INTRODUCTION TO VOLUME I

Obstetricians Speak

Robbie Davis-Floyd and Ashish Premkumar

For the first time in social science history, this coedited volume—with the exceptions of the preceding Series Overview, this Introduction, and the Conclusions—consists entirely of chapters written by obstetricians (obs) who have been much critiqued by others yet rarely have had the chance to speak for themselves in the social science literature. Some of its chapter authors are also studying to get their PhDs in medical anthropology or already have them; these authors describe what that means for their ability to autoethnographically self-reflect and self-analyze within the broader context of their cultures, countries, and professions, which in this volume include Hungary, Brazil, India, Turkey, Canada, Australia, and the United States.

In the Series Overview, we presented some theoretical constructs and frameworks that will be employed in all three volumes. These include Robbie Davis-Floyd's delineations of the technocratic, humanistic, and holistic paradigms of birth and health care, which are much used by the chapter authors in this volume, along with her descriptions of the "4 Stages of Cognition" and "Substage." Now we proceed to a summary of what you can expect to find as you read through these chapters.

Introducing the Chapters in This Volume

In Chapter 1, US obstetrician Scott Moses provides an autoethnographic account of becoming an abortion provider and the ethical dilemmas that entailed for him. While still in medical school, he was attracted to the field of obstetrics because of his fascination with life cycle events and their rituals. In his words, he was "drawn to the privilege of building a relationship with the patient and family during a time of significant

and unique vulnerability and wonder," evoking Rabbi Abraham Joshua Heschel's term "radical amazement." He details his original uncertainty about becoming an abortion provider, his trajectory in moving from rabbinic candidate to women's health care provider—particularly in relation to pregnancy termination—and his extensive research on ethics. He describes his ultimate full commitment to providing a service that so many women need, precisely because of that need and because of his ability to provide it. He also addresses the implications of the Supreme Court's overturning of *Roe v Wade*, and of the recent Texas law that prohibits abortions in almost all cases.

The trope of abortion provision continues in Chapter 2, "Abortion, Professional Identity, and Generational Meaning Making among US Ob/Gyns" by medical anthropologists Rebecca Henderson and Chu J. Hsiao and obstetrician Jody Steinauer. These authors explore the meaning-making processes through which abortion provider interlocutors (who include coauthor Steinauer) have incorporated the provision of abortion as a key part of their professional identities and as an enactment of their core values. The authors show how the meaning of abortion provision has changed over time via the use of narratives from four ob/gyns of four different generations. The *Roe v Wade* generation of abortion providers tended to place primary focus on the lifesaving purposes of safe, doctor-provided abortions, framing them as medical necessities. Over the subsequent decades, abortion access for pregnant people and access to medical education about abortion steadily eroded in a politically fraught climate that generated the marginalization and stigmatization of abortion providers. Then, during the early 1990s, abortion provision became linked with values on feminism, advocacy, activism, and justice. Thus, subsequent generations have moved their meaning making around abortion to a primary focus on reproductive rights and reproductive justice. Like Scott Moses, these abortion providers consistently framed abortion as central to their professional identities as ob/gyns, describing their abortion work as affirming and as "expressing their most important professional values and obligations." They frequently engaged in political advocacy, seeing abortion as a means of addressing the "root causes" of injustice and as "mission-driven" medicine. The links that these interlocutors generated between abortion and ethical obligations also resonate with the ideas described by Moses in the preceding chapter.

In Chapter 3, series coeditor Ashish Premkumar autoethnographically describes his transformation from an obstetrician to a maternal-fetal medicine (MFM) subspecialist, also called a perinatologist. In the United States, becoming an ob/gyn requires four years of training after completion of medical school. To achieve subspeciality training in

MFM—the practice of taking care of pregnant people and fetuses with complex medical issues—one must undertake three additional years of training after residency. While anthropological inquiries into ob/gyn training have used ethnographic accounts to evaluate how obstetricians understand the body through surgery, or how risk is conceived of and enacted through obstetric practices, there has been a limited inquiry into the phenomenological and embodied experiences of undergoing training as a subspecialist, particularly the crafting of the body through procedures unique to the perinatologist—for example, performing maternal-fetal therapies and surgeries, and engaging with pregnant people in the construction and clinical management of maternal-fetal risk. By utilizing autoethnography, Premkumar seeks to shed light on how an MFM's viewpoint is maintained and (re)produced, and what the stakes are for both the burgeoning anthropology of obstetrics (as evidenced in our three volumes) and for wider theories of knowledge production, power, and the body.

In Chapter 4, "Cold Steel and Sunshine," Kathleen Hanlon-Lundberg, also an MFM specialist, provides both ethnographic and autoethnographic perspectives on two perinatal careers "from across the chasm" between biomedicine and anthropology. She compares her obstetric trajectory with that of her friend and colleague Emily: Kathleen worked in large tertiary hospitals, while Emily chose to open a private practice serving members of a small community—a practice that gives her great personal and professional satisfaction. Kathleen achieved her greatest satisfaction during the years when she worked at a humanistic hospital that fully integrated nurse-midwives and the midwifery model of care. Yet once she had children of her own, the long commute became unsustainable, and she moved to a large, nearby hospital where she experienced so much tragedy and grief that, after some years, she left obstetrics behind, eventually deciding to study anthropology to better understand the human condition. Throughout her chapter, Handlon-Lundberg emphasizes that the vast majority of obstetricians whom she knows are "caring, thoughtful, and dedicated to the health and well-being of the persons whom they serve." Yet the first American Anthropology Association meeting sessions on reproduction that she attended "centered on how the obstetricians of the world wrong and harm women. I was surprised, as this was certainly not representative of my experience. I was clearly out of my territory, surrounded by members of a hostile tribe that seemed determined to totalize and essentialize 'the other' using a plethora of multisyllabic words and liberal suffixes."

Let her words be an inspiration to all social scientists to avoid "totalizing" and "essentializing" the members of any groups we study. There should not be a "chasm" between biomedicine and anthropology, but

rather a "plethora" of mutually rewarding interactions and fewer uses of "multisyllabic words and liberal suffixes"—of which we admit that we and our chapter authors are guilty of doing, as these days it seems that one cannot be an anthropologist without using plenty of those multisyllabic words and liberal suffixes.

In Chapter 5, US obstetrician Jesanna Cooper describes how she experienced "an awakening" after her difficulties with breastfeeding her first child, whose birth was highly medicalized. These difficulties led her to rethink her role as an obstetrician. Noting that "we obstetricians suffer from a flawed and dehumanizing maternity care system," she states that obs work in a professional setting of fear—fear of being wrong, of lawsuits, of professional ostracism, of being bullied, of disappointing their patients and themselves. They also fear the consequences of not meeting standards set by courts, hospital governance bodies, governments, and insurance companies, and of not being able to support their families financially and emotionally. Cooper explains the traumas of her own years of residency in terms of the "Dementor's Kiss" described in the Harry Potter book series, and how she graduated from residency as "a shell of her former self." Bullying, fatigue, and fear had extinguished her intellectual curiosity, joy, and love of service. Then she had an awakening. She said, "I remembered who I was. I realized that my position in the medicalized maternity care system gave me a platform for change. I could partner with midwives and doulas. I could create a culture where our team approaches patients with understanding, compassion, and respect." Her chapter goes on to describe the resulting changes she made to her practice, the tolls her paradigm shift has taken on her mental, emotional, and physical health, and, paradoxically, the successes and personal satisfaction this paradigm shift has given her. Yet ultimately, those tolls proved too much for her to bear, so, as she explains in her chapter, she sold her clinic in 2021, and is now officially retired.

In Chapter 6, Rosana Fontes, a Brazilian obstetrician, also describes the repercussions of a similar paradigm shift from Stage 1 technocratic to Stage 4 humanistic practice (for explanations of these terms, see the Series Overview, this volume) in both her professional and personal lives. Fed up with the "blind obedience" required by the technocratic approach, which excludes and punishes those who don't conform, Fontes and her like-minded partners conceived and founded the Mátria Clinic, where "deeply humanistic" (again, see the Series Overview) practitioners responsibly attended over 1,000 deliveries in the Paraíba Valley, São Paulo, Brazil, in a multi-professional team. In her chapter, Fontes provides the excellent statistical results associated with this Stage 4 humanized care, and notes that including midwives generated this clinic's success.

Fontes demonstrates that pregnant women attended at the Mátria Clinic were more satisfied with their labor processes because their choices were respected. The workload and responsibility normally entirely deposited in the obstetrician, Fontes, were reduced, along with her stress levels. The implementation of multidisciplinary group prenatal care also contributed to success in this model, as did the fact that clinic practitioners followed the WHO recommendations to ensure maternal and child safety. Fontes demonstrates that, even within a country where the cesarean rate is very high (56%), it is remarkable to see that adaptation to this humanistic model is easy to perform, low cost, and entirely possible. Yet eventually, tired of the persecutions she experienced from other doctors, and in an effort to achieve a better work/life balance and in hopes of having a family, Rosana sold the Mátria Clinic despite the strong objections of the staff, and today attends only a few births per month—those referred to her by the midwives with whom she still works.

The trope of the repercussions of a paradigm shift, this time to entirely holistic practice, is continued in Chapter 7 by former Brazilian obstetrician Ricardo Jones, who told us that he found his chapter both "emotionally challenging and psychologically cathartic" to write. He details his paradigm shift to Stage 4 holistic obstetric practice and his reasons for making it, and briefly describes his 34 years of attending both home and hospital births with his midwife and doula team. Jones then proceeds to the major focus of his chapter—the heavy prices he paid for practicing outside the Stage 1, fundamentalist, and often fanatical technocratic silo in the forms of bullyings and persecutions by the obstetric establishment in his city of Porto Alegre in the far South of Brazil and the ways in which he managed to withstand these. Jones concludes with an account of how the obstetric establishment finally managed to take away his license over a neonatal death that he did his best to avoid, only to be defeated in his efforts by NICU doctors who failed to give the baby the proper antibiotics in time to save his life. With this chapter, Jones hopes to call attention to the persecutions as experienced by himself and by many other holistic obstetricians and midwives like him, and to offer his own efforts to withstand these as a pathway for others who are presently experiencing the same types of persecution, in what many call "the global witch hunt."

By far the most famous obstetric practitioner who experienced the effects of that "witch hunt" is Hungarian obstetrician and midwife Ágnes Geréb. Coauthored with her friend and colleague Katalin Fábián, in Chapter 8, "Hungarian Birth Models Seen through the Prism of Prison: The Journey of Ágnes Geréb," Ágnes (Agi) describes her transformation from working as an ob/gyn for 17 years to becoming a certified mid-

wife, her efforts to re-establish home birth in her country, the love and support she received from her homebirth clients, the trumped-up malpractice accusations against her, and her resultant 77-day imprisonment and years of house arrest. Agi's official prison term was for two years, but, due to the flood of letters and petitions the Hungarian President received from multiple national and international organizations and thousands of individuals, he granted her an early release, followed by house arrest for an additional three years and two months, lasting until February 2014. She was additionally prohibited from practicing for ten years; she was 67 at the time. Agi is now an international heroine and inspiration to the birth humanization movement, and we are proud to include her chapter in this volume!

In Chapter 9, "Adopting the Midwifery Model of Care in India," obstetrician Evita Fernandez describes how, in its 63rd year of existence, the Fernandez Hospital in Hyderabad, India, launched an in-house two-year Professional Midwifery Education and Training (PMET) program. At the time, the word "midwife" (*dai*) was perceived as referring to traditional midwives/traditional birth attendants (TBAs), who are very much disparaged as "illiterate" and "ignorant" among biomedical personnel and the middle and upper classes of this country. Prior to Fernandez's work, India did not have a dedicated cadre for professional midwifery care. As Fernandez shows, the challenges faced in introducing professional nurse-midwives as accountable and trustworthy healthcare professionals and colleagues into a strongly biomedically led maternity hospital were enormous. Evita, who played a major part in initiating this change, describes that with growing numbers of nurses trained in midwifery, there has been a visible change in childbirth practices. Women receiving midwifery care endorse their services with positive feedback. The obstetricians also began to appreciate midwifery care and new working relationships between obs and midwives were established.

Fernandez also explains that the government of India had been battling with an unacceptably high cesarean birth (CB) rate. National consultation on the causes and determinants of the high CB rate in 2016 suggested midwifery care as a vital option to help decrease unnecessary interventions, including CBs. The government of Telangana State, with the highest CB rates in the country, decided to pilot its first midwifery training program with a cohort of 30 registered nurses. The success of this program led the Government of India to launch the *Guidelines on Midwifery Services* in India and to establish 14 national midwifery educator training institutes to help scale up midwifery training to meet India's enormous needs. Evita's chapter tells the story of this journey, which she describes as "the start of a revolution."

In Chapter 10, Turkish obstetrician Hakan Çoker first describes his 19 years as a "classic" obstetrician whose main concern was a healthy mother and baby at the end of the birth. Yet after sneaking into a childbirth education class in Turkey out of sheer curiosity, and later attending childbirth classes in multiple countries, "my perception of birth irreversibly changed." He cocreated a birthing team called "Birth with No Regret," which consists of an obstetrician, a midwife who also acts as a doula, and a birth psychotherapist, who importantly helps both the practitioners and the families they attend process their emotions before, during, and after the birth. Hakan and his team organize childbirth classes for families, childbirth educators, and doulas, "so that we can grow the concept of humanistic births everywhere"—a much-needed process, as in Turkey, the cesarean rate is 58%, with many routine interventions. Hakan has become a widely known advocate for humanistic births and humanistic birth teams, yet there were heavy prices to pay in the form of attacks by other obs, as he describes in his chapter. Importantly, his responses to those attacks were neither defensive nor argumentative; rather, he took each attack as an opportunity to further explain the benefits of evidence-based, humanistic care. This respectful approach led to some of the obs who attacked him secretly attending his childbirth education classes and eventually adopting his model of "Birth with No Regret."

In Chapter 11, Australian obstetrician Andrew Bisits explains that in Australia, Canada, New Zealand, and the United States over the past decades, there has been a near-complete disappearance of vaginal breech birth as a legitimate option for women with babies in the breech position at term, as obs in those countries are no longer trained in breech delivery techniques. Other countries in Scandinavia and Europe have maintained vaginal breech birth as a supported and responsible option for such women. In his chapter, Bisits describes how his interest in breech births developed and what he has learned about vaginal breech deliveries over time, with the aim of informing, teaching, and giving confidence to all obstetricians and midwives so that they can be safe breech birth practitioners as well.

In Chapter 12, US ob Marco Gianotti describes how he mixes modalities in his "traditionalist," technocratic obstetric practice, and the ideology and rationales that underlie that practice. He notes that, although biomedical obstetric practice became much more trying during the coronavirus pandemic, he still found it possible to integrate more humanistic and holistic measures into care plans for patients seeking such a balance. Gianotti demonstrates the difficulties of incorporating more holistic practices into traditional biomedicine and how they depend on

a particular physician's practice style and philosophy, relating back to how the physician was trained and to personal beliefs. Gianotti believes that the practice of obstetrics presents a particular opportunity to incorporate home deliveries, the support of doulas, and holistic modalities.

In Chapter 13, world-renowned obstetrician André Lalonde takes us to the global stage by describing his career trajectory as it developed over 40 years to address respectful maternity care and promote physiologic childbirth. From the introduction of humanistic changes as Chief of Maternity Services in a community hospital to teaching residents at McGill University, André questioned the "paternalistic practices" of obstetrics that gave childbearers few choices. Having made major humanistic changes in labor and delivery practices in these places, he then served as President of the Society of Obstetricians and Gynecologists of Canada for 21 years, during which he helped to draft many guidelines that addressed women's major concerns. Also during that time, he served on the Executive Board of the International Federation of Gynecology and Obstetrics (FIGO) and as Chair of FIGO's Safe Motherhood and Newborn Committee. As he describes in his chapter, André's work on this international committee led to the development of important international policies and guidelines and to the launch of the *International Childbirth Initiative* (ICI)*: 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care*. The ICI Principles and 12 Steps are now being implemented in multiple birth facilities and practices around the world (see Robbie's bio below); André lists all of them in his chapter.

Having completed our brief Introduction to this volume, we now turn to its chapters, in which, as our book title states, "obstetricians speak."

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