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# A MIDWIFE IN THE NORTH COUNTRY

By Emily Bobrow December 22, 2019

The sun was still rising on a brisk Monday morning in October last year when Sunday Smith, a midwife in New York's North Country, pulled into the gravel driveway of a small dairy farm, scattering some chickens. She had driven for about ninety minutes, along dark country roads, for a prenatal appointment with Jennifer, who was twenty-nine weeks pregnant with her fourth child. At the front door, an Australian cattle dog named Tickle enthusiastically greeted Smith, followed by Jonathan, Jennifer's husband. The entire family gathered in the wood-panelled den, with finger paintings on the walls and cartoons flickering on a big television.

Smith took Jennifer's blood pressure and checked the baby's heartbeat, using a handheld Doppler fetal monitor. As Smith scrolled through her medical files on a tablet, Jennifer and Jonathan explained why they planned to deliver their child at home. Their experience at a hospital for their first child wasn't "horrible," Jennifer said, but it struck them as needlessly stressful and intrusive. Her labor had stalled in the hospital; the problem, she suspected, was that she was tethered to her bed by a fetal heart-rate monitor, which uses belly bands and an ultrasound machine to follow a baby's heart rate during contractions. Jennifer wanted to work through the animal pain of labor by moving around, maybe taking a shower; when the time came to push, her instinct was to squat, or bear down on her hands and knees. But hospital protocols fixed her on her back, with her legs spread. Jennifer believes she narrowly avoided a Cesarean section only because of a turnover in staff; the hospital's midwife was the one to catch their child.

"I was dumbfounded," Jonathan recalled. "I've delivered hundreds of calves. If I poked and prodded a cow as much as she was poked and prodded, a calf would never come out. It's just not natural." Jennifer's next two children were delivered by an unlicensed midwife, who has since moved to another state.

*One of fifty-seven newborns whom Smith delivered this year.*

Smith has worked for the past two and a half years in the North Country, a sprawling, sparsely populated area that stretches from the Erie Canal to the Canadian border. The area's Adirondack Mountains pull in some tourists, but not during the long, cold winters. There are a number of colleges, but the students mostly come from elsewhere; otherwise, the population is largely poor, white, and aging. The biggest employer is the Fort Drum military base, which makes the nearby city of Watertown lively enough to include a zoo and a couple of country clubs. Local jobs in mining and manufacturing have been drying up in recent decades, which has helped make the unemployment rate one of the highest of any region in the state. A glut of affordable farmland has lured Amish and Mennonite families, marking a rare source of growth in the region. Traffic signs for tractors and buggies pepper the quiet roads, which are dotted with weathered barns and small churches.

Jennifer was the first of five house calls that Smith had scheduled in the westernmost reaches of her territory, over seventy miles away from her home in Potsdam. Her clients in this area tend to be either Army wives in prefab homes or devout Christian farmers with big families of homeschooled children. Some days, Smith drives thirty-five minutes north to see mothers on the American side of the Akwesasne Mohawk reservation. Other days, she drives ten minutes west to see undocumented Central American women in a trailer on a three-thousand-acre commercial dairy farm. She has delivered a couple of their babies, but mostly what these women want from her are birth-control shots, because getting pregnant could cost them their jobs.

Smith is forty-nine, and she dresses like someone who often gets ready for the day in the dark: black fleece, blue Dickies, clogs. Her hands are large and expressive, and her hearty laugh has a telltale rattle, a souvenir from her years as a smoker. Driving from appointment to appointment, she was especially alert every time her phone rang—five of her clients were within a few weeks of their due date. On this day, though, the calls were mostly from clients with general questions, such as whether it was O.K. to go swimming in a river in the third trimester (yes, but only if you avoid hot tubs and

remove your swimsuit immediately afterward, to avoid infection). On the dashboard of Smith's Subaru was a baggie filled with herbs that soothe tender perineal tissue which she calls "vagina tea." By the time she made it back home that night, she'd travelled more than a hundred and fifty miles.

*Smith leaves the home of an Amish patient who had suffered a miscarriage.*

Sunday Smith is likely the only certified nurse-midwife offering out-of-hospital births in a hundred-mile radius, and her services are in high demand. Many of her clients see her as the surest way to avoid a C-section: the two hospitals closest to her home—Canton-Potsdam Hospital and Claxton-Hepburn Medical Center—have C-section rates of 51.3 per cent and 47.5 per cent, respectively. (The national average is thirty-two per cent; less than twenty per cent are medically necessary, according to a 2015 study in the *Journal of the American Medical Association*.) Other clients, like Jennifer, want to avoid a hospital birth because of a previous experience, and plenty are happy to try to dodge a hospital bill. One couple that was uninsured told me that they had to pay around twelve thousand dollars "just for a normal, no-problem vaginal birth" at the nearby Samaritan Medical Center. They prefer Smith's lump sum of three thousand dollars plus gas mileage, which covers all prenatal visits, a home delivery, and six weeks of postpartum checkups for mother and baby. Smith gives a discount to those who pay in cash.

Smith, her husband, and her two children, who are now fourteen and eleven, used to live in Indianapolis, where she worked as a midwifery resident and nurse at an urban hospital. On a typical day at the hospital's clinic, she treated around twenty women, and she was never sure that she would see any of them again. When women came to the hospital to deliver, she was often meeting them for the first time. Smith sensed that most laboring mothers needed only time and some coaching to push a baby out, but those things were hard to come by in an often crowded hospital, where beds needed to be turned over. The women were tethered to monitors, so that short-staffed nurses could track their progress remotely. "Many midwives' hands were tied by staffing ratios and protocols," Smith said. "Watching, but not intervening, takes so much time." Smith recalled one obstetrician telling her that no one ever sued him for performing a C-section.

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The Comforting Fictions of Dementia Care

In many wealthy countries, midwives assist most births, leaving obstetricians to handle only the complicated cases. But, in the United States, midwives attend only around ten per cent of births, as opposed to close to three-quarters in France and more than half in the United Kingdom. Half of U.S. states limit the role midwives can play as autonomous providers—a vestige of a time when doctors pressed for a monopoly in obstetric care, beginning in the late nineteenth century. Physicians, who were mostly men, regularly accused midwives, who were mostly women (and often immigrants or black), of crude, unsanitary, and potentially fatal practices. A letter about midwives in the *Maryland Medical Journal* in 1895 expressed a need to "drive these unclean murderers out of their unlawful business." Joseph DeLee, an influential obstetrician, declared in 1915 that midwifery was a "relic of barbarism" and described childbirth as a "pathological" event that required forceps, sedatives, and, often, heroism.

Although most midwives lacked formal training, they had better mortality statistics than general physicians in the early twentieth century, according to federal records. Yet states, bowing to pressure from an increasingly well-organized medical establishment,

began either outlawing midwifery or introducing requirements that effectively banned most practitioners. By 1940, nearly six in ten births in the U.S. took place in a hospital under the care of a physician. By 1970, this number rose to more than nine in ten.

*Thank-you cards, in Smith's home office.*

*Smith outside her home, in Potsdam.*

Midwives in America are further disadvantaged by a profit-driven, fee-for-service system of health care, which doesn't align with the watch-and-wait approach of a typical midwife-assisted birth. "The midwifery model of care is very time-intensive, and no one's paying for time," Laura Zeidenstein, the director of the Graduate Midwifery Program at Columbia University, said. Maternity wards are uniquely costly to run, as they need to be staffed and equipped like intensive-care units, while the uncertainty of labor makes it impossible to know when patients will come and go, or what their needs will be. As a result, uncomplicated vaginal births are often money losers. Larger hospitals can subsidize them with interventions (ultrasounds, inductions, epidurals) and neonatal intensive-care units, which are lucrative. But the thin margins of childbirth, together with declining birth rates and rising costs, have forced many labor-and-delivery units in smaller hospitals to shut down. Nearly half of U.S. counties don't have a single practicing obstetrician-gynecologist. The unprofitability of vaginal births, and the fact that insurers often pay midwives less than physicians for equivalent services, has also meant that few midwives can afford to be in private practice unless they refuse in-network insurance, partner with an obstetrician, or both.

Meanwhile, the national C-section rate has gone up by at least sixty per cent since 1996. The awkward economics of hospital-based childbirth bears some of the blame. Neel Shah, an assistant professor of obstetrics and gynecology at Harvard Medical School, notes that, in cases where space in a maternity ward is tight, staff is short, and a mother has been pushing for hours without making progress, "the low-resistance pathway is just to do a C-section." C-sections not only expedite childbirth and reduce some of the uncertainty involved in labor but also earn hospitals around fifty per cent more than vaginal births, as they require more billable treatments and longer hospital stays. "We've designed the system backwards, so that it's set up for the most intense

types of treatment," Shah said, "and we're poorly resourced to do some of the things that really matter to people, like supporting them through the actual process."

State regulations that curb the work of midwives appear to influence perinatal outcomes, according to a study published in the journal *PLOS One* last year. Researchers from the U.S. and Canada mapped out the relationship between federal maternal-newborn statistics and state-level laws for where and how midwives can practice and how they get paid. They found that states that offer greater access to midwives see significantly higher rates of spontaneous vaginal delivery and significantly lower rates of C-sections, preterm births, babies with low birth weights, and newborn deaths.

Yet practicing midwives remain thin on the ground. There are thirty-seven accredited education programs for nurse-midwives across the country, but they receive so little federal support that many have to refuse applicants. Medical students spend years as paid hospital residents because the federal government invests heavily in their education, spending sixteen billion dollars in 2015 alone. Midwifery students, however, have far shorter spells as hospital residents, and it often comes at their own expense. "I am begging every day for hospitals to take a student," Zeidenstein said, "because they get no money for it."

Just before sunrise on the morning after she saw Jennifer, Smith pulled up to the small, wooden house of an Amish family in Parishville, twenty minutes west of Potsdam. She was visiting a woman named Savannah, who was thirty-two weeks pregnant with her second child. Past a narrow kitchen cluttered with crates of rice and apples, Smith sat on a creaky wooden rocker in a living room decorated with plaques bearing religious proverbs. When it was time to listen to the baby's heart rate, Smith used a tool called a fetoscope, which looks and works a little like a stethoscope. With Savannah on her back on a couch, Smith guided the device around her belly. After a moment's silence, she said, "Oh, here we are, loud and proud—can't miss it." As Smith offered the earpieces to Savannah's bearded husband, Nathaniel, she warned that the sound would be subtle, "like a wristwatch under a pillow." He listened closely, with eyebrows furrowed, and then broke out in a wide smile.

Around half of Smith's caseload is made up of Plain women—Amish and Mennonite. They are typically very poor and uninsured, but also young and healthy, making them

good candidates for a home birth. Although they qualify for Medicaid, Plain people decline government assistance. Many who might otherwise have had their mother or sister catch their babies at home are now coming to Smith, in part because word has gotten around that she is willing to be creative about her fee. One new father paid his bill by laying tile in her basement. Another trimmed the trees in her back yard. Smith helped an elderly woman with a prolapsed bladder in exchange for fresh bread. She already has too many quilts.

Smith learned how to use a fetoscope out of respect for clients such as Savannah, who tend to be skittish about anything that seems needlessly medical or newfangled. Plain women are also wary of pharmaceuticals, so Smith has schooled herself in evidence-based nutritional herbology and uses a number of holistic remedies for common problems: coconut-oil suppositories can help prevent vaginal tearing, a mix of cotton-root bark and other herbs can help induce labor, and evening-primrose oil can help soften the cervix in the days and weeks before a due date. Smith has noticed her Plain clients are more open to the prospect of a medical intervention if she has already experimented with a tea or poultice first. "It's a trust thing," she said.

Once, Smith told me, an Amish client was so reluctant to allow Smith to use a Doppler during childbirth that she waited until she was ready to push before she called to say she was in labor. In the twelve minutes it took for Smith to arrive, the mother had pushed out her child's buttocks and testicles, the baby having moved into a breech position in the days since their last appointment. Smith called an ambulance for backup, got the tired mother on her hands and knees, and managed to wrench the baby up and out. By the time the rescue team of volunteer firefighters arrived, minutes later, Smith was able to turn them away. (She visited the firehouse the next day with coffee and doughnuts to thank the crew for their time.)

*A new mother who lives on the Akwesasne Reservation, near the Canadian border, holds her newborn as her partner, a doula, and Smith assist.*

Smith has attended a hundred and eighty births since moving to the North Country, and the vast majority went according to plan. Several, she said, were what she calls "butter births," in which everything goes so smoothly, even peacefully, that it can seem like a mother "just melts her baby out." So far, nine per cent of Smith's clients have had

to transfer to a hospital while in labor, and only one was an emergency (another breech birth). In most cases, she said, her clients simply needed an epidural and some rest before they resumed laboring. Yet many of these transfers were surprisingly unpleasant, particularly when she was first starting in the region. She recalls one client who labored for fourteen hours and then "ran out of steam" when it was time to push. Smith drove her to the nearest hospital for some pain relief, but the physician on call whisked the woman to the surgical suite for a C-section. This rattled Smith, but she learned that several local hospitals were skeptical of home-birth transfers because a local midwife, who is no longer working in the region, often waited until it was almost too late before bringing clients in. "I have some bridge-building to do," Smith said.

Although demand for home births is slowly rising among women in developed countries, good data on their safety are rare. In Britain, a health-advisory body has found that low-risk mothers are just as safe, and are less vulnerable to interventions and related complications, when they deliver with a midwife outside of a hospital. Although nearly half of first-time mothers in Britain who intend to deliver at home end up going to a hospital (for women who have had a baby before, the transfer rate is closer to ten per cent), clear protocols and effective collaboration between midwives and doctors limit the risks involved. A similar situation holds in Canada, the Netherlands, New Zealand, and everywhere else where midwives play a central role in the delivery of obstetric care.

In the U.S., however, the medical establishment takes a mostly dim view of home deliveries, which make up less than one per cent of the country's births. Part of the problem, according to Katie Sigler, a hospital-based certified nurse-midwife in New York City, is that the only exposure most doctors and nurses have with these births are the urgent cases that end up before them. "If every home-birth midwife called the hospital every time she had a woman in labor to say she may have to transfer, and then called back hours later to say that everything went great, people would have a better sense of how successful most home births are," Sigler said.

According to Zeidenstein, between fifteen and twenty per cent of mothers who plan to deliver at home will need medical help of some kind, whether it is an ultrasound, a consultation with an obstetrician, or a hospital transfer in labor. If a midwife has an adversarial relationship with local hospitals and providers, it increases the risk that she

will keep a birthing mother at home too long in an emergency. A 2016 study in the *Journal of Perinatal Medicine* found that babies in the U.S. were twice as likely to die when women planned to deliver at home.

Smith understands the concerns of hospital staff, having trained in a hospital herself. Labor-and-delivery wards have to accept everyone, which means they handle many women who are sick and overweight, with high blood pressure and complicated pregnancies. This can distort their view of the risks involved when a mother is healthy. "They've seen it all," she said.

*Smith sifts through closed accounts of clients, in her home office.*

*A pair of umbilical-cord scissors and curved forceps, in Smith's home.*

To help streamline transfers, Smith has been visiting area hospitals to give presentations to health-care providers about her practice and bring doughnuts for the nurses. She explains that she is not some "witch doctor going rogue" but a trained medical professional, and she seeks guidance for how she and the hospital staff can work together as a team. She shows them studies indicating that midwives lower costs and improve outcomes for most low-risk mothers and babies. She boasts that the American College of Nurse-Midwives, a professional association, has singled out her practice for its high breastfeeding rates, low preterm-birth and Cesarean rates, low costs, and high rates of patient approval.

She learned the value of a sales pitch from her previous careers: she has sold wedding-photography packages, car parts at Sears, Mary Kay cosmetics, and medical-conference plans. This was before she and her husband, who was a chef, lost their jobs in the financial crash and had to sell their home in Illinois; before she decided to go to college, at the age of thirty-eight, with a toddler and a baby at home, to become a midwife. Before all of that, she told me, she understood that making a sale required instilling a sense of confidence in a product. "What I'm selling now is that you can trust this process, you can trust your body, you can trust my judgment, and you can feel safe with me."

Smith is the sole earner in her family. When she went back to school, her hours were so punishing that she and her husband agreed that he should stay home with their kids. "We had to ask ourselves, are we going to be at each other's throats, or are we going to be poor?" Smith said. "We decided to be poor." Their margins are tight. Many of Smith's Plain clients are reluctant to pay for certain tests and supplies, so Smith covers some costs herself. Because she works in a rural area in one of the poorest counties in the state, Smith had hoped some of her hundred and seventy-thousand dollars in student loans would be forgiven by one of several federal and state programs designed to attract health-care workers into underserved parts of the country, but such programs do not apply to anyone who is self-employed. She is resigned to the idea that her loans will probably outlive her.

Few home-birth midwives can support their practices with what insurers pay them, and some insurers refuse to recognize out-of-hospital births at all, so women typically pay for home births out of pocket. This is why most home-birth providers are clustered in urban areas, where there are more people who can afford what is often a hefty bill. In the North Country, few have the funds for serious discretionary spending, but Smith doesn't want to refuse any good candidates. Her services are "for healthy women, not wealthy women," she said. But she still needs to pay her rent.

*Smith examines a client during a prenatal visit, while the client's twenty-month-old daughter, whom Smith also delivered, looks on.*

Smith used to bill for everything all at once, at the end: the prenatal appointments, the delivery, the postpartum care. But then a couple of uninsured women saw her for all of their prenatal checkups, gave birth without her, and then stiffed her on the entire bill. A couple more clients kept whatever reimbursement they received from their insurance companies instead of forwarding the sum to Smith. Some were surprised to learn that their insurers paid out so little, and then failed to make up the difference. These cases were instructive. Smith's contract has become stricter: she now asks for deposits from nearly everyone who is not on federal assistance and not Plain. Although her fee is a fraction of the more than eighteen thousand dollars commercial insurers pay, on average, to hospitals for a vaginal birth, some clients have to pay more out of pocket with her than they would have if they delivered in a hospital. The problem, Smith explained, is that she is always out-of-network, partly because she doesn't carry

malpractice insurance, which would cost a prohibitive twenty-seven thousand dollars a year.

Most of Smith's non-Plain mothers are on federal assistance, and Medicaid often pays poorly, when it pays at all. She would rather not think about all of the time she has spent filing claims and counterclaims and then appealing decisions before the claims time out. One popular Medicaid managed-care company in the region covers around half of her fee, but sometimes none of it, without explaining why. If she transfers a client to a hospital, this Medicaid insurer pays the hospital the full fee, and she is paid nothing. She wonders if this approach to reimbursement encourages some midwives to waste precious time in an emergency, trying to fix things at home. She has started guiding her Medicaid clients toward a particular managed-care company that pays more reliably than others. Smith said that she sympathizes with how complicated it all is for patients, as she used to qualify for Medicaid herself.

*Smith on the road.*

As Smith makes a name for herself in the North Country, she is getting calls from farther afield. Women are reaching out from towns two hours from her home. It makes financial sense for Smith to fill up her calendar as much as possible. But the sprawl of her territory sits uncomfortably with the unpredictability of childbirth. On a few occasions, she had two babies "bump into" each other. To still be on the road when a woman is ready to push, she said, is "not a fun drive."

Smith has cultivated assistants—three midwives-in-training and two doulas—in different pockets of her territory who can reach her clients quickly in the event that she is tied up. She dreams of one day opening an accredited birthing center, perhaps one that has a relationship with a nearby hospital. State regulations vary widely between states, and are especially tight in New York, which has only three freestanding birthing centers: two in Brooklyn, one in Buffalo. In the meantime, she has set up a birthing suite in her own home, which she can do as an accredited midwife. Clients come to her to deliver if Smith is concerned about rivalling due dates or if their homes are too far from a hospital.

As 2019 draws to a close, Smith has caught fifty-seven babies. The first of the year was Jennifer's. Smith arrived at Jennifer's farmhouse just after 10 P.M. on January 6th, carrying a birthing stool and her kit: antibiotics, oxygen, Pitocin, a speculum. The lights were dim, and the three children were asleep upstairs. Jennifer's husband, Jonathan, was rubbing his wife's shoulders. Smith timed contractions, checked the baby's heart rate, and suggested positions. (One of her favorites is the Captain Morgan, in which the mother leans against a leg raised on a stair or a stool.) But, for long stretches, Smith sat quietly in a corner, knitting. She is always vigilant during a birth, she said, but she believes it helps her clients to see her calm, the click-click-click of the needles complementing the deep breathing required in labor. Jennifer said later, "Sunday's there without being a huge presence if you don't want her to be."

Just before 1 A.M., and after about fifteen minutes of pushing, Jennifer delivered an eight-pound, eight-ounce boy, chubby and hale, whom she and her husband named Isaac. "That was a butter birth," Smith said. "She just followed everything that her body is supposed to do."

*Emily Bobrow, a former editor at The Economist, is a writer in New York.* *Read more »*

## Video