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RESEARCH ARTICLE

Authoritative knowledge of childbirth and obstetrics: analysis of discursive practices of Russian perinatal specialists

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Abstract

The article discusses discursive practices of official and alternative perinatal specialists: obstetricians and gynecologists, midwives of maternity hospitals, domestic midwives and doulas. To analyze these practices, the author uses the notion of *authoritative knowledge* proposed by Brigitte Jordan and dating back to the *power-knowledge* concept by Michel Foucault. The author focuses on controversial but widely used concepts such as *obstetric violence* and *natural childbirth*. Additionally, the author regards such relatively new for the Russian community concepts as *humanization of childbirth, obstetric model*, *demedicalization of childbirth*, etc. The study is based on the materials of the founding conference of the professional non-profit association *Obstetric Union*, which was held at Moscow Perinatal Medical Center *Mother and Child* on November 30 – December 1, 2019.

Keywords

authoritative knowledge; discursive practices; medicalization of childbirth; obstetric aggression; natural birth; model of continuous obstetric support; humanization of obstetrics

JEL codes: I1

1. Introduction

1.1. Birth care in modern Russia: The consequences of reforms and new challenges

Health care reforms, which continuously took place throughout the post-Soviet period, led to significant but controversial changes in the Russian obstetrics system. On the one hand, the system became more commercialized (paid services were introduced in state maternity

hospitals, private maternity hospitals were opened across the country, etc.), and on the other, it faced an increase in bureaucratic and state control, expressed in additional forms of reporting, threat of criminal prosecution for a medical error, etc. (Rivkin-Fish 2005; Temkina 2014; Novkunskaya 2019; Litvina et al. 2020). The programme of birth vouchers (2006), which could be used at prenatal care centers, maternity hospitals and children's clinics, aimed at increasing the financial interest of medical institutions in attracting patients. The statement on informed voluntary consent (Art. 20 of Federal Law No. 323-FL of 21.11.2011 "On Basics of Health Protection of the Citizens in the Russian Federation") allowed women to officially refuse ineligible (in their own opinion) medical manipulations. In recent years, the practice of labour companionship has spread significantly (in accordance with Art. 5 of Federal Law No. 323-FL, a woman can request the presence of the child's father or of other family member at child delivery, even if it is carried out within the state programme of Compulsory Medical Insurance). Currently, 30% of babies in Moscow and over 70% in some maternity hospitals in Moscow and St. Petersburg are delivered in the presence of a partner (Olenev 2019). Maternity hospitals are becoming more open: they hold meetings and conferences involving future parents, arrange courses preparing for childbirth and breastfeeding. The novelties mentioned above meet the requirements of the patients, who are now more informed and responsible in their choice of maternity hospital, doctor and delivery tactics (Tyomkin 2017, 2018).

Currently, as well as in the Soviet period, child delivery is performed by a team of specialists – an obstetrician-gynecologist (a doctor) assisted by a midwife (an obstetrician). However, the powers and responsibilities of obstetricians have been significantly reduced: they obey doctors who independently determine the tactics of the delivery and who are responsible for its outcome. The successes of high technologies, including those observed in relation to the surgical delivery, and the lack of significant improvements in classic (or basic) conservative obstetrics determined the main tendencies in the field (Starodubov and Sukhanova 2012:10]. As a result, the situation in Russia is evolving in a direction opposite to trends observed in Western countries, where the *obstetric model*, when a physiologic birth is delivered by an obstetrician without a doctor, is becoming more and more widespread.

At the same time, in some maternity hospitals, mainly in large cities, new categories of perinatal specialists have emerged: individual obstetricians (usually they are home midwives who received medical education), who often work part-time and perform delivery exclusively within the contract, and doulas[1], who officially or semi-officially provide services to accompany delivery and act as a mediator between employees of maternity hospitals and their clients (Ozhiganova 2019a, 2019b).

Home birth in Russia is not legalized and it is classified as "illegal performance of private medical practice" (Art. 235 of the Criminal Code of the RF), licensing of obstetric activities outside medical institutions does not exist. Nonetheless, voluntary home births are practiced, especially in large cities, but their prevalence is unknown, since no such statistics are gathered.

Generally, the situation in Russian obstetricians can be described as "insufficiently coordinated for successful implementation of professional projects of obstetricians and gynecologists" (Novkunskaya 2019:84). The high health risks observed in obstetrics not only create

1 A doula, a woman's assistant in pregnancy and childbirth, providing practical, informational and psychological support, is not a health care worker and has no medical education (Who is a doula? 2020).

a *vulnerable patient*, but also increase the vulnerability of health care professionals (Litvina et al. 2020). According to the Investigative Committee of the Russian Federation, obstetrics traditionally leads in the number of patient complaints (Petrova 2017), and according to forensic experts, it ranks first in number of established errors in the medical care provision (Loban et al. 2015).

1.2. Conceptualization of childbirth and obstetric practices

In her pioneering work on the study of childbirth in a cross-cultural perspective, the renowned American anthropologist Brigitte Jordan proposed the concept of *authoritative knowledge* (on pregnancy and childbirth) (Jordan 1993). In later works, she continued to develop this concept, dating back to Michel Foucault's concept of *power-knowledge*, focusing on ways to construct authoritative knowledge (Jordan 1997). In analyzing the nature of power, Foucault demonstrated that power produces reality by creating knowledge which in turn acts as the guarantor of power: people rule themselves and others through production of truth, with truth not meaning true statements but "regulating control over areas where the practice of true and false can simultaneously be subject to certain rules and have relevance" (Foucault quot. by Castel 2001:10).

Jordan, observing births at an American hospital, found that it was the doctor's knowledge, based on technology and procedural protocols, that was crucial: without his or her team, labour cannot continue even if the woman is ready to give birth to her child: the competing kinds of knowledge possessed by the woman and others involved in the event are jointly suppressed and managed. What her body says, what she knows (and demonstrates) by virtue of her bodily experience, in this setting makes no difference (Jordan 1993:152).

It was this experience that allowed Jordan to formulate the concept of *authoritative knowledge*: concepts that are created and translated through joint interaction, "knowledge that is in this community considered legitimate, consistent, official, worthy of discussion and appropriate to justify the specific actions of the people engaged in the fulfilment of the tasks set" (Jordan 1993:154).

Further development of the authoritative knowledge concept took place mainly in the context of criticism of the biomedical approach to birth care and analysis of competition of different forms of knowledge (biomedical and alternative), as well as within studies of female resistance strategies, such as home birth choices and activism. The collective monograph *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* lists many ethnographic examples illustrating how the authority of medicine is designed and maintained, how it affects the choices a woman makes during pregnancy and childbirth, how non-medical forms of knowledge, such as women's bodily experience and the experience-based knowledge of traditional midwives, are delegitimized and displaced (Davis-Floyd and Sargent 1997).

Works on anthropology of childbirth formulate concepts describing competing forms of authoritative knowledge: technocratic and holistic models, or paradigms, which differ dramatically in their approach to the organization of medical care and the doctor-patient relationship, as well as the perceptions of bodiliness and the relationship of body and consciousness (Lock 2004; Davis-Floyd 1992). The technocratic paradigm lies at the heart of modern biomedical obstetrics, engaged in the development of new tools and technologies to "improve the initially imperfect delivery process" (Davis-Floyd 2011: 6). The holistic

model represents the complete opposite to the technocratic position. It deals not with individual organs or systems of the body, but with a holistic person, declares the essential unity of the practitioner and the client, individualization of care, attention to subjective sensations and the needs of the patient and is realized in folk (traditional) obstetrics, as well as in alternative practices of modern lay midwives (Lock 2004; Davis-Floyd 1992; Davis-Floyd 2001).

At the same time, the process of interaction between different types of authoritative knowledge about childbirth and the mechanism of possible transit of authoritative knowledge of doctors themselves gains much less attention, but such works also exist. The renowned American researcher of childbirth and obstetrics Robbie Davis-Floyd observes that in recent years the strict dichotomy of technocratic and holistic approaches cedes to the trend towards the creation of a new, humanistic concept of obstetrics. Unlike the holistic approach, the humanist one does not abolish the technocratic model entirely, but it proposes to reshape it and make it more flexible, collaborative and considering of individual characteristics of patients. In a humanistic approach, the patient is perceived as the subject of a relationship, a relationship of care is built between the doctor and the patient, decision-making and responsibility are shared between the doctor and the patient. An important feature of the humanist model is its openness to the perception of other approaches, which gives reason to see it as a new trend which seeks to unite the best achievements of technocratic and holistic models (Davis-Floyd 2011).

The active search for a compromise between different approaches is evidenced by the new WHO guidelines that consistently criticize the excessive and unwarranted medicalization of childbirth and remind that the ability to choose *how, where and with whom* to give birth is an integral part of women's reproductive rights.

The increasing knowledge of how to initiate, accelerate, discontinue, regulate and control the physiologic process of childbirth has led to an increase in its medicalization. There is now a growing understanding that this approach undermines a woman's ability to give birth on her own and has a negative impact on her childbirth experience, which, within a different approach, could be a positive life-changing experience (WHO 2018).

For physiologic uncomplicated births, WHO recommends *an obstetric model*: delivery is taken by a licensed midwife (obstetrician) without the assistance of a doctor, at a special maternity center (obstetric care center), in conditions closest to home, without the use of epidural anesthesia, stimulation of labour activity or any other medical interventions. The stated goal to be sought is the practice of obstetrics ensuring that "women give birth in an environment that in addition to being safe from a medical perspective also allows them to have a sense of control through involvement in decision making and which leaves them with a sense of personal achievement" (WHO 2018). It is particularly noted that all these recommendations are based on evidence-based medicine.

Beverley Chalmers, who worked in the 1990s as a consultant for WHO/UNICEF on maternal and child health in Russia and other countries of Eastern Europe, notes: unlike Western doctors, Russian medical workers recognize that change is important and long overdue, and they are ready for a "transit of authoritative knowledge" (Chalmers 1997:275). She also points to the factors that can trigger the process of transforming authoritative knowledge of doctors in these countries where, unlike to the US and Western Europe, the women's movement is too weak and is unable to embrace women's struggle for the right to choose how, where and with whom to give birth. First, this is the spread of evidence-based medicine, since a meta-analysis of large-scale randomized studies often results in exposing the

inadequacy and even harm of procedures that were previously considered to be routinely useful for women and infants. Second, it is the enhancement of the influence of midwives, who represent alternative authoritative knowledge but, at the same time, are capable of compromising with a biomedical approach.

What kind of authoritative knowledge dominates the Russian birth care service market now, almost 20 years since Chalmers noticed a tendency to shift from a Soviet paternalistic approach to more progressive and humane practices? Let's consider how the new international trends in particular, voiced by WHO, have been reflected in discursive practices of medical perinatal specialists (obstetrician-gynecologists and midwives), as well as what new approaches and concepts alternative perinatal specialists (individual (home) midwives and doulas) have brought to Russian maternity hospitals. Analyzing the concepts that perinatal specialists use to describe the negative and positive experience of childbirth, the author will attempt to answer the question whether there is currently a unified concept in Russia of obstetrics and the corresponding language of its description, or active search for an adequate model and concepts continues through competition of different approaches and discourses.

1.3. Empirical base of the study

To analyze the relevant authoritative knowledge in the field of childbirth, the author uses field materials collected by the method of participant observation at open events maternity hospitals located in Moscow and at meetings of obstetrician-gynecologists, home and maternity clinic obstetricians at the Center of Traditional Obstetrics (CTO) and round tables at the Center of Medical Anthropology of the Institute of Ethnology and Anthropology of the Russian Academy of Sciences (IEA RAS). The core of the empirical database is the archive of the presentations recorded at the founding conference of the professional non-profit Association *Obstetric Union*, entitled *Prospects of implementation of the obstetric model of childbirth aid in Russia*, which took place on November 30 – December 1, 2019 in Moscow Perinatal Medical Center *Mother and Child* (PMC). The scale of the event defined importance of these materials for analysis; the conference gathered over 150 participants – obstetrician-gynecologists and midwives, heads of maternity hospitals, as well as alternative perinatal specialists (doulas and home midwives) from Moscow, St. Petersburg Chelyabinsk, Yekaterinburg, Kaliningrad and other Russian cities. Future mothers and young parents also attended the conference and participated in the discussion. In addition, the materials of this conference are of particular interest for the study of discursive practices, since it was organized specifically for the purpose of developing a new concept of childbirth and a new language of obstetrics. The conference program included 20 presentations, in which doctors and midwives shared their experiences on the implementation of the elements of the obstetric care model and discussed the issues arising in this regard (Obstetric Union 2019). A great contribution to the establishment of the Association was made by midwives of maternity hospitals, advocating professional autonomy, improving the status and powers of midwives, in particular, for the right to independently carry out healthy pregnancy and maintenance of physiologic delivery (Kuznetsova, and Bogdanova 2014). It is expected that these conferences will become annual and will contribute to progressive changes in the Russian obstetric aid system.

All 20 presentations at the *Obstetric Union* conference, as well as the discussion held within the framework of the round table *Relevant problems of Russian obstetric aid* (IEA RAS,

27.06.2019) were recorded on voice recorder and fully transcribed[1]. A discourse analysis was carried out in relation to the texts to identify different types of discourse and basic concepts describing modern approaches to obstetrics.

All the sources included in the empirical database were open and participants agreed to the use of their presentations; however, in order to comply with research ethics, the author does not specify the names of the participants or the names of the organizations in which they work when citing.

2. The main concepts of childbirth and delivery in the Russian context: *obstetric aggression* and *natural childbirth*

2.1. A case in a maternity hospital in Moscow

In December 2019, a criminal case was initiated against the head of one of the maternity hospitals located in Moscow. It was provoked by the numerous complaints from parents. The maternity hospital had a high rating, it was considered elite, and in November 2019 it received the international status *Baby-Friendly Hospital*, which is awarded by WHO/UNICEF experts for implementation of programmes that support breastfeeding. Doctors of the maternity hospital managed to achieve a low percentage of caesarean sections (c-sections) – 13% compared to 30% on average in Moscow. "The maternity hospital team is focused on "soft," natural delivery" – said its website. However, the investigation revealed that doctors deliberately refused to carry out emergency c-sections and used aggressive obstetric practices, including the prohibited *Kristeller maneuver* (fundal pressure during the second stage of labour)[2], which led to severe injuries and even death of newborn children (In the Family Code... 2020). These events caused a wide public response, involving not only members of the medical community, but also, rather unexpectedly, alternative perinatal specialists, home midwives and doules. Some believed that this maternity hospital was just one of those that began a change towards humane attitude to childbirth, others worried that this case would have negative consequences for the practice of delivery and will generally push the medical community towards "safe caesarean births". Thus, the paradox of the situation was not only that childbirth in a prestigious maternity hospital was far from safe, but also in the fact that the supporters of *natural* childbirth involuntarily have come forward in defense *of obstetric aggression*.

This case revealed the conflict of various obstetric discourses and, accordingly, different perceptions of normative, "proper" births and obstetric practices claiming the status of authoritative knowledge.

2.2. *Obstetric aggression*: Expansion of the semantic field

The concept of *obstetric aggression*/*obstetric violence* is found in a wide variety of narratives about childbirth and obstetric practice in two different meanings: rough, aggressive behavi-

1 Overall, the materials consist of 11 presentations by obstetrician-gynecologists, 10 presentations and comments of midwives, 12 speeches and comments of doulas, as well as a speech by one neonatologist.

2 The so-called Kristeller delivery (including fundal pressure to deliver the baby) were banned in the Russian Federation by Clinical recommendations of the Ministry of Health of the Russian Federation in 1994. In a number of European countries, doctors who performed Kristeller delivery are subject to a lifetime ban on the profession (Congress of the European Association of Obstetricians and Gynecologists in Lisbon 2008).

our of hospital staff towards patients or excessive and unreasonable medical intervention in the process of childbirth (see, e.g. Mendeleeva 2017).

The term *obstetric aggression* was proposed by the renowned obstetrician-gynecologist, doctor of medical sciences and Corresponding Member of the Russian Academy of Sciences Victor Radzinsky, who sees *obstetric aggression* as *iatrogenic, unreasonable actions aimed at allegedly benefiting but resulting in only harm*, including increased complications of pregnancy and childbirth, as well as increases in perinatal, infant, maternal morbidity and mortality. He refers such practices as unreasonable emergency c-section, unreasonable birth initiation, labour induction, etc. to aggressive obstetrics (Radzinsky 2011:17). Generally, Radzinsky's criticism goes is in line with the WHO guidelines:

"We, doctors, are "covered" with many different, not always scientifically based methods, procedures, techniques and tactics, behind which we lose the true essence of things. Of course, most achievements in obstetric science have the noble goal of reducing perinatal and maternal morbidity and mortality rates. However, the understanding of the modern state of obstetrics shows that often we drive ourselves into a dead-end while implying the most modern practices" (Radzinsky 2011:330).

According to Radzinsky, origins of obstetric aggression might be found in the medical approach subjecting "proper" delivery of a child to a rigid timeline, not to the dynamics of the labour process itself: for example, limitation of the second period of labour to one hour is unreasonably understood as "the need for a woman to give birth within this time by any means" (Radzinsky 2011:267).

Thus, Radzinsky considered obstetric aggression precisely as the medicalization of childbirth, i.e. excessive and unreasonable medical intervention in the physiologic process. At the same time, he stressed that this practice not only had no evidence base but directly contradicted medical research data, including those set out in obstetric practices standards. He considered the reason for the prevalence of obstetric aggression in Russia to be an insufficiently developed legislative framework and medical standards, as well as unqualified medical staff, often not familiar with modern medical research and preferring to act in the old-fashioned way (Radzinsky 2011).

Outside the medical community, the concept of obstetric aggression is commonly used in a much broader sense. It became popular in Russia due to the series of posts in social media entitled *Violence in childbirth* and the community of the same name in the social network *VKontakte*, founded by doulas Julia Goryacheva and Maria Ushankova in 2016. At the moment, this community has gathered over 14,500 members[1]. In the description of the community, obstetric aggression is used as an expression synonymous to *violence in childbirth* and includes both psychological (insults, blackmail, gaslighting) and physical violence (slapping the mother, pushing the baby externally, episiotomy, and other interventions without woman's consent) [to find the posts and discussion use the Russian hashtag #насилие_в_родах]. Veronica Nazarova, a doctor and publisher of the famous French obstetrician-gynecologist Michel Odent, explains that obstetric aggression is an intervention unjustified by the situation and medical needs which leads to following health complications. Generally, women

1 The Russian social media activism is part of an international movement against obstetric violence. Since 2012, grassroots social movements for women's rights in reproductive health and childbirth services have emerged in many countries, for example: #bastacere: le Madri Hanno voce in Italy, #PrekinimoSutnju in Croatia, #PayeTonUtérus in France, #Genoeggezwegen in the Netherlands, Másállapotot in Hungary, Minä Myös Synnyttäjänä in Finland, etc.

might perceive neglect of their opinion as violence. Quite often it happens that the delivery was successful, but the woman remembers it as something terrible; the injuries she received are not physical, but emotional. The consequences may include depression, cardiovascular disease, family breakdown, and here we can draw parallels with intimate life – if your desires are ignored, you are not asked about anything, but are simply treated "according to the procedure", it is experienced as violence (Nazarova 2019).

Thus, the concept of obstetric aggression is used in a very broad sense, it embraces many meanings including any form of inhumane attitudes faced by women in maternity hospitals. This approach goes in line with modern international practice. The concept of obstetric aggression, which was previously virtually unused, was first officially voiced in the report of a UN expert on violence against women in June 2019 and, most likely, will be now enshrined in international human rights standards. It was recognized that "at the global level, there is a lack of global consensus on how violence against women during facility-based childbirth is defined and measured" (Šimonović 2019:6). Nevertheless, the range of phenomena falling within this concept was outlined: open physical violence, humiliation and verbal abuse, forced or uncoordinated medical procedures (c-section, labour induction, pushing the baby externally, amniotomy, episiotomy), non-observance of confidentiality, absence of full-informed consent, refusal to provide medical pain relief, gross violation of privacy, denial of hospitalization, inattentive attitude and sexist remarks (Šimonović 2019:32).

Representatives of the medical community, who took part in the Obstetric Union conference, used the concept of obstetric aggression mainly meaning excessive medicalization of the delivery process. One of the speakers, an obstetrician-gynecologist, former head of one of maternity hospitals in Moscow, spoke about her experience of limiting the use of artificial oxytocin (one of the methods of medical stimulation of labour activity, that causes avalanche growth of contractions and is accompanied by elevated pain level): "How to reduce aggression in the conditions of our maternity hospitals? You can register oxytocin, introduce strict control for its use. But at the end of the day, everything is written off formally, post-factum. Bans and registration protocols do not work" (Obstetric Union 2019).

Another speaker, deputy head at a large regional perinatal center, shared her observation that obstetrics in general was becoming more aggressive: "I have been practicing medicine for 34 years, and over this time in the Chelyabinsk region the prevalence of c-sections has grown from 5 to 30%. I should also say: the more active, the more aggressive obstetrics is, the more dangerous it becomes" (Obstetric Union 2019).

Within the semantic field of the obstetric aggression concept there are expressions such as *controlled childbirth* and *programmable childbirth* (a process that is induced artificially with medication and medical manipulations): "When I had my medical residency, we were taught: you should control delivery, not the other way around" (Obstetric Union 2019).

At the same time, several reports have used the concept of obstetric aggression in a much broader sense. Thus, the head of the medical center recalled that November 25 is the International day for the Elimination of Violence against Women and showed a video message from women from different countries opposing such aggression, including intimacy violations, lack of informed consent to medical manipulation and abusive treatment by medical staff. In general, any actions of the staff of the maternity hospital which caused a woman to experience negative emotions can be described as obstetric aggression, including those performed by doctors and heads of maternity hospitals: "Our task is not to allow such a "fear

and run" scenario in childbirth, because a woman does not come to us for this. We should not scare her" (Obstetric Union 2019).

Thus, obstetric aggression was understood by the conference participants, firstly, as excessive medicalization of childbirth, and secondly, as an inhumane attitude towards a woman during pregnancy, delivery and in the postpartum period. Medicalization in this case is not a practice based on the results of medical research, but rather an approach ignoring scientifically based methods and following outdated procedures. Medicalized delivery does not mean that it is safe, on the contrary, it is acknowledged that obstetrics are made more dangerous by excessive medical intervention. This paradox was pointed out by Radzinsky when he contrasted obstetric aggression with safe obstetrics, by which he understood "a set of scientifically-based approaches supported by achievements of modern science and practice", as well as "natural perinatal technologies", which are based on a good knowledge of the physiology of the process of labour and delivery (Radzinsky and Kostin 2007:68). Thus, Radzinsky's criticism shows that authoritative knowledge of doctors is often based not on scientific research but on familiar routine practices. As Jordan pointed out, defining some set of knowledge as authoritative is in no way indicative of its truth: "The power of authoritative knowledge is not that it is correct but that it counts" (Jordan 1993:154).

Analysis of the use of the obstetric aggression concept shows that not only alternative perinatal specialists, but also many doctors go beyond purely medical discourse: they recognize the value of women's subjective experience, call for the abandonment of the paternalistic model of doctor-patient relationships, and even claim that "the maternity hospital is not a hospital, but a sociocultural object, a place where a citizen first meets the state" (Obstetric Union 2019).

2.3. Natural childbirth: Crisis of the concept

The concept of the holistic approach to childbirth is practically not used in the Russian context, the role of an alternative to the biomedical paradigm is fulfilled by the concept of "natural" childbirth (and its common abbreviation NC). It is a *slippery concept*, which can designate completely different practices and approaches: childbirth through so-called "natural birth pathways", i.e. vaginal delivery; minimization of medical interventions; priority of the maternity preferences over the requirements of medical standards (in particular, the possibility of free behaviour during delivery); a high degree of responsibility of a woman for the outcome of delivery; active participation in childbirth of the partner or other family members (Borozdina 2014, 2019).

The concept of NC is absent in the official medical discourse: the only notion that might be found in the official documents is a "delivery through natural birth pathways", i.e. delivering the baby without surgical intervention. However, the concept of NC is actively used by obstetrician-gynecologists and obstetricians of maternity hospitals, on the websites of maternity hospitals and in the private medical contract titles, meaning childbirth with minimal medical intervention – without medication stimulation, anesthesia, amniotomy or episiotomy, etc. Ekaterina Borozdina proposes to call this understanding of NC *a hybrid model of natural births*, as it combines a biomedical model (childbirth through natural birth pathways) with an alternative ("natural births are home-based births") (Borozdina 2019:132).

It should be noted that none of the participants of the Obstetric Union conference used this concept in its narrow medical meaning, as childbirth through natural birth pathways.

Speakers recalled NC in the context of fundamental changes in the work of maternity hospitals and obstetric practice, and linked the increasing interest in demedicalized childbirth with a turn towards a *natural*, or healthy lifestyle: "Now everyone needs clean water, clean air, natural fabric, not operated by medical team or programmable childbirth, but natural, physiologic delivery" (Obstetric Union 2019). In general, NC is equated with concepts that are quite legitimate for biomedical discourse such as *normal* or *physiologic* births, i.e. childbirth that does not require medical interventions. In turn, alternative specialists also use the concept of NC in a purely technical meaning: "This is the absence of oxytocin stimulation, amniotomy or episiotomy, and the free behaviour of a woman during contractions and the active pushing phase" (Obstetric Union 2019).

Thus, the concepts of "aggressive" and "natural" in relation to the tactics of delivery are often used as antonyms, forming a kind of binary opposition, in which an "aggressive" approach means medical intervention (and extreme case is a c-section), and the "natural", or conservative approach means physiologic birth: "Obstetrics has never been so aggressive and so conservative at the same time. Thanks to the development of intensive care technologies, we can perform delivery in any life-threatening situation. On the other hand, we have a tremendous desire for the most natural conduct of childbirth and want to ensure the most natural course of childbirth" (Obstetric Union 2019).

It should be emphasized that naturalness has many degrees, depending on the situation, since this is a physiological process that occurs in all different ways: "There are different boundaries of physiology, these boundaries can and should be expanded. The main thing is an individual approach, individual characteristics should not exclude the physiologic process" (Obstetric Union 2019).

Many speakers addressed the concept of naturalness proposed by French physician, obstetrician Michel Odent, author of the famous books "Birth Reborn", "Primal Health: Understanding the Critical Period Between Conception and the First Birthday", "The caesarean", and other. Back in the 1970s, in his clinic in Pithiviers, he introduced pools to obstetric practice to relieve birth pain, as well as rooms with a home-like environment. Odent believes that for the normal course of childbirth, a woman needs certain conditions: a sense of safety, peace and privacy, which ensure the production of a sufficient amount of hormone oxytocin, responsible for contraction of the uterus during labour, and, accordingly, the natural course of childbirth (Odent 1994). The seminars that Odent conducts worldwide are very popular among alternative perinatal specialists, although very few Russian doctors attend them (privately, not institutionally). Nevertheless, doctors and even managers of the national medical systems often turn to Odent's concept to explain the mechanism of natural childbirth. Particularly popular is his "dark, warm, quiet room" scenario (in Russia, it is often called the "three T's formula" with Ts standing for *temno (dark), teplo (warm), and tikho (quiet)*). For example, it is cited by Anton Olenev, chief specialist in obstetrics and gynecology of the Department of Health of Moscow:

"We notice in our work that the more comfortable a woman is in childbirth, the more calm and protected she feels, the more safe (we even have such a "three T rule" with the Ts standing for warm, dark and quiet), and the more comfortable she is in this situation, if there is a close person with her – her close relative or spouse, whom she is comfortable with, with whom they have decided in advance that they are ready to go this way – the more favourable is the delivery, the better are the outcomes. World data prove this" (Olenev 2019).

At the Obstetric Union conference, Odent's concept was mentioned in many presentations with little variation, for example:

"A woman gives birth well when a lot of oxytocin is produced. Oxytocin is the hormone of love, the hormone of rest, pleasure, it is produced only in safe conditions, when a woman feels her protection. If she feels aggression, if she feels fear, then there are no chances to see endogenous oxytocin in sufficient quantities to have a good birth. Adrenaline is a fear hormone, a stress hormone, it interferes with the normal production of oxytocin" (Obstetric Union 2019).

In general, we can say that all participants of the conference used the concept of NC in one sense: as minimization of medical intervention and the optimal method for each specific case of delivery. At the same time, the boundaries of physiologic (normal, natural) births were not defined, the discussion focused on the problems of their implementation: organization of the maternity hospital routine, development of medical protocols and training of obstetricians. As part of the experience exchange, representatives of the Russian regions presented their projects, and some presentations were dominated by biomedical discourse, while others – by alternative ones.

In a small maternity hospital in Khakassia, the project *In the maternity hospital, just like at home* is carried out. The project is organized by a freelance employee of the maternity hospital, who is a home midwife and has children herself. The project, which is carried out within the state programme of Compulsory Medical Insurance, provides individual supervision during delivery. Within this project, in the hospital were installed baths, launched special psychophysical training courses for pregnant women. The doctors working within the project follow the principle of rational *laissez-faire*, and the practice of obstetric interventions – manual manipulations performed during delivery, such as control of the movement of the baby's head, rotation of the head, release of the shoulder girdle, etc. – is abolished.

The Yekaterinburg Perinatal Center has developed its own clinical protocol based on evidence medicine and the WHO guidelines, and it contains a number of serious innovations. Here, accompanied delivery (presence of the father of the child or other family member) and individual supervision are available for all patients under the state programme of Compulsory Medical Insurance. The delivery is performed by an obstetrician, and one obstetrician works with two women simultaneously at most (usually in maternity hospitals an obstetrician works with all admitted patients and can serve 20 or more deliveries per one 24-hour shift), and the doctor comes only if necessary. The introduction of checklists for medical manipulation led to a sharp decrease in the number of invasive procedures, routine amniotomy and episiotomy, and routine vaginal examinations were completely abolished, while the prescription of antibiotics has significantly decreased. It is worth noting that this presentation entitled *Efficiency of basic technologies in improving perinatal outcomes* was entirely based on biomedical terminology and the concept of NC was not even mentioned there (Obstetric Union 2019).

Despite the fact that these projects are promoted by different types of specialists (alternative ones in Khakassia, biomedical – in Yekaterinburg), guided by different "ideology" of childbirth, the practical results were very close. Nationally, however, these examples are more of an exception to the rule. The individual delivery supervision is usually provided only within contract programmes that use in their names the concept of NC or synonymous ones ("Soft delivery", "Home delivery") as a marketing trigger:

"Our rooms do not resemble the usual boxes at an ordinary maternity hospital. There are sofas, pillows, plaids, curtains, sports equipment, baths and even swings. However, despite all this entourage, in each room there is modern equipment to monitor the health of the

mother and the baby. After all, we, obstetricians, are sure that despite the fact that the processes of pregnancy and childbirth are strictly physiological, nevertheless, very often they are complicated by various conditions that require emergency medical care. That is why we are convinced that giving birth at home is reckless and extremely irresponsible. But it is possible and necessary to give birth in the maternity hospital as at home" (Department of Home Childbirth 2016).

Home-like delivery departments attract patients buying expensive contracts and thus increase the efficiency of the maternity hospital. The high price of natural childbirth services reflects the high symbolic value of this approach "associated with the ideals that the population strives for" (Beckert 2011:123).

In general, the concept of NC is exceptionally contradictory. On the one hand, it continues to be used as an empirical and ideological category, denoting an alternative to the biomedical approach (Borozdina 2019:119). On the other hand, the given analysis of discursive practices shows that at present it is no longer quite correct to consider this approach as an alternative to biomedical obstetrics. Supporters of NC, both doctors and home midwives and doulas, appeal not to the folk obstetric tradition (in Russia it is absent) and not to esoteric (spiritual) obstetrics, but to medical research, the WHO guidelines and experience gathered in developed countries. At the same time, obstetric aggression as excessive medicalization often exists in the zone of violation of standards of practice or inadequate protocols. If obstetric aggression is opposed to safe delivery, the ratio of NC and safe births remains ambiguous: as the situation in a Moscow maternity hospital shows, due the actions of doctors who positioned themselves as supporters of natural childbirth, newborns might suffer:

"After the tragedy, the connotation "natural childbirth" is branded: it is about fanatics who are determined to carry out childbirth through natural birth routes at any costs" (Nazarova 2019).

It is likely that the concept of NC will eventually be discredited, and its place will be taken by new concepts that more adequately denote the rational demedicalization of childbirth, which is recognized as a correct, normative approach by midwives, doctors and health organizers:

"We strongly support accompanied delivery with a partner. We attempt to pursue a policy of so-called soft, home-like births (this is all synonyms). <…> As I said, more than half of the births are absolutely physiological, normal and do not require intervention of doctors" (Olenev 2019).

3. Conclusion: Transformation of authoritative knowledge about labour and childbirth

As a result of recent changes in the sphere of Russian obstetric aid, authoritative biomedical knowledge of childbirth has encountered serious challenges. Modern medical research has proven the inefficiency and insecurity of many common obstetric practices: some are banned by new medical standards, some are considered highly undesirable. The authority of medical knowledge is also reduced due to criticism of existing practices by "dissident doctors" such as Radzinsky or Odent who have become widely known, as well as by ordinary obstetrician-gynecologists who moved into alternative obstetrics, starting to perform deliveries at home (Ozhiganova 2019b). Recognition of the influence of a woman's psychop-

hysical condition on the delivery outcome, spread of *wait-and-see tactics*, the need to obtain informed consent of the patient to any medical interventions require doctors to change the communicative model and establish dialogue with the patient. In this regard, discursive practices of both doctors and patients are changing, doctors use popular explanatory concepts of physiology of pregnancy and childbirth, while the patients master biomedical terminology and study clinical protocols.

Competition between obstetrician-gynecologists and obstetricians within the medical community forces obstetricians (midwives) to look for partners outside the medical community: they build alliances with alternative (home) midwives and even social researchers, supplementing their authoritative knowledge with concepts and approaches borrowed from social sciences (Kuznetsova and Bogdanova 2014). Home midwives interact with maternity hospitals and even take part in the development of medical protocols. The doulas are disseminating information on new trends in international obstetric practice, the WHO guidelines and large-scale medical research data. So the doctors' monopoly on having authority knowledge is eroded.

Competing systems of authoritative knowledge about childbirth – biomedical and alternative – create new practices of interaction, resulting in active transit of knowledge. Some concepts, such as *natural childbirth*, are eroded, devalued, lose their relevance and are gradually replaced by other, more precise: *wait-and-see tactics, non-invasive methods, abolition of routine medical interventions.* Other concepts, such as *obstetric aggression*, on the contrary, are amplified, expanding the field of their semantic meanings, find reinforcement in international standards and become more popular.

Brigitte Jordan noted that knowledge forms hierarchical structures by devaluing some knowledge systems and giving weight to others (Jordan 1997:56). However, she was sure that other – horizontal – forms of knowledge distribution are possible, when, as a result of mutual coordination of different approaches, "emerges a single authoritative structure of knowledge" (Jordan 1997:73). Horizontal distribution of authoritative knowledge is achieved in the situation of having a child through "low" rather than high technology, such as birth in an obstetric center. In this case, the doctor does not take a central position, and all decisions are made on the basis of what all participants know about the current delivery process. Since "knowledge is not a substance that humans possess, but a state that is achieved jointly within the community of practitioners" (Jordan 1997:58), the production and use of knowledge can become common to all participants: a doctor, an obstetrician (a midwife), a woman and her accompanying loved ones.

The creation of a new professional non-profit association *Obstetric Union* shows that in Russian obstetrics there is a process of convergence of the official biomedical and alternative approaches, which manifests itself in the active search for a new language that can unite different perinatal specialists. Concepts such as *obstetric model of care, continuous obstetric support, humanization of obstetric care*, etc. were new to the Russian obstetric discourse. Thus, it is assumed, first, that it is the obstetrician who will become the leading and primary specialist, accompanying the entire motherhood cycle and coordinating the delivery of obstetric care (On the Model... 2019:2). Second, this model assumes that the obstetrician will provide personified and continuous care to the woman throughout her delivery. Members of the *Obstetric Union* Association cite medical studies presented, in particular, by Cochrane reviews and proving the clinical efficacy and safety of the model of obstetric aid. They also refer to the WHO guidelines calling for the observance of the principles of humanism in obstetric practice and respect for the individual and women rights. Thus, there is a noticeable

shift from a binary model of competing forms of authoritative knowledge to a new synthesis of biomedical and alternative approach and the creation of new, more effective and safer, forms of obstetric care.

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Author's field materials

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