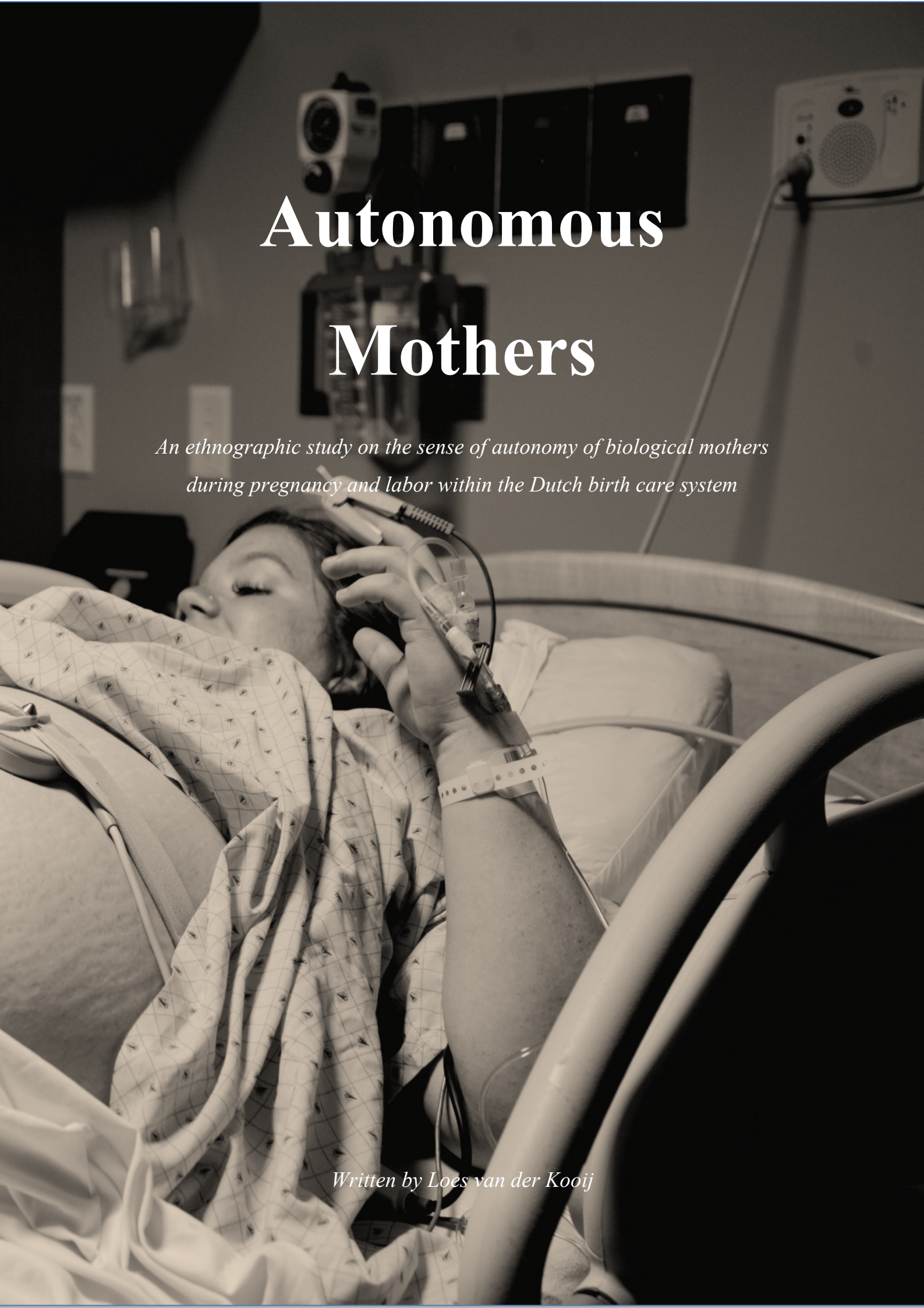

Autonomous Mothers

An ethnographic study on the sense of autonomy of biological mothers during pregnancy and labor within the Dutch birth care system

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Master thesis

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July 2022

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Date: 03-07-2022

Wordcount: 21898

Universiteit Utrecht

This thesis is written for all (future) midwives, (future) mothers and their (future) children.

Acknowledgments

Here in front of you lies my thesis that I have worked on with a lot of love and passion for the past nine months. It is the product of my two-year journey to becoming an anthropologist. A journey with many ups and downs, but certainly one that I will never forget because it has made me the person I am today. I would not have been able to write this thesis without the help of certain people.

My gratitude goes out to all the professors and lecturers within the Cultural Anthropology department of Utrecht University who have taught me to approach the world through the well-known anthropological glasses with their source of knowledge.

I would like to thank my wonderful supervisor Evina van Marrewijk for her support, trust, and always valuable feedback. Your insight and knowledge gave me even more enthusiasm and motivation for my subject.

Special thanks go to my dear parents, who always stand behind all my choices and have always supported me unconditionally, especially during my years as a student. I also thank my dear boyfriend Stef for his everlasting support, enthusiasm, and confidence in me, and of course for always listening to my anthropological speeches about neoliberalism and everything that has to do with childbirth.

In addition, I would like to thank my classmates, Pip, Rosalynn, Marlies, and Pleun for their support, involvement, and encouragement in stressful times. The hours-long library sessions, stress and liters of ‘ditch’ coffee that we shared together made the process a lot more manageable.

The insights I gained during my fieldwork were not possible without all the mothers, midwives, and doulas I spoke to over the past few months. Sharing your intimate story has been incredibly valuable to me. Special thanks go to my key informant Margot van Dijk. The midwife who, through her masterclasses and valuable insights, has inspired me and many other women and birth workers. Your work is of immense value!

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Prologue

A letter from my mother

Dear Loes,

On a beautiful sunny Tuesday 5 August 1997, in the middle of a heat wave, the time had finally come. At 4 am I woke up from the contractions, in our own bed on the Pietheinstraat in Maassluis. I got out of bed and looked for a place in the house to be alone for a while. I didn't want to wake your father because we probably had a long day ahead of us, I thought. He could use his sleep. At 8 o'clock in the morning I thought it would be a good idea to take a nice bath. The warm water seemed nice for relaxation. A few hours after the contractions started, our sweet midwife Laura came to check my dilation. I was already at 8 centimeters!

There you were. You were born at around 10am after 25 minutes of pushing and a total duration of 6 hours from start to finish. At home, in our own bedroom. Strangely enough, I did not experience your delivery as really painful. It was a super pleasant ***birth that you*** *wish for everyone.*

What a ride it was. A true transition from woman to motherhood. During your pregnancy I went through a complete metamorphosis which was accompanied by huge mood swings. But after you were born, these moods swings faded away like snow in the sun. Afterwards I found the new phase of life in which you end up quite intense. Suddenly you are a parent and responsible for your own child. Luckily you were an easy baby and got used to it very quickly and it was like you had always been there.

Love, Mama

Introduction

"*It's time for a birth revolution. Time to reclaim birth as a rite of passage, a life-changing transformation that turns women into mothers, gives confidence, and is an experience to look forward to. A tremendous opportunity to share the most challenging belief that an empowering, positive birth experience is possible for everyone. And I think we all have a right to it.*" - (Nina Pierson 2021, 10)

Ever since I was young, I have been fascinated by one of the world's greatest wonders in the world: the birth of a new life. The way birth rituals have been passed from woman to woman for centuries, the way birth is naturalized as a woman's purpose and at the same time found to be life-changing. As the beginning of a new life, birth has something magical for me. My fascination with birth soon brought me into contact with the current problems within the current Dutch birth care system. Research by several gynecologists has already shown that 10 to 20 % of women found their childbirth process traumatic (Hollander & Stamrood 2017). Further research has even shown that 1 to 3% of women are even left with post-traumatic stress disorder (De Graaff et al. 2018, 649; Hollander & Stamrood 2017). Of the approximately 170.000 women who give birth in the Netherlands each year, 2000 to 5000 thousand therefore develop PTSD and about 20.000 to 30.000 women have a negative birthing experience. In the study by Hollander and Stramrood (2017), 2200 women with traumatic childbirth experiences hardly mentioned any medical reasons for their trauma because, even though childbirth in the Netherlands is physically safer than ever, resulting in minimal maternal and infant mortality in this century, many women feel they have lost autonomy over their childbirth, which they perceive as the primary cause of their trauma.

According to anthropologist Davis-Floyd (2003), over the last 300 years in the Western world, we have increasingly shifted toward a technocratic birth system in which emotion, intuition, and respect for the physiology of birth have been replaced by the assumptions that the baby develops mechanically and involuntarily in the woman's body, that the physician is in charge of the baby's proper development and growth, and that the physician will deliver the baby at the time of birth (Davis-Floyd 2003, 28). A system that provides a physically safe birth

environment for mother and child, in which lives are saved and opportunities are generated. But at the same time, this system also causes a loss of confidence in the body by the care provider and woman, which reduces the woman's autonomy during, but also before birth. Furthermore, while many people think that all birth care decisions are based on scientific evidence, many medical interventions have a low weight of evidence. In fact, decisions during pregnancy and birth are largely made on the basis of medical rituals such as routine obstetric procedures that stem from our beliefs about the superiority of technology over nature (Davis-Floyd 2003, 2). Ultimately, I believe that all women should have the right to make informed decisions regarding pregnancy and childbirth, whether in the hospital, at home or anywhere else they feel safe giving birth. The arrival of birth activists who are committed to healthier birth care by sharing open and honest information about birth could contribute to this. Therefore, in this research, I try to find an answer to the question:

How is the sense of autonomy of young biological mothers related to medical birth rituals formed in the context of the Dutch birth system and its growing technocratic influences?

This thesis sheds light on different sides of the current birth system in the Netherlands, which in recent years has been heavily influenced by technocratic influences. Therefore, I will delve deeper into several features of the technocratic system. In order to get a good idea of the origin of the growing technocratic influences within the Dutch birth care system, I will first go deeper into its history. Then, I will discuss the current notions on risk and time, which have a major influence on the way the Dutch birth system is set up and its influences on the perception of autonomy before and during birth. In the final chapter, I demonstrate how the demand for doulas can be viewed as a reaction to technocratic influences in order to assist mothers (to be) in regaining autonomy before and during childbirth.

The field

During my fieldwork, I focused on Dutch biological mothers aged 20 to 40 who were about to give birth or had recently had a child, as well as birth coaches and doulas who prepare (expecting) mothers for childbirth or provide support during childbirth. Because most women

are not sick during their pregnancy - as suggested in a technocratic birth care system - I purposely do not call them 'patients' but 'clients' or ‘biological mothers’ in my thesis. Moreover, I purposely mention the word 'biological' because it is important to emphasize that while there are different types of relationships called 'mother' such as adoptive mother, foster mother, or stepmother, my research focused on women who experience and carry out pregnancy and childbirth. Furthermore, I find it important to mention that am aware that there are people who do not identify as female but who are pregnant, have given birth or would like to give birth in the future. The reason why I only refer to ‘women’ in my thesis is that during this period of fieldwork, I have only been in contact with people who identify as female. However, I want to mention that the need for a healthier birth system applies to everyone and I think it is important that attention is also paid to gender inclusiveness within birth care.

As mentioned earlier, in response to the increasing medicalization of the birth process and the high percentage of negative birth experiences among Dutch women, there has been an increased demand - and supply - of doulas, birth coaches and caseload midwives within Dutch birth care. A doula is a birth coach who offers non-medical support to the expectant mother and her partner before, during, and occasionally also after the birth. The doula will provide the mother-to-be with emotional and physical support. In response to the ever-growing influences of a technocratic birthing system, the demand for doulas to assist women before and during childbirth has also risen. Including doulas in this study is valuable because it can show the influence of the doula on the sense of autonomy for birthing and pregnant women. In addition, it is possible to give an impression of the problems within the current birth care system by analyzing the reasons why women hire doulas. In addition, in response to the high workload and loss of job satisfaction, which I will discuss in more detail in Chapter 3, there has been a shift in midwifery care in recent years, with more and more midwives choosing to remain solo rather than to join a large-scale practice. By including the midwife caseload in my research group, I was able to gain insight into their motivation to spend more time with their clients.

In addition to interviewing the participants I described above, I conducted participant observation several times during my fieldwork at various midwifery practices. Midwifery practices in the Netherlands come in all shapes and sizes. Most midwifery practices consist of independent midwives who practice their profession in teams of 3 to 6 midwives or more (Royal Dutch Organization of Midwives 2017). On average, one primary midwifery practice

is involved in the care of 90 to 100 women per participating midwife. In addition, midwives typically work 12 to 24 hour shifts providing prenatal, natal and postnatal care for all clients within the practice with their team (Koninklijke Nederlandse Organisatie van Verloskundigen 2017). For example, a woman who is cared for in a practice with a team of 5 midwives may have seen all 5 midwives prenatally. Any midwife in such a practice will give her share of prenatal consultations to most of the 300 pregnant women who attend this practice each year. Because the research focused specifically on the autonomy within the Dutch childbirth system, delineation of the research location was not of great importance. The women and their partners, midwives, doulas, and birth coaches I spoke to came from all over the Netherlands.

Methodology & Operationalization

I encountered some difficulties in joining the group of birth mothers because, as a non-pregnant, non-mother with no prior experience with births, I needed to find a way to reach this group. However, I had been following several midwives on Instagram for a while who introduced me to the field of Dutch childbirth culture. During my fieldwork I started contacting women who had just given birth in my area. Through the snowball method I came into contact with other young mothers. In addition, I created an Instagram account named @degeboorteantropoloog[1] where I introduced myself and explained my research. Within a very short time I received many responses from many different women who would like to help with my research. In this way I could come into contact with women with all kinds of different, valuable stories. Women who had experienced multiple births, women who had PTSD from their birth, women who were pregnant with their first child, but also many other women who had experienced very autonomous deliveries.

During my fieldwork I also came into contact with midwife Margot van Dijk. She had just started her online platform 'Vraag De Vroedvrouw' (Ask the Midwife) with the aim of providing pregnant women and maternity care workers with honest and open data based on scientific studies in order to make maternity care healthier. I scheduled an interview with Margot and decided to sign up for her masterclasses. Margot eventually became my key informant throughout my fieldwork and thesis writing because of her insider knowledge. Therefore, her name will appear frequently throughout this thesis.

[1] In English this translates to: ‘the birth anthropologist’

The method I have used during my fieldwork varies from conducting 20 semi-structured interviews with mothers, pregnant women and maternity care workers, doing participatory observation by visiting midwifery practices and joining midwives for a day, following live masterclasses and doing online ethnographic research. Because all my participants are Dutch speaking, all interviews were conducted in Dutch. All quotes in this thesis have therefore been translated into English. For the interviews, I used a short topic list that ensured that all questions remained within the topic and that I got answers to the most important questions (O'Reilly 2005, 149). Because labor and birth can be such an intimate and personal process, I started each interview by asking informal questions at the beginning of the interviews that can make the (future) biological mothers feel more comfortable (O'Reilly 2012, 116).

In addition to the many interviews that I have conducted in the past month, I have also participated in various midwifery practices and doula practices a number of times. Participant observation allowed me as a researcher with an emic perspective to learn the explicit and tacit components of my participants daily activities, (medical) birth rituals and interactions with birth care workers (DeWalt and DeWalt 2011, 1). This was important because it allowed me to learn about the meaning biological mothers and birth workers place on their surroundings, as well as the behaviors they exhibit in that setting. Furthermore, participant observation created an opportunity for informal conversations that strengthened my relationship with my participants because I had more time to create mutual trust and strengthen my relationship by explaining more about my research' academic relevance and informal conversations (O'Reilly 2012). During my participant observation I kept a diary, in which, in addition to fieldwork notes, I could write down important statements from people around me that also gave me input for interviews and participant observations at doulas and midwifery practices. The midwifery practices I visited all had their own vision, so I spoke to women with different birth wishes. This aided my research because I was able to obtain a more accurate picture of the sense of autonomy during pregnancy and birth because I did not only interview women who spoke out strongly against technocratic influences within the birth system. By conducting participatory observation in different parts of the country and speaking to different women from different socio-economic groups, I got a more inclusive view of my research group.

In addition to participant observation and interviews, I was able to experience a completely different valuable way of doing research in the past months. Several young mothers showed me their birth video, birth photos and birth diaries and offered me new information emerged

that would otherwise not have been found (Boeije 2010, 67). These visual data was valuable because it allowed me - especially with the videos - to watch the birth and get useful information about the feeling of autonomy because I could observe everything well. At the same time, I was not actually present in the delivery, so I could not influence the birth of the young mother. While showing their birth videos or photos, the mothers could update me about the feelings and experiences they had during labor.

Positionality and Ethics

I was born at home in the middle of a heat wave in the summer of 1997. My mother, supported by her midwife and my father, experienced her childbirth from me as empowering and autonomous. This experience, or even more, the experience of my mother, became decisive for how I see birth: as a 'natural' process that usually does not require interventions and where if there is real danger for the mother or child, you as a woman in labor are in safe hands of health care providers. Sharing this vision of birth with birth activists fighting for healthier birth care helped me come into contact with my participants and has been my primary approach to acceptance as a researcher, building rapport and accessing the birth worker community (O'Reilly 2012). Because my story has been shared multiple times by influential birth activists such as anthropologist Anna Myrthe Korteweg and midwife Margot van Dijk, who both have a large number of followers on social media, my research came across as more serious and professional, which allowed me to build rapport with my participants because I was able to demonstrate to a large number of people that I desire healthy birth care for all. As young mother Marloes told me in an interview: "Whatever fears, expectations and wishes we have for childbirth, in the end all women just want the same thing: a positive birth experience." With this premise, I was able to gain the trust of maternity care workers, pregnant and childbirth women, after which I was able to have the most open and personal conversations with them. During my research I sometimes got into deep and sensitive conversations with my participants. Before each conversation, I made it clear that they have the option to stop discussing these subjects at any time.

During my fieldwork and writing my thesis, I was well aware that I am a young, highly educated white woman who wanted to pay attention to a potentially vulnerable and memorable event in someone's life. The fact that I am a Dutch woman, with a deep wish to have children in the future but as yet without experience with pregnancy and childbirth, could have worked

in my favor. Firstly, because I am a woman myself, so my participants might trust me more quickly than if I had been a man. Secondly, because I have no personal experience with childbirth, I can listen more objectively and consider the stories and experiences of women who have. It is important to reflect on the 'place from which the observer is observing' at the start of the fieldwork in order to understand the impact of the observer on the research (DeWalt and DeWalt 2011). However, I am aware that my positive view toward a "physiological" birth may prejudice my position as a researcher. (DeWalt and DeWalt 2011, 93) Furthermore, while I am determined to present the data as objectively as possible, I am aware that all researchers are biased (DeWalt and DeWalt 2011). Prior to and during my fieldwork, I heard numerous stories of mothers who had a negative birth experience and consequently developed psychological illnesses. Due to this, I occasionally focused only on the negative effects of the technocratic influences of the Dutch birth system. By speaking with women who had very positive and medical birth experiences, I was able to lessen my own perspective's prejudice and form more analytically solid conclusions.

Although I am not a mother, midwife, gynecologist, or doula, I owe it to my participants to do all in my power to understand the participants point of view, their relationship to life, and to fulfill their vision of their world (Malinowski 1922, 25). I was dubious about the idea of being present at births because I was afraid it would disturb the process for the young parents themselves. Giving birth is so personal and the woman giving birth is often in her own bubble. Moreover, it can seriously disrupt the physiological process of childbirth if an 'unknown' person like me is watching the delivery. I therefore no longer actively looked for a way to attend childbirth. I found another challenge in approaching birth care activists, whom I wanted to give the choice to appear in my thesis with their (brand) name. All participants in my thesis, except those who have given explicit permission to mention their names, have been anonymized. The locations and dates of the interviews are also omitted or fabricated to prevent their identification. Furthermore, I used pseudonyms for my research participants to ensure anonymity (DeWalt en DeWalt 2011).

Outline

This thesis contains four chapters in which I link the ethnographic data collected during my fieldwork to various anthropological concepts. The first chapter outlines a brief historical background of the Dutch birth system in order to expand the context of the field and provide an initial elaboration of the technocratic influences that have become increasingly prevalent in Dutch birth care in recent years. The identification of historical facts is pertinent to this study because it provides context for the current understanding of concepts such as risk and time in Dutch birth care. Within this chapter, I will describe how patriarchal influences caused the female body to be portrayed as weak and unpredictable, leaving the female body constantly monitored and regulated. In addition, I describe how, since the scientific revolution, the arrival of technological instruments ensured that we got more and more control over nature, which led to seeing death as the greatest enemy.

In chapter two, I continue with the consequence of our fear of death, in which I describe how the constant desire to dominate nature, which stems from our fear of death, within the current Dutch birth system has created our current 'risk society' as described by Beck (1992). I explain how protocols and guidelines, as a result of this risk society, could make women feel that their bodies are less able to independently complete a healthy pregnancy and delivery, causing women to lose confidence in themselves and thus their sense of autonomy because the body is portrayed as weak and unpredictable.

In chapter three, I describe the friction between our current notion of time, which we want to structure, routine, plan, and control, and physiological time, the universal time of the body, where time is irrelevant and the body only initiates a process when it's ready. Time becomes a guideline in maternity care, limiting women's autonomy because technological interventions dominate nature. Furthermore, Marx's (1906) theory demonstrates how time is linked to money in our current understanding of time. Using this theory and my ethnographic data, I argue that women can 'buy' autonomy by purchasing more 'time' and 'space,' which reinforces trust in their own bodies and the midwife.

In chapter four, I delve into a consequence of the growing technocratic influences within the Dutch birth system, with the demand for greater emotional and mental support as a result of approaching the female body as a machine. Using ethnographic data, I demonstrate that a doula can significantly contribute to a pregnant or giving birth woman's sense of autonomy. However, a doula requires a financial investment and is frequently not reimbursed by health insurance,

so I argue that doulas are a luxury product visible only to a certain socioeconomic group. This thesis concludes with a brief conclusion in which I explain the key findings of my research and attempt to answer the research question.

Chapter 1

A brief history of technocratic childbirth

History is full of unknown information that give you a basis to look differently, but especially to look deeper at contemporary problems. Therefore, I take you on a journey through the history of the Dutch birth system in this first chapter. This chapter examines the complex history of labor and birth in Western medicine, which has shaped the way Western medicine views pregnancy, childbirth, and the female body. It is important to analyze this history in order to demonstrate how far-reaching and problematic a biological paradigm that ignores the mother body and its variability can be. Because this paradigm is at the root of the possible loss of the young mother's sense of autonomy during birth, it is important to delve deeper into the history of birth care to unravel the problems posed by the paradigm.

I will take a closer look at the birth care system in early (pre)historic times, and the Industrial and Scientific Revolution, ending with the most important developments of modern birth care in the past century. Although midwifery is one of the oldest professions in the world and the story spans the entire human revolution, the most significant changes to the American and European birth systems have only happened in the past three hundred years. First, I give a brief description of (pre)historical practices and changes within the model of birth in which I introduce the slow process of change within the larger problem that has arisen over the past three hundred years. I will then go into more detail about the development of the contemporary technocratic maternity care system that emerged in Europe during the time of the industrial revolution around the year 1800. Each of the tenses I discuss in this chapter are important for considering midwifery as it is today. Within the paragraphs I zoom out on important concepts that give context to the current problem of the loss of sense of autonomy among young biological mothers in the current Dutch birth care system with its growing technocratic influences. I will delve deeper into the concept of patriarchy, nature and fear of death, and gender. Although my thesis mainly focuses on Dutch birth care, the historical shifts outlined in this chapter took place in European and North American societies. However, these shifts through colonialism, capitalism and globalization from the early modern period have had a worldwide impact (Stone 2009, 41). That is why I do not focus only on the history of the Dutch birth system in this chapter.

It takes a village to raise a child

The profession of midwifery goes back to the dawn of mankind.[2] It's no wonder, then, that midwifery is seen as the world's first holistic profession in which 'care' has always been a woman-centered phenomenon. Yet in recent centuries there has been a major shift towards a birth system known - mainly in Europe and North America - for its patriarchy principles in which the humanistic and holistic process of birth has slowly but surely given way to a mechanical birth system (Davis-Floyd 2001, 6). These principles of patriarchy, still stand in the way of a more humanistic policy in current Dutch birth care today for several reasons. First, according to Davis-Floyd, in this patriarchal system, the technocratic concept of the body is applied differently to men and women, so the male body is presented as a better machine (Davis-Floyd 1994, 1126). It would reproduce patriarchy in that women's bodies are constructed as weak and valuing masculine attributes like effectiveness, action-oriented activity, individualism, rationality, and reliance on technology (Davis-Floyd 1994, 1126; Davis-Floyd 2003, 152). The male physique is more machine-like in design and function, more defined, constant, and predictable, and less prone to break (Davis-Floyd 1994, 1126; Davis-Floyd 2003, 52). The same anthropologist argues that due to the deviation from the male prototype, female anatomical traits including the uterus, ovaries, and breasts are naturally prone to failure (ibid.). According to the technocratic paradigm, a degenerating woman's body is often better off without her (Davis-Floyd 1994, 1126). During pregnancy and birth, the female body machine is at risk of significant failure or entire collapse (Davis-Floyd 1994, 1126). Davis-Floyd (1994, 1127) reports an increase in pregnancy pathology and calls for art to augment "inefficient forces of nature" in her endeavor to ensure normal birthing. Realizing that a patriarchal power system expects efficacy, speed, efficiency, and physical health in birth care gives less room for humanistic care. A paradoxical shift, because for centuries birth has been scaled under a woman's space. Before the eighteenth century, women nearly always seek assistance from female relatives, friends, and/or experienced birth attendants, with partners and other men almost completely excluded (Stone 2009, 42). Examining ancient sources and images of women giving birth in early history reveals that childbirth was a woman's affair. Midwife Margot van Dijk explained in her masterclass on the history of the Dutch maternity care system that in several early times in history, the midwife was often the most experienced

[2] Notes on Masterclass Margot van Dijk: The Story of Midwifery: *the history of birth care* on February 10th 2022

and wisest woman in the community who only intervened when something was about to go wrong. [3]

The emergence of agriculture ten thousand years ago was the first significant shift from viewing birth as a true women's affair to a technocratic birth system in which birth is considered as a service medicine owns and provides to society as we know it today (Barnawi et al. 2013, 115). Furthermore, midwife Margot van Dijk explained in her masterclass on the history of Dutch birth care that nomadic tribes are increasingly looking for a permanent place to stay due to the arrival of fertile soil. Land is becoming increasingly important: if you have land, you have property and the more property you have, the more you are worth. This time also characterizes the period in which there is less and less time between pregnancies since children are needed to help with the heavy work (Barnawi et al. 2013). Women have a big role in preserving property, since having children and taking care of the family makes for a stronger possession. According to Davis-Floyd (2004, 46), birth therefore presents an important conceptual challenge to male domination, as male dependence on women for reproduction seems to require women to be revered as the goddesses of the survival of their society. Despite the gradual emergence of patriarchal ideas in these societies, childbirth still appears to be a woman's space, with the mother being positioned at the center of the process and the man being essentially shut out of the birth circle.

The Middle Ages: The influence of religion

In addition to the emergence of patriarchal ideas within societies in Europe during the agricultural revolution, there is another important development in the early ages that contributed to the technocratic midwifery system we know in this way. For example, the rise of religion in the Middle Ages had a major influence on the profession of midwifery. Religion filled in the role of women's responsibility, so that fortune and bad luck were no longer linked to chance or knowledge as before the advent of religion, but to the evil and peace of God (Davis-Floyd 2003, 45). During these times, the midwife's role within childbirth was mainly to oversee all the rituals that had to be done to manage evil. Midwife Margot van Dijk, who has worked as a midwife for years and now as an entrepreneur produces honest and scientific information about birth and pregnancy, described an example of a ritual in which all keyholes

[3] Notes on Masterclass Margot van Dijk: The Story of Midwifery: *the history of birth care* on February 10th 2022

within the birthing room were closed in her masterclass about the history of the Dutch childbirth system.[4] It was the midwife's job to see to it that all rituals and customs were performed properly. Witchcraft was punished and midwives were regularly persecuted. Because midwives in Catholic Europe were worried with life and death and difficulties, and so conducted specific rituals, they were seen as suspect not only by the community, but also by the church (Ehrenreich, B. & English 1973). Midwives were often accused of contact with the devil and mistaken for witch, as a result of which they were seen as inferior within society. As midwife Margot in her masterclass from the book Malleus Maleficarum (1487) quoted: “No one harms the Catholic Church more than the midwife”. Furthermore, the connections between the arrival of patriarchal principles within the original 'woman's space of giving birth' and the current technocratic birth system in the Netherlands can be found in the Greek Aristotelian tradition that was a developmental stimulus for modern science (Davis-Floyd 2003, 49). Returning to Europe in the twelfth and thirteenth centuries as a result of renewed trade with the Arab world, Aristotelian precepts were thoroughly studied and eagerly incorporated by several religious thinkers and early scientists like Galileo, establishing a hegemony of opinion about the superiority of the male in both scientific and religious thought in post-medieval Europe (Davis-Floyd 2003, 50). Furthermore, as I will explain in the next paragraph, women were not allowed to practice science and medicine professionally because they were thought to be less intelligent than men (Davidson 2020, 3). The reputation of the midwife today through the influence of religion may therefore lay the groundwork for the times that followed when patriarchy in health and birth care slowly further developed and the shift from childbirth as a holistic and humanistic process to a more mechanical one could begin.

The Scientific and Industrial Revolution

The real foundation for the current technocratic birth care system as we know it today lies with the onset of the scientific revolution in which patriarchy is slowly reflected in today's medical world. Until then, traditional obstetric surgery like for example a Caesarean Section[5], was not widely practiced, and male practitioners attended labor only as a complement to the midwife, or in place of the midwife when she was unavailable (Wilson 1995 cited in Stone 2009, 42). The male medical profession did not consider reproduction to be a subject at all for them to get

[4] Notes on Masterclass Margot van Dijk: The Story of Midwifery: *the history of birth care* on February 10th 2022
[5] A caesarean section is an operation in which the baby is delivered through the abdominal wall.

involved in since having children was not a disease and clearly a task for women (Stone 2009, 42). Their indifference was irrevocably altered with the Scientific Revolution. During the scientific revolution, the human body and biology were receiving more attention (Davis-Floyd 1994, 1126). As stated before, during the Scientific Revolution, the male body was presented as a better machine (Davis-Floyd 1994, 1126). It would reproduce patriarchy in that women's bodies are constructed as weak and valuing masculine attributes like effectiveness, action-oriented activity, individualism, rationality, and reliance on technology and would further reproduce patriarchy in that women's bodies are constructed as weak (Davis-Floyd 1994, 1126). This fascination is now being complemented by the fact that men are progressively tampering with the operation of the human body, such that the physical process of delivery is presented in a highly mechanical fashion, transforming the organic human body into a machine, with less and less emphasis on the social and emotional process of childbirth (David-Floyd 2003, 45; Stone 2009). Thus, we can say that the men who established the idea of the body as a machine also established the male body as the prototype of this machine (David-Floyd 2003, 51). A patriarchal value that is still clearly visible in the current birth care system and that highlights the shift from giving birth as a female matter with feminine values such as emotion and support to giving birth to a mechanical process seeing the body as a machine that distances itself from giving birth as a holistic whole.

The development of patriarchy in birth care not only influenced the perception of the female body as weak and subordinate to the male body, but also influenced the role of female midwives in the birthing process. Women's gender ideals of vulnerable and dependent gave rise to a notion that women would not be able to give birth without the help of male experts (Macdonald 2006, 237). Therefore, female midwives ended up in a position subordinate to their male colleagues. In addition, the superiority of men in the scientific revolution made education available primarily to men (Davidson 2020). Because midwives in this time were still seen as inferior partly due to religious influences, midwives were not allowed to learn to read. Because almost all women - and therefore all midwives - were illiterate, they had no access to science. This slowly shifted the importance of the practical experience that midwives had and the power during birth came closer to the surgeons or grandmasters.[6] In addition, the understanding of the birth mechanism opened the way to the search for tools to resolve obstructions during labor

[6] Notes on Masterclass Margot van Dijk: The Story of Midwifery: *the history of birth care* on February 10th 2022

(Davis-Floyd 2003, 51). Instrumental or operational obstetrics[7] brought advancements within midwifery care. However, these instruments remained available only to surgeons and grand masters: the use of instrumental aids was denied to midwives.[8] The experiential expertise built up by midwives in the course of their practice was downplayed by the physicians as "mere" practical experience and their own theoretical and technical knowledge was elevated to the pinnacle (Stone 2009). This resulted in female health being further pushed into the realm of male practitioners by shifting societal norms in the eighteenth century, which enabled a manufactured sense of dependency on medical systems (Ehrenreich and English 1973 in P.K. Stone 2009). Due to this power distance and the inaccessibility to medical knowledge based on gender, the midwife was seen as less capable, and their prestige decreased. This shows that on the basis of gender, the midwife was slowly pushed away from the formerly feminine space of delivery. Therefore, this tendency breaks with the traditional way of organizing delivery as seen in earlier times. It emphasizes the shift from delivery as a woman's space to the lack of woman influence in childbirth, which is still clearly visible in the current Dutch birth care system.

The narrative of giving life to preventing death

During the industrialization period, the female body, as it diverged from the male ideal, was regarded fundamentally weak and unsafe under the influence of nature, which, due to its unpredictability, was seen as in need of continual regulation by people (Davis-Floyd 2001, 6; Cheyney and Davis-Floyd 2009, 5). As a result, despite growing acceptance of birth as a mechanical process similar to all other bodily processes, it was viewed as an inherently imperfect and unreliable mechanical process, and the metaphor of the female body as a faulty machine eventually became the philosophical foundation of modern obstetrics. Furthermore, according to Davis-Floyd, when factory-made items became a fundamental structuring metaphor for social life, it also became the dominant metaphor for birth: "The hospital became the factory, the mother's body became the machine, and the baby became the result of an industrial manufacturing process" (Davis-Floyd 2001, S6). Obstetrics was thus ordered to create tools and technology for manipulating and improving the intrinsically flawed process of

[7] Obstetrics is the study of pregnancy, delivery, and the postpartum period.
[8] Notes on Masterclass Margot van Dijk: The Story of Midwifery: *the history of birth care* on February 10th 2022

birth, as well as to convert birth to the industrial assembly-line paradigm (Davis-Floyd 2001, S6).

The impulse to improve nature, and therefore the female body through technology, has the ultimate goal of liberating us completely from the limitations of nature (Davis-Floyd 2001, S10). Anthropologist Davis-Floyd (2001) calls this theory the technocratic imperative. The more capable we are of controlling nature, including improving our natural bodies, the more afraid we become of the aspects of nature we cannot control (Davis-Floyd 1994, 1126; Davis-Floyd 2001, S10). This results in a consequence that is visible in medicine all over the world: the fear of death. This theory has led to a phenomenon that Anthropologist Peter C. Reynolds (1991) calls the 'One-Two Punch' theory of technological intervention, explaining that problems arising from 'improvement' of natural processes with technology are often solved with even more technological processes (Davis-Floyd 2001, S9). Reynolds theory is therefore well applicable to the birth process. For example, when the physiological process of birth is disrupted by medical interventions such as an initiation, where the woman is given hormonal synthetic oxytocin[9] that is supposed to stimulate labor (punch one), and then a caesarean section has to be performed (punch two) to save the baby or the mother, we as a society congratulate ourselves on 'saving the baby' (Davis-Floyd 1994, 1126; Davis-Floyd 2001, S9). This impulse to improve nature through technology has the ultimate goal of liberating us completely from the constraints of nature (ibid.). Therefore, death becomes the ultimate symbol of defeat, proof that we have failed to transcend nature's bounds, and hence the ultimate enemy, one that must be defeated at all costs (Davis-Floyd 2001, S10).

The Dutch birth system as it is today

As a result of the need to dominate nature and the great fear of death, Europe and the United States have seen a tremendous growth over the past forty years in high-tech solutions that have, among other things, expanded medical interventions during birth (Davis-Floyd 2001, S9). Medical interventions such as caesarean sections would not only reduce the risk of maternal and/or child death but would also ensure that the delivery proceeds faster and in a more structured manner (Davis-Floyd and Cheyney 2009, 7). In addition, the same anthropologists

[9] A hormone. It causes muscles of the uterus and mammary glands to contract. To induce contractions during childbirth (infusion). Often also used after childbirth to prevent a lot of blood loss (infusion or injection).

argue that partly due to the strong growth in the number of births in the past century, the patience for a physiological birth without medical interventions has slowly but surely run out. As I will explain further in the following chapters, this development contributes to the current problems in Dutch birth care for both mothers and maternity care workers, such as a loss of autonomy, a heavy workload for midwives and gynecologists, the development of protocols and guidelines, and the expansion of medical interventions. Partly because of these developments, according to anthropologist Davis-Floyd (2001), we have lost a great deal of information and insight into physiological birth.

According to Davis-Floyd (2001, S5), the maternity care system is primarily embodied by the prejudices and beliefs of the society in which the system resides. The Dutch midwifery system and delivery culture is unique in its kind compared to the rest of the Western world. The birth system in the Netherlands has a romantic image, with approximately 20% of births taking place at home (Royal Dutch Organization of Midwives 2022). Dutch women and men frequently respond that home births are more "gezellig"[10] when asked why they prefer giving birth at home than giving birth in a hospital (De Vries et al. 2009, 45). De Vries states: “For the Dutch, birth at home is gezellig in a way birth in the hospital never can be.” - (De Vries et al. 2009, 45). In addition, midwives have a degree of professional independence that is unmatched by midwives in any other country (De Vries et al. 2009, 31). With its high number of home births, the home birth culture has even been on the Dutch Inventory of Intangible Heritage since 2021. Midwife Margot van Dijk also argued that partly due to our Dutch sober '*just act normal then you are crazy enough*' view of life, pregnant women are more often seen as 'low risk' than in comparison with other Western countries.[11] This high number of low-risk pregnant women in the Netherlands gives midwives a strong position in the Netherlands, enabling women to provide more personalized care while also giving the woman more autonomy over how and where she would like to experience childbirth (De Vries et al. 2009, 41). However, with the loss of the 'normal' nature of giving birth, the autonomy of pregnant women is also at stake. Furthermore, midwife Margot explained in her masterclass about the Dutch birth care culture I attendant on March 8th, that also in the Netherlands, many medical birth rituals and interventions are based on cultural notions of health care and gender instead of on scientific

[10] A typical Dutch word that is used a lot in the Dutch language. ‘Gezellig’ does not translate well into English. In this context, it comes close to the English word ‘cosy’
[11] Notes on Masterclass Margot van Dijk: The Dutch Birth Culture: *What Are We Doing Exactly?* March 8th 2022

substantiation[12]. About this, the midwife stated: “About 1/3 of what we do is scientifically proven. The other 2/3 of the actions are culturally determined and passed on.” Rituals can ensure that the midwife habitually performs certain interventions without consulting the client, so that there is no informed consent and the client in question has no influence in the decision-making process. Furthermore, in maternity care, opportunities and statistics are frequently discussed, but there is a good chance that the intervention will not be in line with the client’s preferences. Margot further explained: “And that is exactly why it is so important to make your own choices as a pregnant woman, because who knows you better than yourself?” Therefore, as far as I am concerned, it is above all that a pregnant woman is in control, makes her own choices and that the midwife - or other care provider - provides the options. Some women choose high-tech births, while others prefer to give birth at home, but all women want humanistic care that is courteous, compassionate, and relationship-focused (Davis-Floyd 2003, xiii).

[12] Notes on Masterclass Margot van Dijk: The Dutch Birth Culture: *What Are We Doing Exactly?* March 8th 2022

Interlude 1

A Midwifes diary: An ode to all midwives

Oh how those dark nights on the road to new life fill me with happiness. The sounds of women giving birth, so synchronously recognizable in every woman. The babies arriving into the world, some calm and clear-eyed, others crying or eyes still closed.

Oh how those babies grow in their mother's bellies and move under my hands. How even I get to know them a bit. The happiness in the eyes of the parents on the way to their child. The breasts (or bottles) that feed, sometimes more and sometimes less. The hands that carry and comfort and caress. The tears that flow from happiness and sadness.

Oh how my heart cries when parents lose their child or desire to have children. How my heart cheers when after a previous heavy birth, a finer birth follows or another heavy but then autonomous one. How I rejoice when a woman is seen and heard and carried.

Oh how my stomach rumbles when I forget to fill her or my bladder whines when it's overfull. My pelvis sometimes hurts after being there for hours and hours and my head whimpers if I sleep too little or worry too much. My shoulders are creaking because I carry so much responsibility. My thoughts that lament because I want everyone to understand that this is the most beautiful profession, but sometimes it is also just really heavy. That sometimes I want everything to be life and that I know that for sure and can trust with eyes closed. But that I don't do exactly that (because I can't), and I am just a midwife with open eyes and heart.[13]

- (Midwife Margot van Dijk, on Instagram March 16th, 2021)

[13] Instagram @vroedvrouwmargot, Midwife Margot van Dijk, posted on 16th March 2021

Chapter 2

The risk of birth rituals

In this chapter, I zoom in on the consequences of our fear of death, which I discussed in detail in the first chapter, and how these consequences as a risk contribute to the feeling of autonomy in the pregnant woman and biological mother during childbirth. As described in Chapter 1, with the development of seeing death as the greatest enemy since the development of technological solutions to control nature and improve our natural bodies, the concept of risk in pregnancy and childbirth has become a major discourse. There are several ways in which risk affects the sense of loss of autonomy for pregnant and laboring women. In this chapter, I will focus on the development within our current 'risk society' and 'guilty culture' described by Beck (1992) and Douglas (1990). I describe how our growing fear of death creates a lot of responsibility for midwives and gynecologists, so that the arrival of protocols and guidelines within the birth care system turned out to be a foothold. Furthermore, I will also describe how protocols can cause a lack in communication and decision-making because doctors and midwives sometimes do not dare to hand over responsibility for fear of claims and lawsuits. Finally, I argue how the further removal of responsibility and intuition from the mother brings this responsibility even closer to the doctor and midwife.

Introduction to the theory and focus on risk

As explained in chapter one, with the development of seeing death as the greatest enemy since the development of technological solutions to control nature and improve our natural bodies, the concept of risk in pregnancy and childbirth has become an important discourse. According to Davis-Floyd we are not only afraid of death, but also afraid of the unknown (Davis-Floyd 2001, S7). Since the world of the pregnant woman is full of unexpected events, you never know in advance what will happen or how the pregnancy and delivery will unfold (Wall 1995 cited in Chadwick and Foster 2014, 69). Beck (1992) states that we live in a 'risk society' defined by increasing risks, in which responsibility for risk management is individualized. As individuals, we have access to a wealth of knowledge and the freedom to make choices and negotiate risks (Beck 1992). As a result, 'risk awareness' has become an integral part of individual subjectivities (Lupton 2012 cited in Chadwick and Foster 2014, 69). Many women I spoke to during my fieldwork indicated that they felt safe with doctors and midwives. Some women

may feel well cared for and safe when their gynecologist or midwife informs them about medical checkups or possible interventions when childbirth is at risk. This imposes a reassuring cultural order on nature's other terrifying and potentially uncontrollable chaos (Davis and Davis-Floyd 1996, 238). For example, young 28-year-old mother Nina, who lives with her family in Utrecht, explained in an interview that she felt safe during the checkups during her pregnancy. Nina stated: “They don't do medical checkups or interventions to bully you, they really want the best for you. They will do everything they can to make the delivery as safe as possible.” Trust in science and in doctors and midwives is high, partly because we are so focused on avoiding risks and dominating nature. In addition, midwifery care in the Netherlands has never been more physically safe for mother and child than in our contemporary birth system, resulting in minimal maternal and infant mortality in this century. However, our current Dutch midwifery system is increasingly influenced by the current risk society in which we live. Because although in developed world contexts childbirth is physically safer than ever, resulting in minimal maternal and infant mortality in this century, our ever-growing fear of death ensures that women are protected from the risks of their own bodies through ever-increasing medical procedures, guidelines, and protocols (Chadwick and Foster 2014, 69). Anthropologist James states that the reason for this is because decreased risks of maternal and perinatal death are followed by increased risk of lawsuits, fueling a growing fear of lawsuits among midwives and gynecologists and an increase in risk avoidance strategies to avoid lawsuits (James 1993 cited in Lankshear et al. 2005, 362). Protocols and guidelines therefore provide midwives within the technocratic healthcare system with a sense of fear, but at the same time security.

Protocols as guide

Due to our growing urge to dominate nature and thereby the expansion of the current technocratic midwifery system in the Netherlands is characterized by the growing number of protocols over the past 20 years. Both midwives Margot and Saskia could clearly tell me during an interview that in 2005 there were 'only' 10 protocols that midwives had to take into account, and from there on, 100 protocols have been added in 2022. According to anthropologist and midwife Rebecca Ashley, this is also the reason that all actions within (birth) care are documented.[14] Rebecca stated in her podcast about the politics of midwifery, that by

[14] Podcast Rebecca Ashley: Contraction II: Crisis with Rebecca Ashley, December 2020 accessed on 12 February 2022

documenting procedures with protocols and guidelines in mind, midwives can protect themselves against risks. Childbirth is no longer seen as a purely physiological process where outcomes are the product of chance and adverse outcomes are inevitable 'accidents'. It is increasingly seen as 'man-made' with the advent of technological developments, and therefore adverse results cannot be accidental (Green 1999 cited in Alaszewski and Scamell 2012, 5). Nurses and midwives are so often held responsible for negative outcomes in maternity care, leaving many midwives and doctors afraid of making mistakes. Midwife Margot, for example, said on her Instagram, where she has more than 13,000 followers, that she feels a great responsibility for death. She writes: “When it comes to death, I feel a responsibility. What if I...? Can you be guilty of death?”[15] Margot's concerns may be linked to Douglas' (1990) theory in which he argues that the concept of risk underlies the development of a "guilty culture" in which all harmful events are seen as a product of human action and every accident is someone's fault. Therefore, midwives and gynecologists have become responsible and accountable for their decisions, or at least feel that they have become responsible and accountable for it. According to both midwives Margot and Ashley, this sense of responsibility has been ingrained for years, the beginning of which can be found in the midwifery training. Midwife Margot stated: “We want to prevent the death of mother and child and in this way we build frameworks and boxes and go from guideline to protocol. As long as you follow it you are 'safe'. If not, you are 'reckless' or 'guilty'.” Decreasing autonomy - albeit not unconsciously - to guarantee the physical safety of mother and child via protocols. Margot further explained: “As long as we have that control, are in control, nothing can happen. Until…. it happens anyway. Death comes. Death does not adhere to rules and protocols. Death takes and gives.” It is not only midwife Margot who is sometimes concerned about her great responsibility within birth care. Several midwives I have spoken to say that they find this responsibility quite intense because it is not inconceivable that caregivers sometimes make mistakes. However, in an interview with midwife Margot, she explained to me that if the role of care provider were to shift from 'care provider as lifesaver' to 'care provider as guide', she would experience a less high sense of responsibility as a midwife. In this role, midwives share knowledge and experience without, as I have often experienced during my fieldwork, drawing up a plan for the client and let her client choose what would suit her personally and what she feels comfortable with. According to Margot, the role of 'care provider as guide' can also ensure that the client becomes aware of the fact that she is in charge of the birth and does not become the leading object. But since there is

[15] Instagram @vroedvrouwmargot, Midwife Margot van Dijk, posted on 27th December 2021

a great deal of trust in doctors in our society and since we are afraid of death, many women I have spoken to indicate that they sometimes find it difficult to listen to their own intuition and wishes instead of the advice of the midwife or doctor. Margot continued: “If I make a choice and it's the wrong choice, you know. It's easier to leave those choices to someone else. It's not easy to take responsibility for your life.” With this conviction of 'doctor knows best', the huge responsibility therefore rests entirely with the care provider instead of with the biological mother. Furthermore, Margot told me during our interview that this responsibility causes stress and anxiety for many midwives. She stated: “Because what if I don't know any better? What if complications cannot always be prevented? Or: what if the convenience of some interventions causes complications?” According to Margot, this is the reason why midwives often turn to protocols and guidelines when they fear this responsibility, and that when something goes wrong with the baby or the mother, they immediately look back at whether the guidelines and protocols have been implemented. Margot told me:

> What you often see happening is that.. Suppose something very serious has happened, for example the baby has died, then we always look back at the protocols and guidelines. And when these protocols and guidelines have been followed, we say: 'What a relief! Fortunately, we did.’ While, if they are not followed, it will become a big issue..

Margot's statement shows that it is quite difficult for a midwife to deviate from protocols and guidelines, because many midwives believe that this is taking a risk of a possible lawsuit. In addition, the midwife's statement shows how the focus on risk aversion has put a lot of pressure and responsibility on birth care workers, with protocols and guidelines providing guidance and safety for the birth care worker. However, while the introduction of these guidelines and protocols provides guidance and safety for birth care workers while also considering biomedical risk management, no emphasis is placed on the emotional aspect for the pregnant woman. Thus, acting on the basis of protocols and risks is what is prescribed, but is this the best care? While talking about this topic, midwife Margot said: “It is in the directive, nobody has listened to their wishes. No one listened that she might say: 'Well maybe it's not a good idea, it doesn't feel right' But: the guideline has been followed! And that's the most important..” So although the advent of protocols provides security and guidance to cope with the pressure and responsibility of the profession as a birth care worker, it can lead to a less focus on the wishes of the biological mother. The intuition of the woman in labor and her autonomy

completely pushed into the background. Moreover, as mentioned in the introduction, protocols and guidelines are not always based on science, but rather on cultural notions of health care and gender. Dutch midwives' decisions are thus not always based on research, but rather on a 'ritual' passed down from midwife to midwife, and only about 1/3 of medical interventions as a part of these rituals are scientifically proven. In addition, every person is different, and every woman has different wishes and fears during her pregnancy and in the run-up to birth, as I have discovered during fieldwork in recent months. This allows women to have a conversation about opportunities and statistics during a midwife consultation, but still, no one knows what would be best for her personally. When 2/3 of the interventions are based on cultural notions and midwifery rituals, there is a good chance that an intervention will not work for you personally. About this, Margot explained: "And that is exactly why it is so important to make your own choices, because who knows you better than yourself?" According to the midwife, caregivers are quickly inclined to perform an intervention without taking into account the personal situation of the woman. A good example of a medical intervention often done on the basis of cultural notions of health care and gender during childbirth is a so-called 'episiotomy[16]', which prevents the woman from tearing out during birth. In the Netherlands, this intervention was performed as a preventative measure in 24% of the deliveries in 2015, while scientific research shows that the episiotomy can unnecessarily lead to side effects such as pain, more blood loss and pain during sex (Seijmonsbergen-Schermers 2020). Midwife Anna Seijmonsbergen-Schermers (2020) argues in her article that the decision-making for the episiotomy is mainly based on the midwife's own clinical expertise and her own vision about childbirth, as a result of which women are often not included in the decision-making process which can lead to a reduced sense of autonomy during pregnancy and birth.

Woman's intuition

During my participant observation at midwifery practices and during my conversations with young birth mothers, I learned that looking for possible risks is often indeed the main focus during the consultations. The detection of possible abnormalities often starts during the very early stages of pregnancy. One of the first steps a woman takes when pregnant is to find a midwifery practice and schedule an appointment for the first ultrasound, often at 8 weeks of pregnancy. As previously stated, due to the high responsibility of the midwife and doctor

[16] An episiotomy is a medical operation that involves making a tiny incision in the vaginal mucosa with scissors during birthing.

previously described, the delivery should be constantly managed by experts such as doctors and midwives, and the pregnancy should be constantly monitored and subjected to a series of examinations to investigate dysfunction and abnormalities (Chadwick and Foster 2014, 69). As I mentioned earlier, for some women, the constant scrutiny of the female body and baby can mean increasing confidence in a successful delivery by being connected to some of the highest technologies that society has invented. Because of this, many women feel that they are well taken care of and safe, imposing a comforting cultural order on nature's other terrifying and potentially out-of-control chaos. Trust in science and in doctors and midwives is high, partly because we are so focused on avoiding risks and dominating nature (Chadwick and Foster 2014, 69). However, constant monitoring during pregnancy and childbirth does not provide every woman with a sense of security and confidence. The interview at her home with young mother Nikki, who had given birth to her daughter six months before the interview, made it clear to me that risk avoidance is already a matter at the beginning of the pregnancy, which caused her a lot of stress. Nikki explained: “It actually already started at the first appointment with my midwife. The first thing she told us was: “Congratulations, you are pregnant! Now here you have a shitload of things that can all go wrong.” These types of risk that Nikki mentioned mainly fell under biomedical risks of birth, in which physical states influence a person's risk of disease. Emotional risks, such as the possible loss of physical control, dignity and privacy during the intensely embodied birth experience, are omitted. Other mothers I spoke to about the focus on possible abnormalities that were detected at the start of the pregnancy also often experienced this as stressful. By naming these possible abnormalities, women can be made to feel that they no longer trust their intuition and also see their own body as weak and unpredictable (Davis-Floyd 2003).

Several women in my research felt that their bodies were less capable of independently completing a healthy pregnancy and delivery, causing women to lose confidence in themselves and therefore their sense of autonomy because the body is portrayed as weak and unpredictable. For example, Catharina, a 36-year-old mother who lives with her husband and 1-year-old daughter in Amersfoort, explained in an interview that she experienced a lot of stress because in the beginning of her pregnancy, her baby was initially estimated to be much too small. The doctors indicated that there might be something wrong with the child in the form of a disability. Catharina told me: “During my whole pregnancy I felt quite tired but fine, and I really didn't feel like there was anything wrong with her.” Although Catharina her intuition told her that there was nothing wrong, she took into account the fact that there might be something wrong

with her baby throughout the entire pregnancy. In addition, young mother Nikki told me that during her pregnancy and childbirth she had experienced dozens of times when doctors and caregivers did not want to trust her own intuition. For example, Nikki indicated that she had complete confidence in her body throughout the pregnancy and felt that everything was fine. However, due to the many ultrasounds and comments from doctors and midwives, she got the feeling that she could not rely on her own body. Young mother Nikki told me:

> In total I had about 8 or 9 care providers who all thought something of me. And most of them are in the risk stories. 'Oh do I see something here? Do I see something there?' So I found that so stressful. If a woman says she feels good, you can trust her feeling.

Although Nikki would have preferred more responsibility during her pregnancy, it was not assigned to her, but her body was constantly monitored trough technologies. This is based on the theory of seeing the female body as a faulty and dysfunctional machine that is unpredictable and capable of breaking and therefore needs to be managed and repaired (Martin 1987 cited in Maffi 2013, 22). Female physical traits like the uterus, ovaries, and breasts, as well as female biological processes like menstruation, pregnancy, and birth, are naturally prone to failure due to their departure from the male prototype (Davis-Floyd 2003, 48). Intuition in the current Dutch birth care system with its growing technocratic influences is thus seen as too great a risk of body failure and must therefore be checked with technological processes such as CTG scans[17] and ultrasounds. However, it emerged that several women I spoke to during my period of fieldwork felt passed over and not taken seriously because they were not trusted on their intuition. About this experience, young 30-year-old mother Rosa explains during an interview at her home: "When my first son was born, she placed a fetal scalp electrode[18] on my child's head. I just didn't understand why they did that, he was just healthy, wasn't he? There was no indication at all. As if that midwife didn't trust the situation and me." When placing the fetal scalp electrode without informed consent, Rosa was cast in the role of a 'passive object', depriving her of responsibility for decision-making, as a result of which the mother felt a sense of loss of autonomy (Lankshear et al. 2006, 367). The responsibility and therefore the confidence in decision-making at Rosa did not lie in the hands of Rosa herself, but in the hands of her midwife. The excessive sense of responsibility that is a feature of the previously

[17] A CTG, short for cardiotocogram, is a test in which a device measures the heart rate of your unborn baby (cardio). It can also detect and monitor any activity in your uterus (toco).
[18] A thin metal wire that is attached to the baby's scalp. This allows a direct recording of the baby's heartbeat.

discussed "guilty culture" in which all harmful events are seen as a product of human action and every accident is someone's fault can mean that midwives do not dare to hand over the risk because they feel that the responsibility is in their hands (Douglas 1990).

Another example in which the responsibility was taken away from the mother and placed entirely with the midwife is the example of Margriet. During our meeting at her home in Eindhoven, 31-year-old newborn mother Margriet also told me about her experience with the feeling of not being involved in the decision-making process and experience with the lack of informed consent. Her baby was initially estimated too small, so her midwife directed her to make certain decisions that Margriet and her partner did not want. A baby who is too small may pose a risk because the placenta may not function properly. In addition, babies who are too small are more likely to have low blood sugar after birth and that can be dangerous. However, Margriet and her partner found it especially annoying that no attention was paid to explaining and substantiating these risks during the discussion of risks. Margriet explained: “They couldn't explain to me why they wanted to make certain decisions. She just said, "Protocol is protocol". I can't handle that very well." Because Margriet and her partner were not included in the decision-making process and information about the process, it gave the expectant parents the feeling of losing autonomy about their pregnancy, which made them look for a midwifery practice that would listen to their wishes and feelings and would be open to a conversation that focused on more than just discussing the biomedical risks. When I asked during my fieldwork what midwives think about care questions outside the guideline, many midwives I spoke to indicated that they were cautious about handling care needs outside of guidelines and protocols. During an interview at her midwifery practice in Amersfoort, 40-year-old midwife Saskia explained:

> If a client comes to me and tells me that she would like to give birth at home while she had a caesarean section during her first childbirth, I think it is just irresponsible. I won’t go along with that. It is my responsibility to provide good care and to ensure that my client and the baby are as safe as possible.

The decision by midwives not to let the mother take responsibility herself stems from our 'guilty culture', where the idea that all responsibility lies with midwives and doctors, due to their fear of lawsuits and complaints (Douglas 1990). During my visit on 10 April in the small-scale midwifery practice where 35-year-old midwife Linda works in Gouda, she told me that there

are indeed many midwives who are afraid of lawsuits and complaints. However, Linda indicated that it is okay to guide women with childbirth wishes outside the guidelines, because this is also a woman's right. She said that as a midwife she can advise her clients, but that the mother in question is then responsible for her own choices. However, midwife Linda also explained that it is very important to document all choices and conversations so that there is evidence that the guidance outside the guideline was not a personal choice of the midwife herself, and that she can protect herself against possible charges. Linda her statement stems from the theory of James (1993), who states that decreased risks of maternal and perinatal death are followed by increased risk of lawsuits, fueling a growing fear of lawsuits among midwives and gynecologists and an increase in risk avoidance strategies to avoid lawsuits (James 1993 cited in Lankshear et al. 2005, 362). Protocols and guidelines therefore provide midwives within the technocratic healthcare system with a sense of fear, but at the same time security. The result of the constant management and control of the female body through guidelines, medical interventions and protocols during pregnancy and birth for abnormalities in the technocratic maternity care system, has pushed back the importance of a woman's intuition (Lankshear et al. 2005, 362). Furthermore, with the help of technology, the importance of midwives' and gynecologists' knowledge has only grown, as has their responsibility.

The paradox of responsibility and risk

The shift of responsibility from birth care worker to mother can be seen as a major paradox. Because although the belief of 'care provider as lifesaver' that I described earlier in this chapter, creates a great deal of responsibility and high workload for doctors and midwives, the growing number of protocols and checks resulting from this responsibility ensure that even more responsibility and intuition is taken away from the mother. The further removal of responsibility and intuition from the mother brings this responsibility even closer to the doctor and midwife. Even though shared responsibility would reduce stress for doctors and midwives, in a technocratic birth system, women are not trusted on their own intuition through protocols and guidelines. By constantly checking the body, some women may come to believe that they can no longer trust their intuition and that their own body is weak and unpredictable, so that they do not 'lead' the birth but are 'guided' by our constant cultural control of natural processes. The sense of being 'led' into the role of a passive object depriving her of responsibility for decision-making, as a result of which the mother felt a sense of loss of autonomy (Lankshear

et al. 2006, 367). As I discussed previously in this chapter, the emphasis on a move to 'care provider as guide' could lead to a shift toward shared responsibility, lowering stress for midwives and, as a result, reducing the number of protocols and guidelines produced, as decision-making shifts more to the mother. However, as I previously stated, in this role, midwives share their knowledge and experiences with their clients and assist them in developing a personal plan that allows them to choose what is best for them and what they are comfortable with. This, however, requires a significant amount of time and attention to the client during midwifery consultations, which is not always possible in the current Dutch midwifery system. In the next chapter I will elaborate on the concept of time within the current Dutch birth care system.

Interlude 2

Vignette - A day at the midwifery center

Monday 7th March 2022 – 13:15

When I walk into the midwifery practice in Amersfoort, I immediately feel at home. The waiting room looks friendly with its soothing pastel colors on the wall. It gives me a safe and warm feeling since the atmosphere is so calm. How exciting it must be to walk in here for the first time as parents-to-be? I take a seat on a chair next to a large board with colorful and creative birth announcements. I carefully read the names on the birth announcements and dream away a bit with the thought that I might be pregnant here myself in a few years. A pregnant woman sits down next to me and greets me in her soft voice. Little nerves are starting to play up, although I can't quite place why. I've spoken to midwife Saskia a few times already. Then I see her walking with big strides. “Oh you're already there!” she calls to me. Saskia looks welcoming but I can hear the rush in her voice. The energetic tone fills the calm space. "Come to my consulting room and we'll start right here." I follow her big steps and walk into the consulting room. A spacious, yellow room that reflects the rest of the midwifery practice: the room again gives me a safe and warm feeling. When Saskia asks me what I want to drink, I answer that I would like tea. She stands up again and walks quickly towards another room. On the way there I see her hurriedly looking at the clock while I hear her yell something unintelligible to a colleague. When she returns after a minute with a cup of hot water, Saskia quickly sits down behind her desk in front of me and starts to rattle. Saskia is a spontaneous woman with clearly a lot of passion for her profession. After fifteen minutes of hurried small talk and preparation in which we go through the expected clients of this afternoon, Saskia asks me if I want to drink my tea. “Soon my clients will think they all get tea from me” she laughs. I laugh along, but somehow her comment scares me a bit. Isn't it so crazy to offer your clients something to drink? I get up, hand my empty teacup to Saskia and take a seat behind the large desk. Saskia again hurries to the door of her consulting room and calls the first client in. A pregnant woman in her early thirties enters the room and takes a seat in front of us. After introducing myself and my research, a small check-up with Saskia follows. I don't say much and feel a little uncomfortable since I have the feeling that there is little time to talk. In my

view, the haste I'm experiencing makes that the woman is guided by her midwife. After the check-up, Saskia asks if the pregnant mother has already worked out her birth plan. The woman nods enthusiastically and tells every detail about her wish for a bath birth at her house. She wishes a birth without pain relief, preferably also without an intern and maternity assistant during the delivery. Even before the woman could explain her entire birth plan to Saskia, time is suddenly up. Saskia wishes the pregnant woman good luck with the last stretch and informs her that there is a good chance that her colleague will be present at the next check-up.

Chapter 3

Time and Capitalist practices

In chapter two, I argued that the emphasis on 'care provider as guide' could result in a shift toward shared responsibility, lowering stress for midwives and the number of regulations and guidelines as decision-making is transferred to the mother. However, this necessitates a substantial amount of time and focus on the client during consultations, which is not always achievable in the current Dutch midwifery system. This chapter begins by demonstrating the effect of a risk society on our current notion of time, highlighting the conflict between the physiological time of childbirth and the institutional time of the birth system. Then I elaborate on the relationship between time and money in our contemporary society and how this, combined with the conflict between physiological time and institutional time, results in a greater workload for midwives and a possible loss of autonomy for young biological mothers during pregnancy and childbirth. In response to the loss of job satisfaction and personal contact with the client, I conclude with a paragraph on the caseload midwife in which I argue that the sense of autonomy can be purchased to some extent.

The influence of risk to our notion of time

As I mentioned in previous chapters, since the scientific revolution, the woman's body has been seen as unpredictable, fundamentally weak and unsafe under the influence of nature (Davis-Floyd 2001, 6). Furthermore, as I explained in previous chapters, the more we got to grips with nature, including our natural bodies, the more afraid we become of the aspects of nature we cannot control. Therefore, we constantly try to dominate nature. Our current notion of time, also referred to as institutional time by various anthropologists within the healthcare sector, in which we attempt to structure, routine, plan, and control life within various timeframes, is a feature of the technocratic model of birth, because adherence to timetables during labor is critical for safety (Davis-Floyd 2003, 160). Because timing within pregnancy can be a measure of abnormalities within pregnancy or birth, our current concept of time with its schedules can help to 'control' structure risk. Time therefore plays an important role in dominating nature. However, the physiological time of childbirth and our current conceptions of time are in conflict. Physiological time, as in principle with a physiological process such as pregnancy, is

the universal time of the body, where time is irrelevant and the body will only initiate a process when it is ready (Davis-Floyd 2003, 160). Physiological time is also described by Walsh (2009, 131) as: 'as long as it takes to complete something' - in this case pregnancy or childbirth'. However, physiological time, like childbirth, is unpredictable and uncertain. And since we are afraid of the unknown, as explained before in chapter 1, physiological time conflicts with our current notion of time. This conflict provides a background to contemporary problems within technocratic birth care such as the loss of autonomy for pregnant women and mothers in labor.

Like the manufacture of any factory good, birth must be culturally shaped to occur inside a specific time frame (Davis-Floyd 2003, 98). During my participatory observation in several midwifery practices, for example, it became clear to me that during consultations with women who first came to the midwifery practice, often around 8 weeks of pregnancy, a due date for the delivery was immediately set. The recording of a so-called 'due date' fits in well with the technocratic birth care system, which is characterized by a desire for certainty and 'control'. Getting a precise date not only allows the midwifery practice and hospital to plan the likely number of births within a narrow time frame, but also allows women to provide maternity leave and support systems around the specified due date (Downe and Dykes 2009, 68). Time and standard measurements thus become the arbiter of normal and abnormal (ibid.). All days that the woman has not given birth after the 'due date' is called 'overdue'. Up to a week after the due date, the woman receives an invitation to talk about the possible possibility of being induced[19]. Midwife Saskia told me during our interview that a lot of midwifery practices in the Netherlands apply a maximum of between 41 and 42 weeks of pregnancy for women, after which they must meet with the midwifery practice or hospital to discuss the possible options for inducing labor. In my interview with young mother Nikki, she explains that the midwife indicated that if she would not have given birth at 41 weeks, she would have to go to the hospital to talk about the possible risks. Nikki stated: "Then you're going to think towards the end: Oh shit.. She really has to come now because I really want to give birth at home and shouldn't I start induction anyway? But I thought: I really don't want that." For Nikki, the early days of her birth felt like a race against time, which caused her to experience a lot of stress. Marjolein, mother of a 1-year-old son who lives in Utrecht, also experienced the pressure of time during her pregnancy and during her delivery. Marjolein told me that when she was 41 weeks

[19] Induction is the artificial initiation of labor (induction). This is done with drugs (oxytocin) that induce contractions.

pregnant, a balloon catheter[20] was placed to induce her labor. When the contractions did not start because of the balloon catheter, Marjolein had a meeting with her midwife who discussed the possible risks of waiting longer for the delivery. During this meeting, Marjolein made the choice to be induced in the hospital, where the delivery was induced with synthetic oxytocin. Although Marjolein took the risks that the midwife told her very seriously, she indicated that she was disappointed in her body. She stated: “I would have preferred to give birth in a ‘natural’ way, yes. I really hoped that my body would do it itself.” Time, such as recording a so-called 'due date' to create a dividing line between 'normal' and 'abnormal', can thus be used as a tool to assess risks (Downe and Dykes 2009, 68). As a result, time becomes a guideline in maternity care that can take away women's autonomy because technological interventions such as the administration of contraction inducers (synthetic oxytocin) ensure that nature is dominated by culture. Dominating nature can make women feel that she is the directing object of childbirth, rather than directing the childbirth and through our cultural perception of time the woman can lose her autonomy. The laboring woman could feel detached from her body and perceives it as something that the system controls and manages. Women as Marjolein portrayed themselves as being "fragmented" as a result, lacking a sense of autonomy in the world and feeling pulled along by forces outside of their control. This shows the friction between our current notion of time, in which time in pregnancy and delivery is used as the measure of the 'normal' and the 'abnormal', and the physiological time of labor. The physiological start and end times and duration of labor are unpredictable and uncertain, and since we fear the uncertainty, as previously described in Chapter 2, when time threatens to become 'abnormal', there is no more room for the physiological time of childbirth is no longer in the current birth system.

Time and capitalist practices

Our current notion of time, in which, as described in the previous section, attempts are made to structure, routine, plan and control life within different timeframes, like the concept of risk described in the previous chapter, became increasingly important with the advent of technology and the industrial revolution. The arrival of the clock is central to this current notion of time and forms a link between political-economic and socio-cultural changes in early modern Europe (McCourt and Dykes 2009, 20). Before the advent of the clock, our notion of time was linked to astronomical time with the sun leading to effectively define the course of a day. The

[20] One method to make the cervix mature is to insert a thin tube (catheter) into the cervix. After insertion of the catheter, a balloon at the top is filled with water the size of a bouncing ball.

advent of capitalism can thus be linked to how we experience time today (McCourt and Dykes 2009, 20). According to Marx (1906), in our current notion of time, time is associated with money, in which time is viewed in terms of money exchange, shift work, and exploitative modes of commodity production (McCourt and Dykes 2009, 20). The more work that could be done in a shorter time, the more money could be made. According to midwife Margot, this principle of time is money can also be seen in birth care. The midwife stated in her masterclass about the current Dutch birth culture that the 'time is money' principle is discussed early in midwifery training.[21] By applying a mathematical formula (the partogram) in which the time in relation to the dilation is measured and it can be calculated to what extent a birth proceeds 'normally' - in our perception of time, not including the physiological time. As I described in the previous section, the use of time as a 'measurer ' is used to distinguish the 'normal' from the 'abnormal'. When a delivery does not proceed 'normally' via the lines, it can be chosen to help the delivery process a little with medical interventions, which disrupts the physiological process, where the body works from the physiological time. Furthermore, according to Margot, the partogram ensures that the time in relation to the number of centimeters of dilation can provide an indication of when the midwife or gynecologist should intervene. Instead of offering the pregnant woman a constant accompaniment and waiting for the physiological time, the partogram makes it possible to emphasize concreteness, visibility, physicality, and progress, presenting the phenomenon, in this case 'birth' as statistical, quantifiable and observable (Downe and Dykes 2009, 76). This contributes to the notion that a woman's labor is best represented as progress on a graph rather than as feedback from her own experience. Aside from allowing the partogram and other technological advances such as the CTG to emphasize concreteness, visibility, physicality, and progress, presenting 'birth' as statistical, quantifiable, and observable, technological advances also allow for the separation of several women while still controlling and analyzing the various birth processes (McCourt and Dykes 2009, 29). For example, women are connected to the CTG scan to monitor the baby to enable midwives to observe a number of deliveries remotely, from a central station, instead of staying with the client (McCourt and Dykes 2009, 29). Doula and mother Leanne, who lives with her husband and two young kids in a little town near Utrecht, indicated in an interview that during the birth of her first child, in which the young mother was placed on a monitor and inducted with synthetic oxytocin, she missed the one-on-one care very much. She stated: “I felt so lonely during the birth.” So although Leanne could be observed constantly - from a distance - through

[21] Notes on Masterclass Margot van Dijk: The Dutch Birth Culture: *What Are We Doing Exactly?* March 8th 2022

the CTG scan, and so there was always someone around to help Leanne when needed, she still felt alone. 37-year-old mother Heleen, who lives in Amsterdam with her partner and two kids, also recognized herself in Leanne 's story. During an interview at her home on 10th February 2022, Heleen explained:

> I really wanted to do the delivery in the hospital on my own time, but everyone was ready to speed up the delivery as quickly as possible. During my delivery I was given contraction inducers and immediately after my delivery I was given a shot of oxytocin to allow the placenta to be born quickly. I really felt like a number and not seen at all.

Iris, a 34-year-old mother of two young kids, explained that her experience during childbirth was different, but that her delivery had different circumstances. In an interview at her home, she explained: "I felt taken seriously by the midwife at home and by the midwife in the hospital. But I also realized I was lying in a corridor with I believe 9 maternity suites and I was the only one there. I can also imagine that if those 9 were full I would have had a completely different feeling." All the attention and focus young mother Iris experienced during her birth made her feel heard and supported at that moment, whereas young mother Heleen sometimes missed that support and autonomy during her delivery due to the hectic schedule of the hospital staff.

Time and workload

The rush during childbirth can be traced back to the high work pressure that midwives often experience. The feeling of peace and warmth I felt when I entered the midwifery practice that I described in my vignette on March 7 [see interlude 2 on page ..], contrasted sharply with the feeling of stress and tension I experienced during this walk-in day with midwife Saskia. [22] If I have learned anything from this period of fieldwork, it is that the workload under midwives is incredibly high.[23] According to midwife Lisa, with whom I spoke extensively during the day that I joined her at the midwifery practice in Amersfoort where she works, it is not uncommon for midwives to perform multiple tasks at the same time, resulting in missed toilet visits and meals. The unpredictable physiological time of childbirth does not take into account the structured planning within the notion of time of midwives. As a result, Lisa explained that midwives often have to divide themselves between different clients and at certain times within

[22] Fieldnotes on participant observation on Marcht 7th 2022
[23] Fieldnotes on participant observation on March 7th, April 8th and April 15th 2022.

a busy period quality is raised above quantity, whereby the personal care for the client is pushed into the background and the focus is on handling the delivery quickly. In addition to their responsibilities in the hospital, midwives must meet their own basic needs such as sleep, toilet visits, food, and water, and they must maintain a personal life outside of work hours. Working in a midwifery practice, the hospital or at the client's home is one part of their lives, but in addition, midwives and gynecologists have even more obligations, such as social life, family and household. They must therefore be able to deal with physiological time within their work in maternity care, but also outside their work and within the institutional time. Moreover, due to the high workload, quality is often raised above quantity. This can make women feel unseen during labor, or after birth such as during placental birth. During the interview with young mother Heleen, she described her birth experience:

> I really wanted to do the delivery in the hospital on my own time, but everyone was ready to speed up the delivery as quickly as possible. During my delivery I was given contraction inducers and immediately after my delivery I was given a shot of oxytocin to allow the placenta to be born quickly. I really felt like a number and not seen at all.

Wanting to regulate the physiological time of delivery, as with the above experience of Heleen, is either at the expense of the midwives' workload because they are unable to plan the physiological delivery and therefore cannot adjust the time schedule accordingly, or at the expense of the woman giving birth. Due to the high workload and unexpectedness of many births, quality takes precedence over quantity, so that personal attention for the woman giving birth fades into the background.

Compassion Fatigue

The high workload among maternity care workers within the current Dutch birth care system, in which sleep, toilet visits, meals and time with the family are regularly skipped, often not only leads to physical exhaustion but also emotional exhaustion. According to Leinweber and Rowe (2010), the physical and emotional exhaustion of midwives can disrupt the bond between midwife and client, resulting in worse - physical and emotional - outcomes such as loss of a sense of autonomy during childbirth because the midwife responds less empathically to the pregnant or giving birth woman. For example, midwife Saskia, mother of two children and, in addition to her work as a midwife, also a member of the midwifery union, told me the following

during a visit at her midwifery practice: “When I am very, very tired, and I feel like going back to my kids and husband, I sometimes respond so curtly to the client. I have to admit that sometimes I feel a little less for the client. I just work a little harder. And that it doesn't bother me that much. I'm just so tired then.” Saskia explained that discussing the loss of empathy is a big taboo in midwifery care. About this, she stated: “Nowadays, there is a lot of attention for the loss of autonomy in pregnancy and childbirth but that is also a result of the system. Not a lot of people take our story into account, the story of how hard and exhausting being a midwife sometimes can be.” According to Baird and Kracen (2006), the loss of empathy stems from emotional and physical exhaustion, a phenomenon that is also called 'compassion fatigue'. In a podcast with young midwife Madyasa Vijber, who has just graduated from the midwifery academy in Amsterdam, compassion fatigue is described as: “a condition characterized by emotional and physical exhaustion, leading to a decreased ability to empathize or feel compassion for others, often described as the negative cost of care, and is the result of exposure to distressing and traumatic events.[24]” Several midwives I spoke to indicated that they sometimes found the work pressure so high that they had the idea that, due to physical and emotional fatigue, they could respond less empathically to their clients. In her podcast, Madyasa states: “Sometimes you can notice that you're just not as responsive to other people's pain or their questions maybe, or the state they are in because you simply don't have the capacity anymore.” Furthermore, as midwife Saskia also argued before, according to Madyasa, many midwives do not feel the space to talk about their emotions before, during and after the delivery of their client. She explaines that for example, midwives, and especially midwives in training, are often pointed out that they are 'too sensitive' and that little attention is paid to taking a break after a serious event or when it becomes too difficult for the midwife, physically or mentally[25]. Due to this, Madyasa explains that she experienced the transition to a birth professional as physically and emotionally intense. However, she was repeatedly told by her supervisors that she would not be suitable for the profession if she allowed her emotions into her profession. Furthermore, Madyasa states in her podcast:

> I think that we as midwives need to be so sensitive so many times and then to me it's just mind blowing that that same sensitivity is something that is seen as a very negative trait. […] The amount of times that I heard from mentors in my internship that I'm too

[24] Podcast Madyasa Vijber: Contraction II: Self Care with Madyasa Vijber, May 2021 accessed on 16 April 2022
[25] Podcast Madyasa Vijber: Contraction II: Self Care with Madyasa Vijber, May 2021 accessed on 16 April 2022

> sensitive, I could count I think on two hands. Or that I was too soft or you need to toughen up a little.

This experience of Madyasa shows that pregnancy and childbirth are often experienced as a real women's space, in which intuition, experience, sensitivity, emotions and religious teachings are values that are much return to birth care (Donnison and Macdonald, 2017 in Pendleton 2019, 630). However, as I described in Chapter 1, the shift from childbirth as a 'women's space' to a practice of male domination, in which the notion that women would not be able to give birth without the help of male experts emerged, made feeling 'emotions' during a mechanical process like childbirth inconvenient and helpful. Not feeling emotions and empathy could speed up the process of childbirth, which from this perspective, giving birth under the male gaze was an opportunity to generate income. However, the fact that Madyasa was unable to express her feelings caused her to bottle up her feelings and not feel empathy for the client anymore because this became too much for her. In her podcast she says: "If I'm not allowed to be touched by the work first, that is pressing on me. I'm also not allowed to be touched by you it's very hard to be selective in what's gonna touch you and not. So what happens mostly is that you just get very hard and get this very tough shell and you're not being touched by a lot of things."[26] Because Madyasa lost her empathy for many clients because of compassion fatigue, she also did not, or did not always take into account the wishes and feelings of the client. This also ensured that the client has a lesser chance of feeling autonomous than if the client did feel that he or she did feel heard and supported. However, the current Dutch midwifery system has a dominant male discourse in which guidelines and practices are aimed at 'fixing' things when things go wrong instead of offering emotional and empathetic support. This shift from midwifery as an exclusive domain of women to a system of male domination has resulted in it becoming subservient to men's dominant – patriarchal – beliefs about what counts as knowledge to improve childbirth outcomes (Pendleton 2019, 632).

Caseload midwifery

In response to the high work pressure and loss of job satisfaction described in the previous paragraph, there has been a development in midwifery care in recent years, with more and more midwives opting to continue as solo midwives rather than committing themselves to join a

[26] Podcast Madyasa Vijber: Contraction II: Self Care with Madyasa Vijber, May 2021

large-scale practice. According to anthropologist Stevens, time in regular midwifery practices is more often seen as routinized, controlled, scheduled and little-personalized, while for solo midwives – also called caseload midwives - time is seen more as purposeful, flexible, uncertain and personalized (Stevens 2009, 116). Midwifery caseload is defined by Offerhaus et al. (2020, 2) as: “a model in which one-to-one continuity of care throughout pregnancy, childbirth and the postpartum period is guaranteed by a single midwife, with backup provided by a partner midwife and in good collaboration with other professionals.” Within this care, a full-time caseload midwife usually provides care to about 35-45 women per year compared to an average of 100 clients per year for midwives working in a regular midwifery practice (Wiegers and Janssen 2005). Instead of providing a fixed number of hours of midwifery care, caseload midwives are committed to performing broadly specified activities - or responsibilities (Stevens 2009, 116). With the advent of the midwife caseload and the abandonment of fixed hours, a radically different orientation to time emerged, forcing midwives to redefine their concepts of time and its use (Stevens 2009, 116). Midwives can self-divide their time – to a certain extent by uncertain physiological time – and do not have to stick to fixed times, which reduces the chance of physical exhaustion. Midwife Margot, who also worked as a caseload midwife for two years, explained during our interview that she got a lot of satisfaction from her work as a caseload midwife because she had all the time and space to fill in her days herself. Margot described: “As a caseload midwife, I could determine everything myself, so I didn't have to reach a consensus with anyone about this is allowed, this is not allowed, or you have to work that many minutes or do I know a lot. Yes, I was completely free there." Working without time rules offered Margot great flexibility in her work. According to Stevens (2009, 116), the maternity service tacitly acknowledges the power it holds over those still using the traditional service by "giving back" control of time to midwives. Although physiological time is seen as uncertain and irregular and time in regular midwifery practices is more often seen as routinized, controlled and scheduled, Margot experienced more freedom. So, while strict time scheduling of work is often associated with 'efficiency', caseload midwives are able to use their time more effectively and no longer have to 'waste' it when it is quiet and there is nothing to do (Stevens 2009, 116). As a result, midwives do not have to do double work or work extra shifts when there is talk of shift change (Stevens 2009, 116). In addition to having more flexibility, Margot furthermore experienced that her time within her work as a caseload midwife was of greater value than when she worked in a regular midwifery practice. According to the midwife, this was because the use of time allowed her to build a better relationship with her clients. She stated: “In those two years working as a caseload midwife, I think I actually went through the

greatest development. Because I just had so much time with those women and could discover what was important in their lives." Furthermore, Brenda, a 40-year-old midwife who works in Amsterdam, stated during an interview at her midwifery practice that she was able to develop more as a caseload midwife than in a traditional midwifery practice. The midwife said that she has made great progress during her work as a caseload midwife compared to when she worked in a regular midwifery practice. Brenda explained: "Because I had more time with the client, I could stay with her longer and I learned a lot about the physiological process during childbirth." With this valuable knowledge, the midwife was better able to analyze and help other clients.

During my fieldwork, I spoke not only with caseload midwives about their experiences in caseload midwifery, but also with biological mothers who had consciously chosen to go to a caseload midwife instead of a regular midwifery practice. Many women I spoke to who were supervised in a regular midwifery practice indicated that they had constantly changing midwives and that they had little time and space to develop a good relationship with the midwives, which meant that they were less likely to be understood and to be taken seriously. For example, Sarah, a 31-year-old mother who lives in Rotterdam stated: "I missed that personal layer so much. And let's be honest: suddenly there is a strange person is in your house looking at you being naked and vulnerable. Even when you're in labor, it's not really that cool." This was the reason Sarah wanted to see a caseload midwife for her second pregnancy. She further explained: "During and after giving birth I really felt like a number. Everything went so fast, but I was not guided at all, especially right after she was born." Sarah found the support she needed during her second pregnancy, when she went to a caseload midwife and felt heard and supported. Sarah explained:

> It made a world of difference. At my previous practice [regular midwifery practice] I was already outside after a 15-minute consultation. Now they take their time with me and I really feel understood and heard. Sometimes it is even a kind of psychological session. Yes, I feel really autonomous.

Sarah furthermore explained that she was very pleased with the fact that she felt heard and supported, which has greatly contributed to her confidence in her body, her midwife, and her delivery. The young mother stated: "During this pregnancy they took me seriously. During the previous pregnancy I had the idea that she sometimes thought my wishes were strange." During my fieldwork I often heard from people around me - women who often had not given birth

themselves yet - that they find it strange that some people like to give birth outside the guidelines.[27] According to midwife Margot, who herself worked as a caseload midwife for a while, in an interview with me, she said about the clients she had in her practice:

They [her clients] were all very normal women who just wanted a familiar face, that's all. And of course they sometimes wanted something outside the guidelines and such, but I never really experienced that they wanted anything strange or abnormal, they just wanted to be seen and heard.

When talking about the feeling of autonomy, almost every woman I spoke to indicated that feeling seen and heard is a crucial component of feeling autonomous before and during childbirth. In caseload midwifery, the midwife's role is thus not only to ensure that mother and baby are born healthy and well, but also that they feel heard and supported before, during, and after delivery. As a result, one could argue that the body and the mind are not two distinct entities, contrary to what the technocratic birth model suggests. In addition to this argument, Davis-Floyd states that mechanizing the human body and defining the body machine as the actual object of medical treatment frees technomedical practitioners from any sense of responsibility for the mind or soul of the patient (Davis-Floyd 2001, S6). Because the biological mothers I spoke to did not feel heard or felt that the midwife was not paying attention to the woman's mental state, simply because there was no time for it, she realized that the relationship with their midwife was vital for a positive birth experience. In caseload midwives, the 'role' and 'person' of the midwife became one, making the professional/client dichotomy a reciprocal relationship in which the expertise of both the midwife and mother was valued (Stevens 2009, 122). This provided a more positive birth experience for the young birth mother, in which the way midwives used their “time” enabled midwives to meet mothers at a level that recognized and facilitated the physiological timing of labor.

The price of autonomy

Although many of the women I spoke to during my fieldwork indicated that the relationship with the midwife has been a very important factor in feeling trust towards the healthcare provider and in the ultimate feeling of autonomy and confidence in one's own body, not a lot

[27] Fieldnotes on 22 April 2022

of women chose to go to a caseload midwife. A caseload midwife often requires a much greater financial investment than a midwife in a regular practice. This has everything to do with the principle of time is money. As explained earlier in this chapter, the principle of time is money can be connected to the theory of Karl Marx (1906), who in his theory of the commodification of labor highlights that the value of time is related to the value of labor (McCourt 2009, 38). In general, the more clients a midwifery practice can support in a given time period, the more money is earned. However, as my research participants' experiences show, the more clients a midwife guides, the less space and time there is to get to know the client personally and her wishes and to build a relationship. This establishes a 'scale' between money and time. Several times during my fieldwork observational participation, I came across the principle of 'time is money.' During the interview on March 28th, midwife Margot provided an interesting insight into the relationship between money and time, demonstrating that autonomy for the mother can be bought to a large extent because a caseload midwife has more time and personal attention for the client, which has been proven to lead to a greater sense of autonomy during pregnancy and childbirth, but also requires a greater financial investment. This insight, combined with Karl Marx's (1906) commodification of labor theory, leads to the conclusion that the biological mother's sense of autonomy can be purchased to some extent while pregnant and giving birth.

In addition to the relationship between money and time for young mothers and midwives, Midwife Margot also indicates in this same interview, that among midwives, money is also seen as giving value to time that doesn't give 'satisfaction' for midwives. All the midwives I spoke to indicated that they get a lot of satisfaction from their work when they can give personal attention to the client and build a relationship with the client. Time brings value to the midwife, because it gives her satisfaction when she can build a good relationship with the client. When midwives give up their time as routine, controlled, and scheduled in order to fill it with purpose and personalization, they could experience midwifery as an even more unstructured and uncertain profession. However, not all midwives are willing and able to spend their time in an unstructured and uncertain way because, for example, they still have a family and household that they have to take care of. For example, midwife Margot explained: “I also realize that I also had that freedom [to work as a caseload midwife] because I didn't have a family, so I didn't have that responsibility anywhere, just to myself. Who cares you know. I'll be fine.” Furthermore, Margot explained that she had plenty of time to discover what works best for her as a midwife, and what gives her the most satisfaction and energy, without having to worry about giving up time or structure for her social life and partner. Moreover, Margot explained

that a midwife's motivation for pursuing a career in midwifery must be either work satisfaction or financial gain. This has to do with the fact that as a (caseload) midwife you have to sacrifice a lot. Margot told me:

> As a midwife you give so much all the time: you give up your sleep, you give up your lunch, you sometimes give up your toilet visit, you know you give so much of yourself, there has to be something in return. And the moment you don't have a relationship with the client or not as deep a relationship as I experienced it later, that becomes money.

Because of this, the valuation between time and money could be seen as a twofold: women could 'buy' autonomy because more 'time' and 'space' are bought, which reinforces the feeling of confidence in their own body and in the midwife and the feeling of autonomy. At the same time, money becomes a value for the midwife that arises when the midwife experiences no or less work satisfaction. The principle of buying autonomy has become increasingly visible in birth care over the years, owing to technocratic influences in which more and more women have lost their sense of autonomy as a result of the arrival of protocols, guidelines, and a lack of time among midwives. In the following chapter, I will examine the rise of the doula and demonstrate how the doula can assist in maintaining autonomy before and during childbirth, in order to demonstrate how the principle of buying autonomy as the consequences of loss of autonomy is visible in the current Dutch birth system.

Chapter 4

The rise of the Doula

In previous chapters I have described how our fear of death since the scientific revolution has led to a constant desire to dominate nature, which has made birth care in the Western world increasingly more of a women-centered one over the past century, space has moved towards a technocratic birth care system based on patriarchal ideas. In recent years, more and more birth activists have risen in recent years to fight against the increased medicalization of birth care, in which the woman's body is increasingly seen as a machine and as a result have lost their sense of autonomy. One such form of birth activists is the doula. According to Morton and Clift, the existence of doulas is both a criticism of the present system for not emphasizing women's emotional delivery experiences and a response to this criticism: the labor support function is an addition to the current clinical responsibilities inside the current system of medicalized birth (Morton and Clift 2014, 36 cited in Johnson Searcy and Castañeda 2022, 471). In this chapter I show how the doula could be a solution to the problem of loss of autonomy among birth mothers during childbirth in a birth care system that has growing technocratic influences. I will look more closely at the concepts of risk and time, as well as the meaning that a doula can have within these concepts and the issues that have arisen as a result of it. Furthermore, I show that, as with the caseload of midwifery, the doula asks for a financial investment, which makes me argue, as in Chapter 3, that time can be bought to a certain extent.

Introduction to the doula

As previously described in Chapter 1, before the medicalization of childbirth in industrialized countries, women supported each other during labor and the postpartum period, and in different cultures and times, other women were present during labor to support women during this process. support (Johnson Searcy and Castaneda 2022, 469). While this woman-to-woman support in high-income countries has virtually disappeared since the scientific revolution, over the past 20 years there has been an increasing demand for someone who guides the birth emotionally rather than physically: the doula. A doula, Greek for 'serving a woman,' is a birth coach who helps the pregnant woman and her partner before, during, and sometimes after birth (Hunter 2012). Doulas offer a listening ear after the birth to help process it. According to

midwife Margot van Dijk, the doula ensures the birthing woman feels safe and familiar. Doula and mother Leanne explains during an interview that there are different types of doulas. About this she says: “I think every doula has his own thing. There is a kind of doula that suits every woman.” For example, Leanne describes that there are doulas who focus on the physiological process of childbirth, doulas who focus on the mental aspects of childbirth and even doulas who are there to support the partner of the giving birth. According to medical anthropologist Hunter, doulas provide physical and emotional support, education, and advocacy (Dona 2005 via Hunter 2012, 316). Young mother Nikki indicates during an interview at her home in a conversation about the difference between the midwife and the doula that more time was spent on the physical, but also especially mental and emotional process before and during the birth. Nikki states: “With my doula Caroline, I immediately felt so familiar. She asked all kinds of questions that made me think more deeply about my birth wishes. Questions that my midwife had never asked, but in my opinion were important.” Nikki experienced her birth as extremely positive, partly thanks to the support of her doula. She describes the doula's arrival during her birth: “I was suddenly able to step into a deeper layer again. I felt her hand on my shoulder and then I felt like: Yes, there she is.. It was really a support. It really felt a bit like coming home or landing. We were finally complete.” The special bond Nikki had with her doula created intimacy and trust, allowing Nikki to relax and have confidence in her environment and her own body.

The doula and the risk society

As mentioned in chapters 1 and 2, the female body in the ‘Western’ world has been portrayed as pathological and flawed since the scientific revolution, requiring external intervention during childbirth for all women. As previously substantiated by ethnographic data and literature, pregnant women are taught about the potential risks of childbirth and encouraged to accept the medicalized nature of childbirth (Hunter and Hurst 2016, 2). In contrast to this view of the female body, according to Hunter and Hurst (2016, 2), the doula considers the female body to be inherently capable and resilient during childbirth, and doulas claim that normal birth does not require medical intervention (Hunter and Hurst 2016, 2). Furthermore, Regan et al. (2013) argue that women who are unable to articulate the benefits and risks of medical interventions because they are not aware of the benefits and risks of these interventions, are unable to fully understand the potential consequences of making these choices (Regan et al.

2013 cited in Hunter and Hurst 2016, 44). The doulas' role as educator is defined by Gurevich (2003) as helping women to be informed about various options, including the risks, benefits, and associated safety precautions or interventions (Gurevich 2003 in Hunter and Hurst 2016, 3). By engaging a doula, these benefits and risks of medical interventions can be discussed on a physical and emotional level, allowing women to be better prepared for childbirth and able to make more informed choices when a potential complication presents itself. Nikki, a young mother, also experienced that her doula could teach her a lot about the potential benefits and risks of interventions, as well as make her aware that all scenarios are possible during childbirth. Nikki explains: "A midwife asks: 'where do you want to give birth? At home or in the hospital?' Well, I wanted to give birth at home. But Caroline [Doula] asks: Yes that's all right, but shall we make a plan from A to Caesarean section?" Working out a birth plan when Nikki's preferred scenario would not be possible due to complications made Nikki, as she says, aware of all her options, boosting her confidence in herself as well as her doula Caroline. In addition to creating a well-thought-out birth plan, Doula Leanne says that a doula can work through certain traumas incurred during previous births. In an interview with Leanne, she indicates that her clients are women who especially do not feel supported or heard during pregnancy or during their previous birth. Leanne says about this:

> I get a lot of requests from women who have been through a trauma or a particularly unpleasant experience. They sometimes think the delivery is satisfactory, but they are also aware of some things they would change. A lot of women feel so lonely during birth. Particularly when they are simply sitting with a regular caregiver.

Loneliness, according to the doula, is a common reason why many women consider hiring a doula. Because a doula has the time to mentally guide the woman, discuss all of her options and wishes, and assuage her fears, she provides direct and personalized care rather than one-size-fits-all care, increasing the likelihood of a more autonomous delivery.

A cure to one-size-fits-all

As described in Chapter 3, the conflict between the current notion of time – also referred to as institutional time – and the physiological time of the female body and childbirth means that we are increasingly trying to control childbirth through technological interventions to in this way

to be able to structure, routine, plan and control childbirth more and more. With the attempt to control the unpredictable duration of labor through medical interventions, women can feel that they are the direct object of the labor, rather than that she is leading the labor that forces the woman through our cultural perception of time and may therefore feel less autonomous. Although more and more midwives are deciding to continue as caseload midwives so that the midwife can provide more personal care to her client and so that both the client and the midwife have a higher labor and work satisfaction, not every caseload midwife has the time and space to give birth to women while also providing physical and medical support. In the conversation with doula and young mother Leanne it became clear to me that the role of a caseload midwife cannot be compared to a doula. For example, Leanne told me that prior to her delivery – when she was not yet a doula herself – she thought that if she chose a caseload midwife, instead of a regular, larger midwifery practice, she would not need a doula because she thought that the caseload midwife would fulfill all her mental and physical needs. However, this turned out not to be the case for Leanne. Leanne stated: “A (caseload) midwife is alone, and a lot happened during my delivery. And then she can't do the medical stuff and be there for you all mentally. And you can't expect that from your partner either.” The caseload midwife and doula differ significantly in that, while the caseload midwife already guides far fewer pregnant women to improve the quality - personality - of the guidance, the doula guides far fewer pregnant women to meet all of the pregnant woman's and her partner's wishes and options in order to generate the most positive possible pregnancy and delivery. According to mother and doula Leanne, doulas see a pregnant woman over a longer period of time, and they make a personal plan with their client in which they can map out all the wishes and options with their client. As Leanne described: “As a doula you really tune in to the client, that is really the biggest difference with midwives and gynecologists. You really work 1 on 1 with your client. So yeah, you can't have 4 clients per month.” The differences between a midwife and a doula were also discussed in a conversation with 40-year-old doula Femke, who has been working as a doula for 2 years in an near Amsterdam. For example, she explains that both caseload midwives and midwives who work in a regular midwifery practice guide their clients a number of times per pregnancy and the consultations last between fifteen minutes and an hour. Doulas can arrange where to meet with the client, which may also mean that the doula can come into the client's safe home environment, allowing for a more intimate observation of the client's personal situation. Where midwives are hospital insiders and have a clinical view mediated through the use of medical technology such as ultrasound machines, doulas are hospital outsiders, enabling them to fully focus on the emotional and psychosocial needs as they not being able to interfere with any

physical problems (Hunter and Hurst 2016). In addition, where midwives are tied to the working hours of their shift, according to Femke, doulas are available much more flexibly. As the doula states on a flyer for her doula practice:

> I am personally 24/7 available for you. During your pregnancy we have email, app and telephone contact, sometimes even in the evening. These are often short conversations with a small question, I am curious how you are doing and you sometimes ask me a question that you would not quickly call your midwife or gynecologist. There are no strange questions for me as your doula and for me it is a small effort to text you back.[28]

As previously described in Chapter 3, the current Dutch birth system is geared towards structuring, routinely, planning and controlling time, accepting it as the 'norm' for midwifery work, whereas birth and pregnancy are in origin not institutional but physiological. By always being available to their client, doulas counteract the friction between our current notion of time in which structuring, routine, planning and controlling are paramount, and they focus more on the physiological time of pregnancy and the personal needs and wishes of the client. The doula can therefore contribute to the feeling of autonomy in a young mother (to be) in a different way than (caseload) midwives.

The fault lines of doula

Although the doula can provide mental and physical support for many women, which could contribute to a sense of autonomy, there are also several tipping points. During the interviews I conducted with various young biological mothers, it emerged that many young parents, among others, do not opt for a doula because this requires a large financial investment. According to doula Femke, the costs of a doula are between 500 to more than 2000 euros. Similar to a caseload midwife, a doula spends a lot of time with a client and works irregularly because the start and end time of a delivery is often unplanned. As a result of this professionalization, an already exclusive service has become a "luxury service," with excluded socio-economic groups having even less access. Midwife Margot explained in her masterclass about the problems in the current Dutch birth culture that many doulas therefore desire to be reimbursed by health insurers, so that the doula becomes more available and accessible to more

[28] Flyer Doula Practice Femke. “Op Zoek Naar Een Doula?” Accessed on 3 April 2022

people from other socio-economic classes. During the masterclass, however, Margot expressed her concerns about the possible consequences of involving health insurers, because health insurers could interfere with the doula's profession as a result. For example, Margot explained in this masterclass that the KNOV trade union[29], which has been completely deregistered from the Royal Dutch Organization of Midwives, wanted to introduce a quality mark to guarantee the quality of doulas. About this, Margot said: “I also find that dangerous because then you also get a lot of guidance from midwives there. And I think that's exactly where we shouldn't get our finger in the pie.” So, while the doula's reimbursement in the basic health insurance package could ensure that more women have access to a doula, and thus increase the chance of a large group of women's sense of autonomy, it also increases the risk for doulas themselves to lose their sense of autonomy. In addition, according to Adeleke (2007, 49), health insurance is a technique for controlling and managing health risks, whereby the quality of health is guaranteed. However, the use of a quality mark or quality requirements for doulas, due to the guidelines and protocols that may emerge as a result of this, can contribute to the loss of personal care for the pregnant biological mother.

[29] The Royal Dutch Organization of Midwives (KNOV) is the Dutch professional organization of and for midwives.

Conclusion

Within the Dutch birth care system, there has been a shift from childbirth as a true women's affair to a birth care system with growing technocratic influences, in which medical birth rituals offer guidance in times of uncertainty and high work pressure for many midwives, but also for biological mothers. However, 1/3 of these medical birth rituals are not scientifically substantiated. The other 2/3 of the actions are culturally determined and passed on. However, rituals can ensure that the midwife habitually performs certain interventions without consulting the client, so that there is no informed consent and the client in question has no influence in the decision-making process. Even though childbirth in the Netherlands is physically safer than ever, resulting in minimal maternal and infant mortality in this century, a high percentage of women feel that they have lost autonomy over their childbirth, which can lead to a negative, or sometimes even traumatic childbirth experience. A contribution to a healthier maternity care system is therefore also a contribution to the position of women and people in our society.

This research examined the influence of medical birth rituals through the lens of young birth mothers, midwives, and doulas. Through ethnographic methods, this thesis aimed to answer the question: *How is the sense of autonomy of young biological mothers related to medical birth rituals formed in the context of the Dutch birth system and its growing technocratic influences?* Presenting the technocratic birth system as a system that only affects pregnant women and mothers during labor falls short in presenting the socio-cultural context of the system that is deeply rooted in our society in which concepts such as time and risk have a major influence on medical rituals in birth care. The aim of this thesis was therefore not only to investigate the influence of medical birth rituals on the sense of autonomy of young mothers, but also to offer an anthropological lens to the midwives and doulas in our current Dutch birth system with its growing technocratic influences to see how these technocratic influences have an effect on the emergence of medical birth rituals.

This study was not intended to criticize medical rituals within Dutch birth care. It would be unfair to criticize medical rituals because they would provide midwives and doctors guidance and security within the medical field due to the high work pressure and uncertain aspects of the profession in today's risk society, which arose from patriarchal influences and our constant desire to dominate nature through medical technologies since the scientific revolution. It is

important to emphasize how patriarchal influences, the constant urge to dominate nature, and capitalist practices have ensured the growth of technocratic influences within the Dutch birth system. Ultimately, medical rituals are formed out of necessity to deal with uncertainties within our notions of time and risk, which arise from these same patriarchal influences, constant urge to dominate nature and capitalist practices. Medical birth rituals, including protocols and guidelines, provide a foothold for midwives and doctors because due to these technocratic influences, they have become increasingly responsible for death. Paradoxally, even though shared responsibility would reduce stress for doctors and midwives, women are not trusted on their own intuition in the technocratic birth system due to protocols and guidelines. While more one-on-one time with the midwife may help pregnant women and women in labor gain confidence in their intuition and knowledge, giving them a better idea of what medical ritual options would suit them during labor, it comes at a cost. Because, while 'time' and 'space' can be bought in the form of a caseload midwife or doula, which can increase the young biological mother's sense of autonomy, this requires a financial investment, which allows us to argue that certain socioeconomic groups are less likely to experience a sense of autonomy during childbirth. It is therefore impossible to imagine the sense of autonomy in the current Dutch birth system with its growing technocratic influences outside of capitalist practices. However, while doula reimbursement in the basic health insurance package may ensure that more women have access to a doula, it also increases the risk of a large group of women losing their sense of autonomy. It also increases the risk of doulas losing their sense of autonomy because health insurers may interfere with the doula's profession as a result. Thus, medical rituals have a significant impact on biological mothers' sense of autonomy, as they can cause the mother to feel disconnected from her body. Medical rituals, on the other hand, could provide a foothold and security within the current notions of risk and time for midwives, and while a shift toward greater maternal responsibility and the provision of more one-on-one care during pregnancy and childbirth could provide a greater sense of autonomy for both the pregnant woman and the midwife, the principle of time is money means that buying autonomy is not for everyone. Making 'time' and 'space' available to everyone can lead to a loss of autonomy for the midwife and doula caseload, reducing the autonomy of the pregnant woman and young biological mother.

Although this thesis has its roots in anthropology and therefore cannot conclude on a physiological or medical basis, I can state through my collected ethnographic data that medical birth rituals do have an influence on the mental health of both the pregnant woman and the

biological mother during and after childbirth. Although medical birth rituals can contribute in many ways to the sense of autonomy for both the pregnant woman, the woman in labor, and the midwife, these rituals can also make women feel that they are a product and that their bodies function like a machine. I therefore envision the Dutch birth care system in a vicious circle, fueled by patriarchal ideas, capitalist practices, and our growing fear of death.

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