Of Missing Voices and the Obstetric Imaginary: Commentary on Jankowski and Burcher

Melissa Cheyney

ABSTRACT

In this commentary, I respond to an ethical analysis of a case study, reported by Jankowski and Burcher, in which a woman gives birth to an infant with a known heart anomaly of unknown severity, at home, attended by a midwife. Jankowski and Burcher argue that the midwife who attended this family acted unethically because she knowingly operated outside of her scope of practice. While I agree that the authors’ conclusions are well supported by the portion of the story they were able to gather, the fact that the midwife and mother declined to engage in the ethics consult that informs their piece means that critical segments of the narrative are left untold. Some important additional considerations emerge from these silences.

I explore the implicit assumptions of the biotechnical embrace, the roles of the political economy of hope and the obstetric imaginary in driving prenatal testing, and institutional blame for the divisiveness of the home-hospital divide in the United States. The value of Jankowski and Burcher’s case study lies in its ability to highlight the intersections and potential conflicts between the principles of beneficence, patients’ autonomy, and professional ethics, and to begin to chart a course for us through them.

I want to begin with praise for Jankowski and Burcher’s piece, for their clear and courageous assertion of a woman’s right to choose the birth setting and birth attendant type that aligns most closely with her value system and desires for birth. I concur wholeheartedly with their affirmation of women’s autonomy (and that of the American College of Obstetricians Gynecologists—ACOG), even in cases when the fetus may be compromised. I also accept Jankowski and Burcher’s conclusion—that the midwife who attended this family at home, despite the unknown severity of the heart anomaly, essentially acted unethically as she stepped outside her scope of practice. In my position with the State Board of Midwifery in Oregon and through my involvement with the MANA Statistics Project in the U.S., I have had the opportunity to review a small number of cases where what started as “going out on a limb” for a well-informed and well-loved client turned into life-altering grief for all involved.

Even so, I was tempted to rethink the authors’ final assessment in light of the positive outcome. Although the mother’s voice is absent, it is hard to miss the fact that it is precisely the midwife’s unethical conduct that enabled this woman to give birth at home, with her midwife, on her own terms, and in the space she believed was the best choice for welcoming her baby—a child she hoped to give natural birth to, and if needed, a natural death to. Yet, because this outcome could have just as easily gone the opposite direction, ultimately Jankowski and Burcher’s conclusion is well supported by the portion of the story they were able to gather. This piece’s
value lies in its ability to highlight the intersections and potential conflicts between the principles of beneficence, patient autonomy, and professional ethics, and to begin to chart a course for us through them.

However, as a medical anthropologist and homebirth midwife firmly grounded in narrative medicine/midwifery, and the ethnographic contexts of women’s birthing stories, there is something unsettling—a feeling of incompleteness—to this case study due to the absence of the voices of the midwife and mother; Jankowski and Burcher note that both mother and midwife declined to speak with them. It is difficult not to speculate or attempt to fill in some of the gaps. What might this family have been thinking? The midwife? In contemplating these silences, I see three additional reflections worth considering.

First, from the mother’s perspective, I am left wondering what was heard and what was missed when she was told of her baby’s absent corpus callosum and asymmetric cardiac ventricles. Having been present with patients as they received dreaded news, and in hearing them recount these experiences as what Kristina Wirtz called “telling moments,” we do well to remember the “how” and not the “what” of the hearing: “The earth fell away under my feet”; “My ears started ringing, and my heart was pounding”; “I couldn’t hear what anyone was saying”; “My vision went away, even though my eyes were open.” Current institutional constraints—short visits and fragmented care—can mean that women are left to process the shaky details and make decisions far from anyone who can help to clarify the “facts.”

Of course we do not know if this is the case here. This mother’s actions in seeking out a funeral home may indicate that she heard more about potentially lethal anomalies than she did about uncertainty. Anthropologists are fond of pointing out that “normal” is simply what we are used to, and while we can become socialized into very high levels of trauma in medical care, women’s narratives remind us that a diagnosis like this can obscure rational thought by turning one’s world upside down. The midwife in this case is the closest connection to the mother and the greatest assurance that informed, shared decision making is occurring. Yet, her voice is also absent. We do not know why this is, but in my immediate professional world, such exclusions are often a function of homebirth midwives’ position along the margins of culturally sanctioned maternity care—a place they occupy either by choice or as a result of systematic discrimination.

To complicate matters, once a mother begins to see through the grief, she may view her options through a unique lens—a lens that I think may be much more common among homebirth clients than in the larger U.S. birthing population. In 2007, in an edited volume on subjectivity in ethnographic investigation, Mary-Jo DelVecchio Good argues that an ethnographic slice through patients’ narratives reveals an affective and imaginative dimension of high-tech medicine that envelops all actors in the clinical encounter in what she calls the “biotechnical embrace.” Patients and doctors metaphorically embrace new technologies, testing, and treatments for the promise of health, wellness, a reduction in suffering, and/or the ability to prolong life—although this promise sometimes proves empty. DelVecchio Good refers to that which energizes modern medicine, making the biotechnical embrace second nature to so many, as the “medical imaginary.”

In my own international work, I have reshaped this term into the “obstetric imaginary” to help capture the widely held belief that the massive application of U.S.-style obstetric technology in the birthplace will improve care, save lives, and reduce maternal and neonatal suffering. U.S. homebirth clientele are less likely to accept this “truth” and are more likely to point out that the sheer power of the obstetric imaginary can prevent exploration of the opposite side of the coin—that is, that the hyper-valuing of technology brings with it its own costs: a reduction in normal physiologic birth among low-risk women, for example. DelVecchio Good argued that what emerges from the medical (obstetric) imaginary and the biotechnical embrace is a particular political economy of hope that functions to propel patients toward more testing and more intervention; as these become more experimental, heroic, and costly, the likelihood of return also diminishes. Women who choose homebirth often do so, at least partly, because they see how the political economy of hope serves for-profit medicine, but they may feel less clear on how it serves them. They are often less mystified by the obstetric imaginary, holding instead to a critical stance based on their own or a loved one’s prior experience when obstetrics did not offer an appealing return on what the patient anticipated. While homebirth clients are often up for a biotechnical handshake, many would eschew the full embrace.

Secondly, from the midwife’s perspective and again tied to the political economy of hope, I would say that if I have any critique of this article, it is that the authors may be overestimating the degree to which additional follow up or consultation would...
have clarified the situation in this case. I bump up against the limitations of prenatal testing and diagnosis all the time: fetal weight, gestational age, and rarely (thankfully), type and severity of anomaly are often incompletely known prior to birth. I have, in fact, found myself in the reverse situation described here where chorionic villi sampling, ultrasounds, and numerous consultations indicated a normal child, who was later born at home with severe anomalies, requiring urgent transport. In the days and weeks that followed, as we chased a diagnosis and treatment plan, I was struck by the way the mother held to the experience of her gentle labor and birth: “At least I gave him a loving birth.” This “loving birth” may actually have been more of a gift to the mother, as she called on that memory to help her weather those early weeks of surgeries, testing, and suffering that left her questioning, at times, whether she should just have stayed home.

From the midwife’s perspective, I think also of the estimated 32 percent of women planning a homebirth in the U.S. who do not have an ultrasound prior to a planned home delivery.10 This article raises questions for me: Is it unethical to care for these women? Or only for those who begin testing, but do not carry through to a seemingly reliable conclusion/diagnosis? What about women who stop prenatal testing due to the financial burden of being underinsured? These are important questions to resolve given: (1) the rising number of women choosing homebirth;11 and (2) the high percentage of special groups like the Amish and Old Order Mennonite who tend to decline prenatal testing and who are also overrepresented in homebirth samples.12

In addition, just under 1 percent (0.9 percent) of the babies whose mothers go into labor intending to birth at home will require transfer to the hospital following a completed homebirth, and the most common reason for transport is respiratory distress.13 When babies are born with respiratory distress—nearly all without any prenatal indication—we resuscitate them according to the most recent Neonatal Resuscitation Program guidelines and transfer care. We rarely, if ever, know what the underlying problem is in the moment or how extensive it might be; as Jankowski and Burcher point out, midwives are不合格 to make that assessment. We know the most important thing we need to know in the moment—how to effectively ventilate the lungs and monitor heart rate until a more specialized assessment and treatment plan can be made. How much more quickly might a baby be evaluated, diagnosed, and treated if born in the hospital versus transferred in from home via emergency medical services? What difference might this make for such a baby? For a mother? These are systems-level questions that lead me to my final reflection.

This case study and the dilemmas faced by both the parents and the midwife are, I believe, a symptom of a larger problem in the U.S.—what anthropologists have called the home-hospital divide.15 It is heartbreaking to think that these parents may have chosen to birth at home even with an anomaly of unknown severity because they could not conceive of a gentle and loving birth in the hospital, a birth where their wishes were heard and respected, where they did not have to fight for the birth they wanted, where they could welcome their baby for however long he would be with them, held, cuddled, and nursed, rather than poked, tested, and prodded. For families that envision a particular kind of entrance into the world, and for whom this type of birth is deeply valued—for example, as the first step toward a more peaceful world, or as a necessary precondition for bonding, attachment, and empowered parenting—the line where modern medical science becomes harm rather than help may be drawn in a different place. The stories of these women add to the complexities careproviders face in navigating autonomy, beneficence, and professional ethics.

In closing, while I see more to think about around the voices that are absent, the role of the political economy of hope and the obstetric imaginary, and institutional blame for how divisive the place of birth debate has become in the U.S., over all I am elated to see critical discussions of risk and choice moving beyond the overly simplistic question of whether women should be allowed to give birth at home. More nuanced ethical considerations and reflections like those raised by Jankowski and Burcher offer a vital new direction.

NOTES


6. Ibid.


10. Unpublished statistics compiled by the Midwives Alliance of North America; readers may contact the author for these data.


13. Ibid.
