy, supportive, or validating care from a nurturing figure. On the other hand, Midwifery is a model that is socially coded as feminine. Midwives are supposed to be motherly, caring, empathetic, and supporting. The disruption of masculinity found in the male midwifery provider was brief and mostly lost by, at the very latest, parturition. The mothers experienced a relationship arc with their masculine midwives as a result of the dynamics of midwifery care. An initial confrontation with their midwives' genders quickly dissipated as a result of the structural components of midwifery prenatal and birth care. That is, the profession of midwifery crated a format

within which the male midwives practiced. This format, this care style was paramount in the shared experiences in said care of visibility via validation and communication, individuality, and autonomy. These three core tenets of experienced midwifery care were universally described in my cohort, and were central to the personal transformations the women experienced during their birth. As such, the mothers eventually considered the masculinity of their midwives irrelevant due to the structural care standards upheld by the midwifery model.

Masculinity in Midwifery

I – The Midwifery Model of Care

In the previous chapter, the mothers who participated in this study discussed a relationship arc with their cis-masculine midwifery providers. In the interviews with midwives, it was apparent that the midwifery model of care intentionally empathized with, and empowered midwifery clients. This resulted in a mitigation of the midwife's masculine gender, and allowed the client to bond and feel safe with their midwives. The midwives' and clients' discussions mirrored each other, suggesting that the structural similarity in the care provided arose from the training each midwife received.

Empowerment

The cohort of respondents in this study described empowering women and other pregnant people as a central tenet of the midwifery model of care. The midwives described two main approaches to empowering their clients. I call the first of the two validation. The most common description of validation as a form of empowerment was the way the midwives engaged their clients in discussing their birth plans. Reid, a genderqueer CNM practicing in Seattle, stated that pregnant folk who "come in with a nine page birth plan…are worried about being out of control." Reid's response is to "name that 'it sounds like you might be really scared about labor,' or if they had trauma from their birth last time, and so they are trying to set everything up just perfectly this time." Reid validates their clients attempt for control, and their fear of labor and birth. Stewart, a transgender CNM practicing in Seattle, keeps to a similar practice when engaging with clients' birth plans. They first voice their clients desires, like "you really

wanna make sure that you're getting really solid like emotional and physical support during your labor." Then they reaffirm the team's commitment to supporting their client: "everyone on this team is really excited to like help you through an unmedicated labor, like we love that." And even in the case that a client's desire contradicts hospital protocol, Stewart assures their client that they will "work very hard on [their client's] behalf to make that happen." In validating their client's concerns, Reid is able to set up a situation where, should the need arise, they can "give [their client] the information that they need to know what's going on, to talk about risks [and] benefits of different options…available… and make sure that they have the information…to make the best most informed decision for themselves and their families and their babies."

The second mode of empowerment that the midwives used was education. The midwives discussed how educating their clients gave them the ability to make informed decisions about their own care. Killian, a genderqueer CPM in Seattle, stated this specifically, describing midwifery care as "a shared decision-making model, or, at the very least, informed decision-making." This described a model wherein the medical provider spends time with their patients so that the patient may fully understand the pros and cons of their decisions, and choose the course of care best suited to them. Reid "will have an hour-long conversation [with their client] about what your low amniotic fluid levels mean, and you can decide at that end…that, now that you know all the possible risks including stillbirth…you don't want to have the induction." Reid educated their client with all the relevant information, made a recommendation, and "supported [their client] in that decision." This model of educational empowerment distinctly lacks

coercion unlike the common practice in medicine that Reid described: "I'm going to give you just the information that you need to make the choice I want you to make."

Similarly, Stewart described how they utilized communication to both educate their clients about the care they will receive, and empower them to have control over the clinical care, in this case a pap smear:

> *"I walk them through and I say, "Ok, this is what I'm gonna do." I show them all the equipment…tell them what to expect, and every step of the way, I say, "I'm gonna do it this way. Other providers may use stirrups…I think you feel more in control of your own body if you don't use stirrups. If you want me to pull 'em out I will."…I don't do anything without explaining what- you know? And It's hard sometimes like with interpreter visits, my exams take forever because…I'm gonna sit there and say, "The first thing you'll feel is my hand touching your leg." And then I wait for it to be translated, and then I look at her face and see how she's doing and then I do it."*

Stewart meticulously explains every action that they perform in a clinical setting. They do so in a way that details not just what is happening, but *why* the action is being done, being sure that their client fully understands the care they're receiving. The inclusion of purpose in Stewart's educational communication gives their clients a knowledge base from which they can approach their care in control. Stewart showed how this functions in reality by describing how clients will exercise their control over the clinical space:

> *"Most of the time if you said it that way, people don't need you to stop…because they don't have to panic about if they need you to stop because they know all they have to do is say it and you'll do it. And I have had some people who like test me…They'll be like "Stop" and I'll be like, "Ok. Do you want me to remove my hand or just stand still?" And they're like "Oh, actually I'm ready now."*

The tools of education that Stewart described here establish a trust between practitioner and client that was predicated on the client's knowledge, and the practitioners promise, that the client was, in fact, presiding over the clinical space.

Empathy

Together with the work put in to empower their clients, the midwives in this study discussed the ways in which they provided empathetic care. To develop this empathy, midwives listened to a patient's needs, spent time with pregnant folks to provide care that simultaneously developed a relationship, and ensured that the care was specifically tailored to the needs of each client. Kory, a cis-masculine CNM in San Francisco, believes that, to do his job well, he must "read people quickly, and figure out what they need to feel safe and comfortable quickly." In other words, Kory's philosophy of care is to "listen, sit down and listen. It's really not more elaborate than that." In doing so, Kory is "being caring and present" with his clients in a "nonstop stream of giving. Giving to somebody else. Taking care of somebody else." The care Kory provides is predicated on establishing a complete understanding of his patients' needs and desires, while creating a sense of equality and camaraderie, as indicated in his discussion of the importance of "sitting down." The care Kory discussed is labor intensive, and requires an "ability to provide labor support," or the active presence and engagement with clients during their labors: "the expectation is we're in the room, yeah. So you can easily go 24 hours without leaving the unit, cuz we're with our patients when they're in labor." Kory's method of implementing empathy is listening to, and being present with his clients.

Daniel, a cis-masculine CNM practicing in Washington, DC, provides empathetic care by creating clinical experiences tailored to the individuals for which he cares. Even for high-risk patients, Daniel discussed being able to provide "high touch low tech" care that attempted to reduce the theatricality of "a physician-run delivery…with all kinds of screaming and yelling and bright lights and drama and chaos." Daniel's approach creates

a compassionate clinical setting. He enters the client's room and recognizes the stress they made be under, he turns down the light to create an environment of calm. He spent time with his clients; "I would just go in there, I wouldn't hang out at the desk, I hung out in my patient's rooms, with them." This is the same tactic of enacting empathy as described by Kory. Daniel "wanted to be able…to have a relationship with women" because "pregnancy is a very vulnerable time where what women need and want more from their provider is time. Time equates to care, for women." Daniel's use of time to create a relationship with his patients allowed him to provide care that recognized the emotional needs of his clients. So in the case of a miscarriage, Daniel would share the news in a way that recognized the emotional distress of the situation; "'The ultrasound you had showed that the baby is not alive, we were not able to observe a heart beat, this means you've had a miscarriage, I'm so sorry. I'm going to give you some time to sit with that' and then do that, let them sit with that." This statement seems simple, seems to contain only common courtesy. But Daniel described this interaction in contrast to the obstetric method of "[being] very sterile about it…[making] it very clinical." The midwifery model of care intentionally incorporates a recognition of the emotional situation of the pregnant people midwives care for.

Often, the respondents discussed how they employed empathy within the context of very difficult clinical situations. Jeffery, a cis-masculine CNM from San Francisco, defined a difficult client as "somebody who…isn't getting the amount of attention they need." This definition alone considers the difficult patient not as somebody inherently hard to work with, but rather a patient that needs more attention, and a tailored approach. Jeffery, "if [he feels] a patient is just not, didn't get enough time, [he'll] either have them

come back, or [he'll] see them over lunch, or [he'll] call them at the end of the day." Jeffery creates time to devote attention to his client because he understands that said client needs that added attention. Jeffery described his approach to caring for each patient; "I want to treat patients the way I want to be treated: one is being respected, being listened to, and, at the end of my visit, that all my needs have been met…so I make sure that all the patient's needs are met before they leave." Jeffery conceptualizes his patients' needs as his own, empathizing with his patients so that he can focus on fulfilling all of their needs. Making sure that "all the patient's needs are met" is an intentionally broad statement grounded in the idea that no two patients are the same. This creates a paradigm of care that is tailored in its foundational traits. This is distinct from the model of care provided by Jeffery's colleagues, all of whom are doctors that stop their analysis of a patient at recognizing that the patient may be "a big challenge."

II – Critical Response

When the midwives who participated in this study decided to pursue midwifery, they met critiques from many difference sources. I categorize the critiques into to groups, informal responses and the enactment of gendered barriers. Informal responses arose in personal and familial relationships. They were characterized by people's quickly made judgments based on their preconceived ideas regarding midwifery as a feminized profession. This contrasted the enactment of gendered barriers by the formality and intensity of the responses. Midwives, medical professionals, and other officials set gendered barriers in place in a manner both descriptive and indicative of a hyperfeminized profession. Additionally, participants faced with gendered barriers

needed some formal counteractive support in order to continue in their pursuit of the profession.

Informal Responses

Categorizing midwifery as a hyperfeminine profession excludes men or masculinity from the concept of midwifery. This was apparent in the way the midwives discussed the stereotypes and assumptions about midwifery. Jeffery, the cis-masculine CNM practicing in San Francisco, stated that, "when anyone brings up the term midwife they just assume it's female." Reid, the genderqueer CNM practicing in Seattle, echoed this assumption, stating that, "people have this idea that midwives are supposed to be women." This assumption is popularly confirmed by the title of 'Midwife.' The English name of this ancient profession strongly associates with women via the inclusion of the word "wife" (we see this repeated in other languages like the French "sage-femme" meaning "wise woman," or the German "Hebamme" meaning "grandmother who lifts the newborn"). This gendered title created the basis for the initial informal response that Ezra, a cis-masculine CPM practicing in Seattle, experienced "about 17 billion times, which is like 'oh, do they still call you a midwife? Shouldn't it be midhusband?'" A response like this invalidates the entrance of the masculine person into the profession of midwifery. More often than not, this is stated as a joke (I personally have received this comment in discussion about my career choice countless times), but it encourages a rebuttal on the part of the midwife; in Ezra's case, "Actually, midwife means 'with woman'" functions to place the gendering effect of the English term onto the client,

rather than in the body of the practitioner. But this navigation does not eradicate the feminized conception of the profession.

In their assumptions that midwives are women, people ascribe a very specific set of characteristics to those women because of their profession. "[The] stereotype would be…less interventive, more crunchy, meaning…more of a holistic approach as opposed to a more medical approach…more motherly, and just that calming kind of approach to care. Crystals, lavender, and a good trail mix: the modern midwife." This description of midwifery by Jeffery helps to establish the popularized imaged of midwifery. That is the opposing ideas of medicine and holistic care. Reid provides a case study in their own midwifery practice that presents this image enacted:

> *"There is something maternal or motherly that is projected onto midwives which is why some of our clients really connect well with our oldest midwife who is in her 60s…she comes across as very motherly and maternal, she will tell you what to do rather than…she gives you information, but she is a lot more grandmotherly and giving advice and like 'oh no that's not the way to do it, you should it this way,' or like 'Oh, you are constipated because you are not eating enough of this thing, here is a recipe.' She will give you a fucking recipe for power pudding that is made with prunes and bran. It's disgusting, I'm sure. But people are like 'oh, my grandma, my midwife who is a grandma told me to eat this shit so I can poop, great! I'm going to do that.' And I don't think that would the same coming across from me. People would look at me like, people would look at me like what? Why? Umm, so some of that is this projection that midwives are supposed to be a certain way and she meets that stereotype really well, she's the one that will tell you weird stuff. If you're expecting your midwife to tell you to drink tea made out of sticks, she will probably tell you to drink tea made out of sticks, if that came up and you would do it cause she your grandma."*

In their experience, Reid sees clients coming to their practice for the experience of a holistic, motherly, nurturing form of obstetric care. The assumption that midwives provide this "natural" version of care especially informs the immediate informal

responses received by the midwives. It places midwifery in conceptual subordination to medicine, so the responses to masculine folk are often founded in this assumption.

When Isaiah, a cis-masculine CNM from Seattle, began the process of pursuing midwifery, often his family members asked him, "well why aren't you going to medical school?" The family predicated this question on their conceptualization of "the status" of midwifery. Lifting his hand above his head, Isaiah described how his family sees that "medicine is up here," and, moving his hand to chest level, "nursing is below that." As a man, Isaiah's family expected him to pursue medicine because of the status the profession holds in society. Isaiah eventually had to confront his father and ask directly for support in order to stop the devaluing of nursing and, subsequently, of his professional pursuit. Similarly, an obstetrician colleague of Reid's once told them, "I just don't understand why you didn't go into obstetrics, like you are so smart...If you didn't want to do OB you could do Maternal Fetal Medicine?" For Reid, the OB's assertion that their intelligence should indicate a pursuit of medicine reinforced the "hierarchy where it is assumed that if you could make it through medical school and be a physician, you would choose to do that because that's better." The obstetrician's assumption invalidates Reid's pursuit of midwifery. Furthermore, it reinforces the association between the "masculine" trait of intelligence and medicine that were established by 18th and 19th century physicians as described in the first chapter of this thesis.

Gendered Barriers:

Fellow midwives, classmates, professors, hospital officials, and the ACNM often established formal barriers in opposition to the cis-masculine midwives in this study.

These gendered barriers contrasted from the informal responses to masculine folk entering the profession of midwifery because they often stopped the cis-masculine midwives from progressing in their field, or created blatantly inhospitable social situations towards cis-men and masculinity. The most formal of these barriers consisted of discriminatory hiring practices. Daniel, a cis-masculine CNM practicing in Washington, DC, had received an undergraduate scholarship in nursing in exchange to work for one year at a hospital close to his university. He applied to three different areas, including OB nursing, at the hospital, and when he was hired to the position he least desired, he found that the OB hiring staff were "not comfortable hiring a male nurse into that area." Nothing changed this position as Daniel attempted to push back against what he felt were discriminatory practices. The "interim vice president of nursing…was like talking to a brick wall - she said 'nope, that's the decision, there's nothing that can be done, we've never had a man in that department, that's just not normal.'" When talking to the "vice president of human resources…he was gentler about it, however, [they] didn't make any further progress. He pulled out a healthcare law book that talked about a legal case of a male nursing assistant in a rural nursing home where the male nursing assistant was assaulting female patients." The exchanges of this discrimination indicate a belief held by the gatekeepers to the OB unit that the presence of a cis-man would be both essentially deviant, and a potential risk for the patients because cis-men have sexually assaulted patients.

The assumed potential for patient discomfort founded the bases for this hiring discrimination in some cases. When he first graduated, Isaiah faced some difficulty finding a job; "the stated reason was because the clients might not want a man caring for

them." Kory, the cis-masculine CNM practicing in San Francisco, stated that "other midwives and other healthcare providers assume patients are gonna react based on gender, and often project that." The basis described here for establishing these gendered barriers to hiring cis-masculine midwives is an assumption made by medical providers about their patients. Interestingly, the previous chapter provides some support for this assumption in the discomfort by cis-feminine clients when meeting cis-masculine midwifery providers for the first time. But in making the assumption, medical providers ignore the structural capability of the midwifery model to create comfort and empathy regardless of provider gender, as discussed above and below.

Furthermore, this contrasts to Christine Williams' findings on a glass escalator effect in hiring practices of men into feminine professions by creating a precedent by which cis-men experienced barriers that prevented their entrance into the profession in the first place. Kory typically gets "a lot of responses to paper, to applications submitted online, to resumes sent out, noting that [his] name is not gender-specific. Usually the interview process stopped at the phone call, or a voicemail when they heard [his] voice." The masculine midwives experienced a discrimination that more readily appears in the literature about other minorities. According to Williams, men, especially white men, typically rise through the leadership in feminine professions very quickly, and don't often experience hiring difficulties – except for in the most feminized of sectors (Williams 1995). In this case, Kory and the other midwives experienced hiring discrimination because of their masculine gender identities.

Not only did the cis-masculine midwives experience gendered barriers in the job market, but they also experienced the barriers in educational environments. When

bidding for his undergraduate, senior spring semester in an area specialty, Jeffery's dean told him, "'no, you're not doing OB, and you're not... no, we're done, we're done with this. If you wanted to do OB, boys just don't do that.'" Again, a gatekeeper presented this essentialist argument to prevent a cis-man from entering the obstetric nursing profession. When he attempted to apply to a joint naturopathic-midwifery program, the director of the midwifery program told Ezra not apply because he would "never…find a preceptorship, so what's the point?" In order to be admitted to the midwifery program, the school require students to find their own preceptorship prior to admission, so the "students…like male students, [who] were just not able to find preceptorship sites…never applied, and they never got in." The director's words above were predicated on her belief that because Ezra was a cis-man, he would be unable to find a preceptor willing to train him due to the fact that clients would never want to hire a cis-masculine midwife, and he would therefore be unable to apply to the midwifery program.

The midwives discussed the construction of inhospitable environments in the academic setting by both professors and classmates. On Jeffery's first day of midwifery school, two girls in his program stood up to say, "'had we known there was a male on the program, we would've deferred a year.'…It was 8 o'clock in the morning, day 1 of midwifery school…[the] whole conversation became having a guy in the program, and how that would affect their educational program." Jeffery's masculinity instantly became a force that students in his class felt would inhibit or negatively affect their education. This concern was echoed by the faculty; "It's been a rough thing for us, and we met all summer with a therapist over this." Furthermore, the inhospitable environments created in educational settings sometimes had the intent of blocking a cis-masculine student from

receiving the education required of him to practice as a midwife. During his midwifery education, Ezra and his classmates were expected to spend on day practicing vaginal exams on each other; his professors "wanted to…tell [him] that [he] couldn't come that day." The presence of a cis-man held more significance to the school, so they felt more inclined to create a deficit in Ezra's knowledge than allow him to learn necessary examination skills. Furthermore, Ezra recounted an experience in class wherein his professionalism was taken into question; "I asked a question or something and either the teacher or another student made some sort of like lewd remark about how I would like that nipple or something like that." This remark shows that the women around Ezra felt that his masculinity would be inseparable from a sexual desire for women, and thus he would be incapable of refraining from sexualizing his clients. This mirrors the HR director's response to Daniel's application to the OB nursing area as described above.

Generational Responses to Barriers:

The midwives had different responses to the gendered barriers created by their classmates, colleagues, and superiors. Most notably, however, was the generational shift in the tone of the midwives responses. When barred from the OB unit at his first job out of undergrad, Daniel, the cis-masculine CNM from Washington, DC, responded with outward confrontation to the HR director, in a display of masculinity that ultimately ended in a compromise of him being hired into the unit:

> *"I said, 'well, I guess I'm gonna have to do what I need to do,' and he said, 'what do you mean by that?' And I said, 'I've already been in touch with an attorney,' and he said, 'well let's not get rash,' and I said, 'this is 1990, you would never tell a woman that they could not work on a unit of the hospital based on their gender, but you find it okay to tell a man the same thing.' And I said …'I'm committed to work for you for one year, so*

> *we need to figure out where to go from here,' and I said, 'sounds like an attorney is the only route to go.' He said, 'Well I really think you should reconsider that,' and I said, 'I imagine you really think I should.'"*

Daniel had not, at the time of this confrontation, had counsel from an attorney; rather his cousin who was a lawyer had offered to send a letter on legal letterhead to the hospital. This exchange was a display of power and confidence. And although Daniel made this display in the face of gender discrimination in the work place, he did not take into consideration the power dynamic in the obstetric space wherein masculinity sits, paternalistically, in control. Daniel made his claim considering only his personal situation. Similarly, at an ACNM conference when their motto was "women caring for women," Jeffery "crossed out the 'wo'" on the organization's paraphernalia so that it "just said 'men caring for women.'" The cis-feminne midwives did not receive this design change well. Jeffery's attempt at reclaiming his role, and cementing his validity as a midwife, counters the narrative of midwifery in the US. Although he intended to protest the exclusion of masculine folk from the profession, Jeffery's edit unavoidably mimicked the cooption of midwifery space by male physicians during the 18th and 19th centuries. Both Jeffery and Daniel's responses to the barriers created against their gender were performed in personal frustration, ignoring the social context of midwifery.

Miles, the cis-masculine midwifery student from Chicago, was surprised to meet skepticism from the director of his future midwifery program about his ability to succeed when "swimming upstream" in a hyperfeminine profession. Miles defended his genderin a manner distinct from the midwives discussed above: "I think the goal of doing this is not to be the token guy. It's to contribute to women's health, and to empower women and do all these other things that I feel really strongly about." This response shows Miles' awareness of the mechanism of "tokenization" of men in feminine professions that sets

men apart for distinction and upward mobility rather than becoming stagnant like when tokenization affects minorities. Furthermore, Miles made apparent his intentions in becoming a midwife, a choice based in a desire to practice for the empowerment of women. Feeling as though the program director had made her displeasure in his gender clear, Miles' immediately, and silently though, "I might as well just apply elsewhere." This especially contrasts Daniel's combative reaction to discriminatory hiring practices. Instead of pushing forth his own personal cause, Miles stepped back from this interaction. He did ultimately apply to the program, and was accepted, but his discussion of this interaction gives no indication that he fought to be accepted to the program based on the claim of equal opportunity.

Kory, the cis-masculine CNM from San Francisco, spent three months working at a birth center with a group Certified Professional Midwives. He stated that he was "initially put off by her- by the whole group not wanting [him] there," referring to discomfort the CPMs expressed in relation to both his gender and his CNM credentials. Dissimilar to Jeffery's reaction to invalidation, however, Kory recognized the inherent power dynamic of masculinity in the practice with a specific nod to the history of said power. He ultimately valued her critique, and appreciated working with her specifically because of her critique:

> *"I really appreciated working with [her] because she…was incredibly smart and articulate, and she was very clear with me by the end that while she respected me, and appreciated the way I was a midwife, she still didn't think I should be a midwife, that men should be midwives. Because of the roots of midwifery, in that it was, that it was a sacred profession, and it should be protected as a sacred profession, that should not be infiltrated"*

Kory accepted the critique made by this midwife. He felt it an important lesson to incorporate into a belief that "there's a way [for midwifery] to in general evolve while

respecting history." Kory's reaction recognized and incorporated the historical trauma of masculinity's takeover of midwifery.

Roughly split between those who attended nursing school prior to the year 2000 (pre-2000s) and those who attended nursing school after 2000 (post-2000s), the midwives in this study reacted differently to the gendered barriers enacted by members of the broader nursing, midwifery, and medical spaces. The pre-2000s generation of masculine midwives in this study did not incorporate the historical significance of masculine power into their interactions with discrimination and barriers. The post-2000s generation of midwives in this study, on the other hand, did incorporate the historical power imbalance into their interaction with discrimination and barriers. Although I saw this generational difference in the utilization of the history of American midwifery in the midwives' responses to discrimination, all the midwife respondents did recognize the historical significance in the gendered takeover of midwifery by men.

Support Despite Gender:

Despite the gendered barriers and responses the midwives described, all the respondents received support in their pursuits of the profession. During his "midwifery graduate program…sometimes it was hard for faculty to find [Isaiah] a clinical site because some…preceptors did not want to take a man, but they always did find a site for [him]." Not only did Isaiah's faculty always work to find preceptor sites for him, they also "tried really hard to mitigate that and not let it become an issue…they didn't want to have [him] aware." The faculty in Isaiah's program wanted him to feel like any other student in the program, they tried to remove any sense of a difference between him and

the other students. Daniel experienced a similar equalization from his obstetric nursing instructor when he voiced his anxiety about being a cis-male student caring for a newly post-partum mother; "Daniel, I didn't tell any of our patients that they have student nurses, now go take care of your patient." This statement removes gender from the equation of care, makes Daniel's cis-masculinity a nonissue, and allows him to practice effectively without having to worry about his gender acting as a barrier to gaining the necessary experience required of nursing students.

When he entered the navy, Jeffery worked in the post partum unit as a result of his experience in the area from his fifteen-week specialty training in OB during his senior spring. While in the navy postpartum unit, "a lieutenant commander…said, 'You know you're being underutilized, how would you feel if I brought you to labor and delivery and I trained you?'" Despite the fact that OB nurses in the navy needed to work for two years before being allowed to move to Labor and Delivery (L&D), the lieutenant commander still made her offer, and "the next month [Jeffery] started the training program in labor and delivery." This was most likely a glass escalator effect allowing Jeffery to ascend in his career earlier because of his masculinity. The lieutenant commander did propel him forward, especially despite navy protocol. And although Jeffery discussed no specific indication to affirm or contradict this suggestion, the promotion supports Jeffery in this feminized nursing specialty despite his cis-masculine gender identity.

Notably, the pre-2000s midwives all received support in their profession from people above them, be they faculty, educators, leaders, or bosses. However, these midwives specifically discussed the antagonism of their classmates and peers, with the softest response described as ambivalence. The post-2000s midwives, however,

experienced a lot of support from their classmates and peers. Kory described his cohort as, "like family. It was a small group…[he] loved them like family, that's what got [him] through the program." Similar to Daniel's experience, Kory's family of peer student-midwives "didn't treat [him] like [he] was the only guy in the group. They just treated [him] like [he] was their classmate." Despite the fact that Kory was the only cis-man in the group, Kory never felt that his classmates interacted with him in any capacity that specifically referenced his masculinity. The act of normalizing Kory's gender both validated his presence, and created an environment wherein his education was not tinted by his cis-masculinity. Furthermore, Kory's cohort was so close as to be instrumental to his success in the program by providing the support necessary for him to succeed.

Miles, a current midwifery student in Chicago, also discussed this cohort support: "graduate school, a lot more supportive, in that I've only had one person kind of bat an eye, but not dissuading…not discouraging…would say most everybody's been fairly encouraging, all of my classmates." Miles described a supportive peer environment in his Doctorate of Nursing Practice program. While not as enthusiastic as Kory's description of his cohort above, Miles depicted his classmates' behavior as distinct from the cohorts describes by the pre-2000s midwives. Whereas Jeffery described antagonism and Ezra described defensiveness from their respective cohorts, Miles' cohort presented him with no issues; even the one case of slight surprise Mile's experienced neither had any affect on his educational experienced, nor extended beyond that one person. The post-2000s midwives described distinctly dissimilar cohort experiences from their pre-2000s counterparts, reporting a high degree of peer-to-peer, student support.

III – Gender Politic

In the above section on the critical response to masculine midwives, I explored two shared experiences of pushback. The gendered expectations held about midwifery gave rise to the informal responses from the midwives' friends, family, and other acquaintances. When members of the midwifery community created gendered barriers against the masculine midwives of this study, they overpowered the presence of said masculinity, and, therefore, defined the structural process of hyperfeminization in midwifery. But the interplay of masculinity and femininity in this clinical space goes beyond the objection to masculine folk by the cis-feminine members of midwifery. First, Gayness was utilized as a framework for permission to practice midwifery as cis-men. This feminized the masculine. But masculinity still held privileges. Cis-masculine midwives sometimes vied for leadership positions, and were overvalued despite the hyperfeminine rejection of masculinity.

Gayness as Permission to Practice

In the previous chapter, women discussed wanting their provider to be gay in order to navigate/mitigate the potential sexual space created by the cis-male-female dynamic. The midwives in this study echoed this mitigation effect of gayness in their interviews. Interestingly, and in every case, people other than the midwives about whom it concerned enacted this emphatic identity mitigation. Kory said, "some patients seem to feel better if they think I'm gay. I don't care, I don't talk about my sexuality at work, so it doesn't matter to me." In this case, the patients ascribed a gay sexual identity onto Kory without any prompting in order to feel better about receiving care from him. But

the presentation of sexuality seemed unprofessional to Kory, as it did to Jeffery whose "self-identification has nothing to do with [his] career." Regardless, when Jeffery voiced some anxiety about "being a guy taking care of women" early in his career, his "physician backup at the time said, 'you're gay, why would it be a issue?'" This statement, prompted by Jeffery considering his need to utilize a chaperone in rooms during physical exams, suggests that the physician placed the consideration for malpractice on the sexuality of midwife rather than in his professional integrity. In other words, the physicians believed that Jeffery's gay sexuality navigated the gendered power dynamic in midwifery, and reduced the structural cis-male-female conflict by feminizing Jeffery in the eyes of his clients.

Ezra's gay sexuality mitigated his cis-masculine gender identity for his clients' partners. But, rather than using this mitigation method himself, his practice partner utilized his sexuality; "when my partner sometimes would be like, 'the husband seems like he's not into it, can I tell him that you're gay? I think that would help.' So like if it was clear that I was not gonna be sexually attracted to this woman…that was gonna be better." Unlike Kory and Jeffery, the ease with which his sexuality allowed Ezra to care for his clients left Ezra unconcerned with the use of his sexuality. This was probably due to the fact that his CPM status made him more vulnerable to the potential for legal action taken against him by clients due to their discomfort. However, he did not utilize his own sexuality, as he felt that his true value lied in the skill and compassion he brought to the midwifery space. This removal of potential sexual attraction by implicating homosexuality in fact utilized femininity to deescalate the anxiety induced by the provider's masculinity. Reid explained that "if a patient perceived from whatever

information was available to them that the man taking care of them was gay or queer, that it would be easier to ascribe feminine traits…and to bond with them." In this vein of thought, Reid was the exception that proved the conflation of sexuality and gender because they could not benefit from the assumption of homosexuality since patients interpreted their external presentation of genderqueerness, in some cases, as a lesbian sexuality. So Reid's deployment of masculinity created the potential to be construed as sexual attraction by their patients.

Privileged Masculinity

The masculine midwives who participated in this study still experienced privileges as a result of their gender identities, despite midwifery being a hyperfeminized profession. As with masculine privilege in other feminine professions, the privilege discussed by the midwives in this study functioned at the intersection of the midwives' personal intent, and the overvaluing received/perceived via the actions from the people around them. In her seminal study, Christine Williams found that men who went into nursing more often than not desired to work in the nursing specialties deemed higher-tech, more prestigious, or more physical; furthermore, the men in her study frequently professed a desire to ascend into leadership positions. (Williams 1995). The interviews in this study do present some similarity to Williams' findings, although there doesn't seem to be a pattern. Miles, the cis-masculine midwifery student from Chicago, described his undergraduate nursing school experience as "wanting to find a leadership role, and…wanting to go to graduate school." Miles' intention from the beginning of his

education in nursing was to get a PhD, and do research into high-risk pregnancies. This desire to pursue both leadership and a high tech/high prestige has been maintained as he has worked through his midwifery degree. Miles, however, was the only participant in this study who desired to pursue more masculine divisions of nursing, and leadership positions within nursing upon entering the nursing world. Daniel, the cis-masculine CNM from DC, has had a career defined by a progression through nursing leadership positions – even now, he is studying for a Doctorate of Nursing Practice in Executive Leadership. Although he pursued leadership on his own accord later in his career, a cis-female colleague of his initially prompted his desire to rise through the profession:

> *"In 1999, I had been a midwife 5 years…and the woman I had worked with as a nurse…called me and she said, 'Daniel, how long have you been a midwife now?' and I said '5 years, why?' and she said 'you speak Spanish, right?' and I said 'I'm not fluent, but I'm conversational,' and she says 'Why aren't you applying for a director position?'…I laughed and I said 'I don't have any leadership experience - other than being a nurse and running a committee,' and she said 'You're definitely a leader, and in many people's eyes, you should throw your hat in the ring.'…So I got my resume together and I applied to both places, I got interviews at both places, I got an offer from both places…so that's how my career in leadership got going"*

This experience mirrors those described by Williams' in her study. A colleague who valued Daniel encouraged him to pursue leadership positions based, not on his leadership experience, but rather on her trust in his capabilities as a leader. This experience then pushed Daniel to pursue leadership opportunities throughout his nursing career, fostering his image as a capable nursing leader, and increasing the opportunities set before him by colleagues and friends in the profession. When prompted to discuss his personal trajectory through leadership, Daniel was not only aware that it "men in nursing go up the leadership trajectory much faster," but he blatantly stated, "I think that happened for me."

The midwives in this study experienced far more instances of being generally overvalued because of their masculinity than pursuing the masculine divisions of nursing practice, and the upward push towards leadership positions. Kory stated, "people give me a lot of credit…both from being like a really good guy and a really good midwife." Kory went on to explain that, "when people ask why I chose midwifery, they're really asking why a man would choose midwifery, and they're assigning me some special status as a male midwife." The "special status" Kory experienced as a result of being both a midwife and a cis-man contributes to his overall sense of the privileges he receives as a midwife. Daniel felt privileged in his "rapport with physicians" as a result of his gender. By being both a man and having good communication skills, "The physicians [he] worked with…would say, 'If Daniel is asking for help, he needs help now.'" Daniel gained the respect and responsiveness from the physicians with whom he worked, something that was not gained by every nurse-midwife in the hospital. Daniel especially attributed this connection to fact that it is "easier for a male physician to let a male nurse-midwife practice more independently than the women, just because that's the nature of the beast." Daniel had gained the confidence of the people that held the most power in the medical hierarchy by being the type of person that the physicians felt they could instantly connect with: a cis-man.

Jeffery experienced a similar overvaluing at the hands of physicians. Jeffery's first job out of his midwifery program was "basically handed to [him]…There was a physician that was a resident that…said, 'Hey, I know you completed the program, I wanna hire you, what do you think?' And that's how [he] got [his] job." The physician who hired Jeffery right out of school had worked with Jeffery as a flight nurse when she

was a resident. He didn't ever have to give her a resume, and never needed to interview. This hiring experience references Williams' descriptions of cis-masculine nurses being hired upwards more readily than their cis-feminine counterparts because of the relationships they could build with leadership as a result of their gender (Williams 1995). Jeffery's hiring experience maps onto Williams' framework especially because it came as a result of the physician and Jeffery working together when Jeffery was still an RN. Once a part of the practice, "the other physician…kind of took [Jeffery] under his wing." The OB at the practice spent individual time training Jeffery, allowing him to shadow the OB and gain both confidence and experience. This personalized training and physician valuing of his presence raises some topics for consideration when discussed in the context of his gender.

The first comes as a direct result of the training Jeffery received. He described a common reaction he has received from physicians he works with; "I hear this a lot, when the physicians say, you know, 'We value you as a very important part of our group and we don't really distinguish between your educational background, you know we treat you the same as we would any other physician, colleague.'" Jeffery acknowledges, as well, that he's "in a situation that not many midwives get to experience." The training he received under the OB in his first job shaped the way Jeffery cared for his patients and worked clinically, and therefore shaped the way that the physicians he works with treat him. The second outcome was the trajectory he followed after being trained in a physician/OB-based practice of continuing to work in physician/OB practices. This clinical trajectory had a lasting affect in affording Jeffery the privilege to refrain from thinking about the gender politics inherent to the profession of midwifery. In discussing

the fact that he doesn't often think about how he is a statistical anomaly in the profession of midwifery, Jeffery stated, "I think I tuned out most of it…maybe I just, ignorance is bliss and I don't really think about it…my experiences as a nurse-midwife has always been with a physician practice where there have been a couple males." The physical space of obstetrics acts as a barrier that privileges Jeffery to a career free of, not just blatant push back from the cis-female midwife community, but also his own thoughts about being a cis-man in midwifery.

Queer Masculine Experince

I – Queer Masculinities in Midwifery

Like their cis-masculine counterparts in this study, the queer masculine-of-center midwives described many experiences of gendered barriers and informal responses to their presence in midwifery. In the cases of the queer midwives, however, these experiences were characterized by an element of transphobia. Occurring due to the external perceptions of the midwives' genders, the transphobia was distinguished principally by a) an invisibility of their gender identities, and b) a sense of isolation. There were, as well, instances where cis-feminine midwives utilized a more blatant expression of transphobia as an exclusionary tactic. Despite the transphobic experiences of the queer midwives in this study, they still described instances where their queerness became a privileged identity. These dynamics of queer masculinities in midwifery are a further indication of the mechanisms of hyperfemininity as exclusionary of all non-feminine identities within the midwifery space. They are an additional depiction of the structural ideology of adherence to femininity as a requirement for participation as both agent and recipient of midwifery care.

Invisibility

In analyzing their experiences of invisibility, I delineated between two distinct forms: passive and active invisibility. Passive invisibility resulted from an interaction between the decisions about self-presentation by the queer midwives, and the external perceptions/understandings about gender from the cis-feminine community of midwives. When Stewart, the trans CNM from Seattle, began to voice their desire to become a

midwife, the responses they received were very encouraging. But "people being accepting of [Stewart] wanting to be a midwife…also was a cue to [Stewart] that they didn't know who they were talking to." In Stewart's experience, these positive reactions were based on the fact that Stewart "fit into their idea of who a midwife would be…'Oh, you're female, you say you wanna be a midwife, that totally makes sense.'" The external perception of Stewart's gender as cis-feminine shaped how people reacted to their career choice; Stewart fit the normative assumptions that cis-women practice midwifery. The invisibility of their queerness, however, was exposed by Stewart's description of how their "process of transition was like really mixed in with the process of becoming a midwife. The closer [they] got to becoming a midwife, the more male [they] appeared…but, as soon as people started perceiving [them] as male…everyone was like…'That's weird. That's kind of suspect. Like why would you want to do that?'" People externally perceived Stewart as either cis-feminine or cis-masculine respectively prior to and after their transition. People interpreted Stewart's passing status as a cis-gender identity. The passive assumption of non-queerness, based in the cis-normative hegemony of gender, effectively removed Stewart from visible queerness.

For Reid, the genderqueer CNM from Seattle, their self-presentation was constrained by the institutional atmosphere at their university and first job:

> *"I didn't officially come out as non-binary until after school to most people…I went to a Catholic, well Jesuit, but still Catholic school. And my first job as a midwife it was with a Catholic healthcare institution and I didn't feel like I could come out there. I was out as queer but the thought of socially transitioning as nonbinary and being more visible or medically beginning to transition, that didn't feel possible at that job or in school…Throughout school as well as at my first job, I didn't feel like anybody was seeing me. Everybody was gendering me female and that got heavier and heavier for me to hold"*

This quote describes the interactional forces behind the midwives' experiences of passive invisibility. The Catholicism of Reid's first two midwifery institutions created an environment within which they did not feel safe or capable of being visibly queer/nonbinary. They made the choice to stay hidden from any potential backlash because the morals professed by Catholicism, and a personal history growing up in a family of Catholic missionaries taught them to be cautious about their gender identity. The external perceptions of Reid as cis-feminine combined with their decision to be closeted about their gender identity to create a "heavier and heavier" invisibility. The queer midwives in this study characterized passive invisibility as the result of assumptions made within the cis-normative paradigm of midwifery.

The queer midwives described active invisibility as concrete actions taken by their cis-feminine counterparts to hide, minimize, or ignore the presence of queerness in the midwifery space. When Killian, the genderqueer CPM from Seattle, was in school for midwifery, the only terminology available to discuss non-cis-feminine pregnancy was "lesbian pregnancy;" there was no concept that genderqueer/trans folk could or would carry a pregnancy. In response to an assignment to present on lesbian pregnancy, Killian approached their instructor with a concern about the presentation; "'Look, I can't cover lesbian pregnancy in 10 or 15 minutes.' And she said, 'You know, just talk about the garden variety lesbian.'" Although the limited understanding of queer pregnancy created a passive invisibility about queerness, Killian's instructor actively encouraged Killian to minimize and hide the already limited concept of queer pregnancy. This active obfuscation limited the educational scope of the student midwives in the class, and thus

reinforced a cis-normative viewpoint on pregnancy, allowing queerness only where it wasn't offensive to that stance.

In their discussion of active invisibility, Stewart depicted a situation where cis-feminine students hid their experience of trans-ness.

> *"In the past, in midwifery school, like you learned pelvic exams on each other…For good reason, [my university] and other schools have been like 'We don't do that'…but there's a few folks in our cohort who were like, 'I understand why like you're not supposed to do that…but I feel like we need more experience'…And so they decided to like have a day where they did that. Off school grounds, like just at someone's house…And then I said like, 'Yeah, y'all, I don't know,' like they all knew I was trans or whatever. I was like, 'Yeah, I don't feel super great about showing you all my junk.' And then immediately, like a white girl crying situation happened, where like this girl, you know, sitting next to me, starts sobbing and says, 'I don't feel comfortable with my body either!' And just like everyone immediately looks at her as like, 'What can we do to make you feel better?' Like, and I just like sat there, and nobody said another thing to me the entire class."*

First, the fact that these practicum days were commonplace in nurse-midwifery programs, and are still utilized in many non-nursing/professional midwifery programs, emphasizes the cis-feminine, normative idea of midwifery and women's health care wherein the concept of its practice by women and for women makes all bodies within midwifery desexualized, and available. From the interview, it is unclear as to whether or not this is a result from the cis-feminine hegemony functioning within midwifery, or because of its history of cooption by men and masculine obstetric practice. Either way, this practice existed only because all students were assumed cis-female. When Stewart shared their discomfort in participating, a cis-feminine midwife coopted the space, and thus actively hid Stewart's experience of being trans. Stewart's trans identity founded their discomfort with showing their body to their classmates. But when their cis-feminine classmate equated that experience to her body issues, she reified the cis-feminine hegemony of midwifery that denies space and visibility to queer bodies. These excerpts describe how

both active and passive invisibility created transphobic barriers within midwifery space for the queer midwives who participated in this study.

Isolation

In their interviews, the queer midwives discussed another mechanism of transphobia that I term isolation. Similar to invisibility, the queer midwives described both a passive and an active form of isolation. The passive form of isolation arose simply by being in a space almost entirely made up of cis-women. Reid described it as such: "I feel like in some ways, I didn't fit in with my classmates because of my masculinity…there's this group of fairly femme students and then there is me…there were no other queer people who were openly queer. So I felt like an anomaly in the program…but I've spent my whole life feeling like I didn't fit in." In feeling like an anomaly, Reid had a concrete sense of themself as deviating from a distinct cis-feminine norm because of their gender identity. Midwifery reinforces the idea that all agents of the profession should be cis-women, so Reid experienced passive isolation as a result of their anomalous presence in midwifery. The other two queer midwives echoed this experience of anomaly, of being the only queer person in their class/practice, and the resulting sense of isolation. However, the cis-masculine midwives, who were also anomalies in midwifery, never discussed a feeling of isolation. The last sentence in Reid's description gives some insight as to why. Reid feels like an anomaly in their everyday life, whereas cis-men would be very unlikely to feel like anomalies due to their normative gender alignment in a cis-patriarchal society. So in a space that reifies the gender binary, simply being queer emphasizes their deviance – hence, passive isolation.

The queer midwives described active isolation as exclusionary action taken by cis-feminine midwives. Killian described themself as an activist and educator, so when a situation arose of blatant exclusionary transphobia, they tried to change the space of midwifery to be more inclusive. But the response from their midwife community was an act that isolated them:

> *"It pretty much got me kicked off the board. Like people here were not fully receptive, and I really definitely felt very much like, you know, the genderqueer person on the Midwives' board, saying 'Hey! We need to do something about this.'...but then when it came to changing our own documents to making them gender-inclusive, there were people who threatened to leave the board, who did leave the board, who said 'No way, we should put this up to a vote of the membership,' which like a completely uneducated membership in a very you know, feminized profession, and asking them to vote on the inclusivity of a marginalized group, yeah, and people did leave the board, and I lost friendships that I thought were friendships, over it."*

The cis-feminine midwives felt that changing their bylaws to be inclusive of trans and genderqueer clients would somehow be controversial. Therefore, they isolated Killian from the group, ended friendships and mentorships with them, and removed them from the board. Furthermore, the cis-feminine midwives wanted to isolate Killian's voice by putting the inclusion of queer folk "up to a vote of the membership." While that would be the democratic way to include all the people affected by the vote, it would also be a drowning out of the queer opinion by the overwhelming cis-feminine population of midwives. The active form of isolation thus emphasized the dominance of cis-femininity in midwifery that, in cyclic fashion, emphasized the deviance of queer midwives that results in passive isolation.

Exclusionary Transphobia

In some cases, the midwives discussed experiences of exclusionary transphobia that enacted barriers to the profession reflective of the gendered barriers experienced by the cis-masculine midwives. The exclusionary transphobia was characterized by creation of toxic spaces, and barriers to advancement in the profession. In being removed from their midwifery board of governance, Killian experienced a transphobic construction of toxic space; "This TERF group, trans-exclusionary radical feminist group, had written this open letter about why we shouldn't be gender-inclusive in midwifery, and midwifery is about women, and like really disgusting like make you have to run to the bathroom and vomit, and when I saw it, I was livid." The letter Killian discussed based its argument in the belief of the pure and universal, biological fact of motherhood as a result of sex, and that midwifery primarily existed to care for clients within that biological fact. This letter was highly controversial. As Killian described above, it created enough dissent to end friendships, and remove multiple people from the midwifery governance board in their area. The toxicity created by the exclusionary transphobia of this letter mirrored the stories the other queer midwives told about the transphobia they experienced.

The barriers the midwives faced to advancing in their professions began as soon as they attempted to enter the profession. Stewart discussed an experience with an admissions representative at a university that put up an explicit barrier to their acceptance predicated on their gender;

> *"At the interview that I had, we had this like wonderful interview and then at the very end, she was like 'Why do you want to do this? Do you really think like patients want you to do this?' And then she said, 'Now of course you would be our student if we accepted you, and we'd be under obligation to make sure like you got your clinical experiences, but nobody*

is gonna want you so we wouldn't be able to like- we definitely couldn't guarantee you that you could graduate.'"

The barrier to Stewart's education, while explicitly transphobic, was sourced from the standpoint of potential patient discomfort. This standpoint actually founded the basis of every instance of exclusionary transphobia described by the queer midwives, as if to transfer the blame from the people being transphobic to the patients. Cis-feminine midwives transferred their transphobia to the potential discomfort of clients in a similar fashion that they used to raise barriers against the cis-masculine midwives.

Queer Masculine Privilege

The queer midwives did experience some privileges in the midwifery space. There were basically two sources for this privilege. The first privilege used queerness as a buffer for the affect of masculinity in the clinical space. Killian described how their queerness mitigated their interactions with clients; "I was very visibly queer, but people could read me however they wanted to read me, so it wasn't like I walk into the room and people are like 'Oh, who's that guy?' Or 'what is it?' It was like people could read me as a woman. I mean I'm very curvy and I've got big breasts." Physically, Killian appears quite androgynous. On the day of their interview, they wore a more masculine outfit: a blue polo shit, jeans, a short-cropped hairstyle. And although their own description of their body contrasts that dress style, the style and body type combine to create an external image of androgyny where they don't fit into a binary image of masculine/feminine gender. This allows their clients to pick out the gender they need to feel most comfortable receiving care. So while this does contribute to the invisibility of queer midwives, it removes the masculine impetus for the relationship arch discussed in

Chapter Three. This androgyny gives the queer midwives an easier time navigating their relationships with clients.

The second privilege the midwives described was that which came with the presence of queer masculinity in the hyperfeminine space. The privilege mirrored two common privileges of masculinity in feminine professions. The first concerns the undue praise the midwives received for simply being good midwives. During their midwifery education, Stewart felt lauded often for characteristics that are more commonly associated with femininity; "If I was just a decent person, I got way more accolades than I should get right? It's like, if I'm nice to someone in labor, which is my job, right? Like it is my job to be compassionate and provide respectful, kind, like safe care. If I did that as a student, they would be like, 'Oh my gosh, you're so incredible!'" Compassion, respectfulness, and kindness were not associated with Stewart's deviant gender identity because their identity did not exist within the assumptions of feminine qualities. So when they were able to present said qualities, they were celebrated for doing something above and beyond their assumed normal capabilities.

Reid described the second privilege of queer masculinity in their experience of being tokenized by the midwifery community. The community often relied on Reid as the resource for queer midwifery care; "I feel like this token…within the birth community…I think people have an idea of me as this token queer trans midwife…so my name comes up all the time when someone posts asking 'Hey, I need a queer-friendly provider.'" Reid described feeling singled out as a representative for all of queer midwifery because their gender was a minority among midwives. This affords Reid more opportunities to care for queer folk, valuing their work over the work of cis-women who

may have the same or more experience working with queer folk. These descriptions of privilege, of being able to mitigate their masculinity via their queerness, being praised for work expected of all midwives, and being tokenized as a provider of specifically queer care were all discussed in less frequency and less importance than the descriptions of transphobia that the queer midwives experienced.

II – A Queer Paradigm of Midwifery Practice

Distinct from the other midwives in this study, the queer folk discussed an intentional approach to midwifery that created space and support for queer and transgender clients. The cis-masculine folk talked about midwifery as a space to support and empower women, but none of them, not even the gay cis-men, discussed an intentional support of gender variant clients. The queer midwives based the intentionally queer approach to midwifery on their own experiences of medical care that failed to be, for the most part, gender affirming. So not only did the queer midwives attempt to create space for queer folk in midwifery care, they also outlined a new, structurally affirming model of midwifery care for queer clients.

Creating Space for Queer Folk

The queer midwives' intended to use midwifery as a medical space to care for queer folk prior to when they began studying midwifery. While Stewart trained as a doula before going to grad school for midwifery, they "would say 'I'm going to become a midwife,' and people would be like 'Oh, that's great!' And then [they] would say, 'So that I can help queer and trans people have babies.'" This explicit desire arose from an

experience where Stewart helped their queer best friend give birth unattended at home. They knew that queer midwifery care really didn't exist – as exemplified by the reactionary "eye roll" from their doula classmates – and they explicitly wanted to fill this gap. Similarly, Reid felt that being in a midwifery program was profound in terms of what it meant for the future of midwifery care; "The fact that I was in that program and was becoming a midwife meant that people like me would have access to provider like them…Thinking about who, as a 19-year-old or as a 25-year-old, who would I have wanted to go to for care. I wanted a provider that represented me and I never to my knowledge had a queer provider before." They felt necessary in the midwifery space because they would be able to provide affirming care to fellow genderqueer folk. They described this desire as a result of never having received queer care from a provider that physically embodied a representation of themself.

This idea of provider embodied-representation is the first of the two ways that queer midwives understood that they could create space for queer clients. As Reid described above, they realized this embodied-representation as a consequence of self-reflection. In some cases, practitioner-client interactions allowed the queer midwives to understand that their queerness gave space for queer clients to experience affirming care. Killian described one such interaction;

> *"I had a client tell me, butch-femme couple, and the butch partner was conceiving…they told me that a fundamental part of their being able to go through with conceiving and their like sense of self through that process was my gender identity…I was like 'Wow! I'm holding space for even more than I even realized that I was, just by being me.'"*

This idea of holding space is really important to the production of provider embodied-representation. In Killian's depiction, "holding space" creates space for queer clients by being a physical body that said clients could use as a reflection of themselves while

receiving care. Embodied-representation passively created space for queer clients simply by having the queer midwives on the path to midwifery. It is for this reason that Stewart is "always out to trans people" they care for. They intentionally present themself to the client in an image the client can relate to, and in doing so they construct a clinical space that affirms trans identities.

The queer midwives also created space for queer clients through activism in the midwifery community. The midwives intended the activism to encourage cisgender midwives to provide care that affirms queer clients. Killian's activism centered around education;

> *"[I] do a fair amount of public speaking at conferences and sometimes organizations will hire me for consulting on gender inclusivity issues…I have like funneled my ability to articulate what a lot of people perceive as a complex topic into not only easy to understand terms, but also in a way that is like deeply, fundamentally moving…I have people do this visualization, like that takes you back to the formation of your own gender identity in order to understand what folks are going through who are not typically gendered through the pregnancy process"*

Killian's activism on gender inclusive midwifery goes beyond simply encouraging the inclusion of queer folk. They have created a curriculum that encourages cisgender midwives to build their empathy for queer clients. In doing so, Killian expands the clinical space in which queer clients are both empowered and affirmed in their embodied experiences of pregnancy. Reid echoed this need to educate and affect change within the midwifery community to create space for queer folk. In discussing this, they gave me a directive, telling me that I am "signing up for activism and being a voice of reason within the college for an underrepresented population." They found it imperative to create a future within midwifery that allowed for the affirmation and support of queer folk. This was necessary because the queer midwives believed that the "underrepresented

population" of queer folk was mostly ignored, poorly cared for, and misrepresented in the midwifery community.

A Queer Model of Midwifery Care

In their discussions about caring for queer folk, the queer midwives in this study outlined a queer model of midwifery care. They based the model in the idea of creating affirming clinical space for queer clients that restructures midwifery to fit a queer experience. The queer paradigm of care started with affirming the queer identity of the clients, and validating them within a system that required them to conform to a binary. Killian's private, LGBTQ practice starts care with preconception because their clients often require donor insemination. This preconception care requires Killian to "do a lot of like talking, and counseling, and holding, and teaching, and like healthcare systems navigation" with their clients because the typical infertility care model is based entirely on a "cis/het-centered model of care." The idea of infertility exists within a binary between "what we call 'natural' vs. 'artificial'" conception. This dichotomy forces trans and queer bodies into the category of artificial and unnatural, undermining their right to conceive by depicting their pregnancies as inhuman. Furthermore, Killian explained that, while the infertility clinics might be accepting of queer families, they often wouldn't change their documents to be linguistically inclusive. So their clients frequently reported; "We were accepted and it was very much like the forms were mother/father." This language rarely represented the queer folk the infertility clinics cared for.

The queer midwives discussed the ways in which they navigated the use of affirming language with their queer clients. Even the CNMs, who work in more

medicalized spaces of midwifery, and have to conform to many binary gendered constructs, used language to validate their genderqueer and trans clients. Reid described how to use language as a form of validation by reflecting on the aspects of care that lacked from their own receipt of clinical experiences; "Having a provider that uses the same pronouns as me, that asked me my pronouns, that asked me if I had a preferred name that was different from the legal name that is on my medical chart, like basic, basic, basic things you don't have to be trans to provide…I would have had such a better experience." The first of the three aspects refers to the above embodied-representation of the client in order to create space for that queer client. Having a provider that used the same pronouns would have given Reid an immediate sense that their provider understood and recognized their gender and bodily experience. But even without a trans or genderqueer clinician providing care, to ask the client for preferred pronouns and a preferred name validated their identity, and told the client that the clinician would provide care that affirmed their queer bodily experiences.

The idea of the body as a manifestation of the queer experience informed the ways that providers changed the midwifery model of care to approach queer bodies. Killian's described their model of care in specific relation to the ways their clients would relate their queer identities to the processes and physicality of their bodies;

> *"My philosophy of care is that every person should have a provider where they feel seen and heard in the totality of their being. Becoming a parent is a transformation of identity, it's one of the major transformations of identity that we go through…And so I firmly believe that a person's healthcare during that time should encompass that…I think that for a certain percentage of trans folks, I'm helping them integrate that this means they're doing this with their body, and that there is a relationship with the reproductive function in their body…When I teach a cis person about what fertile signs to look for…like 'Wow did you know that if you look at your cervix with a speculum at home with a flashlight and a*

> *mirror, that it tells you when you're ovulating?' Where like for somebody who is not gonna be able to interact with their body in that way, because of their gender dysphoria, that's not gonna be on the table. So I'm, without making them feel like they're missing something, or that there's any inadequacy in them, that just meeting them where they're at…even just that, being able to use language that's gender-affirming when talking so intricately about the body, I think opens a doorway for people to be able to relate to their bodies when they're not being misgendered by the terminology that's being used…Talking about what it feels like to have a baby growing in your body, and naming what different people experience in terms of body dysphoria during pregnancy, while at the same time making space for, and planting seeds for, connection and embodiedness…people can and do completely disconnect from their pregnancy and from their body during pregnancy…my goal is that people are both physically and psychologically and relationally intact by the time they're parenting a newborn"*

This provides a profound depiction of queer pregnancy wherein the physiological process of conception and gestation are so thoroughly detached from the person's psychological experience of their body. For the majority of the time they spend caring for their queer clients, Killian helps queer and trans folk integrate their physiological and psychological selves so that their pregnancy experiences don't lack in any way because of their non-normative appearance. Killian accomplished this work by creating a clinical model that affirms through language the client's self-image, that helps the client listen to their body however they need rather than how the clinician needs, and that reconnects the clients to their bodies in ways that does not undo the work the client has already done to disconnect their self-perception of their body from society's relegation of their body to the cis-feminine polarity.

Conclusion

Over the course of this study, I have explored the ways in which masculinity functions within American midwifery. The history of midwifery in the US is a tumultuous story wherein male doctors coopted the profession, removed the presence of women, pathologized childbirth, and medicalized its care. So when midwifery was reintroduced to the medical profession via nursing in the 1920s, it was categorized as subversive and subordinate. As this new practice of midwifery developed, it began to reassert the idea of childbirth and its care as centered in womanhood and femininity. This association between childbirth and femininity was reflected by the mothers in this study who experienced their pregnancies as inseparable from their identities as cis-women; this translated into their expectations of midwifery care, and their relationships to masculine clinical providers. The adherence to femininity was inescapable for masculine providers, both queer and cisgender. It functioned as the defining characteristic of their work, in many ways subordinating their masculinity unlike other feminine professions. Queer midwives, who faced a considerable amount of transphobia in midwifery, simultaneously used the profession as a safe clinical space to provide care for other queer folk. The degree to which femininity controls, and is constructed by the midwifery space designates midwifery as a hyperfeminine profession distinct from other feminine professions.

I define hyperfemininity within midwifery as an active process that establishes femininity as both default and regulation. It is active because agents of the profession and recipients of their care must work to constantly reaffirm femininity's control over the social space. The results of this study show how hyperfemininity is reified even when

agents identify as masculine. The mothers who participated in this study discussed their motherhood identities in essentialist terms. In other words, they never held a self-conception that failed to incorporate an image of motherhood, and in retrospect saw their childhood as an indication of their present identity as a mother. Motherhood was an unavoidable reality for these cis-women because it was thought of as an innate manifestation of their feminine gender identities. Thus the cis-women searched out healthcare that aligned with that normative feminine conception of pregnancy. In most cases, that normative conception aligned with the naturalistic care of midwifery. In the two cases of cis-women who chose obstetricians, they believed there was no other option in American birth care. The other cis-women chose midwifery because they perceived it as nurturing, motherly, natural, holistic, and as related to the home – all qualities considered feminine. Furthermore, they approached midwifery with a critique of obstetric care, and a desire for pregnancy and birth care that did not medicalize their womanhood via their processes of becoming mothers. They actively sought out medical professionals and a model of care that supported their preconceived ideas about femininity, and its relationship to pregnancy and birth.

In approaching midwifery with both an assumption of and desire for femininity, women added to the cementing of femininity in midwifery. This construction of midwifery structurally appears like a call-and-response where the call is the desire for and assumption of femininity, and the response is the cis-feminine practitioner. This call-and-response is an active process that is constantly reifying the hegemony of femininity within the midwifery space. It also set the basis for the cis-women's relationships to their midwives. In this study, their relationships all started with a confrontation with the fact

of their midwives' masculinity because the masculinity failed to answer the cis-women's calls with an appropriately feminine response. The masculine midwives therefore had to work with the women in order to give them the care they were searching for. The call-and-response is a symbolic method of reasserting femininity within midwifery, but it's also a request for a certain type of clinical care predicated on the above feminine qualities. So in order to effectively respond to the woman's call, a masculine midwife would need to care for that woman with the same feminine qualities. This request for feminine clinical care is so specific because it is founded in opposition to the model of obstetric care that arose throughout American history.

Obstetrics' origins define modern American midwifery. Prior to the mid 1700s, only women could practice midwifery. When male physicians were called into the birthing rooms of the early Americans to assist, their presence was feared because they brought certain death (of the baby more often, but also of the mother). But, as anatomical science grew, so did their concern with pregnancy. From the mid 1800s to the 1960s, male physicians ran a campaign that effectively stripped women of their right to assist other women in the birth room. The process was a violent one. As men gained more control over the birth room, their interventions expanded in number and invasiveness. Women came to expect their babies to be pulled out from their uteruses with the assistance of forceps; they came to expect to be shaved, receive enemas, and placed on a table alone in a room of strangers with their legs wide open; they came to expect to be placed under hallucinogenic anesthesia while they were tied down; and they came to expect their desires about their own births to be irrelevant.

Obstetric care has changed since the 1970s when the voice of midwifery gained some more mainstream momentum in changing the discourse about birth in the US. But obstetrics still functions on a medicalized model of birth (varying in degree of pathological conception) that brings with it thoughts of the above. And, more importantly, obstetrics is still the paradigm with the authority over the knowledge and methods of American birth care. Obstetrics is still the assumed way that birth care is supposed to happen. So choosing midwifery over obstetrics is a choice to move outside the obstetrics model of care, and as far away from its authority as possible. For many of the cis-women who participated, cis-masculine medical practitioners still were indiscernible from the definition of physician, and thus the idea of a cis-masculine midwife was very distressing for some of the cis-women. But the model of care they experienced with midwives mitigated this distress because it was founded on the feminine modes of care that were desired by the cis-women.

In receiving the type of affirming, empowering, and empathetic care from their cis-masculine midwives, the cis-women in this study experienced a relationship arc with their midwives. Following the confrontation discussed above, the cis-women were met with empathy, nurturance, and empowerment during their gestation that set the groundwork for the birth. Birth transformed the relationship between the cis-women and their cis-masculine midwives. The intensity of birth and resulting need for solid support throughout were met not just competently, but with all the qualities of feminine care that the cis-women wanted to begin with. They discussed a positive change in their sense of comfort with their masculine providers. The care the cis-women received from their masculine midwives, however, did not create a global shift in their preconceived ideas

about masculine medical providers generally. The cis-women continued to associate masculinity with negative medical experiences, which suggests a conflation of the medical/obstetric model and masculine gender – a conflation that reflects the historical obstetric takeover of midwifery. The shift to a comfortable relationship with their providers, on the other hand, indicates the presence of a third, mitigating agent in the relationship: the midwifery model. All the cis-women described very similar methods of empowerment and empathy produced by their masculine midwives. The model of care that the midwives employed, a structural model they all learned in nurse-midwifery or professional midwifery schools, created a clinical environment that upheld the feminine standards that the cis-women initially desired. So the gender of their own individual midwives became irrelevant in the face of the hyperfemininity that founded their care.

Masculine midwives both contribute to, and are affected by the active process of hyperfemininity. The masculine midwives in this study reported similar mechanisms for employing empathetic and empowering care as experienced by the mothers. Masculine midwives respond to the call from clients by performing the feminine tropes of midwifery on which they were trained. As such, the midwives were able to minimize the presence of their masculinity in the clinical space, and allow their clients to experience the same model of care they wanted from feminine providers. The clients associated the tools they use in the clinical space with feminine behavior/performance. The tools were ubiquitous among the midwives, which suggests a structural adherence to feminine behavior upheld by the midwifery model that is reinforced by the call-and-response symbolic interaction between midwives and clients. Midwives and their clients implicitly assume that the space requires femininity; even though the masculine midwives felt that

their gender didn't affect their ability to produce midwifery care, they still adhered to feminine standards. The structural femininity in midwifery care, however, created a precedence to push back against the masculine midwives.

The midwives came up against many barriers in their pursuit of the profession both in school and in jobs. Their masculinity was seen as an outsider identity. In many ways, this pushback reflects the pre-physician take over of midwifery where men were expected to stay away from the birthing room. Teachers, classmates, school admissions representatives, and hiring bosses all discriminated against the midwives because of their masculinity. And in every case, the midwives said the stated reason for the discrimination was either that midwives are supposed to be women, or that patients would be uncomfortable having masculine providers. Both of these worries are predicated on the historical constructing of American midwifery as feminine. After coopting midwifery, male physicians began to set themselves apart from midwifery by changing their title to obstetrician, and campaigning against midwives with the claims that their womanhood left them ignorant of, and incapable of practicing the medical care of pregnancy and birth. Thus, they set midwifery apart from obstetrics as not only a lesser practice, but also as a feminine practice. This later was reconfirmed in the US by the new nurse-midwives who followed in the footsteps of the nurses before them, defining their career as subordinate to, and shaped by obstetrics. While the nurse-midwives eventually gained their independence as nurse practitioners, the obstetricians of old and the early nurse-midwives had cemented the profession as intended to be practiced by, and for women. Certified professional midwives built their version of the profession in opposition to American obstetrics, and with the clear intention of caring for women in

the face of a patriarchal medical specialty. So it is no surprise that the masculine midwives in this study faced discrimination as a result of their gender because their gender refuted the constructed roles, and intentional origins of modern midwives in the US.

Almost every single respondent in this study discussed gayness as a counter force to masculinity in the midwifery space. Everyone felt that clients/patients would be more comfortable receiving care from a cis-masculine provider that identified as gay. The idea of this identity seemed to transform masculinity of said provider into a type of femininity deemed acceptable. This occurred for two reasons. The first was a removal of the risk for sexual tension. Clients and midwives both discussed how clients and their partners often feel some discomfort with their masculine midwives because of the potential that the provider may be sexually interested in the client. But when the clients and their partners discovered or believed that their midwife was gay, suddenly the risk was gone. Once clients believed that their midwives were gay, they ascribed feminine traits to the midwives that created the basis for the client to bond to the midwife. Gayness mitigated the gendered power dynamic of medicine. The historical process where men coopted midwifery in America created a gendered power dynamic between obstetrics and midwifery that both structurally defines midwifery as feminine, and establishes an institutionalized gendered conflict in women's health care. But gayness seems to deconstruct this conflict, redefining the masculinity of the gay provider as a performance of femininity.

Queerness, however, functioned the opposite of gayness. The trans and queer midwives in this study experienced transphobia as an additional affront throughout their

academic and professional careers. Their cis-feminine counterparts obfuscated, isolated, and excluded the queer respondents because of their trans and genderqueer identities. The structural, gendered conflict within midwifery that allowed gayness to function as the exception to masculinity here problematizes queerness. Where gayness mitigated the power dynamic of masculinity in midwifery because it removed the issue of sexual attraction, queerness was placed squarely within the power dynamic by instating the risk of sexual attraction and sexual touch. Furthermore, cis-feminine midwives obfuscated and isolated the queer midwives by assuming they identifies as cis-women, and requiring their adherence to femininity, respectively. The assumed sexual risk associated with queerness, and the assignation of queerness to femininity show that queer-masculinity functions like cis-masculinity in terms of its deviance in the midwifery context. It is therefore treated with the same discomfort, mistrust, and discrimination as cis-heterosexual men in midwifery.

Masculine midwives do experience privilege, despite the substantial barriers and discrimination they face. But, unlike the privileges that other cis-men experience in feminized professions, the experiences of privilege for the midwives in this study almost exclusive came from outside the midwifery profession. There are some exceptions to this, for instance, some of the midwives felt that they received more accolades than they were due when performing expected duties of midwifery like respecting their clients and providing nurturing care. But for the most part, the masculine Certified Nurse Midwives were privileged in the career of nursing. They were leaders in their undergraduate *nursing* schools; they decided to pursue a Doctorate of Nursing Practice in executive leadership, not midwifery; and they were promoted to *nursing* leadership in hospitals.

This displacement of their privilege into the profession of nursing reflects the adherence to and promotion of femininity within the midwifery space. Certified Professional Midwives did not experience this type of privilege. Outside of the nursing practice, midwives had no precedent for privileging men, especially since the CPM division of midwifery was founded in the 1970s as a counter to the masculine space of obstetrics, and was specifically designed by and for women. As such, the norm of privileging masculine folk, from the inception of the CPM credential, never existed. This suggests that the privileging the masculine midwives experienced within the context of CNM practice arose from CNM's couching in nursing. The queer midwives did experience a sort of privileging in their queer masculinity, but where it differed from the privileges experience by the cis-masculine folk, it coincided with an obfuscation of their identities, and an assignation of their identities to femininity.

The queer midwives, unlike their cis-masculine counterparts approached midwifery with the intention of utilizing the profession to care for other queer folk. The midwives who reestablished the profession in the 1920s simultaneously defined the profession as subversive to the medical profession. So there is a potential that the subversive origins of midwifery in the US allows for queerness to be more easily incorporated than in other more normative medical specialties. However, the midwives did not explicitly discuss this historical link. Furthermore, it seems that queer folk want to enter into many different medical specialties in order to care for queer folk. Further research would be necessary to understand why midwifery was seen as a space within which practitioners could successfully care for queer clients.

This study contains two major limitations. By nature of relying solely on in depth interviews, this study fails to access the live dynamics of gender in the clinical space. Subsequent studies that incorporate ethnographic data from clinic observation of masculine identified midwives and their clients would give deeper insight into the implicit dynamics of masculinity that affect the clinical care. Furthermore, observation data of the interactions between masculine identified midwives and their cis-feminine counterparts would expand our understanding of the symbolic mechanisms of hyperfemininity in reproducing the feminine standard of the profession. All of the midwives and clients in this study were white. White folk comprise the vast majority of the midwifery community, meaning this cohort roughly represented the racial make up of the population of midwives in the US. This dynamic, however, suggests a relationship between the historical, racist denigration of black midwives and today's lack of diversity in the community. A similar interview based study, or an ethnographic study of the experiences of midwives of color could both delineate the mechanisms race in midwifery, and broaden our knowledge about the affect of the history of midwifery on today's paradigm of the profession. While this study discusses one correlation in terms of gender, other social identities merit exploration.

Through the interviews with the midwives, it became clear that they interacted with the partners of their clients in specifically gendered ways. This was true for both the cis-masculine midwives and the queer-masculine midwives, and it factored into the ways both cohorts of midwives practiced clinical care. These findings, however, were beyond the scope of this study because the midwives did not discuss these relations in enough detail. So designing a future study to understand the dynamics of clinical interaction with

partners would be important because the brief discussions of midwife-partner interactions in the interviews for this study outlined some distinctly gendered behavior like cis-men controlling their cis-women partners, cis-men finding discomfort in the masculinity of the midwives, and cis-women partners of pregnant folk needing a tailored approach to accommodate their discomfort with not bearing the family's children. These are all dynamics of gender that were brought out because of the gender of the midwives, and thus may have both social and clinical implications.

Through the course of this study, I have shown that American Midwifery is inextricably linked to its history. The obstetric take over of birth care in the US by male physicians, and the subsequent reestablishment of midwifery as a profession by women founded a gendered power dynamic that created a structural conflict in the medical care of pregnancy and birth. As such, midwifery has become a hyperfeminine profession wherein the social actors work to reaffirm and adhere to femininity. Midwives, clients, and other members of the medical community work together to constantly define and redefine midwifery as feminine, as historically in support of women, and therefore as unique from obstetrics/masculine birth care. In conclusion, the masculine-of-center midwives must conform to the standards of femininity upheld in midwifery in recognition of its history in order to be accepted by the profession.

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Appendix A

Table A: Midwives			
Name	Location	Midwifery Credentials	Gender
Daniel	Washington, DC	CNM	Cisgender
Isaiah	Seattle, WA	CNM	Cisgender
Jeffery	San Francisco, CA	CNM	Cisgender
Ezra	Seattle, WA	CPM	Cisgender
Kory	San Francisco, CA	CNM	Cisgender
Killian	Seattle, WA	CPM	Genderqueer
Miles	Chicago, IL	Midwifery Student	Cisgender
Reid	Seattle, WA	CNM	Genderqueer
Stewart	Seattle, WA	CNM	Trans/genderqueer

Table B: Clients		
Name	Location	Number of Children
Samantha	Seattle, WA	3
Sophie	San Francisco, CA	2
Therese	Los Anfeles, CA	3
Lynda	New York City, NY	Pregnant at Interview
Monica	Seattle, WA	3
Meredith	Connecticut	4

Appendix B

Interview Script – Mothers:

The Experience of Birth and Pregnancy: Perspectives of Male Midwives and their Clients

Interview Guide and Script

Participant ID#_____

Date/Time:_____

End time:_____

Script:

Thank you so much for participating in my research project, and taking time out of you busy schedule to have this conversation with me. As you know by now, I am doing this project of the experience of male midwifes and the female clients of male midwives. I am looking to really understand your perspective, your experience, and to really get a glimpse into what your life is like.

I would just like to take a moment to assure you that your interview here will be kept confidential, and no information that identifies you will be kept available beyond the consent form you signed (which will be under lock and key). I would like to say that I will be using your actual words in the final project, and therefore there is a very slight chance that somebody who knows you may be able to discern who you are if they read

my project. That said, I will make it my duty to keep your responses as confidential as possible.

Again, thank you so much for participating.

INTERVIEW GUIDE FOR CLIENTS

This interview is semi-structured, and is intended to flow like a conversation in order to pinpoint what is important to the clients themselves, not my agenda as a researcher alone. As such, this guide is more suggestive than anything, and will contain questions that may or may not get asked, and will not have questions that may get asked at the time of interviewing; the questions listed here are intended to describe the overall type of questions that will be asked. Furthermore, some sections may be omitted entirely, and other may be added if there is a line of thought the midwife is talking on that seems to be particularly important to them.

Introductions and Background – Possible Questions:

- So why don't you tell me a little about yourself, and how you decided you wanted to have a child/children?
- Do you have a partner? Did they want children, and did they influence your decision to have children?
- When you decided to have children did you make a plan? If so, what did that plan look like?

Provider decisions – Possible Questions:

- So can you walk me through the process of you (and your partner) choosing a practitioner?
- Why did you choose to go with a midwife over an obstetrician as your pregnancy and birth care clinician?
- What did your family and friends think of your choice?
- Did you feel empowered in choosing a midwife? Why?
- How did you come to choose a male midwife? Did this feel unusual in any way?

- How did your partner feel about a male midwife?

Interactions with the Midwife – Possible Questions:

- So before your birth, how often would you see your midwife?
- What were your visits with him like? Can you walk me through a typical visit?
- How did your experience being cared for by a male midwife differ from the experiences your friends had when they were pregnant?
- Was having a male midwife throughout the pregnancy at all difficult? In what ways, and why?
- Was having a male midwife throughout the pregnancy at all helpful? In what ways, and why?

Midwife and Birth – Possible Questions:

- Can you tell me your birth story?
- What was it like to be cared for by a male midwife in the birth room?
- Can you tell me what you know about your partner's experience of being in the room with another man caring for you during birth?
- Were there any especially difficult moments during your pregnancy? How did your midwife help you through those?

Postpartum Period – Possible Questions:

- How has your relationship with your midwife changed since you've given birth?
- What is your midwife's role now that you have given birth? How have they been involved in the health of yourself and your child?
- Have you had any difficulties in health or the health of your baby since your birth? Has your midwife been involved in any way in alleviating those issues? How has he done so?
- Would you choose to use a male midwife again? Why?
- Do you think other women should use male midwives? Why?

Interview Script – Midwives:
The Experience of Birth and Pregnancy: Perspectives of Male Midwives and their Clients

Interview Guide and Script

Participant ID#_____ _____

Date/Time:_____

End time:_____

Script:

Thank you so much for participating in my research project, and taking time out of you busy schedule to have this conversation with me. As you know by now, I am doing this project of the experience of male midwifes and the female clients of male midwives. I am looking to really understand your perspective, your experience, and to really get a glimpse into what your life is like.

I would just like to take a moment to assure you that your interview here will be kept confidential, and no information that identifies you will be kept available beyond the consent form you signed (which will be under lock and key). I would like to say that I will be using your actual words in the final project, and therefore there is a very slight chance that somebody who knows you may be able to discern who you are if they read my project. That said, I will make it my duty to keep your responses as confidential as possible.

Again, thank you so much for participating.

INTERVIEW GUIDE FOR MIDWIVES

Introductions and Background

- So before we get started, why don't you tell me a little about yourself, how long you've been a midwife, and how you decided to become a midwife? Can you point to a specific person or experience that pushed you to becoming a midwife?
- Where you doing anything before midwifery, or has this been your only profession?
- What did you think about midwives before you decided to become one?
- How did you go about telling people that you wanted to be a midwife? How did people (friends, family, co-workers, etc.) respond when you decided you wanted to be a midwife? How did their responses affect you?

Entering into Midwifery

- So can you tell me the story of how you became a midwife?
- Can you tell me of your educational experience?
    - What did the training entail?
    - Do you think it adequately prepared you for midwifery?
    - What were the most important or stressed aspects of midwifery from your professors?
    - How do you feel your rapport with your classmates was?
    - Correct me if I'm wrong, but would I be right in assuming that you were one of a very small group, if not the only, male student in your program. Can you tell me a little about what that was like? Did you feel included or excluded by your classmates because of your gender in anyway? Did being a man/male identifying help or hinder your education in anyway?
- When you first graduated, what was it like breaking into the "real world" of this profession?
- What surprised you when you finished training and started working as a midwife?

- Did responses change from the people you told that you wanted to be a midwife when you actually became a midwife?
- How did your early clients/patients respond to you?
- Did you quickly develop any tools to help you counteract/navigate/engage with/etc. your gender when you started working as a midwife? What were those tools, and how do you think they worked?

The Career

- What are your primary clinical duties? Can you walk me through a typical day of clinical practice?
- Is it different for you caring for a person through pregnancy vs. Gynecological care? If so, how is it different?
- What is your model of care in terms of the amount of time you spend with the women? What does your intake process look like? Would you change anything about your model of care or intake process? Why or why not?
- Can you tell me what it's like when you're caring for a woman? Can you tell me a little about your style of implementing the "well woman" approach?
- How do you go about helping a person craft their birth plan?
- How do you go about getting the consent to practice from your clients? Does it follow the traditional medical assent process? How does this process of consent factor into gearing their medical experience to comply with their birth plan?
- What do you do with an unrealistic birth plan? How would you define an unrealistic birth plan? How do you navigate that conversation?
- What are your methods for finding out why a woman/person might want this sort of unrealistic birth plan? What sort of ideas or concerns from the mothers/pregnant people put you on guard?
- Tell me about your hardest day at work to date?
- What's the most rewarding part of your job? What's the most challenging?
- Can you tell me about special clients/your most memorable clients? Why do they stand out?

- Do you have clients that use you for multiple births? What is it like caring for a woman with her second, third, fourth birth as opposed to her first?
- How do you know when to call a doctor? What level of risk do you believe is the point at which to call a doctor, and why?

Partners

- In your experience, how to husbands/wives/partners typically engage in the birth process? Do you see them behaving differently if they identify as a woman vs. a man vs. queer/trans/agender/non-conforming?
- How do you typically engage the husbands/wives/partners?
- In your experience, how do you think partners feel about having a male midwife care for their wife through pregnancy?

Gender/Profession

- Do you think your practice is different from women/feminine identifying midwives? How do you think it differs?
- (If they've worked for a long time) How has midwifery changed since you started working in the profession?
- Can you tell me about your experience working in an industry that consists of mostly women?
- Do you ever feel devalued because you are a man? Do you ever feel over-valued because you a man? Can you tell me more about those experiences, like how you came to understand that you were being over or undervalued?
- What are your future aspirations? Have they changed since you started working as a midwife?

Beliefs

- Are you married to a woman? Have they given birth/do you have children? Did they use a midwife? Why or why not?
- How do you talk to women who want heavy medical and pain relief intervention? What do you think about these interventions? How do you help these women navigate their pain?

- Are there conflict of interest areas? Would you practice on your family members? Friends? What does the profession think of this? What do you think of this?
- How do you feel about the profession as a whole? Do you consider yourself a professional? Why or why not?
- Do people confuse you as a Labor and Delivery nurse? How do you feel about that? How do you navigate/respond to that?
- What is the prototypical patient/client? Are they "hippies," no vaccines, vegan, etc.? Are they religious? Are they mistrustful of the medical establishment?
- What kind of patient would you not work on?
- Have you had any moments of shock that have totally changed your opinion of midwifery?
- What do you think is the popular belief about midwifery? What do you think is the popular belief about birth? What aspects of that are true? What are false?

Appendix C

Tufts University Department of Sociology

Informed Consent to Participate in a Research Study

Principal Investigator: Max Farber

Contact Information:

Department of Sociology
102B Eaton Hall
5 The Green
Medford, MA 02155

Email: max.farber@tufts.edu

Telephone: (818) 454-0889

The Experience of Birth and Pregnancy: Perspectives of Male Midwives and their Clients

Purpose: The purpose of this research is to understand the experience of two interesting populations. The first is that of male midwives who work in a traditionally feminine profession, and the second is that of their clients. The ultimate goal of this research is twofold: a) to characterize the clinical experience of men caring for women during their pregnancies and births, in a professional tradition of keeping well woman care at the forefront of procedures, b) to understand the way women experience birth and pregnancy when their healthcare provider is not a women, but practices a woman-centric mode of care.

Time required: Participation in this study is expected to take about 1 to 2 hours of your time.

Procedures: If you agree to participate in this study, you will first be asked to read and sign this consent form. Immediately following, you will participate in a 1 to 2 hour in-depth interview lead by the principal investigator, Max Farber. I will ask you to think about your experience as a) a midwife, or b) a person under the care of a midwife during their pregnancy. I will ask you questions that cover many different aspects of your experiences, but I mostly ask that you speak openly and freely, feeling encouraged to expand in any way you feel comfortable. I intend to record this interview with you, but that will depend on your further consent to be interviewed. Recording will facilitate the writing of a full transcription later on that will ensure an accurate retelling of your experiences, keeping my research as closely linked to your actual words as possible. Should you choose not to consent to being recorded, the interview will continue with pen

and paper note taking. Without a recording, I cannot promise perfect accuracy because I am likely not to remember some details of this interview.

Risks: There are no physical risks in participating in this research. There is a slight risk that you will experience mild emotional or psychological discomfort when discussing subjects of a sensitive nature. There is a potential risk for loss your confidentiality in participating in this study, but every effort will be made to protect the confidentiality of your participation. This risk is associated with my use of your words verbatim that may be identifiable to somebody you know personally. This last risk is minimal.

Benefits: There are no direct benefits from participating in this research, but I hope you will enjoy the opportunity to talk about your experiences freely and in depth. Furthermore, I hope your participation helps to further the dialogue on birth and pregnancy in the US, giving a voice to the experiences therein.

Confidentiality: Every effort will be made to keep your participation in this research confidential. No identifying information will be stored with your data. The transcript for your interview will be stored on a private, password-protected computer, only accessible to my faculty advisor and myself. The recording will be deleted immediately upon transcription. The information from this interview and your words will be used in my Senior Thesis, and may be published at a later date in a scholarly journal. However, your name will be changed to a pseudonym immediately following the interview.

Withdrawal of Participation: Your participation in this research is entirely voluntary. You have the right to refrain from answering any question, requesting to move forward with the subsequent questions instead, as well as the right to request an alteration to any question asked. Furthermore, you may withdraw your consent and discontinue your participation, at any time and for any reason, without penalty or question.

Contact:

If you have any questions about this research or experience any problems, you should contact Max Farber at max.farber@tufts.edu or (818) 454-0889.

In the case that you have any questions about your rights in this research, concerns, suggestions, or complaints that are not being addressed by the researcher, please contact the Tufts University Social, Behavioral, and Educational Research Institutional Review Board at:

20 Professors Row, Medford, MA 02155
Phone: (617) 627-3417
E-mail: sber@tufts.edu

By signing below, you are stating that the full purpose and nature of this study has been explained to you, and that you agree to participate. You also state that you understand your right to remove your agreement to participate at any point without consequence.

Please check below if you agree:

I agree to participate in this study, in full knowledge of the above_____

I agree to the digital recording of this interview____

Print Name:_____

Signature:_____ Date:_____

Interviewer Signature_____ Date:_____