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RESEARCH ARTICLE

Navigating the role of emotions in expertise: public framing of expertise in the Czech public controversy on birth care

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Abstract
Despite the abundant scholarship on sociopolitical embeddedness of expertise, its relation to emotions remains understudied. The paper fills this gap by discussing how public framings of expertise work against the inclusion of emotional contexts, affecting what kind of professional knowledge dominates in a public debate. The analysis of the Czech public debate on birth care shows that while midwives embrace emotional contexts of birthing and integrate them as an essential part of their professional expertise, obstetricians see these contexts as troubling their expertise. This professional difference is sustained by the public framing of expertise in the media, favoring obstetricians' expertise over midwives'. The analysis shows that public framing of expertise outweighs evidential work done by midwives and legal advisors and impacts how emotional contexts are understood in the debate. Rather than referring to feelings and personal experience of the body, the "emotional" becomes a discursive label to delegitimize professional opinion. The results raise thus important questions about how the public framing of expertise impacts whether emotional context and experiences of bodily harm are seen as relevant in policy debates and policy regulations.

Keywords Birth · Czechia · Discourse · Emotions · Expertise · Feminism

Introduction

In times when public contestation of expertise rose steeply, the division between rational experts and the emotional public became marked in public discussions. This is an indicator that we need to better understand how expertise involves emotions and how experts use emotions to formulate their positions and arguments. Yet, sociological and political research on expertise echoes this perennial disparity between rational expert authorities

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on the one side and emotional lay citizens on the other (Collins & Evans, 2008; Jasanoff & Simmet, 2017). Although the rise of the role of informed citizens has included personal experience in the production of expertise, expertise remains the bastion of a formalized and objective judgment by experts whose professional training involved reliance on the evidence-based method. This article is thus interested in identifying specific meaningful ways in which language on emotions impacts how expertise is publicly framed as being detached from emotions. The analysis of the public debate on midwife-assisted planned homebirths in Czechia illustrates that emotions have an important role in expertise, both as the context of the inclusion of the individual views and feelings and as a label of unprofessionalism and nonobjectivity. This dual, cacophonic role of emotions in expertise creates a backlash against those forms of expertise related to emotional experiences, harm, and feeling.

Beyond the specific example of birth, the article suggests developing an analytic sensitivity toward the expertise-emotions nexus. The results of this analysis raise important questions of how expertise relates to individual assessments of a situation and how public framing of what expertise is impacts the way emotions are presented and understood in public debates. In public debates, expertise has been understood as a technically oriented knowledge, crafted through its opposition to individual experience and subjective assessments of a situation that might involve an array of emotions (see, e.g., Alexander, 2013). This opposition has consequences for what kind of professional opinions and choices are seen as relevant for governments and policy advisors. Albeit accepting that values and beliefs of a society contribute to establishing expertise (see Weible, 2008 for discussion), public framing of expertise has sustained a dichotomy between professional authorities, established in society as legitimate experts, which gets opposed to lay publics, and those advocating for the lay public's individual interests (see also: Collins & Evans, 2008). At the same time, and more importantly, such a dichotomy has created a somewhat problematic relation of expertise with emotional contexts that accompany social phenomena and that are articulated in public debates in specific language means to describe emotions.

The Czech public debate on planned midwife-assisted home birth elevated between 2000 and 2021 to a highly tensed public controversy on the conditions of birth care, taking a prominent position in the media, which allows for analyzing the public framing of expertise more specifically. The analysis reveals two distinct public framings of expertise related to birth care: the first framing holds that birth should be managed by medical professionals—obstetricians, who are only *assisted* by midwives—this view is supported by Czech professional codes of conduct of obstetrics and neonatology and is articulated in the public debate through emphasis on the importance of the medical profession in maintaining the high quality of birth care in Czechia. The second framing holds that, since birth is a highly personal and emotionally loaded experience, the choice should be managed by women[1] and their bodily and emotional integrity should be the primary focus because this leads to good birth outcomes. This goal is at the same time seen as the core of midwives' expertise. This second framing is represented mainly by midwives, patient advocates, legal advisors, and women's rights advocates. Most importantly, both framings emphasize data, evidence, and

[1] From the perspective of officially recognized sex, only biological women can actually give birth in the Czech Republic, since sex can be officially changed in the Czech Republic only if the reproductive function is rendered impossible (Sect. 29(1) of Act No.89/2012 Coll., the Civil Code). According to the ruling of the Constitutional Court, Pl. ÚS 2/20, the official distinction between women and men is constitutionally consistent. Beyond this legal situation specific to the country of our case study, our analysis merely reflects how persons have acted in the context of the issue in question in the media and public debate, while not denying persons their right to subjectively choose their gender identity.

the need for expertise in their argumentation. In the medicalized birth group, expertise is typically exemplified by the long-term tradition of high-quality obstetrics in the country. The second group refers to expertise in WHO guidelines and international scientific studies on quality of birth care, including studies on obstetric violence, as well as in current European legislation around birthing and birth care.

The article starts by summarizing the scholarship on expertise that allows us to identify some shortcomings in how emotions are understood as opposed to expertise. This discussion opens a gateway to problematize the relation between emotion and expertise through interpretive analysis. The merits of such a gateway are explained in the analysis of the Czech public controversy. The analysis shows that, while both groups use data and professionalism to legitimize their views as expertise, they differ in the way they articulate their relation to emotional experiences around birthing. The public framing of their respective expertise favors obstetricians' expertise as "the expertise," despite the situation that the group around midwives and legal advocates brings more actual data and evidence to the negotiation table and to the political debate. In the media framing, all this remains mostly unechoed. The results of the analysis suggest that gender stereotypes around emotions and specific language means to refer to emotions can override the importance of actual data in the debate. The discussion then provides some lessons going beyond the specific case of birth care, allowing to further the sociological and political scholarship on expertise by paying more attention to the role of emotions in the public framing of expertise.

Re-orienting the role of emotions in expertise

In current scholarship, expertise is commonly understood as 'evidence-based' knowledge (Perl et al., 2018) and is seen as a legitimate vehicle for modern democratic governments (Hawkesworth, 2012; Majone, 1989). At the same time, modern governments have found themselves in a conundrum of a world dealing increasingly with overly complex policy problems, with diverse and even opposing expert opinions, while aiming for a democratic discussion on these problems. Such a situation has opened a terrain for analyzing both the production and the public acceptance of expertise through meaning (Fischer, 2009; Hajer, 2005). In that respect, the emphasis has been put on what Nowotny calls "the social robustness of expertise" (Nowotny, 2003), seen as a useful way to focus on societal and political contexts through which expertise is commissioned or defended as needing to be commissioned (see also Jasanoff, 2004 for discussion). Understanding expertise through and with the sociopolitical contexts of the knowledge it delivers has spurred interest in scholarship analyzing the production of knowledge in policy advice (Voß & Freeman, 2016) as well as seeking to understand the framings of expertise and the power plays behind it (Braun & Kropp, 2010; Strassheim, 2015). Expertise, in this scholarship, is seen not as simply accepted but as mediated through meanings that should be analyzed to understand the role of expertise in policy making better (Hajer, 2003). The rise of participatory democracy, foregrounding the importance of the public in presenting and legitimizing expertise (Fischer, 2009; Peterse, 1995), has further strengthened the view that, in order to understand its role and dynamic in democratic societies, expertise needs to be addressed as encompassing all sorts of knowledge (Blomkamp, 2014), not just scientific or medical knowledge (Beck, 2015; Newman, 2016).

Evidential work is a major characteristic of the current activism around birth care practices, and it is also through this work that women's organizations achieve a legitimate status

in debates related to birthing (Paterson, 2010). Such evidential work opens societal debates on the issue, aiming at changes, while engaging in the public discussion with the traditional stakeholders that dominate the issue, forcing them to enlarge spaces of these discussions (Akrich et al., 2014). However, despite specific situations in which these spaces are enlarged or are at least favorable to discussing 'who' defines 'what' kind of expertise, the focus on numbers and statistical objectivity still dominates the view of expertise (van Ostaijen & Jhagroe, 2015). Most importantly, such a view of expertise becomes translated in public debate in discursive means that present expertise as synonymic to "objectivity" (Frickel & Moore, 2006) and "rationality" (see Alexander, 2013 for discussion).

This discursive framing opposing emotions to objectivity and rationality has contributed to a public image of expertise as something that exists outside of emotions (Durnová, 2019; Weible et al., 2020), or at least it 'neutralizes' them (Memmi, 1999) by prioritizing system and path dependency over individual feelings. This can be viewed, for example, through views articulated in public debates that "emotions should be put aside" to "allow expertise to come in" or in references to opinions as "emotional," meaning "unprofessional." Such examples of treating emotions as synonymous with a bias and/or personal preferences which negatively impact objective expertise can be seen in discussions on the pandemic, climate change, or birth care issues addressed here. The present analysis thus focuses on how the public framing of expertise puts forward specific language means and gender stereotypes and, more importantly, how these means and stereotypes are sustained through the relation of expertise to emotions.

Feminist works on policy process (Hawkesworth, 1994, 2012) have proposed, in this regard, looking more carefully at how policy actors proceed in the policy process through legitimizing a specific type of knowledge as expertise, mostly the one that incorporates and is congruent with a society's already established cultural or social discourses (see also in: Azocar & Ferree, 2016; Kulawik, 2020). An essential part of feminist works is to name and problematize the existent patterns of what is regarded as valid evidence and to show how these identifications impact public framings of expertise. Hawkesworth (1994, pp. 98–99) proposes to address the political power of gender-specific dichotomies, such as males being associated with reason and females with emotion. She argues these dichotomies make policy processes biased because the models advanced to describe and explain them are gendered, limiting the agency of those who might act against those framings and affecting the dynamic of policy processes in general (Hawkesworth, 1994, p. 107).

Other feminist works on policy debates have echoed this need to understand policy processes as a process eclipsing an array of difference rooted in class, ideology or race and have extended it to the issue of expertise. Expertise can be regarded as a framework of knowledge that is typically gendered, favoring dominantly masculine patterns for presentation as inherent to expertise (Cavaghan, 2017). In the context of birth, for example, this creates an important knowledge asymmetry between women (covering both birthing women and midwives) and male professionals (Akrich et al., 2014). The Czech case replicates this asymmetry: while both groups of experts see their respective propositions as evidence-based and understand themselves as experts entitled to deliver the qualified opinion on the matter, midwives, and women are framed as activist and partisan voices in the public debate. The analysis shows that the difference between both framings of expertise combines gender stereotypes with the way emotions are represented and referenced in the debate.

Emotions' role in public debates on social and political issues is generally limited in two ways in the current policy scholarship on emotions. The first limitation can be explained by viewing emotions as relating merely to specific spheres of life, mainly

private or body-related matters (see examples in: Jupp et al., 2016; Orsini & Wiebe, 2014). While compassion, empathy, and assessment of emotional contexts within these spheres are understood to be important (Paterson & Larios, 2020), their inclusion in specific policy instruments and expert opinions is nevertheless seen as complicating action precisely because emotions are reserved for privacy, body and individual situations, and not for collective norms of behavior (see e.g., Durnová & Hejzlarová, 2017 for discussion). This is related to the more general view of emotions in policy sciences scholarship as producing overreactions (Maor, 2012) which then makes emotions working against rationalizing structures of expertise.

The second limitation of the role of emotions in the scholarship on expertise consists of treating them primarily as urges motivating human action, mobilizing citizens for collective action (Gould, 2004; Jasper, 2011). While this view has helped us to understand different collective actions strategies through emotions (Blakeley & Evans, 2009; Clarke et al., 2006; Newman, 2012) and has shown that emotions can explain moral justifications for particular political choices (Jasper, 2008), these insights have been mainly used in studies on participation and deliberation (Maia & Hauber, 2020; Mercier & Landemore, 2012). In such studies, emotions are seen as important elements of decision-making, in particular because they facilitate communication (Cairney & Kwiatkowski, 2017), yet they are viewed through the actions they initiate, prevent, or facilitate (Gould, 2009), rather than through meanings that emotions might reflect and are embedded in.

These two limitations can be overcome by conceiving of emotions as giving meaning to actions and norms (Pugh, 2013). Treating emotions as meaning-making practices represents the main tenet in the interpretive tradition of sociology of emotions (Durnová, 2018; Flam & Kleres, 2015; Rodriguez, 2008). This tradition studies how emotions shape our knowledge on social phenomena (Czarniawska, 2015; Holland, 2007). We do not always attribute the same meaning to the same emotion but differentiate according to gender, race or class of those who feel these emotions or articulate it (Ahmed, 2013) and emotions sustain collective understandings of norms or dominant narratives in a society (Ahmed, 2013, p. 3–4) We generally acknowledge that emotions are involved in knowledge-making processes and cannot really be separated from decisions (see Maia & Hauber, 2020 for discussion), but in public debates the term 'emotional' arises repeatedly, almost as an accusation that feelings and emotions contaminate a rational debate or make policy actors less credible or too enmeshed in their personal biases (Durnová, 2018, p. 99). Interpretive works show that describing knowledge, or its proponent, as 'emotional' means in this context more than the simple relation to the emotional processing in our brains; it frames the view that such knowledge is less relevant for the discussion at hand. Interpretive analytical procedures focus on the specific language use to refer to emotions in order to reveal the discursive framings through which actions and standpoints are presented and understood as 'too subjective,' 'driven by personal interests,' 'irrelevant,' or 'too dangerous'(see, e.g.: Czarniawska, 2015, p. 69). The following analysis of the Czech debate on birth care shows how this discursive framing impacts the public framing of expertise.

Data and methodology

Our data consist of three interrelated data sets. First, we have analyzed the discourses on expertise and experts in the national press debate on the issue of home birth from its beginning up to 2019 using quantitative content analysis for analyzing media messages (Riffe et

al., 2019). The media units were selected via Newton Media Search—the largest Czech media archive, which includes all national and regional titles. Units containing the keywords ‘home birth’ and ‘birth at home’ were generated from daily newspapers, professional journals, TV broadcasting, and radio broadcasting 1996–2019. We gathered 2360 media units and further selected one-fourth of the annual volume of units for our analysis (though we at least selected 10 units when $n > 10$), which resulted in 625 media units (see details on the approach in: Manganello & Blake, 2010). In attempting to understand the meanings around expertise, we focused our analysis of this dataset on who is being given a voice as an expert and what kind of knowledge that person has (see the details on the interpretive analysis below). From the perspective of better understanding the dynamics of policy processes, media are an arena where various actors may raise and discuss specific policy issues along with voices from the general public. This arena has rules—interconnected with the dynamics of relevant policy institutions—so the media presence analysis shows what kind of topics and which form has a chance to become dominant. Therefore, we have used the analysis of the media presence of the actors and their arguments as a basis for further investigating the different discursive framings of expertise through the other two datasets.

The second dataset consists of analyzing the notion of expertise in the professional discourses on birth care. To that end, we collected all press releases and other official statements of the experts on the birth care debate up to December 2020. To identify these experts, we first listed all professional organizations linked to obstetrics and midwifery. Second, we added to this list expert bodies mentioned in the national press debate. We subsequently downloaded the official statements of these organizations or, if the data were not stored online, contacted the organizations to request access to that material. Beyond the government bodies involved in regulating birthing care (Ministry of health, Government office) and the official professional associations of obstetricians, midwives, and emergency doctors, these actors include nonprofits providing patient advocacy and legal services related to home birth (LLP), as well as advocates for better birth care in general (Aperio, ČŽL, HAM). Table 1 lists the 93 resulting documents (see details in Table 1). This dataset helps us identify the respective meanings of what expertise is within these professional groups and how such meanings of expertise support specific recommendations on birth care (Table 3).

Third, we situated these meanings of expertise within the public framing of expertise identified through the analysis of media. Toward this end, we conducted eight interviews[2] with experts who were either directly involved in the policy debate around birth care or who have been advocating for changes in birth care practices from their expertise status between 2018 and 2021. Structured along the data from the media debate, these interviews were conceived as the stage to outline the larger context of how experts see their specific professional expertise as contributing to the dynamic of the public debate or as being omitted in it. This stage was even more important as there were no direct interactions between both expert discourses in the media. To these interviews, we added public lectures, conferences, and meetings organized on the topic of home birth between 2018 and 2021. This includes 2 public lectures of the medially prominent obstetrician Antonín Pařízek (Lecture 2018A), 1 public debate with the medially prominent midwife Ivana Königsmarková

[2] Some of these experts preferred anonymity, so we chose to keep all of them anonymous and refer to them as EX1 – EX8.

Table 1 The list of analyzed expert documents (source: authors)

Name of the organization	Type of document	Period/Number of documents
Ministry of Health Services (Ministerstvo zdravotnictví ČR, MZd ČR)	Press release	2013/1
Czech Association of Midwives (Česká asociace porodních asistentek, ČKPA)	Press release	2015/1
Emergency Medical Service (Zdravotnická záchranná služba, ZZS)	Press release	2016/1
„Stopobstetricviolence " (…) „Todeliverwithlove "	Website	Until 2020/1
„Home-birth.cz "	Website	Until 2020/1
Minister of Health Services by the Czech Chamber of Midwives (Česká komora porodních asistentek, ČKPA)	Press release + open letter	2015–2020/2
Aperio	Position paper	2012–2020/2
Czech Medical Chamber (Česká lékařská komora, ČLK); Czech Gynecological and Obstetrical Society of the Czech Medical Society of J. E. Purkyně (Česká gynekologicko-porodnická společnost České lékařské společnosti J. E. Purkyně, ČGPS)	Website + press release	2012/2
Czech Association of Doulas (Česká asociace dul, ČAD)	Press releases (2) + professional statements (2)	2009–2020/3
Czech Women´s Lobby (Česká ženská lobby, ČŽL)	Press release	2012–2020/3
League of Human Rights (Liga lidských práv, LLP)	Press release	2010–2020/29
Working Group for Obstetrics under the Office of the Government of the Czech Republic (Úřad vlády ČR, ÚV)	Press release, Report, Presentation	2015–2020/22
Union of Midwives (Unie porodních asistentek, UNIPA)	Press release	2006–2020/15
Movement for Active Motherhood (Hnutí za aktivní mateřství, HAM)	Press release	2010–2020/10

(Lecture 2018B), and 3 observations of the "Weeks of Respect to Birth," a festival supporting alternative birthing approaches (2018, 2019, and 2021).[3]

Expert documents, the selected media articles, and the interviews and lectures were submitted to interpretive analysis (Schwartz-Shea & Yanow, 2013), assuming that the knowledge shaping public concerns can be reconstructed through discourses that do not simply mirror the surrounding world but shape it and give it meaning (Hajer, 2005). While there is a contextual overlap between the datasets allowing to depict the dynamic of the debate, the analyzed statements were independent of each other and there is no cross-over coverage. In the analysis, first, all text units were searched to identify the main topical categories describing home birth and birthing: "good birth," "birthing safety," "birth care," "data," "evidence," and "experts" were identified as the main topical categories, on lexicological and syntactical levels as well as on the level of the overall coherence of the text units (see Maingueneau, 1998 for details on the analytical approach). Second, these categories were put in relation to the contexts in which they were used in all those documents and to the actors who used them. Two opposing actor groups were identified through this analytical procedure: the "medicalized birth group" (mainly obstetricians and health authorities); and the "home birth group," consisting mainly of midwives advocating for more respectful birthing care, nonprofits advocating for home birth, and nonprofit patient advocates, who at the same time demonstrate their understanding for the home birth choice (though not always endorsing it necessarily).

Although the groups were identified based on their arguments for or against homebirth, the result is a professional overlap with obstetricians being in the medicalized birth group and midwives along with NGOS in the homebirth group. We analyzed this professional overlap further, by identifying, third, the stylistic means used to describe the topical categories "good birth," "birthing safety," "birthing care," "data," "evidence," and "experts" were examined. This analysis identified that while both groups would understand themselves to be 'experts' and emphasized that their view is actually 'expertise,' they differ in the particular ways in which they refer to individual needs and emotional situations around birthing. This is contingent with their respective understandings of what expertise is. While we present the summary of the interpretive analysis in Table 3, we also expand upon some examples from the dataset to better illustrate the identified meanings and their contingencies.

To understand how these two camps relate their understanding of expertise to "emotions," we revisited finally the whole dataset by looking at different meanings of emotions in both groups. Emotions, in the whole dataset, are understood as explicit references to "emotions," "emotional," "feelings," "feel," or other terms demonstrating the fact of having emotions or an emotional state of mind. Further, an array of emotionally colored vocabulary and words having semantic proximity to 'emotions' and 'emotional' were considered when analyzing the data. These include verbs such as "wish" and "want," as verbs relating semantically to desire and emotional imaginations, and adjectives such as "personal," "subjective," and "individual" that are regularly in the semantic environment of a wish. All these references are identified in our dataset on the level of word choice, sentence structure, rhetorical figures and metaphors, and overall text coherence (see Czarniawska, 2015; Durnová, 2018; Flam & Kleres, 2015 on the details of the approach). This part of the

[3] The event of 2021 has been held in an online format. We have also been following Facebook groups dedicated to the issue of homebirth between 2017 and 2021. For privacy reasons, these data are used as background information only.

analysis aims to understand the context in which emotions are referenced and how emotions contribute to the message delivery and whether the identified contexts make the statements and their proponents part of expertise, or not.

Case: Czech public debate on birth care

The Czech debate on the status of midwife-assisted planned homebirth in the birth care policy of the country cannot be viewed solely in the context of the well-known professional territorialism between doctors and midwives, as it raises larger questions about how the expertise around birth is established and what is seen as relevant knowledge and a legitimate argument (see also Durnová et al. 2022). On the regulatory level, Czech obstetric and perinatal health care is covered by health insurance and is provided only by maternity hospitals. Unlike in countries like the UK, Germany, or the USA, there are no midwife-led units; instead, community midwives assisting homebirths operate under semi-legal conditions and face numerous difficulties (e.g., criminal trials, administrative penalties, and media-driven personalized threats). According to available data, approximately 0.5–1% of women decide to deliver at home (Durnová & Hejzlarová, 2021). Although pregnant women can theoretically choose a maternity hospital, in practice they cannot make an informed decision because publicly available data on medical interventions and procedures provided in these hospitals are insufficient. Some women hire a doula or midwife to assist their birth at the hospital to try to prevent undesirable medical interventions. This may lead both to a more intimate experience as well as tensions between the hospital staff and the birthing woman. This situation is the direct result of the specific professional status of midwives in Czechia: midwives are categorized not as independent health care providers but as assistants of doctors. Some midwives aspire to work independently, and some also try to challenge the idea of birth as a health care issue in need of medical supervision.

It is important to mention that midwives' professional status is reflected in the media, as the media framing focuses primarily on newborn deaths and on midwives sued for these deaths as well as on the low perinatal mortality in Czechia,[4] which is used in the media to underscore the overall quality and reputation of Czech medical care. This underscoring is important because obstetricians use it to downplay the role of international requirements to improve birth care, especially the care standards set by the World Health Organization (WHO). It is worth mentioning in this context that the public debate is also part of the larger context of the post-socialist debates on care choices (Hresanova, 2014; Hrešanová, 2017) and reproductive choices, which situate the professional conflict between obstetricians and midwives within a larger concern about how individual requirements are framed in policy choices and policy discussions (Dudová, 2012; Havelková, 2014; Šmídová et al., 2015). These concerns are demonstrated in the public debate through several moments in which policy makers have tried to pacify such individual agencies, for example through attempts to ban homebirths. Against such attempts stand the nonprofit sector and patient advocacy sector, which challenge the current legal and regulation status quo of birth care through litigation and legal cases in the European Court of Human Rights in Strasbourg, as well as through deliberation efforts coordinated by a governmental working group. The

[4] According to the most recent figures the perinatal mortality is 4,42 ‰ in Czechia. See https://www.uzis.cz/res/f/008279/narzem2018.pdf.

latter remains, however, only on the level of recommendations for good practice in birth care.

A summary of the main moments of the public controversy is helpful to understand the subsequent analysis of the two framings of expertise that appear in the debate. Although the first specific policy negotiations on the status of home birth and individual choices of birth care began in the 2000s, the criminal trial of Ivana Königsmarková—a midwife and the president of the Czech Midwife Union (UNIPA)—was covered prominently in the media, giving a particular emotional and driving moment to the debate and bringing forward the two public framings of expertise. In 2009, Königsmarková assisted at a home birth, after which the newborn suffered severe brain damage and died twenty months later. Government officials and medical doctors, as well as those who supported their view, presented her case as exemplifying why home births threaten child security and why mothers choosing home birth are "irresponsible." At the same time, Königsmarková became a powerful icon of women's need to contest the medical dominance of the debate for both mothers choosing homebirth and for those wanting midwives to have stronger competencies. Although it was not the first assisted homebirth that resulted in a fatality, it was the first to end up in court in 2010. Remarkably, and interestingly for our present purpose to discuss the role of expertise in the debate, the complaint (as the basis for the trial) wasn't raised by the child's parents but by the maternity hospital where the child was transported immediately after the homebirth. The complaint was subsequently supported by doctors from the central expert committee of the Ministry of Health. The District Court announced its judgment in September 2011: a five-year ban on Königsmarková working as midwife, a two-year prison sentence followed by a five-year probationary period, and a fine of CZK 2.7 million for the child's medical expenses. In November 2011, the Municipal Court in Prague considered Ivana Königsmarková's appeal and upheld the original judgment. The twist in the case came in 2013, with the Constitutional Court judgment, which abrogated the previous judgments and returned the case for renegotiation. The Constitutional Court's main argument is important for our discussion here because the court stated that most of the evidence and expertise suggested by Königsmarková's lawyers was not accepted during the trial and that her right for a fair trial was therefore not fulfilled. After this appeal, the Municipal Court in Prague in April 2014 ruled Ivana Königsmarková innocent. In December 2014, her case finally ended when the Supreme Court rejected the appeal of the Highest Prosecutor. Freed of all charges, Ivana Königsmarková then sued the other part for compensation. Since she has been a pioneering midwife for better birth care, her trial gave impetus to a variety of supportive actions—demonstrations, petitions, and a special website where women with children could share their birth stories. These stories are important for the discussion around the expertise around birth care because they highlight the need for emotional integrity and human closeness at birth, which women say is absent in hospital births.

However, the outcome of the Königsmarková trial didn't change much the pending inclusion of midwife expertise as an integral actor in birth care in Czechia. For example, when, in 2012, a working group on childbearing was established by the minister of health care, obstetricians and neonatologists refused to participate in the first session, claiming that such discussions with non-medicals were pointless (Interview EX1, EX8). After a year, the working group was shut down and replaced by a working group in which no proponents of any alternative health care choice or practices were invited to contribute. At the same time, another committee by the Office of the Government was established that included midwives, doulas, human rights lawyers, and NGO members (doctors objected that they weren't engaged in these discussions, and their expertise is thus not represented

by this administrative (Interview EX1)). These working groups and related discussion have resulted in three important changes in birth care policy: (1) anyone with a medical education assisting a planned homebirth can be fined up to 1.000.000 CZK (nearly 40.000 Euros as of April 2012); (2) women after delivery may leave the hospital earlier than the usual 72 h (since 2014); and (3) insurance agencies can pay the maternity hospital for births led only by midwives (since 2014).

While these shifts indicate some broadening of hospital midwives' competencies and the acceptance of some of the women's demands (e.g., personalized care, minimum time spent in hospital), they also represent a great symbolic "no" to homebirths through the threat of fines, and they also represent the exclusion of professionally independent midwives (outside hospital governance). The first midwife who was fined 120.000 CZK[5] for assisting in homebirth was Hana Johanka Kubaňová. In 2018, the Regional Authority accused her of assisting in at least five home births (only one of these was complicated but was solved with no damage). The fine was based on her having insufficient expertise to assist at a birth, as her midwifery license covers only pre- and postnatal care. The case again raised a public debate, and a demonstration was held in Prague in support of Kubaňová. There have been other numerous ongoing or resolved trials in which midwives have disputed the decisions and statements of public administration bodies regarding their licenses as well as trials where women demanded midwife care during their planned homebirths.[6] All these cases underline the conflict around the appropriateness of expertise and relevancy competencies of midwives for birthing. In the expert commission established by the health care ministry, the core of the conflict arose around who has the right to speak about birth care (Interview EX6). The medical doctors invited to the commission objected to sharing the discussion table with midwives and legal experts (Interview EX 4, see also Candigliota 2020).

These events aptly illustrate the polarized discussion environment around birth care in Czechia. For our purposes, the debate can be divided into two time periods. Until 2009, the debate was rather balanced with respect to different positions toward home birth. Along with articles neutrally discussing accidental homebirths or doctors' statements about homebirths as a 'new fashion' (MF Dnes 2009 or Lidové Noviny 2007), there were also very thorough and balanced articles calling attention to a legislative vacuum to insufficient follow-up medical care. The general tone in this first period is appealing, rather than disparaging. The debate is also more on a hypothetical level (although some planned homebirths are happening), and the most speakers talk only about the potential general risks of home births. A contributing factor to this discussion atmosphere might be also the lowered natality during this period, which led to greater competition among maternity hospitals, resulting in facilities offering special packages for mothers—among them special birth accessories and alternative procedures—to make their maternity service more attractive than another.

From 2009 onward, the debate began to be polarized into a pro-versus-con debate on homebirth, with no middle ground. This period offers the most interesting material to follow the interaction between various meanings of what expertise is and how it relates to

[5] (app. 4.700 Euros. The average monthly salary in the Czech Republic is app. 1.400 Euros).

[6] Most prominent has been the Case of Dubská and Krejzová v. the Czech Republic 28,859/11 28,473/12 https://hudoc.echr.coe.int/fre?i=001-148632. The case has been seen as a success despite the outcome because it has made it to public hearing, which not every case presented at the ECHR does (Interview EX6).

emotions. The polarization is situated between a system-oriented expertise defining birth through medical safety on the one hand and the women-oriented expertise, framed through the focus on civil rights, defining birth through mothers feeling safe. Whereas the first type of expertise is assigned to obstetricians and other health care personnel, including emergency staff, the second perspective is represented by midwives, legal experts, and, to a limited extent, by mothers themselves. It is also interesting in this respect that while the first type of expertise relates to the general well-functioning system of birthing, the other type of expertise highlights the role and necessity of individual agency and the legitimacy of that agency. The analysis discusses this division in more detail. In this sense, it remains noteworthy that although our analysis takes into account the context of the public discourse on alternative birth choices, such as homebirth (see e.g., in: Dahlen et al., 2011; Sassine et al., 2020), and reflects the relation between birth activism and feminism (Cheyney, 2008; Hrešanová, 2017), its main interest lies in the analysis of the division between the medicalized birth group and the home birth group.

Results

The analysis shows the dominant focus on safety in discussion of birth care which is either seen as part of emotional circumstances of birthing or as something which should be beyond these circumstances or event go against them. The analysis has identified an opposition between (1) an expert knowledge focusing on the technical aspects of ensuring birthing safety, which is ensured by an unanimous scientific view, foregrounding national medical standards, and supported by the long-term reputation of obstetric care in the country and (2) the expert knowledge foregrounding the importance of birthing safety as an experience of women, which is ensured by an interdisciplinary search for scientific evidence across different disciplines—such as midwifery, medicine, and law—and within international debates on birth care standards. These divergent meanings on expertise are analogical to two ways of bringing emotions into discourses on expertise: while the first type of expertise sees individual feelings and emotions limited to a personal and subjective view that should stay away from experts' recommendations regarding safety of birth, the second type of expertise sees these feelings and emotions as *defining* birthing safety and as something that should be included in birth care and in the notion of birth care expertise. Both types are related to the question of who is regarded as an expert in the public debate which leads us to analyze the role of emotions in expertise more specifically.

(a) **Who is talking in the media as an expert about birthing?**

From the 625 media units we analyzed, 177 units lack a direct speech having more of a news character. In 106 units, the only speaker in the media unit is a medical doctor. There are 103 units in which doctors share the media space with another speaker or speakers. Overall, we conclude that medical doctors have a hegemony over the media discourse, with the coverage of 46.6%. The second-most exclusive speakers in the media debate are celebrities. They made statements regarding homebirth in 45 cases (out of 448 in which a speaker appeared). Midwives are the exclusive speakers in one media unit only in 25 units (out of 448 with a speaker), which means that they have a media

Table 2 Number of media units according to the exclusive speaker. (Source: authors)

	Medical Doctor	Celeb-rity	Mid-wife	Police, judge, lawyer	Woman (in childbed)	Hospital midwife, nurse emer-gency	Politi-cian	Others	Total of exclusive speakers
Number	106	45	25	19	17	16	11	43	282

presence in 5.6% of cases. Women—in their role as birth givers—were the exclusive speaker in only 17 cases (out of 448 with a speaker), that is, 3.8% of the coverage. Women's general coverage (consisting of 61 units) is 13.6%; otherwise, their voice is introduced to the debate by midwives.

If there are two speakers in the media unit, the combination is most often doctor and midwife (19 units), doctor and woman in childbed (13 units), doctor and nurse or other member of hospital staff (9 units), and doctor and judge/lawyer/police (6 units). Other speakers aren't given the media space that often (see Table 2). The analysis identified only a small number of politicians as individual speakers (11 units, 2.5%). Their general coverage (consisting of 27 units) was only 6%, which may indicate an aim to frame the topic as an expert issue rather than as a political conflict over rights. At the same time, the framing of the issue as an expert issue is used by NGOs as a form of politicization, as illustrated in the next section.

(b) **What is being discussed?**

The analysis of the topical categories discussed in the media identifies an overlap of the dominant topical focus with the two dominant voices found in the analysis of who speaks in the media debate (see Table 3): Those against home birth as a healthcare choice are represented by obstetricians, health care professionals, public health officials, and politicians in office (described here as the "medicalized birth group"), while those who claim to respect home births as a legitimate health care choice are represented by midwives, women, legal NGOs, and advocacy groups (described here as "home birth group"). While both camps relate to "safety" as the most important aspect of birth care, they organize its meaning differently (see Table 3, column 2 for summary).

The medicalized birth group frames the birthing safety along two main arguments in the debate: the first is that childbirth is safe only when it occurs in hospital, going along with highlighting childbirth safety as a primordial condition of birth. "High quality of Czech obstetrics" is a phrase used by the majority of obstetricians asked to give an opinion on birth safety, and they all repeat that "Czechs have a unique system." At the same time, the need for a medical expert to be present at birth is highlighted as part of mothers' responsibility to ensure birth safety, as in this from the emergency medical service:

> We wish all expectant mothers to deliver without complications and in an environment, they choose for themselves after mature deliberation. *However, before choosing home birth, they* should *consider the possibility of complications endangering the baby's life or their own. These situations during birth can never be prevented in advance* (ZZS 2016 – emphasis added).

Table 3 Summary of the analysis (source: authors)

	Who speaks	What is discussed	What is expertise
Medicalized birth group	Obstetricians	Safe birth	Medicine & Law
	Medical doctors	Safety is primordial	Fame of Czech “obstetrics; „ivory tower “ but „no data
		Safety occurs only in hospital	
	Emergency staff	Emotional circumstances: “when we get this done, we can talk about emotions”	Based on routine and professional experience
		Downplaying the right to choose emphasizing the subjective choice of a woman “new fashion”	Nonexistence of official statistics / survey of birth practices
		Czechia has a high-quality maternity care	Community of MDs
			No dialogue between experts seen as necessary
Home birth group	Midwives	Safe birth	Law & Medicine
	Nonprofits	Emotional circumstances	International peer reviewed journals, meta-analyses
	Legal advocates	Right to choose	
	Psychologists	Legal conditions and health care quality should be in harmony	Experiences of midwives based on individual stories
	Women rights activists	Harmful practices	WHO
		Learning from abroad	Request for data
		WHO standards	Seeking for truth in judicial trials
		More data on Czech obstetrics is needed	Dialogue among various experts

This argument around safety is eventually seen as a reason to downplay women's right to choose individual care setting. This is generally done by deploying various language means. Mothers choosing alternative birthing, such as home birth, are portrayed as "hazarding with their life," as "irresponsible." The right to choose is framed as a "new fashion," highlighted sometimes by generalizing statements such as "the birth plans, you know, everybody now wants to have these birth plans" (CRO 2018). The third argument, related to those previous two arguments, is that only when the safety condition is fulfilled can mothers' emotional comfort be attended to: "When we get this done, we can talk about emotions" (for example in CT 2013). This aspect became slightly more diversified in the medicalized birth group from 2014 onward. Some medical doctors partially accept the discourse on women's emotional comfort and self-determination (as articulated in our date in: Interview EX8 or Lecture, 2018A). However, these doctors continue to insist on their negative attitude toward homebirths and emphasize the critical importance of medical expertise in birthing, which outweighs emotional circumstances.

The home birth group is also concerned about safety as an important indicator of birthing quality, yet the safety is framed differently in their discourse. "Women *don't feel* safe in Czech hospitals" is the leading argument supporting the choice of homebirth as an understandable one, and even a rational one (see, e.g., MF Dnes 27.7. 2009 or official statement of HAM 2018). This emphasis of individual feelings of safety is further contextualized through the legal principle of the freedom of choice, advanced mainly by women's rights organizations.

In this context, actors in the home birth group cite the emotional stress that mothers might feel and experience as a loss of safety, as seen in this quotation: "Disrespect for the mother, lack of intimacy, stress and tension, unnecessary and unjustified medical interventions—*all these are typical vices of Czech maternity hospitals that can still make* childbirth *not only an unpleasant experience, but also a trauma*." (22/11/2011, UNIPA, emphasis added). Legal advocates for respecting women's rights also frame birthing in hospital as an emotional burden for the mother and consequently as potentially harmful for the child. The Czech Human Rights League (LLP), a nonprofit that advocates for the rights of midwives and parents, refers to care practices in Czech maternity hospitals as paternalistic and as limiting the possibility women must fulfill their bodily and emotional needs during birthing. Consequently, such practices violate their human right to bodily integrity:

> The ban on providing care during home birth goes against the international conventions (…) Childbirth in a hospital, where harmful practices occur, is not acceptable to some women. (Attorney Zuzana Candigliota for LLP 2/12/2015)

Learning from the best practices abroad and referring to WHO guidelines as well as to international legal treaties, represents the backbone of the argument of birthing safety presented by the home birth group. According to WHO professional guidelines, safety is defined as minimal interventions during birth and calling for a proactive establishment of a space in which the mother feels safe. As states, for example, UNIPA, the main professional midwifery association in the country, the data and evidence do not go against women's individual and emotional needs: "Evidence-based practice (EBP) is the most modern type of care, which accommodates women's rights and autonomy, seeks pathways in line with current knowledge, and protects the health professional from decision-making responsibilities by emphasizing informed and free choice of obstetric care" (UNIPA, 20/11/2017). In such a setting, emotional needs neither come after birth safety nor are they secondary to it; instead, they are the core of safety. In this, midwives and women's' rights activities

highlight the need for evidence and data as the basis to enable an autonomous choice to women giving birth.

Related to the argument of safety is the argument that women should have enough information to exercise their right to choose the place and the way of giving birth (UNIPA, 20/11./017). This is generally accepted by all the stakeholders in the debate (see also MZ 12/12/2013). Information delivery is also a recurrent theme in framing the recommendations contributing to the quality of care and to respect for parents and mothers (UV/18/10/2018). The medical group uses this as an argument that birthing and birth care should be in the hand of doctors (MZ 12/12/2013) and that emotions are something individual and subjective which should not interfere in the reputation of obstetrics, while the home birth group highlights this through the need for new or more specific data to make an informed choice on birth care (UV 21/12/2020 and Interviews EX4, EX5, EX6). This request for evidence brings us more closely to the meaningful ways in which expertise is understood by the actors of the debate, as well as the ways in which it is publicly framed, which is discussed in the next section.

(iii) The use of expertise in the birth care debate and its relation to emotions

The professional composition of both groups impacts what is regarded as expertise in birth care. Both groups see law and medicine as important areas to shape the expertise, with the home birth group emphasizing that the law should be seen as not in conflict with medical standards but in concert with it (see Table 3 for overview). Both groups make an interesting distinction regarding the status of Czech obstetrics and its role in birthing care expertise. While the medical birth group emphasizes the fame and routinized professional experience, the home birth group precisely criticizes this. Against what they see as an ivory tower of a bunch of elderly obstetricians, the homebirth group emphasizes instead international studies and analyses and WHO guidelines that should be considered in Czech obstetrics. In this regard, it is interesting that the home birth group sees data and request for data as the most important stake in the expertise debate has also shaped the negotiation efforts around these requests (as extensively reported in interviews EX4, EX5, EX6). That data on birth care in Czechia are insufficient has been at the core of the work of expert advisory bodies both in the Czech health care ministry and in the government office (see also the Mission statement, UV 2012). According to the medical professionals, however, the current data are sufficient, and generating data on quality of care available for women in a transparent data register could “lead to serious misinterpretation by the non-medical public” (as states the prominent obstetrician Antonin Pařízek in a meeting of the Working Group of Obstetrics under the Office of the Government of the Czech Republic: UV, 5/2020). Given that attitude toward the non-medical public, the medicalized birth group is also reluctant to enlarge the scope of expertise around birth care (interviews EX 1 and EX 6). The group sees medicine as the key and only expertise for birth care (interviews EX5, EX6 and EX7 and Pařízek Lecture 2018).

Efforts to enlarge the scope of expertise to include other than medical voices remain therefore rare (Candigliota, 2020), and any specific policy outcome that would support the inclusion of midwifery and patient advocacy in the expertise on birth care are still awaited by those who criticize the current state of birth care (Interviews EX3) or see potential to improve it (Interview EX7). In such a critique, expertise is as the same time portrayed as an interdisciplinary dialogue and as a dialogue with human rights. For example, in one expert interview, the legal advocate says that legal practice should not

conflict with medical professional codes of conduct nor, "above all, with what women want" (Interview EX6). Not that woman should dictate to experts what to do, but that professional guidelines should be in harmony with woman's psychosocial needs when good birth is the goal. This is also supported by repeated statements from the main patient advocate of birth-giving women, the League of Human Rights, in which the organization highlights that "women feel right about (the practice), but their feeling is supported by data" (LLP 2/12/2015).

In the medicalized birth group, the mismatch between what is stated in the media and what can be found in the strategic documents is notable: while obstetricians claim in their media interventions that medical knowledge on birth care is data-supported, they refer in official statements to research results going back to 2008, and they reproduce this dated research in updated press releases (see CLK 2012). Some medical voices explain this with a generational trend inside the obstetric community, where the reputation of Czech birth care is rather asserted than updated through actual research (Interview EX7). The medicalized birth group also demonstrates a negative attitude toward those voices of international science that support midwifery and individualized needs, portraying it as activist science. Neither their professional code of conduct nor the public statements from the obstetricians themselves mention WHO; rather, they talk about "our birth care" as opposed "to fashionable tendencies by the politicized WHO" (Pařízek Lecture 2018).

Additionally, on the side of the home birth group, the 'sciences' are seen not only as medical science: law and especially midwifery are treated as equally important. 'Science' is also conceived as a dialog across these disciplines, and public institutions are thus seen as having the role of facilitating and organizing that dialog. This is most visible in efforts to establish institutional advisory bodies on providing updated professional codes of conducts on birth care that would include midwifery, holistic approaches to medicine, and, above all, women's perspectives and human rights. These efforts remain unechoed by the legal steps and the official steps taken by the ministry of health and they have remained unechoed in the media framing of the controversy over homebirth.

In both framings of expertise, emotions are mentioned as contingent with birthing safety. In the medicalized birth group, emergency workers are put in the forefront as having an already demanding job, which is then unnecessarily challenged by women choosing homebirth and ultimately needing emergency staff: "Nobody wants to see a baby dying, believe me" declares for example one emergency worker in the media (MF Dnes 2016). The professional organization of emergency workers highlights this aspect also in its press releases, such as the following one:

> (…) For rescuers, [home births] mean not only increased demands on their medical skills but also significant mental stress. Although one expects a seamless labor, it can never be determined with certainty. (ZZS 22/11/2016)

While these emotions and feelings are seen as important and needing to be considered, emotions of mothers and their demands concerning personal comfort is seen by the medicalized birth group as "selfish" and "irresponsible." Furthermore, emotions of birthing women are represented in the discussions as something irritating and related to a behavior and practices regarded as pathological. The best example are two specific ways of portraying homebirth. The first portrait describes women choosing home birth as women longing for an orgasmic birth. In this portrait, sexual desire is seen as highly emotional but irritating because it is out of place, as this is about safety and child comfort, so sexual desire is degraded as a selfishness of the woman who tends to her (sexual) needs rather than the baby's needs. In the second portrait, homebirth is described through placenta eating.

Women giving birth are referred to as "placenta-eaters" and passionate "bio-women," which draws attention away from their emotional demands toward spectacularism or even pathological character of behavior sometimes related to home birth.

These portraits are attended by the medicalized birth group's argumentation in which emotional integrity of birthing women is either omitted or, if it is mentioned in these expert statements, it covers mainly the material background of maternity hospitals as something which brings women comfort and thus is seen by these experts as more intimate. This gets translated into efforts of hospitals to make the delivery room look more 'like home' (Jihlavsky Denik 2011) and to promote facilities such as bathtubs, grab bars and the like under the label of "making the birth more intimate" (UK Forum 2021). Such framing of emotional needs of women degrades them to material requests to have a nice and enjoyable birth. What remains unmentioned, however, in these argumentations are the processes and interventions that take place in the medically assisted birth and that might be sometimes unwanted by the mother.

The latter is the dominating focus on the topic of emotions in the homebirth group. The home birth group refers to emotions mostly through mothers 'feeling safe,' relating the importance of this feeling to individual preferences around birth care. The discourse on emotions is brought to the debate either by women (in childbed) or by patient advocates and doulas speaking on behalf of these women. In this framing, the role of emotions changes: emotions are not presented as a spectacularism of women's behavior (presented often as "crazy" by those who criticize it), as a damage controlling of what is seen as irrational women's behavior but are also part of expertise because how women feel coproduces good birthing and good birth care. How women feel is here an indicator: for the legal expertise, it is the indicator of whether women will seek medical assistance at birth or give birth outside hospital at any cost, even if the law forbids it (LLP and interviews Ex1 and EX4 and EX5). For medical knowledge, the emotional integrity of women is part of birthing safety, voicing the studies claiming that physiological birth needs to consider women's emotional comfort (HAM, LLP). Recommendations for respectful birthing practices explicitly mention women's psychosocial needs: "doctors should treat mothers tactfully, kindly and considerately, in a manner appropriate to their social and communication skills, respecting their individuality and personality" (UV 26/5/2016).

Discussion: language on emotions impacts public framing on expertise

While both groups refer to expertise and data, they differ in the way they relate to emotions around birthing. This difference can explain the public framing of experts on birth care. To offer such an explanation, our analysis interprets the public framing of expertise in the media in the context of the expert discourses as presented either in their strategic material or in their personal interventions. Our analysis allows us to see (a) who is established as the expert to decide about this care practice in the national public discourse, (b) what are the topical categories creating the expert's expertise, and (c) how emotions and expertise interact within these categories. By doing this, the paper goes beyond the question of which birth care choice is more likely to accommodate women's wishes for emotional integrity. We look instead at how a set of knowledge that informs a policy debate is framed as a relevant expertise, which actors are understood as legitimate, and how language on emotions used in the debate coproduce this framing.

While the traditional view on expertise has made an incontrovertible distinction between objective data and individual experience of citizen, the debate we analyzed paints a more complex picture in which emotions are among the data to be considered. This concerns, first, discussion around whether emotional concerns as an aspect of birth are relevant knowledge and, second, what kind of actors sees them as such. In this regard, we observe an analogy between the position of women in the debate and that of emotions mentioned in context of birthing and birth care. Home birth–related requirements are embedded in the context of the legitimacy of a personalized health care choice that is respectful of individual requirements, feelings and emotional integrity. The emphasis on emotional integrity is also interesting in the context of research carried out on birthing, revealing that the most common reason for choosing homebirth is the situation in the Czech hospitals and the attitudes and practices of Czech obstetricians (Takács & Seidlerová, 2013), leading in some cases even to post-birth trauma (Mrowetz, 2015).

Yet from the side of the medicalized birth group these requirements are embedded in the context of a selfish mother who wants to enjoy her birth instead of complying with her role of serving the child's best interests. The home birth group counter this by highlighting emotional circumstances as contributing to birthing safety, which makes women the expert of their own birthing (See also Durnová et al. 2022). But since that framing of emotions is represented by midwives, patient advocates, and women—that is, by those who do not comply with the common understanding of a medical expert—they are not given the same amount of space in the media. The media replicates and consolidates the common understanding of expert knowledge as a technical knowledge presented by those who are already established in the field: in this case obstetricians and those who support their views.

That media give more space to the medicalized birth group and to obstetricians who disregard women's perspectives on the issue and women's wish to include emotional integrity and feelings in the debate has an impact on how emotions are understood in the public controversy on birth care altogether. The media priority of the medicalized birth group is sustained by the view of emotions as something detached from expertise, which is manifested in the analysis through a specific language of emotions. In the home birth group, emotions are seen as an understandable part of expertise on birth care because they touch on birthing women's psychosocial needs and emotional integrity. In the medicalized birth group, however, emotions are acknowledged solely as a personal anxiety of medical staff who must not be disturbed in their practice of rescuing and healing. All other emotions, notably those displayed by birthing women, are seen as may be understandable but naïve, subjective, and a sign of professional derogation. This disregard of women's emotions is supported by professional codes of conduct of obstetrician supported by their national reputation and space given by the media. Referring to knowledge and standpoints as "emotional" is then used to highlight that the evoked emotions of women are too subjective, selfish, and too unstable creating even pathological moments, which cannot be integrated in professional codes of conduct. Portraying emotions in such a way gives the medicalized birth group the argumentative means to claim an insufficient expert status of other than medical professions and legitimize their exclusion from the expert discourse.

The focus on the emotions- expertise nexus in the debate shows that the conflict over mothers' role in deciding where and how to deliver, albeit nurtured by the professional territorial conflict between obstetrics and midwifery, reveals the crucial moment of the civil rights dimension forwarded by legal experts and nonprofit organizations. In such a view, using the individual experience of birthing for expertise means not a surplus to the expert debate but an indicator of the same importance as any other expertise. This view is nevertheless not resent in the media framing where the public framing of an expert being

detached form emotions and following routinized standards prevails. This is related to the general view of expertise as something beyond culture and societal changes (because individual moods can change). Such a view excludes emotions from expertise because these are seen as subjective, regressive, not serious, and partisan (because they follow personal or activist goals).

Conclusion

The analysis of the public controversy over midwife-assisted homebirth shows that the opposition between the two groups conceals a more profound opposition between two understandings of expertise. The system-oriented expert knowledge of medical doctors becomes opposed to the expert knowledge oriented toward the individual choice while simultaneously claiming to be women-oriented. This opposition is further sustained through public framing of expertise as something that should not include emotional contexts and individual feelings. The analysis shows how this view is supported by public framing in the media that gives more space to the expertise of obstetricians, as the male-dominated expertise in which collective reputation outweighs the importance of actual data and the system-oriented solution is weighted more than individual traumas and concerns over emotional comfort are.

The results of this analysis thus raise important questions about how expertise relates to emotional experiences and individual assessments of a situation and how in the public framing these are either embraced by the expertise or excluded from it. The issue of birth care makes timely case to discuss the role of emotions in expertise, since individual assessments of bodily feelings and emotional sensations are strongly related to the physiological development of birth and the overall emotional comfort of women is an indicator of a good outcome in birthing care. Yet, even in such a situation, emotions are disregarded and seen as less relevant for expertise, as the case aptly demonstrates. The results thus reach beyond the example of birth care, because revisiting the role of emotions in the production of expertise and in its public accountability can explain better why citizens might prefer to formulate their views counter to such public framing of expertise and may eventually deem it legitimate to contest professional authorities. In a time where informed consent and respect of emotional integrity become key to legitimize public instruments to regulate human behavior, analytic sensitivity toward specific language of emotions will be much needed in studies on expertise. We need to understand what citizen feel and why they feel it rather than make their feelings reject expertise.

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Data availability The interviews were held anonymously and confidentially and thus the transcripts cannot be provided to third parties. These data are stored, password protected, in the project research archive. The collected documents are also stored in the university archive.

Declarations

Conflict of interest The authors declare that they have no conflict of interest to declare.

Ethical approval At the time the study was conducted, the research institution did not have a relevant ethics committee to evaluate the research project. In accordance with professional ethical guidelines of public policy and sociology, as well as those of research integrity of our research institution, the project ensured that all respondents gave their informed consent to participate in the inquiry and have been given the right to retrieve their responses at any time during the inquiry. In accordance with respecting respondents' privacy, all interviews have been anonymized.

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