“Authority Isn’t My Favorite Thing”: How Independent Midwives Define Their Autonomy Against the Political Construction of Docile Bodies

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Introduction: Radical Women

"Woman arrested for practicing midwifery without a license," reads the headline. Given American culture's proclivity to moral panic – a phenomenon in which "media-fuelled public fear and overreaction lead authorities to label and repress deviants," generating a cycle of fear and suppression (Little & McGivern, 2011, n.p.) – the phenomenon of midwives attending women without state sanction arouses ire from many quarters, especially from representatives of the conventional medical system. The presence of midwives who operate outside the medical-industrial complex also alarms many Americans whose notion of childbirth seems to be based on the principle that the sole desired outcome of birth is a live baby and that institutional approval (i.e., licensure) guarantees a sort of consumer protection against the possibility of an undesired outcome. Such consumer protection and prediction of outcomes only functions (insofar as it ever can) when the bodies of women – unpredictable, uncontrollable organisms – and the birth process are monitored and controlled with sophisticated technology and the actions of birth practitioners are strictly circumscribed by hospital policies.

A growing population of radical women[1], however, is challenging the hegemonic narrative of childbirth as a consumer industry in which the hospital is the assembly line, women's bodies are the machinery, and babies are the product (see Davis-Floyd, 1992). They believe the industrial birth complex, or what could be called the techno-patriarchy of birth, is responsible for the United States' abysmal maternal mortality rates (at the bottom of the stack among developed nations), and that midwives who honor women's choices and protect

[1] I call these women "radical" because, first, society considers them radical in the vernacular sense; second, they are radical in the literal sense of the term as they restore childbirth "to its roots" as an elemental human activity, one in which women's desires, not abstract legislative constructs, are the authority, and in which women's bodies, not medical technology, are the source of knowledge; and third, many of them align with radical feminist values, such as the centering of female power, the creation of female spaces, and the freeing of women's bodies from patriarchal constraints and expectations.

physiological birth can do more to solve the maternal mortality crisis – and ultimately make for healthier, happier babies and families – than increasing institutional regulations. Although pioneer midwives like Elizabeth Davis, Suzanne Arms, Gloria Lemay, and Ina May Gaskin started the resistance to institutionalized childbirth in the 1960s-1970s (a period which authors like Arms, 1975, 1994, and Davis, 2004, look back on as the "dark ages of childbirth"), the pressures of competing with an established medical system were overwhelming. Exhausted from persecution by medical authorities, leading midwives sought social and political legitimacy by petitioning for state recognition via certification and licensure. They created the North American Registry of Midwives, which administers a national certification exam for Certified Professional Midwives (CPMs). This process took decades, but as of 2019, all but a handful of states either require a licensure, certification, or some form of registration for direct-entry midwives or continue to outlaw them altogether. The mainstreaming of midwifery care via state approval pathways[2] meant that more women theoretically could access midwifery care, since midwives no longer had to practice underground, but ended up restricting many women's ability to access the care of their choice, as state-sanctioned midwives are limited in the types of births they may attend (for example, states may forbid licensed midwives to attend a VBAC, or Vaginal Birth After Cesarean; a breech birth; a birth of multiples; a birth after 40 weeks; or a birth when the mother has certain preexisting medical conditions).

In response, many licensed midwives bend the rules (for example, instructing clients to fudge their LMP, or last menstrual period, in order to extend the official EDD and evade the 40-week rule); some birthkeepers[3] (like Emilee Saldaya, Yolande Clark, or my co-participant,

[2] I use the word "mainstreaming" extremely loosely, as barely more than 1% of American births take place in out-of-hospital settings (Nitz, n.d., citing 2012 data from https://www.nytimes.com/2015/12/31/health/as-home-births-grow-in-us-a-new-study-examines-the-risks.html).

[3] See page 5.

Stella) support or coach women to birth unassisted (a practice popularized by Laura Kaplan Shanley, 1994, as "freebirth"); some midwives (like Margo Nelson, Cindy Morrow, or Angee Monroe Hock) practice selectively in unregulated states; and some midwives in regulated states or provinces (like Gloria Lemay, Maryn Green, Julie Elliott, Ireena Keeslar, or Emily Render Graham,[4]) resist regulation by practicing underground[5] (often among Plain groups, such as the Amish, even if they themselves are not Plain) or creating a Private Membership Association to contain their activities. These radical women are the subject of my inquiry.

Literature

Research on state-sanctioned direct-entry midwives is slowly expanding, but literature on unregistered midwives remains scant or non-existent. Cheyney's (2010) ethnography *Born At Home* explores the responses of midwives to medical surveillance technology and hospital ritual (first identified by Davis-Floyd, 1992, as the means by which American mothers are indoctrinated into the norms of technocratic birth), but she quotes underground midwives incidentally as part of a broader sample population of direct-entry midwives, not as distinct from registered midwives. Rigg, Schmied, Peters, and Dalhen (2015, 2017, 2018, 2019) have led the way in exploring Australian women's increasing preference for UBWs amid pushback from medical and government authorities (see Dahlen, 2016, and McWhirter, 2018); however, they focus on the women who choose UBWs, rather than the UBWs themselves. Women's reasons for choosing a UBW (she is perceived as being able to offer the choices that institutionalized care is unwilling to give them, along with personalized whole-person support and assistance in

[4] I name the women in this paragraph without protecting their identities because all are widely known, either for being prosecuted for their underground practice or for successfully avoiding prosecution even while practicing aboveground.

[5] That is, they practice only within certain social circles, such as their religious community; advertise only by word-of-mouth; and/or take other measures to protect their identity as a midwife from becoming general public knowledge.

case of an emergent complication, and as being supportive of her choices and intuition rather than telling her what to do) correspond closely with the discourse and values of American independent midwives that I have observed, but do not tell us everything about how radical midwives see themselves.

Research Design

I justify my research in the three ways suggested by Clandinin and Huber (n.d., p. 8): personal: my curiosity springs from “[my] own life experiences, tensions and personal inquiry puzzles” as an aspiring midwife; practical: the crisis of maternity care (including maternal mortality rates and widespread obstetric violence) demonstrates the need for “shifting or changing practice,” particularly clinical practice; and political: protecting the human right of women to choose where, when, and with whom they give birth demands broad “social action” and policy changes. My choice of narrative inquiry resists the belief that knowledge must emerge through scientific “dissection” (Clandinin & Huber, n.d., p. 11, quoting Bateson, 1989, p. 10), a belief that tends to restrict bodies and voices to extractable packets of data that can be assembly-lined for comparison. (Similarly, Bruce, Beuthin, Sheilds, Molzahn, & Schick-Makaroff, 2016, p. 3, found thematic analysis to be “too measured, too fixed, and somewhat impersonal.”) It also resists being pinned into the narrow forms of a standard research paper format.

Instead, I ground my research in a view shared by many autonomous midwives and other traditional healer-practitioners: that knowledge is a shared experience negotiated through relationship and discovered primarily through intuition and subjective body-knowledge, not verbal structures and abstract categories. According to Cheyney (2010, p. 36), midwives “focus on empowering [women] through knowledge sharing” and “attempt to make sure that ‘the flow of information is back and forth and not top down’” (p. 37). As my co-participant Stella explains:

"[I am] invited into their space.... My relationship with the women I serve comes first, and THAT is what defines how I walk with them." Co-participant Jessie elaborates: "I love women who think for themselves and own their choices, even when it's not a choice I would make." Jessie believes the woman deserves to make all her own choices because "no one cares more about their body and baby than the birthing woman herself." For Stella and Jessie, a woman's decisions are constructed out of knowledge shared by the midwife, but mediated through the woman's own intuition and lived experience, creating a fully embodied self-knowledge that leads to action, i.e., the woman's "truth," which will look totally unique to her as compared to all other women (what Stella calls "HER process"); the midwife's responsibility is to protect her articulation of her truth, not construct that truth for her from outside. Likewise, I co-construct my paper from a blend of the knowledge (narrative data and supporting literature) shared with me and an emergent, intuitive process of rendering the results.

The hegemonic narrative of childbirth – the one constructed by the techno-patriarchy establishment – teaches a woman the opposite: that the medical practitioner is the best expert on her body and the birth process. Midwives and mothers engage together in a dance of unpacking and unlearning these cultural norms, as described in delightful detail by Cheyney (2010). My inquiry "shows the bumping up of participants' lives (and [my life]) with dominant cultural and institutional narratives" (Clandinin & Huber, n.d., p. 13), highlighting the pressure we[6] feel to define ourselves and our core values in ever more radical language in order to break away from those dominant narratives. Despite the clear (and often politically radicalized) language that many of us use to differentiate ourselves, however, tracing the narratives that underground midwives tell often ends up producing knowledge that "is textured by particularity and

[6] Although I (the author) do not currently identify as a midwife or birthkeeper, I situate myself deeply within the shared values, attitudes, and beliefs of the independent midwifery community.

incompleteness…that leads less to generalizations and certainties (Clandinin & Murphy, 2007)" (p. 14) than to an appreciation of the profound diversity that exists among women in their values, histories, and choices. There is no single narrative that cuts across all midwives' lives.

Research Language

Throughout this paper, I use the word "midwife" to refer to direct-entry midwives and traditional birthkeepers.[7] A direct-entry midwife (DEM) is formally defined as one who enters the profession of midwifery without undergoing a nursing education (see Davis, 2004). This broad class includes Certified Professional Midwives (CPMs)[8] as well as traditionally trained midwives and birth attendants[9], but excludes Certified Nurse-Midwives, whom many direct-entry midwives derogate as "medwives" (see Cheyney, 2010).[10] In contrast to a CNM education, which prepares candidates to integrate into hospital settings, the CPM is the only credential which requires knowledge of out-of-hospital birth, also known as community-based birth. A "birthkeeper" may be understood as a woman who holds childbirth knowledge, traditions, and intuition as a resource and support for the families she serves. She may or may not operate in the strictly defined roles of midwife (one who attends a birth with the technical skills to assist in delivery if needed) or doula (one who attends solely to provide emotional support and comfort measures for the laboring mother), but often moves fluidly between them. The overlap between

[7] "Birthkeeper" is a term coined by midwife Jeanne Parvati Baker ("About Indie Birth") and used by many instead of "traditional birth attendant" (TBA) due to concerns that "traditional birth attendant" conjures up images of uneducated or unskilled women serving in hygienically primitive environments.

[8] A CPM has met the standards for training and certification set forth by the North American Register of Midwives, including a certification exam written by experienced practicing midwives.

[9] Training may include any combination of apprenticeship and self-study. In some cases, a traditionally trained, experienced midwife may be "grandmothered in" to CPM status by completing NARM's Portfolio Evaluation Process (PEP).

[10] In an interesting twist, while they slur institutionalized midwives as "medwives," traditional midwives seek to shed the older moniker "lay midwife," which they consider derogatory. Gail Hart (in a Facebook conversation in 2019) informed me that it is invariably used by representatives of institutionalized midwifery who wish to imply that traditional midwives are untrained or unskilled – a throwback to the early modern medical trope of midwives as "whores with dirty fingers" (Davis, 2004, n.p.). It is the same reasoning as is used to reject "traditional birth attendant."

DEMs and birthkeepers is fuzzy, since some birthkeepers refuse to call themselves midwives (an act of resistance to how the medical system and institutionalized midwifery have colonized the word[11]) or engage in technical acts of assisting delivery; however, I include them under the same umbrella because they share a distinct belief in what traditional midwifery *should* be ("with-woman" care that honors a mother's bodily autonomy and the integrity of the physiological birth process), and because many birthkeepers undergo midwifery training substantially similar (or even identical) to that undergone by midwives.[12] Australian researchers Rigg, Schmied, Peters, and Dalhen (2018, p. 2) similarly highlight the overlap in their designation "unregulated birth worker," or UBW (a birth attendant who is not a registered health professional, who may or may not be a doula, bodyworker, traditionally trained midwife, or ex-registered midwife).

Bruce, Beuthin, Sheilds, Molzahn, & Schick-Makaroff (2016, p. 3) found themselves deliberately "creating language and concepts more consistent with" the narratives constructed by their participants. In exploring midwifery narratives, I found language and concepts that both evade and invite articulation. DEMs who resist regulation by practicing selectively in unregulated states, practicing underground, or practicing without a license in regulated states might be called be a variety of names (some of which I have seen in print or on social media, some of which were contributed by my co-participants, and some of which I offer from my own reflection) that highlight a kaleidoscope of perspectives on their work (i.e., the spectrum of positive and negative deviance), including

- autonomous midwife

[11] Independent midwife Margo Nelson suggests that birthkeepers who refuse to claim the name of midwife because they are "afraid of persecution" add to the fuzziness and disempowers the independent midwifery community as a whole. "Going to births as a doula instead of claiming what it is you are…adds a lot of confusion to the discussion around independent midwifery" ("Hearing the Call" webinar).

[12] Such training might include online or correspondence coursework from Indie Birth Midwifery School, Ancient Art Midwifery Institute, or HERBAL (Holistically Empowered Rebel Birthkeepers Academy of Learning), along with either apprenticeship or on-the-job experience serving the women of one's community.

- birth friend
- community midwife
- granny midwife
- independent midwife
- maverick midwife
- midwife in the new paradigm
- midwife outside the system
- nonconformist midwife
- radical midwife
- renegade midwife
- rogue midwife
- self-identified midwife
- sovereign midwife
- space holder
- traditional midwife
- underground midwife
- undocumented midwife
- unlicensed midwife
- unregistered midwife
- unregulated midwife

The factor these women have in common is their choice to resist regulation actively (by practicing as if it does not exist) rather than passively (by bending the rules).[13] Rather than create a moral conflict of interest by coming under state jurisdiction, they refuse to consent to a contract with the state that limits their freedom to serve the birthing mother in whatever way she requests (a recurring theme in the Indie Birth podcast by Maryn Green). To represent the unsettledness of the terminology and midwives' own lack of consensus around how they identify, I employ several of these terms at different points in the paper.

Research Limitations

While the majority of midwives (regulated and unregulated) are vocal about the need to equalize maternity care by centering mothers of color, and numerous training organizations now

[13] Compare and contrast Davis-Floyd's (n.d.) description of the "postmodern midwife" who moves confidently between the worlds of traditional/indigenous midwifery and biomedicine, adapting her practice to include tools and technologies, and engaging politically to ensure that her profession is acknowledged ("Daughters of Time," https://pdfs.semanticscholar.org/428e/12fad0540b5dbb7bfe2320704ad135b31a21.pdf).

offer scholarships and enrollment incentives for midwives and doulas of color, most midwives are, and by default primarily serve, women who are culturally and ethnically white. The midwifery resurgence from the 1970s-2000s was led by educated, middle-class white women, and the homebirth movement (as well as its subset, the freebirth movement) appealed primarily to educated, middle-class white women. (Unassisted homebirth has occurred for generations in some communities of color that lack access to community-based midwifery care, due to the desire to avoid encountering racism in the hospital.) The revival of midwifery in communities of color has followed a somewhat different path that was less intertwined with competing against the medical establishment for legitimacy and more concerned with intersectional issues and safety from institutionalized racism. My inquiry focuses on a small subset of the homebirth movement that is heavily concentrated with white voices and Euro-American perspectives on law, morality, civil disobedience, and institutional legitimacy. On the other hand, a growing emphasis on the structural power problems affecting all women, as opposed to the past emphasis on individual rights in childbirth, suggests that white midwifery is listening to and incorporating the voices of other communities, even if not directly crediting their contribution to the discourse.

Inquiry and Discovery: Co-Participant Narratives

My inquiry is grounded in concepts from the narrative inquiry methodological perspective: a “close study of the particular within individual stories as a means to illuminate universals” and the social constructionist stance that “meaning is cocreated and coconstructed; Crotty, 1998” (Bruce, Beuthin, Sheilds, Molzahn, & Schick-Makaroff, 2016, p. 2). As a result, my rendering of it hovers somewhere between narrative analysis (which “produces an individual story for each participant”) and paradigmatic analysis of narratives (which “identifies a typology of story types”) (Ison, Cusick, & Bye, 2014, p. 22). Here, I explore narrative data gathered via

semi-structured interview questions and ongoing ethnographic interactions with two co-participants.

I connected with Stella and Jessie in early 2018 through a Facebook group for "radical independent birth keepers." We interact on social media at least several times a week, reacting, commenting, and sharing each other's posts on topics such as informed consent, bodily autonomy, homebirth, postpartum healing, obstetric violence, homeschooling, the harms of religious patriarchy, and the impacts of regulation on the midwifery profession. As self-identified "crunchy mamas,"[14] we talk regularly about nutrition, medical freedom, and herbal and natural remedies. Along with others in our immediate circle, we participate in the Messianic/Torah Observant movement (see Barrett, 2015) and are actively committed to dismantling patriarchal structures within our faith community as well as being present for all women in a way that helps them to break free from emotional and psychological abuse at home. Issues of abuse and patriarchy are not only a core of our regular discussions, but essential to our individual narratives of how we have served or intend to serve birthing women.

Co-Participant 1 (Stella[15]): Stella is a 33-year-old married mother of four, including an infant, whom she homeschools while working from home as a vocal teacher. Stella, who is culturally and ethnically white, attends births in a Midwestern state where midwifery is not currently regulated; she has been blending midwifery intentions, principles, and techniques with her doula practice at homebirths since at least 2018, but did not share with me exactly how long she has been attending births in any capacity.

[14] The overlap of "crunch factor" (e.g., preference for natural/organic lifestyle choices and alternative forms of healing over the standard industrial American lifestyle and technocratic health care) with a commitment to childbirth autonomy and medical freedom merits study in its own right.

[15] Names have been changed and locations obscured. Clandinin and Huber (n.d.) note: "Issues of anonymity and confidentiality take on added importance as the complexity of lives are [sic] made visible in research texts. Strategies such as fictionalizing and blurring identities and places are often used" (pp. 15-16).

Q1: Do you identify as a birth keeper, independent midwife, autonomous midwife, etc. (including terms I haven't listed here)? What does that term(s) mean to you? How does it define how you serve women?

-I identify as a birth keeper/friend, which means that I serve. I serve women, primarily, and their families secondarily, in their reproductive journeys. It means I am friend first, who is being invited into their space because of my knowledge (that I am continuously working to expand)— not as an authority OVER the birthing woman. My relationship with the women I serve comes first, and THAT is what defines how I walk with them; not a set of rules and regs. I have my own biases and boundaries.

Q2: How did you decide that serving birthing women outside the system was the right path for you?

-Giving birth made that clear for me. And I was blessed to be influenced by elder wise women who carry this ancient knowledge and truly honor women in their work.

Q3: What are your feelings about the state's involvement in regulating midwives? Who or what makes a midwife legitimate, in your opinion?

-I feel abhorrence toward midwifery regulation. The birthing mothers we serve are who make us "legit"— not a governing body whose bodies AREN'T carrying the babies we witness.

Q4: What does your birth practice look like on a week-to-week basis (i.e., how do women find and hire you, what settings do you attend births in, do you offer both midwife and doula services, do you practice full time or part time, etc.)?

-I'm on a hiatus just now, due to mothering my littles and not having a clear way to serve women in an "on call" capacity.

Q5: How would you describe your ideal birth client?

-A woman who understands that SHE is the sole owner of her birth experience, and who makes choices accordingly. Someone who isn't looking at me as a "guarantee" of a positive birth experience, but who understands the reality of trust in HER process.

Q6: Who are two midwives or birth keepers who have inspired or greatly influenced you?

-Carla Hartly and Sister Morningstar

Co-Participant 2 (Jessie): Jessie is a 40-year-old married mother of eleven, several of whom she homeschools while maintaining a busy on-call practice, teaching childbirth classes, organizing spiritual retreats for women, and leading Bible studies out of her home. Jessie, who is culturally and ethnically white, began attending births as a doula and then transitioned to the

midwife role over the past decade. She practices semi-underground in a Southwestern state where midwifery is regulated. Her education includes a period of study with the Indie Birth Midwifery School.

Q1: Do you identify as a birth keeper, independent midwife, autonomous midwife, etc. (including terms I haven't listed here)? What does that term(s) mean to you? How does it define how you serve women?

Yes! Haha! I identify with all those plus traditional midwife and space holder. I think birth keeper and space holder speak of the sacredness and sanctity of the journey of pregnancy and birth. Independent, autonomous, and traditional speaks to me of the original type and intent of true midwifery where the midwife served families from her heart with skills developed through hands on experience and divine guidance to serve birthing families with no middle man to control or interrupt the process. I believe this is how I serve my families.

Q2: How did you decide that serving birthing women outside the system was the right path for you?

For me it is the only path. No one besides the birthing family should decide where or how she births or whom she births with. State regulated midwifery takes ownership of the choices women and families make with only the family reaping the consequences of those decisions. It's insane, because no one cares more about their body and baby than the birthing woman herself. Typically, most of the rules and regulations do the opposite of what they're supposed to do, make women safe, but there are no guarantees of that no matter where or with whom the woman births.

Q3: What are your feelings about the state's involvement in regulating midwives? Who or what makes a midwife legitimate, in your opinion?

I do not believe the state has the best interest of birthing families in mind at all. I see it as big government controlling and manipulating the country and keeping families in the cycle of dependency upon governing authorities to provide for them and to keep them safe. It's a delusion though.

Women and their families are the only ones who can make a midwife legitimate. If a woman wants her neighbor to be her midwife then that makes her her midwife. When a woman has shown education and skills in midwifery, or birth work in general, and a family wants her to be her midwife then that to me is what makes her one. I know this is a radical thought, but this is how midwifery started out, one woman passing down the wisdom and insight to the next. We either believe women are smart enough to invite the right person into one of the most vulnerable and life changing experiences of her life or we don't. Sadly, society says over and over again that we don't trust women.

Q4: What does your birth practice look like on a week-to-week basis (i.e., how do women find and hire you, what settings do you attend births in, do you offer both midwife and doula services, do you practice full time or part time, etc.)?

On average I attend about 10 births a year. This allows me to serve my community and my own family well. I attend only homebirths with an assistant. Since I'm not chained down by governmental rules and regulations where I must adhere to a strict timeline and documentation I'm able to serve as both midwife and doula. Clients find me by word of mouth and other local birthworkers. There is one local licensed midwife here who sends clients to me when hers risk out because of the rules and regulations of her midwifery license. These women, without me, have no other choice but to birth in the hospital (which they're avoiding) or birth unassisted at home. It's really quite sad. I see 2-3 clients a week for hour long prenatals and/or postpartum appointments and I teach a free monthly childbirth education class that I created to my local community.

Q5: How would you describe your ideal birth client?

My ideal birth client sees pregnancy and birth as a natural event her body was created to do. She reads lots of great resources about birth, watches lots of birth videos, and she takes my childbirth classes and follows my recommendations. Ideally she trusts the process and surrounds herself with people who honor and support her without disturbing the process. I love women who think for themselves and own their choices, even when it's not a choice I would make. She also fully recognizes that birth is not a disease to be cured of.

Q6: Who are two midwives or birth keepers who have inspired or greatly influenced you?

The first was Carla Hartley creator of Ancient Art Midwifery School. Carla was the first birthkeeper I knew who believed similarly to me. She's often quoted to say, "Birth is safe, interference is risky." Ah, so refreshing to know there was someone else out there that didn't think a pregnant woman was a ticking time bomb waiting to explode into complications. She also believes women should learn all they can about birth to feel safe sitting on their hands and to recognize when something went outside the entirely huge box of what is normal.

The next most influential was Maryn Green of Indie Birth Association. She was the first midwife I ever knew who had a CPM, but believed women own birth and get to make all the decisions when it comes to their pregnancy and birth. She taught me that you can be a midwife who holds space for women instead of doing things *to* women like routine vaginal exams before and during labor, required lab testing, routine assessment of fetal heart tones with doppler, ultrasound surveillance, etc. For the first time ever I thought I might actually like to be a midwife. All the midwives I knew before that were agents of the state doing things *to* women instead of with and for them as requested.

In Durkheim's famous phrase, "A crime is a crime [only] because we condemn it." Midwives believe the techno-patriarchy has a vested interest in defining the practice of autonomous midwifery as a form of criminal deviance. In Jessie's words:

> I do not believe the state has the best interest of birthing families in mind at all. I see it as big government controlling and manipulating the country and keeping families in the cycle of dependency upon governing authorities to provide for them and to keep them safe.

In other words, the state uses "disciplinary power" (Foucault, 1977) to render women and families docile and dependent on the medical-industrial complex, because (drawing on Davis, 2003), docile bodies are extremely profitable bodies, and discipline "increases the forces of the body (in economic terms of utility)" (Foucault, p. 138). The first way to do this is to convince families that the only safe birth is technocratically managed hospital birth. Davis-Floyd (1992, pp. 152-153, in Cheyney, 2010) found that hospital ritual is designed to create "a woman who 'believes in science, relies on technology, recognizes her inferiority [i.e., dependence]…,' and…accepts the principles of birth as a medical event in need of massive technological intervention by the experts" (p. 34). Hospital ritual uses the same procedures as the prison system: "fixing them [laboring mothers] in space [via IV and stirrups]...coding their continuous behavior [via fetal monitor]...forming around them an apparatus of perfect observation" (Foucault, 1977, p. 231). As Jessie says, the system is built on "doing things *to* women instead of with and for them as requested"; women's bodies are objects to be acted upon, not embodied subjects to be consulted.

The second way is to construct a set of norms in which anyone who assists women to birth outside of the hospital is a danger to society. A compromise in the form of allowing

licensed midwives to perform out-of-hospital deliveries under carefully limited circumstances[16] actually supports this goal by, first, dividing the midwifery community between those who are loyal to "the Man" (i.e., they cannot bite the regulatory hand that feeds them) and those who claim no loyalty except to the rights of birthing women they serve[17] and, second, creating a justification for prosecuting women who do not comply. The deconstruction and reconstruction of birthing women's bodies via the technocratic model of birth (Davis-Floyd, 1992), as baby-making machines that need help from other machines or medicines to progress through labor properly, exemplifies Foucault's (1977) "machinery of power that explores [the body], breaks it down and rearranges it…so that [it] may operate as one wishes, with the techniques, the speed and the efficiency that one determines" (p. 138). The construction of docile bodies as a cultural norm through hospital ritual not only promises to manage labor with perfect efficiency and near-perfect safety; it ensures that women will not become deviant by choosing to birth in a setting that is unprofitable to the industry (i.e., at home). The institutional construction of midwifery regulation as consumer protection serves both to keep families "dependen[t] upon governing authorities to provide for them" (Jessie) and to isolate the dangerous element: the criminal body, the midwife who refuses to become "docile and useful" (Foucault, 1977, p. 231) by transferring her loyalty from women to a regulatory body or to become dependent by asking permission from the state to serve women.

The Politics of Deviance

Ina May Gaskin (1975) opens *Spiritual Midwifery*, a juicy and psychedelic narrative of birth stories in the Farm community from the 1970s to 2000s, with the rallying cry of

[16] As any private American national worth his salt will tell you, a license is merely a permission from the government to do something that would otherwise be illegal. Permission is not a right; it can be granted at the sovereign's pleasure and revoked at any time.

[17] Radical feminist activists frequently observe that the patriarchy is most successful when it can divide women against each other.

independent midwives: the "sacrament of birth belongs to the people and…should not be usurped by a profit-oriented hospital system" (p. 12). She then constructs a double-edged narrative of the midwife's role: political and personal. "The midwives represented by this book feel that the rights of women, the newborn, and the family during the passage of childbirth are among those unenumerated rights [citing the Ninth Amendment] which are to be retained by the people" (p. 12). And, "The wisdom and compassion a woman can intuitively experience in childbirth can make her a source of healing and understanding for other women" (p. 12). In the first sentence, the midwife is a subversive political agent who, by inscribing childbirth as apolitical (that is, outside the bounds of policymakers' rightful jurisdiction) and simultaneously as a constitutionally protected right, stands in the gap between families and the state to intervene against state interference in a private family ritual.[18] In the second, she is a motherly or sisterly figure who stands ready to offer intangible internal resources for the benefit of other women, healing the earth and the human race by humanizing childbirth and protecting mothers and babies from emotional devastation. Thus, the midwife embodies and balances both the masculine and the feminine energies.[19]

Arizona independent midwife and PMA pioneer Maryn Green says, "Authority isn't my favorite thing" ("Hearing the Call" webinar). Based on statements like this one, which pepper the social media accounts of even midwives who keep their practice semi-underground (including

[18] Compare the praxis approach in anthropology, which "focuses on ritual as political practice (Nash, 2007; Paulson, 2006; Robins, 2006)" and holds that "positions of domination and subordination are modified and resisted through ritual" (Cheyney, 2010, p. 42). Privatizing homebirth as a family ritual is a profound political statement that stops the door against domination-subordination practices from the state.

[19] It has been suggested (reference unavailable) that the essence of the masculine is not an active principle per se, but the act of holding space. Many midwives consider their work as anything but masculine, since they oppose the highly structured, hierarchical values of the medical-industrial complex by aligning with the decentralized, messy, juicy, creative, receptive energies of birth; but the patriarchal system is actually a distortion of the masculine, not an embodiment of it. The "guardian" aspect of the midwife's role, rather than being the "crone" principle that midwives tacitly envision (the silhouette of the grandmother), is actually a refined and subtle masculine energy. Just as genuine masculinity is capable of holding the line against toxic masculinity, the masculine energy required to protect the birthing space holds the line against patriarchal (state, medical) interference in birth.

my co-participants), it is easy to stereotype maverick midwives as devil-may-care lawbreakers who get their illicit thrills from skirting the rules and living to tell about it (hopefully the baby lives to tell about it too). While this may be true of some[20], and an exploration of unlicensed midwifery as "edgework" (compare Gailey's, 2009, summary of Lyng, 1990) has the potential to raise many insights into the lived experience of being a radical midwife, I hold that the complex motivations of these women cannot be dismissed simplistically. Rather, radical midwives construct a sophisticated value system that inverts patriarchal categories by prioritizing women's bodies, choices, and knowledge. (Compare Cheyney's, 2010, p. 42, argument that spontaneous upright birthing, as opposed to lithotomy position, constitutes an inversion of the mother-down, doctor-up medical hierarchy.)

In light of findings that organizations construct behavioral norms for their members (see Appelbaum, Iaconi, & Matousek, 2007), I suggest that a key facet of the radical midwife value system is deliberate dis-identification from the authority of regulating bodies (e.g., a state midwifery practice board as well as the legislature). While this dis-identification, or withdrawal from the paradigm, is often framed in terms such as "not wanting to be bound by rules and regulations," it represents awareness that organizational and culture norms exert a powerful pull over members.[21] Maryn Green says, "When I did [have a license], I was so consumed with just staying in the box and not really thinking so much outside that" ("Hearing the Call" webinar). Radical midwives seek to be free of the psychological indebtedness that causes regulated

[20] And, in my observation, *is* true of some leading unassisted birth proponents (whom I won't name here) who deploy their or their clients' freebirths equally as edgework/adrenaline-seeking behavior and as leverage to gain a social media following.

[21] Likewise, the norms of hospital birth culture have a stultifying effect on birthing women. Cheyney (2010) writes, "Such a woman [one who has accepted the notion that technocratic birth is safe and civilized birth] is also likely to conform more broadly to the dictates of her culture, and thus, hospital birth is a profoundly effective way of socializing members of society from the inside, making them want to conform to social norms and values" (p. 33).

midwives not only to comply with regulations that may not be in the best interest of women, but to police, condemn, and report their sister midwives who don't comply with those externally constructed norms. Maryn Green and Margo Nelson encourage aspiring midwives to move beyond dependence on institutional norms and social acceptance ("hoop jumping" and "seeking approval from people you don't respect") into confidence in a legitimacy that is self-created and self-evident. The critique of authority, far from being some warmed-over Beatnik anthem, undergirds the conscious construction by unregulated midwives of themselves as a deviant class.

Deviance as self-perceived by midwives is of an entirely different character than their deviance as it is perceived by the state, the medical system, and the average consumer. "As midwives attempt to communicate the sufficiency of nature over the supremacy of technology, they replace mechanistic views of birth with the language of connection, celebration, power, transformation, and of mothers and babies as inseparable units" (Cheyney, 2010, p. 33). Rather than a rulebreaker, the independent midwife is an enforcer of the rules of nature – the truth of physiological birth, the way things are and always have been: "that 'women's bodies know what to do to birth their babies'" (p. 44), that "birth is not a disease to be cured of" (Jessie), and that "birth is safe, interference is risky" (Jessie, quoting Carla Hartley). By enabling mothers to "tap into [this] intuitive, instinctive, body-level knowledge" (p. 44), she revives the horizontal system of law, grounded in the self-evident precepts of the cosmos and living natural world (the things that "just *are*," Yazzie, 1994, p. 187, quoting Mary White Shirley, emphasis in original), that is a common human birthright. This brings her into direct conflict with the vertical system of law ("rules laid down by human elites for the good of society," p. 175), self-consciously manmade, that defines a crime as an act that violates the "good of society" (i.e., evading consumer protection regulations) rather than one that contravenes the laws of nature. By engaging in

"intentional behaviors that depart from the norms of a referent group in honorable ways" (Spreitzer & Sonenshein, 2004, p. 828), such as offering alternative birth choices to women, restoring women's agency and safeguarding their autonomy, protecting families against interference in the birth process, and re-normalizing physiological as opposed to technocratic birth, she can frame herself as a positive deviant, regardless of how society or the law sees her.

Constructing Legitimacy

Midwives outside the system must find alternative ways to construct their legitimacy, since they have no access to – nor do they desire – a piece of paper from the state confirming their docile-body, dependent status. While factors like experience, education, confirmation from elder midwives, and community acknowledgement may enter the discussion, my co-participants ground their legitimacy firmly in the opinions of the families they serve. First, it is the woman's choice that confers the role of "midwife" on the person she invites to attend her birth. Jessie says unequivocally: "Women and their families are the only ones who can make a midwife legitimate. If a woman wants her neighbor to be her midwife then that makes her her midwife." Second, it is proximity to the family and a personal stake in the success of the birth, not technocratic knowledge or legislative power, that give someone the authority to determine who should be invited to attend. For Stella, "The birthing mothers we serve are who make us 'legit'— not a governing body whose bodies AREN'T carrying the babies we witness." Finally, as stated above, a midwife's loyalty to natural law as opposed to manmade rules confers a certain moral legitimacy that can never be conferred by a piece of paper.

Conclusions and Implications: Whose Metanarrative?

Is it really "wrong" (or "dangerous") to have an undocumented attendant at the birth of a child? Or do we (mainstream Americans) simply recoil from the idea because modern society

has convinced us that “experts” approved by the state are somehow “safer” and more trustworthy? And should midwives accept with docility the regulations of the state simply because it has the disciplinary power to fine or jail them if they don't comply, or is this a betrayal of women and of all humans’ right to bodily autonomy? Unregulated midwives critique and counter the metanarrative that drives these questions. Metanarratives are “those overarching or higher order, grand stories that hold social values and power and act as ‘truths’ at a certain time” (Bruce, Beuthin, Sheilds, Molzahn, & Schick-Makaroff, 2016, p. 4). In the hegemonic metanarrative, the medical industry is the enforcer of quality in maternity care, and the state is responsible for ensuring consumer protection in the business of birth (baby production). In this metanarrative, women who veer from the institutional standards of care (which are determined by technology and routine, not intuition or observation, and which work only when applied in assembly-line fashion) by disregarding institutional authority (serving women without asking anyone’s permission but the woman’s, encouraging women to make decisions as if they are the experts on their own bodies) are criminal deviants because they disrupt social cohesion and the profitability of industrial birth.

In response, autonomous midwives create a counter-narrative in which they claim the role of positive deviants (breaking the rules to benefit the women they serve, by honoring their freedom of choice and offering alternative care, and ultimately all women, by reducing maternal mortality) and in which, in a dramatic social inversion, authority is relocated to the only true expert in the room: the mother. Amidst the diversity of the independent midwifery community, virtually all midwives would agree that practice autonomy for midwives is inextricably tied to bodily autonomy for birthing women. In fact, one cannot exist without the other.

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