

“BECAUSE IT IS MY BODY, AND I OWN IT, AND I AM IN
CHARGE”:

POWER AND RESISTANCE

IN BIOMEDICAL AND MIDWIFERY MODELS OF BIRTH

By

KATHRYN WORMAN ROSS

Bachelor of Science in Sociology and Psychology
Jacksonville State University
Jacksonville, Alabama
2004

Master of Arts in Sociology
Middle Tennessee State University
Murfreesboro, Tennessee
2007

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Dissertation Approved:

Dr. Stephen M. Perkins

Dissertation Adviser

Dr. Tamara L. Mix

Dissertation Adviser

Dr. J. David Knottnerus

Dr. Virginia A. Worley

Name: KATHRYN WORMAN ROSS

Date of Degree: MAY, 2013

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Abstract: I utilize participant observation, autoethnography and in-depth interviews with women who have given birth at home and homebirth midwives in Oklahoma to understand perceptions and responses to society's hegemonic birth system, its power, ideology, and practices. Employing Foucauldian, Foucauldian feminist, and Social Constructivist frameworks, I illuminate issues of reality construction, knowledge, and power related to the homebirth experience. Participants expressed distinctions between biomedical and midwifery models. They described complex processes whereby women's bodies are transformed into docile bodies through disciplinary technologies, including control of ideology and panopticonic domination of time, space, and movements of the body. This process involved technocratic constructions of women's bodies and birth as pathological and women's bodies as defective machines that require application of technology and expert action to birth. Homebirth mothers and midwives articulated narratives of empowerment, knowledge, and control in the philosophy and practice of the midwifery model and homebirth, and subscribed to a holistic paradigm that involved constructing women's bodies and birth as healthy and normal, understanding women as social beings, and valuing nature over technology. Homebirth was directly and indirectly presented as resistance to normalizing medical hegemony whereby respondents claimed ownership of their bodies, births, and babies, pursuing this aim through active creation of agency, empowerment, and practice of alternative birth models.

TABLE OF CONTENTS

| Chapter | Page |
|--|------|
| PART ONE: INTRODUCTION | |
| I. INTRODUCTION | 1 |
| II. BUILDING A FRAMEWORK FOR UNDERSTANDING HOMEBIRTH..... | 6 |
| Social Constructivism: Meaning, Reality, and Power | 7 |
| Foucauldian Feminism: Political Economy, Biopower, and Subjectivity | 9 |
| Biopower, Governmentality, and Panopticon | 10 |
| Power/Knowledge | 13 |
| Subjectivity, Freedom, and Resistance | 15 |
| Analytical Framework | 17 |
| Power and Legitimation of the Biomedical and Midwifery Models | 17 |
| Docile (Female) Bodies | 19 |
| Subjectivity and (Embodied) Feminist Resistance | 20 |
| III. CONTEXTUALIZING HOMEBIRTH: A CRITICAL HISTORY | 22 |
| The History of Birth in the United States: The Rise of the Biomedical Model..... | 23 |
| Lens of Pathology | 25 |
| Body-As-Machine..... | 26 |
| Favoring of Technology and For-Profit Intrusion | 28 |
| Power and Agency in the Biomedical Model | 31 |
| The Midwifery Model..... | 36 |
| Birth in Oklahoma..... | 39 |
| IV. METHODOLOGY | 42 |

PART TWO: WHY WOMEN BIRTH AT HOME

| | |
|--|------|
| V. THE JOURNEY TO HOMEBIRTH: WHY WOMEN BIRTH AT HOME | 52 |
| The Journey to Homebirth | 53 |
| Why Women Birth at Home: Safety and Control | 63 |
| Safety | 63 |
| Chapter | Page |
| Control | 77 |

PART THREE: POWER IN BIOMEDICAL AND MIDWIFERY MODELS

| | |
|--|-----|
| VI. THE BIOMEDICAL/TECHNOCRATIC MODEL VS. THE MIDWIFERY/HOLISTIC MODEL | 84 |
| VII. WOMEN'S BODIES AND BIRTH AS PATHOLOGICAL VS. NORMAL | 89 |
| Pregnancy as Disease and Inherently Abnormal vs. Pregnancy as Normal and Safe | 90 |
| Detecting Disease vs. Achieving and Maintaining Health and Wellness | 96 |
| Fear Promoted vs. Fear Combated | 101 |
| Pain as Problematic vs. Pain as Normal | 109 |
| VIII. FEMALE BODY-AS-MACHINE VS. WOMAN AS SOCIAL BEING | 114 |
| Mind-Body Separation vs. Mind-Body Connection | 116 |
| Relationships | 119 |
| Support | 122 |
| Education | 124 |
| Mother-Baby Separation vs. Mother-Baby Unit | 125 |
| Individualistic Approach vs. Social Approach | 127 |
| The Importance of Family | 128 |
| A Social Approach | 132 |
| Standardization vs. Personalized Care | 133 |

| | |
|---|------|
| IX. THE SUPREMACY OF TECHNOLOGY VS. THE SUFFICIENCY OF NATURE | 140 |
| Medical Management and Intervention vs. Wisdom and Watchful Waiting..... | 141 |
| Machines vs. People..... | 156 |
| IV. POWER AND RESISTANCE IN BIOMEDICAL AND MIDWIFERY MODELS OF BIRTH..... | 163 |
| Power and Agency in the Biomedical and Midwifery Models..... | 164 |
| Power and Agency in the Biomedical Model | 165 |
| Chapter | Page |
| Power and Agency in the Midwifery Model..... | 168 |
| Control and Empowerment..... | 170 |
| Agency: Action and Authority..... | 173 |
| Medical Hegemony vs. Homebirth as Resistance..... | 178 |
| Homebirth as a Response to Medical Hegemony | 178 |
| Homebirth as Resistance to Medical Hegemony | 182 |
| Impacts of Resistance | 188 |
| V. CONCLUSION: POLITICAL ECONOMY OF BIRTH..... | 193 |
| REFERENCES | 199 |
| APPENDICES | 212 |

LIST OF TABLES

| Table | Page |
|------------------------------------|------|
| Homebirth Mother Demographics..... | 46 |

PART ONE

INTRODUCTION

CHAPTER I

INTRODUCTION

Birth is an event that happens every day in every place around the world, and it is an event that has occurred for all of human history. Despite its ubiquitous nature, very few people view birth as mundane or insignificant. Birth has the potential to transform women into mothers, men into fathers, children into siblings. It has the profound ability to create deep and complex relationships, evoke pleasure and pain, happiness and grief. From a sociological and anthropological perspective, the ways in which women give birth tell us a great deal about the cultural and social context within which birth occurs. Birth reflects and has the ability to shape or change the ways that women define their bodies, their social selves and their relationships with others, and the nature and ability of women in general. The theoretical significance of research on birth encompasses these phenomena, including the ways in which birth shapes and reflects the organization of society and the identities of its members.

In this manuscript, I ground feminist Foucauldian and constructivist understandings of power/knowledge, political economy of the body, and resistance in the voices of individuals involved in the homebirth community in Oklahoma in order to illuminate the complex phenomena related to women's lived experience. To better understand homebirth in Oklahoma today, we must understand the larger context and history of midwifery and homebirth in the United States. It is important to recognize the relationship between childbirth and culture. On

one hand, social processes reflect cultural meaning and, on the other, culture impacts expectation, interpretations, and experiences (Bogdan 1990; Davis-Floyd 1994, 2003; Jordan and Davis-Floyd 1993; Rothman 1991; Simonds, Rothman, and Norman 2007). Power and ideology play a significant role in the complex relationship between experience and society.

Though women in the United States frequently birthed at home 100 years ago and nearly exclusively at home 200 years ago, the occurrence of homebirth dramatically declined by the middle of the twentieth century, and rates of homebirth have remained quite low despite periodic upticks (Bogdan 1990; Leavitt 1986; Wertz and Wertz 1989). The decline of midwifery was no accident or inevitable evolution of birth practices. Instead, it was an orchestrated effort, facilitated and made possible by the exercise of power and knowledge (Arney 1982; Edwards and Waldorf 1984; Ehrenreich and English 1973; Leavitt 1986; Sullivan and Weitz 1988; Wertz and Wertz 1989). Consequently, in the U.S. today, most define childbirth as a medical process, where a standardized notion of *normality* is a constant concern and is thought to be assured by medical surveillance and expertise (Block 2007; Simonds, et. al. 2007; Wagner 2006). We often seek to enhance or make the best of the experience of childbirth and to do so, following our taken-for-granted cultural logic regarding health and birth, most Americans turn to science and medicine. Despite the variety of possible and actual birth styles and settings, when we think of childbirth, we think of a medical scene. Birth and medicine are intertwined in our thinking. Medical, and often surgical, birth is the reality for most American women today, though it was only a last resort for women in America in the seventeenth, eighteenth, and nineteenth centuries. How and why has the medical paradigm become so influential in our understanding of birth (and health)? Given the seeming cultural aversion, or at least statistical/numerical unpopularity of homebirth in our culture, why do some women decide to birth at home? Why do these women, along with their midwives, doulas, and significant others, persist despite oppositional cultural practices and understandings? What role does power play?

Following a “renaissance” of midwifery and homebirth in the United States in the 1960s and 1970s (Edwards and Waldorf 1984; Sullivan and Weitz 1988), an impressive body of research

emerged on midwifery, pregnancy and birth—in home and hospital settings—from fields including sociology, anthropology, history, and nursing (Including: Davis-Floyd 2003; Edwards and Waldorf 1984; Jordan and Davis-Floyd 1993; Rothman 1991; Sullivan and Weitz 1988 among others). In light of the social significance and potential theoretical implications of homebirth, there exists a relative paucity of research on the subject, particularly in recent years (Exceptions include: Beckett and Hoffman 2005; Cheyney 2008, 2011; Craven 2011; Davis-Floyd 2011; Pfaffl 2006). An even greater void exists on homebirth in certain regions and states, including Oklahoma.

In my research, I address this lacuna by providing a portrait of midwifery and homebirth in Oklahoma as co-constructed by my participants and me. Ultimately, I illuminate homebirth in Oklahoma from the perspective of homebirth midwives and women who have given birth at home, investigating the reasons they decided to birth at home and assist homebirths. In light of the history of midwifery and homebirth in the United States, and the hegemony of the medical model, the central goal of this project and, thus, my overarching research question is: *Why do women actively choose to birth at home?* In my research, I investigate how women who birth at home characterize and respond to our society's hegemonic birth system, its ideology and practices. At the same time, I explore the philosophies and motivations of midwives who help make homebirth a reality for women in Oklahoma.

As an interdisciplinary project, my research rests most clearly in sociological and cultural anthropological work on birth and power. What emerges contributes to fields of sociology, anthropology, nursing and medicine, midwifery, and other disciplines that incorporate feminist and Foucauldian theory and application. This research adds theoretically and empirically to a growing body of sociological and anthropological work on women's health and reproduction through the use of Michel Foucault's conception of power/knowledge and political economy of the body and social constructivist interpretations of reality construction. This research supports and adds to existing literature regarding birth models as well the systematic and lived inequalities in women's health care. In particular, I assert that the discipline of obstetrics, which is often viewed as a neutral and objective

discipline with the purpose of ensuring safe birth for American women, operates more importantly as a means of governing and normalizing female bodies and citizens. Understandings developed in this research particularly contribute to applications of Foucault's work on gender, power, and embodied resistance. Second, in the feminist research tradition, this research contributes to knowledge constructed from the perspectives of women, drawing on women's voices and experiences, and providing illustrations of the ways that some women seek to control their bodies, exercise agency and constitute themselves, and alter power/knowledge relations. Participants expressed a desire to voice their thoughts and experiences and an enthusiasm for collaboration and action for social change. Finally, I speak directly to how individual practices are shaped by and may challenge powerful social structures. Women's accounts of homebirth and midwifery care were set in opposition to experiences and understandings of disempowerment and dissatisfaction with biomedical care and hospital birth. These understandings of the biomedical model were instrumental in women's complex journeys to homebirth and greater holistic understandings of health and wellness. Homebirth mothers and midwives illuminated how adhering to the holistic model involved opposition and resistance—in both thought and action—to hegemonic biomedical power/knowledge.

In the following chapters, I contextualize participants' motivations for birthing at home and detail my interpretive perspective and methodology before moving on to describe women's perspectives themselves. In Chapter II, I ground my work in pertinent literatures and detail my theoretical framework, leaning largely on feminist applications of Foucault's work on power/knowledge and subjectivity. In Chapter III, I contextualize homebirth in Oklahoma by providing a brief history of birth in the United States and a portrait of birth in Oklahoma. As I discuss history, I include three significant elements of our hegemonic biomedical model of birth, a brief description of the midwifery model of birth, and the ways in which power/knowledge is manifested in history and the two models. In Chapter IV, I address my methodology and introduce participants. I move on in Chapter V to directly address my first research question (i.e. why women choose to birth at home) through women's accounts of their journeys to homebirth. Some research

articulates multiple paradigms regarding birth and/or describes care as existing along a continuum (Cheyney 2011), but participants in this research generally made clear distinctions between birth models, which is more in line with other literature (Davis-Floyd 2001, 2003; Ratcliff 2002; Rothman 1991). In Chapter VI, I introduce the two models articulated by participants and literature, the biomedical or technocratic model and the midwifery or holistic model. In Chapters VII, VIII, and IX, I articulate elements of these oppositional models emphasized by homebirth mothers and midwives. Throughout, I employ constructivist understandings of meaning and experience along with Foucault's work to highlight power/knowledge relations in the models. Chapter VII is concerned with biomedical constructions of women's bodies and processes as pathological and holistic understandings of women's bodies and pregnancy as healthy and normal. In Chapter VIII, I investigate technocratic understandings of bodies-as-machines, specifically women's bodies as defective machines, and alternative holistic understandings of women as complex social beings. In Chapter IX, I continue with discussion of oppositional models as I explain the valuing of technology and nature, respectively. To conclude, in Chapter X, I bring all of these elements together to emphasize power/knowledge and resistance in women's experiences of birth and mothering. Finally, I discuss implications and directions for future research in Chapter XI.

CHAPTER II

BUILDING A FRAMEWORK FOR UNDERSTANDING HOMEBIRTH:

FOUCAULT, CONSTRUCTIVISM, AND POWER IN MODELS OF BIRTH

In our culture, labor and childbirth are often taken for granted as biological, physiological processes that are the same from one woman to another, in any society, for all of human history. Sociologists and anthropologists of gender, labor, birth, and motherhood have shown the complex ways in which culture and birth systems shape ideas about birth and the practices that surround it (Davis-Floyd 1994, 2003; Jordan and Davis-Floyd 1993; Mead 1935; Rothman 1991; Simonds et. al. 2007). This literature exposes historical and contemporary constructions of birth—particularly tensions between women’s own knowledge and medical constructions of bodies and birth—and allows us to question hegemonic understandings of birth as an inherently dangerous event that requires medical oversight and expertise.

Following constructivist and critical ontology, epistemology and methodology, my theoretical framework here is shaped by women’s experiences and perceptions (Guba and Lincoln 2004). As part of this broad constructivist and critical framework, I draw heavily on the work of Foucault, elements of social construction, and feminist theories. Following social construction, I emphasize the process and significance of cultural constructions of reality while staying true to women’s voices. Furthermore, power plays an important role in shaping and maintaining reality and, as social agents, we have the ability to either reify or resist dominant institutionalized

ideology. Much of Foucault's work – which has been variously classified as structuralist, poststructuralist, and postmodern - and feminist applications of his work, illuminates power relations and is supported by participants' views and experiences. In particular, the issues of bodies, social control, knowledge and power are especially relevant. Because the processes of pregnancy and birth are inextricably tied to gender and power, my theoretical framework is also feminist in nature.

In this chapter, I detail the conceptual underpinnings of Social Constructionism, the work of Michel Foucault, and Feminist Foucauldian theories that are pertinent to participants' and my own co-constructions of power and resistance in medical and midwifery models of birth. At the end of the chapter, an Analytical Framework section ties together some of these elements and helps to conceptually bridge theory, history, and women's experiences that will inform this investigation.

Social Constructivism: Meaning, Reality, and Power

Social Constructivism emphasizes the ways in which humans, through social processes, create or construct reality. Relying primarily on Berger and Luckmann's seminal study, *The Social Construction of Reality* (1966), I focus on Social Constructionist perspectives of human thought and everyday lived experience, along with meaning production and social context, connecting micro-sociological phenomena (i.e. experience, meaning, knowledge, etc.) with macro-sociological phenomena (i.e. structure and institutions). Reality is relative and contextual. It becomes reified—or made *real*—in our social practices, ideologies and institutions. Emphasizing the importance of historical and social context, Social Constructivism illuminates the notion that temporal, spatial, and social location individually and collectively shape reality. The complex, socially constructed nature of pregnancy and childbirth can be realized by looking at historical and cross-cultural variations in the definitions and meanings of these processes (Devries, Benoit, Van Teijlingen, and Wrede 2001; Jordan and Davis-Floyd 1993; Selin and Stone 2009; Sullivan and Weitz 1988). Furthermore, power plays an important role in shaping and maintaining reality

and, as social agents, we have the ability (though constrained) to either reify or resist dominant institutionalized ideology. In doing the latter, we have the ability to reify a new reality.

Berger and Luckmann (1966) draw upon the sociology of knowledge and phenomenology as well as the work of Marx, Durkheim, Weber, G.H. Mead and others to connect micro-sociological phenomena (i.e. experience, meaning, knowledge, etc.) with macro-sociological phenomena (i.e. structure and institutions). Theoretically and perhaps even more importantly for the purposes of application, this is one of the theory's most significant contributions. In seeking to explain the connection of microlevel and macrolevel phenomena and how subjective meanings come to be understood as objective reality, Berger and Luckmann (1966) describe three components of an important process that they call *reification*. Reification explains how humans come to perceive things as real and as detached from human creation. The first part of the process involves social construction or creation of knowledge, followed by *externalization*, which involves the spreading or sharing of knowledge. Second, *objectivation* involves a solidifying of ideas, where they become understood as factual and true. Objectivation requires alienation, "a process by which people forget that the world they live in has been produced by them" (Delaney 2005:196). People must think of ideas and reality as external to themselves and their production in order to understand them as facts. A third component of this process is *internalization*. Through socialization and social interaction, we internalize objectivated knowledge; it becomes simply part of our knowledge and how we perceive the world. The process of reification is complex and ongoing. These three components do not necessarily occur in linear sequence and certainly do not occur in isolation. *Legitimation* is often necessary for reification, in that justification or explanation of objectivated meanings is needed to successfully transfer a particular knowledge and reality, especially to new generations. Legitimation works to bridge the gap between objective truth (history) and subjective meaning or experience (biography). Legitimation, then, is one of the key points at which power can be examined in the process of social construction.

Language is a significant factor in the process of social construction and reification. Phenomenologically, language “is the most important sign system of human society” (Berger and Luckmann 1966:37) and is the basis of reality. A sign system can be understood as a collection of symbolic expressions of human subjectivity. Language has the ability to bridge the micro and macro because it is a way of reifying subjective meaning and expression. In fact, “language is capable of becoming the objective repository of vast accumulations of meaning and experience, which it can then preserve in time and transmit to following generations” (37). So language, as a sign system, represents and embodies a social stock of knowledge that reflects and illuminates culture, social structure and institutions, as well as social reality. Furthermore, once objectivated, language can provide a frame of reference individuals can use to understand their experience and shape their own knowledge. In this way, language is an instrument through which objectivated reality shapes subjective experience. Foucault emphasized discourse over language per se, and particularly the power relations involved in discursive practices. “[F]or Foucault, discourse is ambiguous and plurivocal. It is a site of conflict and contestation. [...] Choice, chance and power govern our relationships to the discourses we employ” (Sawicki 1991:1). The language and discourse employed by individual women, by those they interact with, and by others in society can be viewed as a text, then, that illuminates issues of meaning and power.

Foucauldian Feminism: Political Economy, Biopower, and Subjectivity

Enhancing a Constructivist framework, I draw on the work of Foucault and feminist applications of his work to better understand power and birth. Foucault’s theoretical understandings of power/knowledge and the constitution of individuals illuminate issues of body, control, and freedom in society, while feminist theories contribute a deeper understanding of gender, power, and resistance in the processes of reproduction (Bordo 1989; Davis-Floyd, Pigg and Cosminsky 2001; Lorber and Moore 2007; Martin 2001; Sawicki 1999; Weitz 2010a). In this section, I discuss Foucault’s concept of biopower and how individuals are governed, articulating

the roles of panopticon and power/knowledge. Within this context, I turn to principles of subjectivity, freedom, and resistance.

Biopower, Governmentality, and Panopticon

Foucault (1970, 1977, 1978) builds a framework of power that explores the connections between control over the individual and larger historical, social, political forces. He describes this collective of systems of power as a political economy of the body, using the term “biopower” to refer to this specific exercise of power (Rabinow 1984; Sawicki 1991). Biopower operates through a political technology of the body or disciplinary technologies. Disciplinary technology is constituted by “[a] new set of operations, of procedures—those joinings of knowledge and power that Foucault calls ‘technologies.’ These technologies, ‘come together around the objectification of the body’” (Rabinow 1984:17). Foucault (1977) explains that, through methods that have transformed over history, the body is an object of control, punishment, and discipline, a site and instrument of the exercise of power.

“Discipline ‘makes’ individuals; it is the specific technique of a power that regards individuals both as objects and as instruments of its exercise” (Foucault 1977:170). Foucault describes three interrelated instruments exercised in this production of individuals: hierarchical observation, normalizing judgment, and examination. Hierarchical observation involves “internal, articulated, and detailed control” (172) of individuals and populations. Hierarchical observation functions as a “microscope of conduct” (173) and is most important in its role as a “machinery of control” (173). This observation and control is reflected in and facilitated by architecture, such as that of the military camp, hospital, or school building, intended “to render visible those who are inside it; in more general terms, an architecture that would operate to transform individuals: to act on those in shelters, to provide a hold on their conduct, to carry the effects of power right to them, to make it possible to know them, to alter them” (172). Ideally, architecture would allow for complete surveillance, for everything to be seen at once, but this is not always the case (Foucault 1977; Hoffman 2011). Meticulous division, observation, recording,

and training of individuals is “organized as a multiple, automatic and anonymous power” (Foucault 1977:176) that completes surveillance and amplifies power/knowledge. Normalizing judgment is an important element of discipline that works to create docile bodies conformed around a particular social or institutional norm (Foucault 1977; Heyes 2007). Anything outside of the norm is punished, and therefore corrected toward the norm. Normalizing judgment involves measuring individuals in relation to the norm, correcting the smallest departures from the norm. As part of this normalizing judgment, individuals are classified and ranked in relation to the norm and this hierarchy “exercised over them a constant pressure to conform” (Foucault 1977:182). The significant effect of discipline and punishment, then, is normalization; correcting individuals’ thoughts, behaviors, and bodies to coerce them closer to the norm. Normalization is a process carried out by various instruments and agents, particularly through the adoption of internalized notions of the norm and is achieved through hierarchical observation and normalizing judgment. Examination is in many ways the embodiment and practice of hierarchical observation and normalizing judgment and thus of objectification, discipline, power/knowledge, and normalization. “It is the fact of [the subject] being constantly seen, of being able always to be seen, that maintains the disciplined individual in his subjection. And the examination is the technique by which power, instead of emitting the signs of its potency, instead of imposing its mark on its subjects, holds them in a mechanism of objectification. [...] The examination is, as it were, the ceremony of this objectification” (Foucault 1977:187).

Historically, as Foucault (1970, 1977, 1978) demonstrates, power was exercised in direct, obvious, physical, and coercive ways. Over time, there was a transition to subtler, but more effective, forms of punishment. Foucault’s treatment of Bentham’s panopticon—a structure, a prison, designed in a way that inmates could always be observed, but that they could not see the guard observing—illustrates such subtle forms. The function was to create, in the prisoner, behavior as if he were being observed, whether he was or not: “So to arrange things that the surveillance is permanent in its effects, even if it is discontinuous in its action... that the inmates

should be caught up in a power situation of which they are themselves the bearers” (Foucault 1977:201). Thus, discipline and the exercise of power becomes internalized: “he becomes the principle of his own subjection” (203).

In ways, surveillance and discipline have become deinstitutionalized; they are now everywhere. Individuals survey each other and, because norms are internalized through processes of hierarchical observation, normalizing judgment, and examination, individuals survey and police themselves. Panopticism works to improve and make power more efficient “by making it lighter, more rapid, more effective, a design of subtle coercion” (Foucault 1977:209). This understanding of panopticism, then, informs a more complex understanding of discipline: “‘Discipline’ may be identified neither with an institution nor with an apparatus; it is a type of power, a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of application, targets; it is a ‘physics’ or an ‘anatomy’ of power, a technology” (215).

Foucault uses the term *government* or *governmentality* to describe “the conduct of others’ conduct” (Foucault 1985, in Rabinow 1997), as “the techniques and procedures for directing human behavior[;] government of children, government of souls and consciences, government of a household, of a state, or of oneself” (Foucault, in Rabinow 1997:81). “He addresses *government* itself as a practice—or a succession of practices—animated, justified, and enabled by a specific rationality (or, rather, by a succession of different rationalities)” (Faubion 1994:xxiii). He details in his work the ways that both individuals and populations are the subjects of government, with particular emphasis on how individuals or subjects are constituted through (and in some cases, how subjects might constitute *themselves* in the context of) particular forms of government. Given the panopticism of the “new” political economy of the body—and its focus on the mind and soul—the government and treatment of bodies changed and became a more effective, pervasive instrument of power. According to Foucault, one aim of power is to create docile bodies. “A body is docile that may be subjected, used, transformed, and improved” (Foucault 1977:136). Though the body had long been an object of control, the scale of control was

expanded from a hold over the physical body to “an infinitesimal power over the active body” (137). Control was no longer limited to mere “behavior or the language of the body, but the economy, the efficiency of movements, their internal organization” (137). Docility became achieved through new methods, “which made possible the meticulous control of the operations of the body, which assured the constant subjection of its forces and imposed upon them a relation of docility-utility, [and which] might be called ‘disciplines’” (137). Through these disciplines, bodies are classified and controlled with the manipulation of time, space, and movement. This:

‘political anatomy’, which was also a ‘mechanics of power’, [...] defined how one may have a hold over others’ bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus discipline produces subjected and practiced bodies, ‘docile’ bodies. (Foucault 1977:138)

More specifically, certain forms of government and discipline more and less effectively produce docile bodies. The connection between knowledge and power is particularly important in the creation of docile (female) bodies and processes of government and normalization.

Power/Knowledge

Crucial to Foucault’s conception of power, and certainly relevant to birth systems, is the concept of knowledge (Foucault 1970, 1972, 1980; Mills 2004). In his works, Foucault details the political nature of knowledge: how knowledge is produced, how facts become facts, the role that power plays in this process, and the role that knowledge plays in constituting or exercising power. Through complex processes, power produces knowledge and knowledge produces power, and to an extent that they cannot be conceptually detached: thus, Foucault refers to power/knowledge. Regarding power/knowledge, discourse, and cultural logic, each period of history can be characterized by an *épistémé*, “the complex set of relationships between the knowledges which are produced within a particular period and the rules by which new knowledge is generated” (Mills 2004:62). These knowledges are often taken for granted, and Foucault emphasized the importance of making them visible and questioning them. The episteme that developed in the late nineteenth century and is relevant today involves what Foucault called the

‘will to know,’ ‘will to truth,’ and ‘regimes of truth.’ The *will to know* is “a voracious appetite for information, alongside, or perhaps, prior to which, developed a set of procedures for categorizing and measuring objects” (Mills 2004:71, referring to Foucault 1981). To produce information, knowledge, and facts, is to make claims to power. When groups or objects become points of study, when information and knowledge is produced about them, power is exercised upon them. The *will to truth* is “that set of exclusionary practices whose function is to establish distinctions between those statements which will be considered to be false and those which will be considered true,” and a *regime of truth* involves “the type of statements which can be made by authorized people and accepted by the society as a whole, and which are then distinguished from false statements by a range of different practices” (Mills 2004:74, referring to Foucault 1981). In the production of knowledge, truth, and dominant discourse(s) (and, thus, power), there is a systematic exclusion of certain discourses and ways of knowing. The knowledge and truth claimed in regimes of truth denies legitimacy and claims to power to excluded groups and discourses.

Power is not something that is possessed, but instead it is exercised; through various mechanisms, at all levels of social life, and is particularly solidified through control and normalization of micro-level activity and being, such as thought and knowledge. Hand in hand with the will to know and the will to truth in the exercise of power/knowledge are two processes that objectify individuals: dividing practices and scientific classification. Dividing practices work to objectify individuals:

In different fashions, using diverse procedures, and with a highly variable efficiency in each case, “the subject is objectified by a process of division either within himself or from others.” In this process of social objectification and categorization, human beings are given both a social and a personal identity. Essentially, “dividing practices” are modes of manipulation that combine the mediation of a science (or pseudo-science) and the practice of exclusion—usually in a spatial sense, but always in a social one. (Rabinow 1984:8)

Scientific classification involves “the modes of inquiry that try to give themselves the status of sciences” (Foucault 1994a:326) and, as that status is achieved, particular discourses and truths are

legitimated. The creation of women as the “Other” involves defining women as mentally, physically, and/or morally inferior (de Beauvoir 1949; Said 1979). Dividing practices and scientific classification have been combined in the history of obstetrics to accomplish this power relationship by dividing, distinguishing, categorizing, and ultimately objectifying pregnant/laboring/birthing women. Examining and questioning dividing practices, scientific classification, and other techniques of normalization allows us to understand and critique constructions of reality and power/knowledge relations and to realize opportunities for freedom and resistance.

Subjectivity, Freedom, and Resistance

Foucault’s later work (1982, 1985, 1986, 1994a, 1994b) embodies a concern with subjectivity, the subject, freedom, and ethics. He argued that his focus has always been the subject; however, he more clearly and directly addresses this in his later works. Though Foucault’s work is often criticized for describing power as totalizing, and therefore denying the importance of agency, these criticisms are overstated (Heyes 2007; McLaren 2002, 2004; Sawicki 1991). He explains in *Discipline and Punish* (1977), for example, that power wants to be total but that it cannot be. While we can find opportunities for agency and resistance in his earlier archaeological and genealogical work, his later work provides perhaps more fruitful opportunities for reconceptualizing individual political acts, resistance, and subjectivity. It is from this space that many feminists have made a strong case for the usefulness of Foucault’s concepts for analyzing gendered power relations and feminist resistance (Bartky 2010; Bordo 1989, 1993; Butler 2004; Heyes 2007; McLaren 2002, 2004; Sawicki 1991, 1999).

Much of Foucault’s work on ethics and subjectivity depends on his concept of *assujettissement*, which departs from conventional understandings of power as it characterizes power as both potentially oppressive and enabling, and maintains that power and freedom as mutually constitutive (Heyes 2011; McLaren 2004; Oksala 2011; Taylor 2011): “Where there is power, there is freedom” (McLaren 2004:217). Power is not something that exists outside of us;

nor is it something that is exerted upon us. Instead, power is a set of relations that we participate in. Resistance and freedom, therefore, take place *within* power relations. Moreover, freedom is not an end in itself because Foucault does not conceptualize power as something that we can get “outside of” or fully escape, but instead freedom can be exercised to alter objectifying processes and power relations. Freedom is “that which we can make of ourselves within the parameters of a particular historical situation” (May 2011:79). In this way, individual meanings and actions can be understood as ethical, social, and political acts.

Foucault’s early and middle works demonstrate the ways individuals are shaped by broader power relations, including history, discourses, institutions, and interactions; in his later works, he emphasizes the ways that the individual, in relation to those social forces, might constitute himself or herself and might, therefore, exercise freedom. His focus in this later work was on *governmentality*, which he characterizes as:

the relationship of the self to itself and...the range of practices that constitute, define, organize and instrumentalize the strategies which individuals in their freedom can use in dealing with each other. I believe that the concept of governmentality makes it possible to bring out the freedom of the subject and its relationship to others—which constitutes the very stuff of ethics. (Foucault, in Rabinow 1997:xvii)

Individuals “desubjectivize” themselves and behave ethically through critique and through practices of freedom such as “care of the self” (McLaren 2002, 2004; Heyes 2011; Taylor 2011; Taylor and Vintges 2004). As Heyes (2007) explains, critique of norms and normalization is an essential step in the process of individuals constituting themselves as subjects:

One way of parsing all this is to say that normalization typically robs subjects of effective practices of *critique*. For Foucault, “critique is the movement by which the subject gives himself the right to interrogate truth on its effects of power and question power on its discourses of truth... Critique will be the art of voluntary insubordination [*inservitude volontaire*], that of reflective indocility [*indocilitie reflechie*]. Critique would essentially ensure the desubjugation of the subject in the game of what we could call, in a word, the politics of truth. (117)

Because the self is constituted socially, reconstituting the self through practices of freedom and care of the self is an ethical (social) process. He explained: “And it is the power over oneself that thus regulates one’s power over others” (Foucault 1984, in Rabinow 1997:288).

Critique and care of the self, then, can be interpreted as political acts—self-transformation as social transformation. Foucault refers to the ways that individuals act in their lives to respond to authority and create themselves as subjects as “anti-authority struggles” (Foucault 1994a; Mills 2004). “The main objective of these struggles is to attack not so much such-or-such an institution of power, or group, or elite, or class but rather, a technique, a form of power” (Foucault 1994a:331).

Analytical Framework

In this section, I introduce preceding theoretical elements in the context of birth and birth systems. Specifically, I address power and legitimation, ways in which female bodies are made docile, and subjectivity and embodied resistance in birth models.

Power and Legitimation of the Biomedical and Midwifery Models

The dominant understanding or reality of pregnancy and childbirth in the United States today is constructed in large part by obstetrics—the biomedical model of maternity care. The medical establishment, represented by large numbers of individuals, and various institutions and organizations such as the American Medical Association and the American College of Obstetrics and Gynecologists, with cooperation from other social institutions—including but certainly not limited to government, corporations, media, and education—has been able to legitimate this construction of reality through various mechanisms.

Historically, as the field of obstetrics gained legitimacy and the medical model of pregnancy and childbirth became objectivated, physicians became increasingly concerned and vocal in discounting midwifery and the midwifery model of care. In this sense, midwifery can be seen as what Berger and Luckmann (1966) describe as an “alternative symbolic universe” that threatens the legitimacy and power of the medical model, “because its very existence demonstrates empirically that one’s universe is less than inevitable” (108). To combat this threat, those who promote and are otherwise invested and involved in the medical model utilize various conceptual machineries, particularly that of science and technology. Because of its distance from

the “here and now” and therefore from the subjective experience of people’s lives, scientific knowledge is more readily objectivated, particularly when there are scientific experts who authoritatively claim ownership of such knowledge. “[T]he ‘lay’ member of society no longer knows how his [or her] universe is to be conceptually maintained, although, of course, he [or she] still knows who the specialists of universe-maintenance are presumed to be” (112). Berger and Luckmann (1966) maintain that:

power in society includes the power to determine decisive socialization processes and, therefore, the power to *produce* reality. In any case, highly abstract symbolizations (that is, theories greatly removed from the concrete experiences of everyday life) are validated by social rather than empirical support... The theories may again be said to be convincing because they *work*—work, that is, in the sense of having become standard, taken-for-granted knowledge in the society in question. (119-120)

Through the use of specific social distribution of knowledge, conceptual machineries, ideology, mystification, and social organization, the medical model has become the *status quo* and obstetricians claim authority and knowledge over women’s bodies and their processes.

I make use of Foucault’s conceptions of power and political economy of the body as well as facets of the Social Constructivist perspective to describe experiences of birth, institutions of birth, and the multidimensional exercise of power. While Berger and Luckmann’s (1966) framework acknowledges the significance of *power*, a greater emphasis on and examination of the role of power, such as that provided by Foucault (1970, 1977, 1978, 1979, 1984) and some feminist applications of Foucauldian theory (Bartky 1990, 2010; Bordo 1993; Heyes 2007; Sawicki 1991), strengthens our understanding of pregnancy and childbirth. These various theoretical perspectives connect micro and macro social processes addressing existing dynamics of power and gender and the creation of culture and reification of knowledge and reality.

Biomedicine effectively Others women (de Beauvoir 1949; Said 1979) through dividing practices and scientific classification, involving the exercise of knowledge/power (Foucault 1970, 1972, 1977, 1980, 1994a; Rabinow 1984), and the perpetuation of risk and associated fear amplify this Othering. Women’s bodies are transformed into docile bodies through the control

not only of ideology and ideas about the body, but through control of time, space, and movements of the body as well. Existing biomedical ideology and practices of birth in the United States are clear illustrations of attempts to create docile bodies—especially docile female bodies. The fact that women are taught to constantly define and think of their bodies (and natural reproductive processes) as insufficient, broken, dirty, shameful—in the case of ideas about both menstruation (Lee 2010) and birth, for instance—is an instrument and a product of the political economy of the body and the success of masculine control in the production of docile and normalized female bodies. In their own language, through discussion of their own experiences and the experiences of their friends, sisters, and mothers, I will discuss below how participants described a profound understanding of this process.

Docile (Female) Bodies

“[P]ower relations have an immediate hold upon [the body]; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs” (Foucault 1977:25). In describing what he calls the “political economy of the body,” Foucault maintains that “even if [systems of punishment] do not make use of violent or bloody punishment, even when they use ‘lenient’ methods involving confinement or correction, it is always the body that is at issue—the body and its forces, their utility and their docility, their distribution and their submission” (25). Our bodies can be seen as cultural texts informing us of cultural relations and power/knowledge. Particular political technologies of the body are used, and understanding such technologies illuminates the ways in which bodies are instruments of power. “[T]he body becomes a useful force only if it is both a productive body and a subjected body. The subjection is not only obtained by the instruments of violence or ideology; it can also be direct, physical, pitting force against force, bearing on material elements, and yet without involving violence; it may be calculated, organized, technically thought out; it may be subtle, make use neither of weapons nor of terror and yet remain of a physical order” (Foucault 1977:26). While bodies are the locus of

control, docile bodies are a product of power/knowledge exercised in complex ways at multiple dimensions of society and through multiple social institutions.

Analyzing the body as a text that reflects the power/knowledge and politics of our patriarchal culture, feminist theory and research echo much of Foucault's work, showing the ways in which women's bodies are judged, examined, controlled, and punished by mechanisms ranging from rape to ideology to public policy (Adair 2010; Hartley 2010; Wilson and Daly 2010). One consequence of power/knowledge relations and political economy of the body is that women's bodies are viewed as men's property and, in many ways, as public property (Roth 2010; Weitz 2010b; Wilson and Daly 2010). Laws codify a social order where women are men's property, denying humanity and agency to women, who are socially constructed and reified as incapable of being socially, economically, or sexually autonomous. This ideology has justified men's violence against women, and control of women's bodies extends to laws that regulate and restrict women's reproductive autonomy.

Particularly useful is feminist work drawing on Foucault emphasizing the complex ways in which power/knowledge is exercised to create docile female bodies (Bartky 1990, 2010; Bordo 1993; Heyes 2007; McNay 1992; Sawicki 1991). "[T]he ideal feminine body [is] a 'manifestation of misogynist norms flowing from a culture where women are devalued and disempowered.' That is, because women themselves are seen as somehow less than men, their bodies must demonstrate that inferiority" (Hartley 2010:247). Foucault (1977) maintained that in contemporary society such ideals may be physically or externally enforced, but that most often they become internalized to the extent that we enforce them upon ourselves.

Subjectivity and (Embodied) Feminist Resistance

Foucault's work on the ways in which individuals may respond to or resist hegemonic power is useful, though somewhat limited (due partly to his orientation but due potentially more to his untimely death). His later work on subjectivity can be combined with a constructivist approach to agency and feminist accounts of resistance to illuminate power relations within birth

systems. Though both constructivism and the work of Foucault provide conceptual opportunity to begin understanding homebirth as resistance, feminist Foucauldian scholars (Bordo 1989, 1993; Butler 2004; Heyes 2007, 2011; McLaren 2002, 2004; O'Grady 2004; Sawicki 1991; Taylor 2011; Taylor and Vintges 2004) and feminists who do not employ Foucault but articulate embodied resistance (Hartley 2010; Pitts 2010; Weitz 2010) provide the most developed and useful framework in this regard.

For Foucault, bodies are both products and tools of history and power and, because of the connectedness of power and freedom, bodies are also necessarily a potential locus of resistance and liberation (May 2011; Oksala 2011). To the extent that the biomedical model of health/illness and birth have been reified and legitimated in our society, and to the extent that this involves a great potential to produce docile bodies, there also exists in these power/knowledge relations an enabling element and an opportunity for individuals to critique and to resist norms, normalization, and domination.

Given this framework, as I investigate the reasons that women birth at home, I explore how the ideas, experiences, and choices of homebirth mothers, along with the philosophies and practices of homebirth midwives, compare or compete with tenets of the biomedical or technocratic model and the midwifery or holistic model. In particular, I address how homebirth mothers and midwives define women's bodies and bodily processes, especially pregnancy, labor, and birth, and how these women conceptualize agency, control, and empowerment surrounding these processes. Thus I discover how, from the perspectives of homebirth mothers and midwives, power/knowledge operates in biomedical and midwifery models of care during pregnancy and birth, and how these women characterize and respond to these power/knowledge relations.

CHAPTER III

CONTEXTUALIZING HOMEBIRTH: A CRITICAL HISTORY

Being influenced by the sociology of knowledge, and therefore historicism, Social Construction emphasizes the importance of historical and social context. Our realities, both on an individual and collective level, are shaped by our temporal, spatial, and social location; and we, in turn, shape culture, society, and history. Foucault's (1971, 1984) methods of archaeology and genealogy emphasize the importance of history as well, characterizing history as a complex, nonlinear and even incoherent factor in shaping power relations and, therefore, individuals themselves. We can see the complex, socially constructed nature of pregnancy and childbirth by looking at historical and cross-cultural variations in the definitions and meanings of these processes (Bogdan 1990; Devries, Benoit, Van Teijlingen, and Wrede 2001; Jordan and Davis-Floyd 1993; Litoff 1992; Scholten 1985; Selin and Stone 2009; Sullivan and Weitz 1988). We can also see the social construction of pregnancy and childbirth and better understand our current knowledge regarding these processes when we examine its variation over historical time.

Ratcliff (2002) explains that the biomedical model of health care delivery is one key factor influencing women's health today. Though complex, this model can be characterized by three significant elements, which my participants highlighted in our conversations, and which are

problematic in a number of ways for women's health in general, and in pregnancy and birth in particular. These elements are: a lens of pathology, the body-as-machine metaphor, and a favoring of technology. In this chapter, in an attempt to make sense of the complex experiential, ideological, cultural, institutional, and political processes involved in birth systems and to provide necessary context of homebirth and women's lived experiences, I draw on theoretical elements described in the previous chapter, as I weave together a brief history of midwifery and childbirth in the United States with interpretations of the development of these elements in our biomedical model of birth. I elaborate on these elements at relevant historical points and begin to uncover the power relations involved. Finally, informed by this context, I provide an account of the midwifery model of birth and provide some local context for birth in Oklahoma.

The History of Birth in the United States: The Rise of the Biomedical Model

Though midwifery was the traditional and authoritative method of childbirth for much of history, the medical model of birth has become hegemonic in the United States over the last century (Morgen 2002; Scully 1994; Winnick 2004). This medical model has been employed and controlled by obstetric-gynecologists and involves a pathologizing of women's bodies and processes that are otherwise (especially according to midwifery) considered normal and natural. How did thinking about and material conditions of birth change in the United States over history? What were the power relations at play, particularly in terms of gender? To the extent that we can make claims about women as a group, how did historical changes impact their experiences and ability to exercise agency during pregnancy and birth?

In keeping with nearly all of recorded human history, women were experts on birth among immigrating groups and natives in seventeenth-century America (Bogdan 1990; Scholten 1985; Stone 2009; Wertz and Wertz 1989). Rituals, meanings, and understandings varied from group to group, but only women attended and were knowledgeable about birth. Women attended by experienced midwives, then, benefited from attendants with firsthand experience and generations of accumulated knowledge about the process. In colonial times, a midwife was

generally “a highly esteemed member of the community who not only assisted at childbed but also offered advice on a number of gynecological problems. Aided by female friends and relatives of the parturient woman, the midwife’s major function was to provide a moral support and encouragement while waiting for nature to take its course” (Litoff 1992: p. 440-441, discussing the work of Scholten 1985).

In the mid-eighteenth century, women’s expertise began to be questioned, the impetus for which can be traced to sixteenth-century France, where rising numbers of (mostly poor) women were having hospital births where, previously, doctors would only attend problematic or abnormal births. In line with Enlightenment thinking, doctors observed, measured, and recorded birth to uncover “natural laws” of the process, which until this time had been considered by men to be a mystical and mysterious process. This ‘will to know’ and ‘will to truth’, this attempt to produce information about women and their bodies, was and continues to be an act of power/knowledge that involves active discounting and exclusion of women’s authority and traditional ways of knowing:

Heralding their new understanding as based upon a rational process of observation and likening the body and the birth process to the machine [that] the new “scientific midwifery” celebrated, doctors both implicitly and explicitly trivialized and degraded the traditional, experience-based knowledge women and midwives had about birth. (Bogdan 1990:108-109)

In the eighteenth century, men, termed “man-midwives”, came to America bringing claims of scientific knowledge and forceps—the symbol of life-saving promise (Bogdan 1990). In turn, many American men went to Britain and France to receive medical training and returned as physicians who began assisting midwives in the births of white, middle- and upper-class, urban women. By the early nineteenth century, physicians began replacing midwives. They set up medical schools, where numbers of other men were educated and certified as birth attendants. On the rare occasion that female midwives were invited for instruction, they were only instructed on when to call a physician. Here, then, we see, through institutionalization and internalization of

medical ‘facts’ and authority, the shift that growing numbers of men were considered experts of birth. Even *allowing* men at birth reflects change in cultural logic:

To shift from an expectation of [supportive, experience-informed help from women] to that promised by physicians – knowledge of birth gained through education rather than experience, and attendance oriented to altering the course of birth rather than assisting in the course that birth would naturally take – implies that in women’s eyes, childbirth had become an event they might affect rather than one to which they must be resigned. (Bogdan 1990:110)

Framing women’s desire to birth with a doctor, as Bogdan does, suggests the shift as partly a result as women’s exercise of agency. Many privileged women sought physician care, though others were subjected less willingly; most of the latter were poor and urban women and, later, women in rural areas where midwives were driven out. In any case, the shift in thought and practice both reflects and contributes to the growing hegemony of the *biomedical model* of health and the decline of the midwifery model of birth.

Lens of Pathology

The first element of the biomedical model of health care is the lens through which this model dictates that we understand and approach health (Block 2007; Ratcliff 2002; Rothman 1991; Simonds, et. al. 2007; Wagner 2006). Using a *lens of pathology*, health is defined within the biomedical model as the absence of disease in an individual. Consequently, biomedical health care consists of attempts to detect, treat, and eliminate disease within the body. Within a biomedical model, pregnancy is approached as pathology. Pregnant women are constantly measured, tested, and evaluated in an attempt to detect disease. Inherent in this approach is a manufacture of risk and fear. Though fear existed in facing childbirth before this time, fear had historically been grounded in—to the extent that it existed—an objective reality: knowing and possibly witnessing other women dying or otherwise suffering in childbirth. The risk and fear constructed by obstetrics was of a different nature. Through the lens of gender, women’s bodies were created by men as objects of knowledge; one important element of this construction is the understanding of male bodies as the norm. With male bodies and processes taken as normal, and

women's bodies and particularly the processes of pregnancy and birth being defined in relation to men, pregnant and birthing bodies were considered pathological. Through producing information about women's bodies and their processes, the body was objectified and mystified; women were alienated from their bodies. Where women had previously been able to rely on their instinct or other women's experience, there was now a knowledge that claimed to *know* better, a knowledge that, due to gender, and often racial and class differences, was unattainable to women. Women, therefore, were put in a position where they relied on physicians' accounts of their own bodies. By claiming knowledge, obstetricians claimed an element of control. In many ways, they manufactured a problem that only they were adequately equipped to address; in producing this particular knowledge, then, they increased their capacity to exercise power.

During the eighteenth century, women in America had begun to consider the possibility of birth as a disease (Bogdan 1990). For the ease of the physician and for modesty's sake, women were confined to bed for labor and birth. Women gave up some measure of control. Though midwives at this point still had authority to call in a physician or not and to then approve or reject proposed interventions, by the virtue of being male *and* legitimated (even if only symbolically) by science, physicians usurped some degree of authority and control. To some extent, knowledge and reality regarding pregnancy and especially childbirth shifted during this time—from viewing these processes as normal and natural to considering them as problematic and possibly even pathological. This subjective knowledge, in turn and through social interaction and externalization, shaped the large-scale structural shifts in how these processes were treated. This emerging reality was negotiated and legitimated in large part by those with special interests. This included birthing women, but perhaps more importantly physicians and obstetricians.

Body-As-Machine Metaphor

The second significant element of the biomedical model is referred to as the *body-as-machine* metaphor: The body is treated as an entity in itself, separate from the mind or greater person (Block 2007; Davis-Floyd 2003; Ratcliff 2002). Here, bodies are thought of as uniform,

predictable, and quantifiable. When disease is detected with the lens of pathology, the body is understood as a defective machine that requires repair by a skilled technician. In biomedical “management” of birth, labor is defined and much affected by the body-as-machine metaphor. Laboring bodies, in the field of obstetrics, are understood as uniform, predictable, and quantifiable. It is for this reason that the recent popular documentary *Pregnant in America* (2008) incorporated a discussion of Ritzer’s ([1993] 2012) concept of McDonaldization.

McDonaldization, according to Ritzer (2012), is the process by which more and more of society has come to be characterized by elements of fast food restaurants. Of particular importance are the interrelated characteristics of efficiency, predictability, calculability, and control. I will detail these characteristics as findings regarding the body-as-machine but, in short, our medicalized system of birth reflects processes and values of McDonaldization and represent particular power relations. Obstetrics views and, in many cases shapes, labor in very predictable and calculable ways, and is handled in very efficient ways that involves control, especially through the use of technology. As an illustration, obstetrics defines labor as occurring within a certain number of stages (calculability). For each stage, the cervix is to be dilated within a certain range of centimeters and contractions are understood to be a certain duration in time and a certain length of time apart (predictability). In reality, just as women’s bodies and babies’ bodies themselves are not uniform, the process of labor and birth does not occur in such a uniform fashion. However, this reality is not visible within the field of the lens of pathology and the body-as-machine metaphor. When women’s bodies vary from the quantified and set parameters of medicalized and McDonaldized understanding/knowledge/truth, they are deemed as pathological or broken, requiring the skilled technician’s intervention. Such interventions represent efficiency and control; their overuse in the United States is partly blamed on the desire for efficiency on the part of doctors and hospital staff (and even mothers and families), and involves control of time and bodies, largely facilitated through the use of technology, including

electronic fetal monitors, drugs to augment labor, forceps, vacuum extractors, and cesarean section.

The metaphor of body-as-machine is in keeping with Enlightenment thinking and the Cartesian dualism that has characterized our cultural thinking for centuries, and was particularly influential during the development of obstetrics (Davis-Floyd 2003; Rothman 1982; Simonds et. al. 2007). One result of approaching the body as a machine, separate from the mind, is a treatment of the body without accounting for social, emotional, or mental factors that bear on the state of the body. Moreover, the body-as-machine metaphor works to exert and improve power:

The demise of the midwife and the rise of the male-attended, mechanically manipulated birth followed close on the heels of the wide cultural acceptance of the metaphor of the body-as-machine in the West and the accompanying acceptance of the metaphor of the female body as a defective machine – a metaphor that eventually formed the philosophical foundation of modern obstetrics. Obstetrics was thereby enjoined from its beginnings to develop tools and technologies for the manipulation and improvement of the inherently defective and therefore anomalous and dangerous process of birth. (Davis-Floyd 2003:51)

The body-as-machine metaphor is further illustrated in the language of obstetrics, which demonstrates how power is exercised and reified at the level of interaction (Hunter 2006; Kahn 1996; Winnick 2004; Zeidenstein 1998). Commonly (over)used phrases, such as “incompetent cervix,” “lazy uterus,” and “failure to progress,” reflect the expectations of the body-as-machine metaphor as well as the lens-of-pathology explanations of bodies when they do not fit obstetric expectations.

Favoring of Technology and For-Profit Intrusion

The growth of capitalism over the course of the nineteenth century inevitably penetrated the biomedical model. Along with the growth of technology, came the rise of for-profit involvement in health care delivery, two factors that continue to significantly shape women’s health in the United States, including maternal and child health (Block 2007; Ratcliff 2002; Simonds et. al. 2007). Biomedicine’s understanding of the body as a machine, coupled with its interventionist tendency, creates high rates of use of technology. Davis-Floyd (2001, 2003) refers

to this model, which I have called the biomedical model, as the *technocratic* paradigm. She articulates how we socially and culturally negotiate issues of birth through technocratic care and how technocratic practices perpetuate power and patriarchy. Because Davis-Floyd grounds her understandings of birth models in culture and power, I prefer to call this model the technocratic model. However, to stay grounded in women's perspectives and common understandings, I primarily refer to it as the biomedical model.

Technology is so intertwined with medical education, training, and socialization that some (Block 2007; Gaskin 2003; Wagner 2001, 2006) question the ability of most newly or recently-trained obstetricians to attend births without its use. There is a saying: "When you are holding a hammer, everything looks like a nail." When an obstetrician, who is a surgeon by profession/trade, sees a birthing woman and has been taught proficiency in the use of electronic fetal monitor, episiotomy, vacuum, forceps, or c-section (to name only some of the technology involved in obstetric profession), it is likely difficult for the obstetrician to imagine—much less effectively attend or assist—a labor and birth that does not involve these. Evaluation of technology for efficacy and potential harm, is also a problem, because such evaluation tends to be poor and/or biased; corporations that produce and profit from technology are often charged with evaluation. Even when third parties conduct assessment of technology, findings are rarely acknowledged by practitioners, who have little skill to evaluate research methodology themselves. All of these factors combined lead to high rates of technological interventions in pregnancy and birth and throughout women's health care.

Favoring of technology often results in a shift in attention from people to machines (Clarke 1998; Ratcliff 2002; Simonds et. al. 2007). In the case of birth, when an Electronic Fetal Monitor is used on a laboring woman, attention tends to be drawn away from the woman herself, how she feels, how she copes with labor. Instead, the skilled technician turns to numbers on the machine—the baby's heart rate, the mother's blood pressure, the quantification of contractions, etc. Following feminist critique of technology (Martin 2001; Ratcliff 2002; Scully 1994;

Treichler, Carywright and Penley 1998), I will argue that technology perpetuates gender inequality and potentially denies agency to women in birth.

Nearing and into the nineteenth century, physicians attended increasing numbers of American women (Bogdan 1990). Initially, this trend was most prevalent among the urban poor, due to the decline of midwifery and, therefore, other birth options, and increasing numbers of hospitals in urban areas. At the same time, upper-class white women sought physician care, as they desired the luxury of new scientific care. Physicians created and implemented various obstetric interventions in the nineteenth century, including ergot and anesthesia, with inconsistent and often harmful results.

Along with increasing intervention came an increase in accidents, injuries, and infection (Block 2007; Simonds et. al. 2007; Wagner 2006; Wertz and Wertz 1988). Forceps, historically and even into contemporary times, caused pelvic floor injuries for women and head and spinal injuries for babies. Over the course of the nineteenth and twentieth centuries, the burgeoning pharmaceutical industry and obstetricians developed medications and other technological interventions. Physicians used them with or without knowing potential dangers, as seen with routine x-rays, diethylstilbestrol (DES), and thalidomide, to name some of the most infamous cases (Lenz 1988; Saunders and Saunders 1990; Wagner 2006). Routine episiotomies and the administration of Cytotec are more recent examples. In many of these cases, there was some evidence and obstetric research warning of dangers, and in all of these cases there was an absence of evidence to substantiate safety, though doctors implemented them on a widespread basis. Today, physicians employ serial ultrasounds, with little or no evidence of their benefits or safety (Lothian and DeVries 2005; Wagner 2006). The history of obstetrics and technology shows a pattern where safety is assumed and even asserted until long after dangers have presented and women and children have been injured or killed. While the technology implemented by obstetricians in birth changed over time, the philosophy of pathology and body-as-machine remained, and the effects of power intensified. Relying on technology for the production of

knowledge and information, which can only be interpreted by (male) doctors, who now—because of this exclusive knowledge—have an exclusive position of power.

With increasing involvement of corporations, whether providing technology, pharmaceuticals, and even administration in hospitals and other forms of health care delivery, we see a growing phenomenon of business models dictating the philosophy and delivery of health care (Ratcliff 2002). Here, profit is the bottom line rather than health. The consequences of for-profit intrusion into women's health care ranges from lack of care to overtreatment. With increasing costs and the ability of private providers to turn patients away, poor women are more and more often denied care. On the other end of the socioeconomic spectrum, profit is made off of women when they are overtreated for conditions like PMS (a condition that has been socially constructed as a disease here, where other models do not define it as such) and infertility. Cesarean rates have been blamed in part on the ability of doctors and hospitals to profit, because such births are exponentially more costly than vaginal births (Block 2007; Simonds et. al. 2007; Wagner 2006).

Power and Agency in the Biomedical Model

Following Foucault, historical and cultural constructions of health, pregnancy and birth, amplify power, making it more efficient; our understanding and treatment of health and illness makes power more efficient. On one hand, power is indirectly supported through a denial of the critique of power: negation is countered through varied and complex mechanisms that involve the construction of biomedicine as both individualistic and neutral. On the other hand, power is actively reified, through our sociocultural knowledge/power relations and control of time, space, and movement.

The technocratic model's individualistic orientation and claims to objective and neutral knowledge and truth quell criticism and threats to power. By defining health as the lack of disease and defining the individual body (or more often body part or body system) as the site of disease, we neglect the *context* and *production* of health and disease and, consequently, power.

This view neglects the important role that family, community, and environment play in the production of health and ignores the social, political, historical and economic factors that impact the health of entire populations. It denies power; by subscribing to the biomedical model of health, we effectively deny the role that race, class, gender, age, ability, sexuality, and other systems of socially constructed difference, privilege, and oppression play in the health and disease of individuals and populations. As a result of the biomedical model's individualistic orientation, lens of pathology, and body-as-machine metaphor, we attribute disease to individual bodies and biology. At best, the biomedical model may address individual's actions, but without understanding the social context of those actions. In many ways targeting the individual is easier and more convenient than focusing on prevention and confronting social determinants of inequality. Unfortunately, while this biomedical approach may be easier, it does not appear to be more effective. While the United States boasts one of the most medicalized and technologically advanced health care systems in the world, and one of the highest rates of spending in the world, as a nation, we are not healthy when compared to other rich nations (National Research Council and Institute of Medicine 2013; Squires 2011). There are a number of ways in which we can improve our health as a nation, and at the heart of this problem is the fact that health is a social issue. Our biomedical approach does not adequately address social determinants of health, and the "treatment" of individuals simply cannot have more than an aggregate effect on the health of entire populations.

Health care, including reproductive care, reflects the race-, class-, and gender-based organization of society (Ratcliff 2002). I will primarily address issues of gender to demonstrate the role of gender and power in our current birth system, but because these social positions are interconnected, it is difficult (and unproductive) to tease out gender alone. Our history shows that the male-dominated medical field co-opted and continues to dominate authoritative knowledge on women's bodies, pregnancy, and childbirth (Kahn 1995; Luker 1984; Reagan 1997; Sullivan and Weitz 1988; Winnick 2004). As discussed above, power is central to understanding this history

and the shift from midwifery to obstetrics and gynecology. Midwife means “with woman” and, in traditional midwifery, the midwife’s role is to actively be with the pregnant and birthing woman, to assist the mother in her active role in what is considered the natural and normal process of childbirth, and to “catch the baby” (Winnick 2004). In obstetrics and gynecology, the medical model problematizes and pathologizes women’s bodies and the processes of pregnancy and childbirth. This model’s knowledge, reality, and language are objectivated in our society. Doctors—traditionally and still quite often men, or women conforming to the masculine ideal—serve as experts, controlling, caring, and gazing at the pregnant women under their unquestioned authority. Considering their social position, it is no accident that, in our dominant model of health (and birth), doctors are active subjects and patients are passive objects.

Women have had different access and experiences in our reproductive health care system, often due to race, class, age, sexuality and ability. Consequently, inequality structures women’s health outcomes. Still, for most American women, twentieth-century childbirth has been largely an experience of increasing medicalization, hospitalization, and alienation (Block 2007; Bogdan 1990; Edwards and Waldorf 1984; Sullivan and Weitz 1988; Wertz and Wertz 1989). History demonstrates how physicians came to dominate normal births. Concomitantly, by the 1920s childbirth moved fully into the realm of disease, of pathology. These developments greatly facilitated by the insinuation of modern technology as the norm for births under the guise of improving safety and lowering infant and maternal mortality rates. Throughout the century, more and more births took place in hospitals—at first by urban and then other middle and upper class women, to ensure “safety”. Poor women continued to be medical material, only able to afford attendance by students-in-training or interns. However, there seemed to be a fairly early point of diminishing returns, where it becomes evident—though this realization is not reflected in our cultural logic or practice—that medical birth and higher rates of intervention do not necessarily mean better health outcomes such as birth weight and maternal and infant mortality.

Due to this shift in structure and practice, childbirth was mysticized for women in the late nineteenth and early twentieth centuries—as it had been for men prior to the sixteenth century. In moving the birthplace from the woman’s home to the hospital, she gave up what control she might have had left (Bogdan 1990; Leavitt 1986). Women sacrificed control over their bodies and input in decisions about the birth process in exchange for the promise of a safe and less painful birth; however, particularly in terms of safety, data does not support physicians’ claims or promises. As obstetrics rose in hegemony as the authoritative method of managing birth, a particular political economy of women’s bodies was strengthened. When women went to the hospital to birth, they were physically and socially isolated from family and friends; they were on the territory of the masculine medical experts; in this setting and with the particular disciplinary technologies involved in delivery of obstetric care, women’s time, space and movement were strictly controlled.

Individuals actively objectivate, legitimate, and reify cultural meaning through action and interaction, including through the use of language. Men’s cooptation of authority and power regarding women’s bodies was and is facilitated and maintained through language (Bastian 1992; Hunter 2006; Kahn 1995; Simonds et. al. 2007; Winnick 2004; Zeidenstein 1998). Some illustrations of power and agency through language lie in: the language of “delivery” versus “birth”; the language of risk, and; technological language. Midwives generally refrain from the use of the word “delivery” because it literally means “to free”; with this in mind, pregnancy is equated with being captive, and to “deliver” the baby or to “deliver” the pregnant woman would imply, first, that the state of pregnancy or woman’s body itself is a trap and, second, that the midwife is freeing the woman and/or her baby (Lorber and Moore 2007; Simonds et. al. 2007; Winnick 2004; Zeidenstein 1998). Upon further examination of the language of childbirth, another reflection of gender and power can be found in the label of the person assisting the pregnant woman. Often, when a female assists the pregnant woman, a title such as “doula” or “nurse” is applied, implying passive support and more egalitarian roles. However, when men

assist, the term “coach” implies a much more powerful and controlling title (Mardorossian 2003). With the shift of authority from midwifery to obstetrics, the new language of obstetrics reflected cultural and structural changes in authority of birth and even managed to masculinize childbirth: “The [male (understood)] doctor *delivered* the baby.” Women were still giving birth, but men were now not only in control of, but also taking credit for childbirth (Lorber and Moore 2007; Winnick 2004).

As previously mentioned, women’s bodies became medicalized through cultural and structural changes such as the shift from midwifery to obstetrics. Women lost the authority to be knowledgeable about their own bodies (and their sisters’, daughters’, and friends’ bodies) and their own health (Copelton 2004; Kahn 1995; Winnick 2004). Their legitimacy to make decisions about their health and reproduction was undermined by the new medical model. This overall trend has led to the supreme authority of medical explanations (Auerback and Figert 1995). A language of risk works to justify the medical management of birth (Hunter 2006; Simonds et. al. 2007). Obstetricians conceptualize and speak of pregnancy as a “condition” that in itself, along with its “symptoms,” needs to be “managed” and monitored—a disease to be controlled and eventually eliminated in the process of “confinement” (a common obstetric term for labor) (Block 2007; Hunter 2006). The pathologizing of pregnancy and childbirth creates a notion of women’s bodies as passive. The language of risk empowers obstetricians.

A related language, the technological metaphor, combines elements of pathology, body-as-machine, and technology previously introduced (Bastian 1992; Ratcliff 2002). Male experts see the female body as a faulty machine that needs to be fixed. Tied up with this language is the assumption that pregnancy and childbirth are uniform for every woman and predictable to the extent that this process can, therefore, be controlled and efficiently “managed” with medical knowledge, equipment, and technology and this thinking is evident in language. For example, extended periods of labor are deemed a “failure to progress”, as if labor should conform to a

predetermined schedule. Certain parts of the body might also be treated as dysfunctional, for example, the “lazy uterus” or the “unfavorable” or “incompetent” cervix.

Overall, these illustrations represent the androcentric language inherent in the biomedical model of obstetric care. This language both legitimates and reflects our contemporary patriarchal cultural reality regarding pregnancy, childbirth, and in many ways women and men themselves. Sometimes explicitly but often only implicitly, a woman-centered language is proposed to deconstruct masculine power over women’s bodies, pregnancy and childbirth and to empower women themselves (Hunter 2006).

Obstetrics, then, and particularly the ideas and practices related to the construction of women’s bodies and processes as pathological, was a new disciplinary technology that involved objectification of women’s bodies and claims to truth and, therefore, power/knowledge. Through concerted efforts, midwifery was nearly extinguished in the twentieth century (Simonds et. al. 2007; Sullivan and Weitz 1988; Wertz and Wertz 1989). Medical experts discredited female midwives - most of who were poor, racial and ethnic minorities, and/or immigrants - and sought to exclude the midwifery philosophy of care. Even so, some women continued to practice as midwives, some pregnant women employed their care, and over time, as a result of growing dissatisfaction with the medical model of birth management, some women have returned to the midwifery model.

The Midwifery Model

In contrast to the biomedical model, the midwifery model of care is a social model (Cheyney 2011; Davis-Floyd 2001, 2003; Rothman 1991; Ratcliff 2002; Ruzek, Olesen, Clarke 1997; Simonds et. al. 2007). Social models of health emphasize the context and production of health and illness and, in doing so, address the problems of the individualistic nature of models like the biomedical model. Social models take into account family, environment, behavior, mental health, social institutions, race, class, gender, and other social elements that contribute to

health. Feminist models of health are generally social models and are particularly useful for examining women's health and the ways in which gender arrangements of society affect and are affected by gender inequality in health. Davis-Floyd (2001, 2003) articulates this kind of model in describing a *holistic* paradigm or model of care. I will alternatively refer to the midwifery model and holistic model as one in the same.

Where biomedicine defines pregnancy, labor, and birth in pathological ways, the midwifery model defines these processes as normal and healthy for the vast majority of women (Cheyney 2011; Davis-Floyd 2003; Rothman 1991; Simonds et. al. 2007). *Normalcy* in the midwifery model is distinct from Foucault's treatment of *norms* and *normalization*. Foucault (1977) speaks of *the norm* as a rule or an ideal toward which individual bodies and behaviors are punished and corrected and *normalization* as a goal and instrument of such disciplinary processes. Norms and normalization are constraining and limiting. Alternatively, holistic understandings of normalcy involve *natural* processes of the (female) body, the *healthy* nature of pregnancy and birth, and the larger historical and global picture of birth wherein *most* women around the world and over time birthed naturally and/or at home. Furthermore, participants described a great deal of variation in what they consider normal and healthy, and *normal* is, therefore, a somewhat liberating principle. In keeping with the approach that birth is normal, as opposed to the medical model's lens of pathology, health is maintained through preventative measures, such as good nutrition. While birth is not treated as normal in our society, some evidence suggests our approach is problematic. The World Health Organization and the Coalition for Improving Maternity Services are among the organizations that promote a cesarean section rate no higher than 15% (Goer, Sagady, and Romano 2007; World Health Organization 1985). This goal calls into question our 33% c-section rate in the U.S., even without accounting for other interventions and diagnoses (e.g. epidural rates and induction rates). Though the WHO's recommendation has been contested (often by those with vested interests in the medical delivery of maternity care), evidence shows deleterious effects to maternal and infant health beyond a 15% c-section rate,

particularly when applied to healthy mothers and babies (Althabe and Belizan 2006; Block 2007; Childbirth Connection 2012; Hall and Bewley 1999; MacDorman 2006; Villar et. al. 2006; Wagner 2001, 2006). Models of maternity care, such as that of The Farm, a long-standing and now-famous midwifery practice in Tennessee, boast very low c-section and other intervention rates, while having maternal and infant health outcomes and mother satisfaction far better than national averages (Gaskin 2003, 2011). Due to the view that birth is normal and usually safe, and the understanding that use of technology and intervention usually lead to greater, often unnecessary, and potentially harmful use of technology and intervention, those subscribing to the midwifery model generally believe that nature and women themselves are sufficient to safely carry out the work of birth.

The midwifery model is a woman-centered model that defines the pregnant woman as the active subject in birth, as opposed to the biomedical model described above (Davis-Floyd 2003; Simonds et. al. 2007). Power and agency is reflected the authority and responsibility placed with pregnant and birthing women; the mother is the decision-maker and the midwife supports. The fact that the pregnant woman is the active subject (rather than passive object) in the midwifery model is reflected in the model's language: "The woman birthed her baby." Most of the time, the language that represents the most active role of midwives: "The midwife caught the baby." Here, the mother does the work, she and her body and her baby know what to do and are trusted to do it. The birthing mother is the subject, not the doctor or midwife. The midwifery model defines bodies in complex ways that involve the interaction of mind, body, and overall wellbeing; women's social and emotional needs are valued as at least as important as her physical needs. Mother and baby are understood as an inseparable unit with common interests; caring for the mother is the best way to care for the baby. Midwifery care generally involves taking into account the social factors, such as poverty and family life, that affect pregnant women's (and, therefore, babies') health.

By the 1940s and 1950s in the U.S., women began to express dissatisfaction with the alienating process of childbirth and sought alternatives, especially the alternative of the midwifery model, as is reflected in the “Renaissance of Midwifery” and home birth in the 1960s and 1970s (Bogdan 1990; Edwards and Waldorf 1984). In response, however, to women’s increasing desire and attempts to reclaim birth, medical authorities posited increasing pathological directions pregnancy and childbirth might take.

Ultimately, while historians and other scholars emphasize certain aspects or events over others, it is clear that various and complicated factors contributed to the near-demise of midwifery (along with women’s loss of authority in the birth process) in the United States by the 1950s (Kobrin 1966; Leavitt 1986; Litoff 1992; Scholten 1985). These factors include: a decrease in immigration after World War I (many midwives were immigrants and many immigrant communities viewed midwives as birth experts); a decline in the birth rate during the 1920s; public acceptance or even demand for obstetric care, often by white, urban, middle- and upper-class women; desire of women for safer childbirth; formal medical education and the promises of scientific obstetrics; social changes associated with urbanization; and the shift in birthplace from home to hospital. In addition to these factors, the white, elite, patriarchal medical establishment played an instrumental role in discrediting midwives and dislocating birth (Ehrenreich and English 1973; Jensen 1976; Rich 1976; Rothman 1991; Wertz and Wertz 1989).

Birth in Oklahoma

Oklahoma, like many states today, has poor infant and maternal health outcomes, including high maternal mortality and high rates of preterm birth (National Center for Health Statistics 2011). Our state also has a cesarean section rate of 34.2%, a rate that (along with national rates) has increased by 50% over the last ten years. Risks associated with cesarean sections and other interventions are significant, but often overlooked. As discussed above, poor health outcomes are associated with c-section rates above 15%, particularly for healthy mothers and babies (Althabe and Belizan 2006; Block 2007; Childbirth Connection 2012; Hall and

Bewley 1999; MacDorman 2006; Villar et. al. 2006; Wagner 2001, 2006). For instance, while still a small percentage, mortality associated with cesarean section is 10-20 times greater than the mortality associated with vaginal birth (Stone 2009:48). In addition, “[t]here is clear evidence that hospital obstetric units in the United States are not providing evidence-based maternity care, appropriate care for low-risk women, labor support techniques for pain relief, nor support for the natural ability of low-risk women to give birth vaginally without technological interventions” (Boucher, Bennett, McFarlin, and Freeze 2009:124) (Goer 1999; Lothian and DeVries 2005; Wagner 2006). Poor health outcomes coupled with (and many might theorize are even largely a result of) a highly medicalized system of health care delivery that creates great potential for patient dissatisfaction (Block 2007; Wagner 2006), leads some women to question the need to birth within the dominant birth system/environment and to seek alternatives. Through my participation in the homebirth and larger birth community in Oklahoma, I have found that this perspective coincides with that of many women regardless of whether they choose to birth within the medical birth system or to birth at home.

Rates of homebirth in Oklahoma are representative of national averages, which have remained around 1% for several decades (MacDorman, Menaker, and Declercq 2010). In 2004, 99.23% of births in Oklahoma took place in the hospital, while 0.17% happened in a freestanding birth center and 0.55% took place at home. The percentage of homebirths here (0.55%) includes unplanned homebirths, so does not fully represent planned homebirths—the focus of this research. However, for my purposes, this is the best indicator available. Oklahoma is one of thirteen states where homebirth or direct-entry midwifery is *alegal* (Davis-Floyd and Johnson 2006; Midwives Alliance of North America 2011).

When *alegal*, midwifery is not specifically addressed in statutes, but the actions involved in midwifery practice are considered the practice of medicine and/or nursing; these midwives are left vulnerable to criminal prosecution whenever anyone cares to pursue such action. (Davis-Floyd and Johnson 2006:9)

While this legal status presents potential problems, it is viewed positively by many homebirth or direct-entry midwives (DEMs) and homebirth mothers in Oklahoma. Culturally speaking, the alegal status of homebirth midwifery in Oklahoma allows homebirth mothers and midwives to interact openly, as opposed to states where homebirth midwifery is illegal and mothers and midwives operate underground. However, it also does not allow the opportunity for state or insurance reimbursement of midwife fees, as occurs in some states where midwifery is legal and regulated. While a few participants and others in the community emphasize the latter issue, especially in light of the perceived need of midwife care for more women in Oklahoma and nationwide, most praise the lack of regulation in the state, which they understand as potentially restrictive to their agency and birth choices.

CHAPTER IV

METHODOLOGY

For this research, I take an inductive feminist methodological approach, using participant observation, historical research, and semi-structured interview strategies with Oklahoma women who have given birth at home and with direct-entry midwives in Oklahoma. This methodology is inductive and collaborative in that my own perspective plays a part in the construction and interpretation of women's homebirth experience (Personal Narratives Group 1989). This research is feminist in its goal of illuminating women's lives, voices, and experiences and connecting them to women's struggles; this research works to challenge hegemonic gender ideology and institutions, reflecting feminist praxis and seeking empowerment and social change for women (Hesse-Biber and Leavy 2006). My approach is constructivist to the extent that I use women's experiences to construct understandings, but also critical because of my own critical sociological perspective, which works well with participants' sociological and critical interpretations and insights. Additionally, constructivism, feminism, and the work of Foucault all stress the importance of questioning and making visible taken-for-granted elements of social relations, a goal of mine here.

In crafting my ideas, strategies of research, interviewing, and analysis, I draw on knowledge obtained through my journey and participation in two local birth advocate groups: Oklahoma BirthNetwork (OKBN) and Birth Connections of Stillwater. Oklahoma

BirthNetwork's members include local nurses, doulas, midwives (both DEMs and nurse-midwives), yoga instructors, and other birth, prenatal, and post-partum professionals and advocates. The OKBN mission statement is as follows:

The Oklahoma BirthNetwork is a chapter of BirthNetwork National, a consumer-based, grassroots movement based on the belief that birth can profoundly affect our physical, mental and spiritual well-being. BirthNetwork National is a 501c3 nonprofit organization. BirthNetwork National advocates Mother-Friendly care, as defined by the Mother-Friendly Childbirth Initiative (MFCI). By making informed choices and having confidence in the process, families can experience safe and satisfying childbirth. The Oklahoma BirthNetwork is dedicated to empowering Oklahoma families and providers to work together to make informed decisions during the childbearing year. (Oklahoma BirthNetwork 2009)

Birth Connections of Stillwater's (BCS) is a group situated in Stillwater, Oklahoma, made of parents, doulas, and midwives-in-training. Their mission is:

To facilitate and encourage new parents to make informed choices regarding childbirth and child-rearing. To be a resource for evidence based maternity care providers that support the natural process of labor and birth, a resource and support system for mothers seeking VBAC, a resource of breastfeeding professionals, homeschooling groups, and valuable information resources regarding all parts of early parenthood both local and online. To hold monthly meetings that offer useful information to new families on topics including but not limited to, cloth diapering, herbal use, baby sign language, baby massage and childbirth education. (Personal Correspondence 2012)

Through participation in these advocacy groups and through my own maternity care experience in Oklahoma, I discovered and befriended a number of homebirth mothers and connected with several midwives in Oklahoma who were supportive of my research and enthusiastic to participate and facilitate snowball sampling. These groups provided me with not only entry and rapport in the homebirth community, but they also provided an insight into maternity care in the state in a way that secondary research could not provide. Through my participation in these groups and the relationships I have developed with members, I have come to learn about the birth politics in Oklahoma from the perspective of mothers and birth professionals who seek diligently to provide quality care to women in Oklahoma.

My research on midwifery and homebirth informed my personal views of birth and power and, therefore, my own maternity care experiences in Oklahoma. During my twin pregnancy, I planned a homebirth and participated in care from both homebirth midwives and an

obstetrician. Late in my pregnancy, because the midwives were uncomfortable with the position of my second twin, I planned a hospital birth. I was anxious and apprehensive to birth in a hospital, and I hoped for my family's sake that our hospital birth experience would challenge the knowledge I constructed from research. Unfortunately, despite a great deal of support, education, and preparation, my understandings of obstetrics and hospital birth were only confirmed and I experienced what I define as *birth rape*, where I was physically and emotionally coerced, objectified, violated, and disempowered. My autoethnographic experience, then, provided a deep and emotional understanding of the two models of care and of hospital birth and allowed me to identify with participants in numerous ways. In particular, I identified with many elements of women's negative and traumatic hospital birth experiences, and with elements of prenatal midwifery care. I discussed and acknowledged my experience and perspective with many participants and others in the homebirth community. I allowed time to begin processing my thoughts and emotions so that I could determine my own position and bias before I began the interview phase of this research. Additionally, throughout the process of analysis, I acknowledged my position and remained open to other, even opposing, views and experiences. I am confident that this research incorporates my understandings, generally paralleled in research and experience, but that interpretations and findings are grounded in and representative of the homebirth communities I participate in and the perspectives and experiences of homebirth mother and midwife participants.

In addition to participant observation and autoethnographic experience, primary data comes from interviews with both homebirth midwives and women who have given birth at home in Oklahoma. I used a snowball sample technique (Berg 2004; Creswell 2007) beginning with the women I met while involved in Oklahoma BirthNetwork and Birth Connections of Stillwater. Some of the midwives I met referred participants to me. I interviewed 30 women who have given birth at home in Oklahoma and 11 homebirth midwives in Oklahoma. The only requirement for participation was that women had birthed at home in Oklahoma or attended homebirth as a

midwife in Oklahoma and that they were 18 years of age or older at the time of the interview. Participants' identities were kept confidential and pseudonyms were assigned to participants and research materials. In selecting pseudonyms, I felt inspired by the women I interviewed, and chose names with translations around the concept of *strength* (e.g. strong, courageous, powerful) or names of strong women in history.

Homebirth mother participants ranged from age 21 to 52 at the time of the interview and about age 20 to 40 at the time of their homebirth(s). The majority (23) of mothers' last birthed at home within three years prior to our interview, while others' last homebirths ranged from four to sixteen years prior to our interview. The average number of children of homebirth mother participants was three, though number of children ranged from one to 12. Most homebirth mother participants had some college education, though education levels ranged from eighth grade to master's degree. Only about seven of the 30 homebirth mothers interviewed worked outside of the home full-time at the time of the interview and, for these women, most of their jobs were flexible and allowed them to be home from time to time or when needed/desired. At least two of these mothers waited until their children were older to take on more paid work. The remaining (23) homebirth mother participants stayed home with their children most or all of the time. Many have in the past and/or currently work for pay part-time, either outside of the home or at home. Through various subjective measures of class (mother and father occupation, renting or owning a home, self-classification, etc.) I estimate that the average socioeconomic status of participants was upper-lower class to lower-middle class. A majority of the participants identified as white, with a few indicating Native American ancestry.

Ten of the 30 homebirth mothers had only birthed at home (and all of their births were planned homebirths). Of the other 20 mothers, 17 birthed in a hospital at least once before deciding to birth at home, and three first birthed in a freestanding birth center before choosing to birth at home. (Two of the 17 who birthed their first in the hospital, birthed once at a birth center before going home to birth.) At the time of interviews, 15 mothers had had one homebirth, 11

mothers had birthed at home twice, three mothers had three homebirths, and one mother had six homebirths. Many homebirth mothers expressed plans to birth at home in the future; in fact, three mothers that I maintained contact with have birthed at home again since our interviews, and everyone who shared intentions of having more children said they would birth at home unless there was a medical reason not to. The table below summarizes the demographic characteristics of my homebirth mother respondents.

Table 1. Homebirth Mother Demographics

| Homebirth Mother Demographics | Total: 30 |
|--------------------------------------|---|
| Age (at time of interview) | Average: 30 Range: 21-52 |
| Race | All White (a few also indicated some Native American ancestry) |
| Formal Education | Average: Some college Range: 8 th grade – Master’s degree |
| Socioeconomic Status | Average: Upper-lower to lower-middle class |
| Number of Children | Average: 3 Range: 1-12 |
| Birth Place History | Hospital: 17 Birth Center: 5 Home: 30 (10 only birthed at home) |
| Number of Homebirths | One homebirth: 15 Two homebirths: 11 Three homebirths: 3 Six homebirths: 1 |

Interviews primarily took place in the mothers’ homes, with children present. The mothers often welcomed my children to come along, especially if out-of-town travel was required for me to attend our interview, so that I could nurse my children. When I brought my children, a babysitter came along to watch the children during the interviews. We often took breaks for mothers to tend to their children (changing diapers; soothing fussy babies; arranging entertainment, snacks, or distraction for the older children, etc.), and mothers often nursed their babies and held them while they napped as we talked about their lives and birth experiences. Contact and scheduling often involved working around nap, lunch, and nursing schedules for both participants and myself. This, along with the snowball sampling method, where potential

participants' friends, family, and midwives referred us to each other, helped develop rapport and contributed to a level of comfort and openness for mothers to discuss details of their lives.

All of the midwives who participated in this research were direct-entry midwives (DEMs); they all attend birth at home. Most were Certified Professional Midwives (CPMs); one midwife participant with a CPM certification was also a Certified Nurse Midwife (CNM); two were recognized as Senior Midwives through the Oklahoma Midwives Alliance, and one of these was training to be a CNM; finally, two midwives were without, and had no plans to obtain, official certification. Our meetings were usually at midwives' birth centers or offices. The midwives I spoke with account for the majority of homebirth midwives in the state. Only two of the midwives I contacted were unable to meet with me. Aside from the two who did not participate, my participants represent all of the established homebirth midwifery practices in the state. I estimate that there may be a few "rogue" midwives (without established or well-known practices) and/or midwives who are seeing few or no clients; there are new midwives completing training; and there are church or prayer midwives in the state. Respondents characterize a rich and representative set of resources.

Interviews were semi-structured. I generally asked participants to tell me a bit about themselves and then asked about their journey to homebirth or to midwifery. From there, I followed their lead and attempted to address all of the questions I had (and others that emerged) in a way that flowed with our discussions. All interviews were audio-recorded and transcribed verbatim. (See Appendix A for interview schedules.) Each interview was then read line by line and notes were taken using an inductive open coding process rooted in grounded theory (Charmaz 2006; Creswell 2007; Strauss and Corbin 1998) and I identified common and consistent themes (e.g. Birth Story, Midwifery Care versus Obstetric Care, Mind-Body Connection, Why Homebirth) and utilized the constant comparative method where, as I was in the process of identifying themes, new data was compared to developing themes, categories, and properties (Denzin 2004). This method allows for emergent themes and maintains trustworthiness. My

strategy includes a few key stages. First, I listened to interviews multiple times, including while transcribing, observing (with memos) when I noticed a pattern or theme. Reading the interview transcripts, I noted what caught my attention—in the context of both my understanding of what was pertinent from the literature and more importantly, what the participants felt, emphasized, or communicated as most significant. Field notes and personal observations from visits with participants contributed a deeper understanding of women's words and experiences. I then reviewed all 41 transcripts and coded every part of each interview. As I progressed through the transcripts, I revisited my coding categories to determine how they needed to be refined. I occasionally split categories or combined them. In the end, I had 29 coding categories.

Initially, I looked for themes relating to my research questions, especially regarding agency, identity, bodies and experience, but I remained open to other important themes that emerged. I looked for patterns in the ways that the women made sense of their experiences. I was attuned to both the similarities and differences in women's stories and, for those that were similar, the possibility of a collective story. Given the relationship and history of legal policy, medicine, and power, I was interested in how direct-entry midwives viewed their alegal status in Oklahoma (though this is outside of the scope of my chosen presented findings). I was also interested in the ways that midwives characterized their roles in the production of agency and cultural resistance. For both groups, I analyzed the ways in which participants described bodies, agency, and processes in light of issues discussed above and my theoretical approach. Along the way, I noted the themes that emerged as most significant, and these themes are the ones presented in this dissertation. Once I narrowed the themes and categories I would present in the dissertation, I reanalyzed those categories, using a color-coded, pen and paper scheme, making notes as subthemes and nuances emerged, particularly making connections to existing themes in the literature. From this process emerged the organization of my findings here: comparing oppositional holistic and technocratic models, as articulated by participants, through three main elements of these models as well as power and agency in the models.

Participant observation, in-depth interviews, and autoethnography provide an opportunity for triangulation, offering rich information regarding the complex personal and social nature of birth and mothering. Rather than valuing traditional authoritative characteristics of research such as reliability, validity, and generalizability, I prefer to follow postmodern approaches that “seek to anchor a text’s authority in ... more local, personal, and political” ways (Denzin 2004: 452). Accordingly, I strive for trustworthiness, which involves credibility, transferability, dependability, and confirmability. I have achieved trustworthiness through utilizing multiple methods of data collection, acknowledging my own views, experiences, and position, through utilizing the constant comparative method in data analysis, through engaging and sharing with numerous women birthing in Oklahoma and elsewhere over the past several years, and through comparing my data and findings to other research regarding birth.

The greater context of pregnancy and childbirth in the U.S. informs *all* women’s experiences and understandings, though these understandings and consequential choices and actions may vary. Individuals have, to varying degrees, their own unique experiences and therefore will have their own consciousness and knowledge and perception of reality. Because humans do not all share the same position and experience, we do not share the same reality. The same is true of women; women’s social position, due to race, class, age, and ability (among others) varies, and their experiences and realities also vary. This being said, individuals, again to varying degrees, may also share with other individuals similar knowledge and reality based on their shared experiences and context. While we have our own unique personal experiences, our shared social context and history are also very influential in shaping our knowledge and reality. Our knowledge and our reality, for instance, may be similar based on our shared culture (as opposed to the reality of a different culture) or our shared moment in history (as opposed to the reality of a different time or point in history). Throughout this work, I attempt to explain the construction of knowledge and reality, and the exercise of power as experienced by my participants. While I do not attempt to generalize my findings to all women in the state or in the

U.S., or to claim that this is a universal reality, there certainly is value in understanding the strong patterns in my findings – because the patterns identified here were surprisingly strong - and there is no reason to believe that they are necessarily anomalies.

In the next chapter, I introduce participants' experiences through telling their collective story of journeying to homebirth, and recounting their direct explanations for deciding to birth at home.

PART TWO:

WHY WOMEN BIRTH AT HOME

CHAPTER V

THE JOURNEY TO HOMEBIRTH: WHY WOMEN BIRTH AT HOME

In this chapter, I directly address my primary research question: Why do women choose to birth at home? Women addressed this question indirectly, through their stories, and directly, at the end of our conversations. Through learning their experiences, I found that all women described their decision to birth at home as a journey, rather than a decision made quickly or lightly. For most, this involved prior hospital birth(s) and obstetric care. Others have only birthed at home. When asked directly (and this is reflected in women's stories as well), women explained that they birthed at home for safety and control. The safety of homebirth is grounded in particular understandings of natural birth as safest for mother and baby, interventive birth as harmful, and hospital birth as interventive. Homebirth mothers and midwives stressed the important role of education in midwifery care and described a lack of education, informed consent, and agency in the medical model of care. Acknowledging this, women birthed at home for control—control of their bodies, births, and babies. This control is ultimately a way for mothers to ensure physical and emotional safety. Throughout this chapter, I remain close to women's own words with little analysis beyond what is required to tell their collective stories. This is important both to communicate to the reader women's birth experiences, which I do not claim ability to explain better than they, and to articulate the reasons women offered for birthing at home, uncomplicated

by my theoretical interpretations of why they birthed at home. I end this chapter with a brief discussion of theoretical implications that will be detailed in the following chapters.

The Journey to Homebirth

Participants discussed birth experiences with me in detail and also shared parts of their lives relevant to birthing and parenting. This provided a deep understanding of women's experiences, perspectives and motivations for homebirthing. Near the end of our conversations, I asked them to directly explain why they chose to birth at home. I also asked midwives why their clients birth at home, and their responses were in line with what homebirth mothers told me. I anticipated, or at least was open to, a much wider range of reasons for birthing at home, but the patterns in participants' answers to this question are astonishingly strong.

Participants overwhelmingly told me that they and others they know birthed at home for the safety and control that homebirth and midwifery care offered. Whether they told me directly or indirectly, they all have a view that birth is normal, natural, and safe when left alone. This, along with many other elements they communicated leads me to define their perspectives within a holistic or midwifery model of birth, described earlier and detailed in later chapters (Davis-Floyd 2003; Simonds et. al. 2007). All of the women described a journey to homebirth; they described it as a process rather than a moment, which makes sense in light of our birth culture and medical hegemony. While some have always defined birth, and even homebirth, as normal, most described a shift in their lives from a more medical or technocratic belief regarding birth and health to a more holistic view. Most of the women who experienced a shift had negative, if not traumatic, medicalized births or knew someone that did, which led them to birth at home. Judith explains that after her first child's birth in a hospital:

We did everything to get out of the hospital as fast as we could. So I think that [the hospital birth] was the biggest motivator for a homebirth that I could have ever had. I think I would have been interested in having [my first child] at home if I had known more.

All of my participants described a journey to homebirth that involved a process of education. Most often, participants described this journey and their reasons for choosing homebirth through a description of oppositional medical and midwifery models of care and their belief in the latter (which will be described in detail in later chapters). Some participants grew up seeing birth, and even homebirth, as normal. Some of these participants were birthed at home themselves, or their mother birthed some of their siblings at home, or naturally in a hospital. One of these women, Megan, said:

I think the people that are like me that just did homebirth because it is what's normal for me; it's strange and foreign for other people, but that's what's normal. Going to a hospital and having a baby there and having my baby taken from me to be cleaned, that's so foreign to me that this is what's natural and normal for me and my family, which is very beneficial to everything that I do to have it be normal for everybody around me.

Matilda spoke of her mother's homebirths and how many other women in her family and community birthed at home:

Having a bad hospital birth with me was her reason [for birthing at home]. She was young. She had me when she was 19 and she had a horror story with me. [...] For me, it was like, my mom already did that. She made the way for me. All my family, all my husband's married siblings, had homebirth.

Ten of the thirty homebirth mothers I spoke with have only birthed at home. Three mothers birthed in a birth center with their first and then birthed the rest of their babies at home. Three women birthed in hospitals, then went to birth at home and returned to the hospital for some of their later births. This is interesting, because many women who birth at home tend to continue to birth at home. One of these mothers, who birthed at home and then returned to the hospital, explained why she plans to have the rest of her babies at home:

And it sounds simple [how my hospital births went], and you think, "Why wouldn't you just go back to the hospital and do that?" But the whole undertone of, "We're having to induce because you may not survive this childbirth." There was a lot of fear built into it. A lot of, "If we don't do this and that, your baby's going to die." [My nurse-midwife] kept it pretty mild for me during the delivery, but I knew she had a whole team of people waiting for me outside the door. I knew. There were a couple times where she jumped the gun, and started to call people in. Just from fear. And anyway. It was okay. We had babies. And we still prefer them to come at home.

The two other mothers who birthed in a hospital after homebirthing express contentment with both birthplaces. These two women characterize their first hospital births as their only births that they would characterize as negative overall. Still, both describe the hospital and the care there as less comfortable and less personal and described having to fight to have the birth they wanted, though this lessened as they had more children. (One of these participants has five children and the other has 12.) Speaking to this, one of these mothers says:

I think part of the hospital setting, it just was cold and uncomfortable and I hated the hep-lock in my arm. And so I had gradually gotten less interventive in the hospitals, but you still really felt like you had to fight against something.

Ultimately, both women explain that homebirth and midwifery care is more personal and comfortable, and describe home as an environment where they felt safer and had more support and control. Both expressed their belief that the midwifery model is a superior model of care.

Seventeen of the thirty homebirth mothers birthed in the hospital with their first child. Most of the women who first birthed in a hospital wanted or attempted a natural birth. Only two of the women who first birthed in a hospital said their first birth was a positive hospital experience. The other fifteen described their first hospital births as negative. Though some of my participants who birthed in hospitals explained that they anticipated or even planned a medicated birth, most of these women tried to birth naturally in the hospital, often with a doula or other labor support. Sometimes they were successful, but often they were not and, in both cases, most felt discouraged or even sabotaged by the medical staff, institutional protocols, and their care provider. They describe having to fight for a natural birth in the hospital.

For the women who had negative hospital experiences, their assessments ranged from simply unsatisfactory to traumatic. A few mothers explained that they do not see their hospital birth and homebirth in black and white terms, but that homebirth was still better in ways that were important to them. One of these women, Ruth, who had a natural birth with nurse-midwives in a hospital followed by a homebirth with her second child, says:

[T]he hospital birth wasn't *terrible* and the homebirth wasn't just *awesome*. It wasn't like that. After I had the homebirth, all my birth friends were like, "Oh my gosh! Was it awesome?! Was it just perfect and just so much better than [your first baby's] birth *ever* was?!" And I was like, "No." [Shakes head.] But there were little things that made it [the homebirth] so much more calm, and relaxed, and just *fulfilling*.

Other mothers express a similar sentiment. Hospital birth, and even birth at a birth center, for them was not traumatic, though it was dissatisfying in ways, which eventually led them to birth at home. Of her first hospital birth, Emma says: "It wasn't the birth that I wanted, but it wasn't a traumatic birth. I grieve things about it, but it wasn't traumatic." And of her second hospital birth, and how it influenced her decision to homebirth:

Finally, when I was trying to push, she put her finger in there and popped my water [without consent]. Before I was pushing! And so it was squirting all the way to the back of the room. And I'll never forget the nurse, standing in the back, you know—because there was like a crowd of people I think, I don't really know who they are—saying, "That's why we have babies in hospitals." That really annoyed me and I don't know—I just remember giving birth and thinking, "I'm not doing this again. If I have any more babies, I'm never coming back here," like in the middle of pushing, I'm thinking this. I just remember thinking that. Like, "I'll show you, nurse! I don't know who you are! But I'm going to show you." (laughter) [...] After [my second son's] birth, I thought, "It's too much of a fight. I know I can give birth. I know birth hurts, but I can do it. I don't think I'm going to, like, one day get an epidural." And both pregnancies have been healthy, and so [my husband] and I were just both like, "Let's not waste our time at the hospital. Let's not fight the hospital anymore." So I guess it was kind of a progression for us.

One mother of twelve, who birthed multiple times both in the hospital and at home, as well as once at a birth center, explains the negative nature of the way her first birth was managed:

Well, the first baby in the hospital, I had gone to classes and all that and I was determined to have natural childbirth and to breastfeed. And I did have natural childbirth, to most people: I had a local anesthetic [to stitch] the episiotomy, that's all. But I felt like they didn't keep their promises. I felt like there were more interventions that I hadn't wanted. Especially after I had the baby. They catheterized me an hour after birth, so it was like they didn't give me a chance. You know, you're sitting in a room trying to urinate, in a big room that's open, on a toilet, and there are nurses [who are strangers], it's not going to come out. And so that was painful and humiliating. And then afterwards, you only get your baby for this many hours. [...] So I just felt like that was disappointing.

Of this birth, she said:

My first baby was my worst hospital experience. And it wasn't horrible by someone else's standards, but for me it was traumatic. They gave me an enema that I didn't want, but they just have you have one, they don't really give you a choice, even though that was in my birth plan. The nurses ignored the birth plan, the birth plan meant *nothing*.

Another mother, Eleanor, had her first child in the hospital when she was 18. She described it as a traumatic experience, and—as opposed to other mothers’ births—can more clearly be identified as such by those outside or separated from her experience. Eleanor was given a fourth degree episiotomy (a cut in the vagina that extends to the rectal muscles) that caused long-term injury and that she believes was unnecessary and administered by her doctor out of spite:

My doctor, when I was pregnant with [my first child], he was involved in a church, and he asked me if I would be willing to go around to schools with him in an organization and speak to girls about a pro-life movement to encourage girls to have their babies. And I didn’t want to do that. I’m not really sure what my reasoning was, because I actually was very pro-life at the time, but I was eighteen and impressionable, and didn’t want to stand out as a teenage mom, even though I was. So, I told him no, and my husband thinks that he deliberately cut me the way he did, because my husband saw him do it and there was just no reason for it.

While she explained that she has healed emotionally from this event, she explains that the physical harm was long-lasting: “I do have some problems that have carried on beyond that. For six months, I wasn’t able to have a normal bowel movement. I was in horrible pain.” In assessing her experience, she described a lack of agency:

My labor was fine as labors go, but the things that happened afterward were very traumatic. My daughter was drugged. I was drugged because I was in so much pain. We were separated. I was afraid, and I remember feeling that mother’s instinct for the first time, and being so young, I didn’t know—it was harder for me to stand up and be like, “This is my baby and I want her in this room right now!” and people were very pushy with me and forceful and like they knew what was best for me, even though I was very sure of what I needed to do. And so, it was just, overall, not a pleasant experience. And the episiotomy was the worst.

She went on to say:

From the hospital experience, I felt very—almost violated, you know, like they didn’t take into consideration anything that I wanted or that my husband wanted, and so, it’s very belittling and I just remember feeling very insecure and like the whole hospital situation was just crazy.

Isa, who is accompanied by a number of my participants in her sentiment about their hospital births, including the two mothers above, says her first birth, in a hospital, was traumatic. When she had her second baby, again in the hospital, she felt she did it by herself and didn’t need the hospital and staff to birth again:

And when I became pregnant with my second child, I planned on a hospital birth. I planned on painkillers, I planned on, you know, just the very conventional, typical kind of birth, and I had [my daughter] very quickly and easily in the hospital – so quickly and so easily in fact, that I realized that I really didn't need to have been at the hospital. [...] I kind of started to get some confidence back with that birth, just because it had been, essentially I had no assistance from anybody at the hospital. She just sort of came. And I realized, "Wow, if I can do that here...[I can do it at home]."

Luisa's experience was similar. Her first birth was an unwanted c-section and a traumatic hospital experience. Her second birth was a VBAC (vaginal birth after cesarean) in the hospital. Explaining why she birthed her third at home, she said:

With [my second child], I labored at home. I got to the hospital and pushed her out. What did they do for me?! The first time I went to the hospital, they screwed me over; the second time, they did nothing at all. Why would I go back to them? That's just ridiculous. So we decided we were going to have our baby at home. And we did!

To varying degrees, all of the mothers I spoke with, including the two mothers who described their first hospital birth experience as positive, employed a narrative that generally defines the hospital experience as a negative one, particularly because of a lack of agency and resulting risks of iatrogenic harm (harm caused by doctors and medical interventions). Here, the two mothers who described the hospital positively evoke this narrative. The first explained:

I really liked [my doctor] and had a very good hospital experience. There were no problems. I had a completely natural birth. It was pretty stress-free. [...] I had a good experience, but I've seen a lot of things where the littlest thing goes wrong and they jump on it and do a c-section or an episiotomy. I like the idea that birth is a natural thing. And if it's not necessary to go to the hospital, I'd rather just do it at home.

The second mother articulated:

[After my birth, I wasn't contracting and my uterus was boggy.] And again, you know, [the midwife] knew what to do. And I don't know what they would have done in the hospital. [...] I never checked into it, but I think it would have been something I didn't like—something invasive. So, and not that what she did wasn't invasive—it was—but it was natural and it didn't involve any, what she did was she reached up and she pulled the clots out. And that experience was even more painful than the whole birth itself. I mean it was. If the doctors would have done something like that, I can't imagine them being as gentle as she was in that situation. And I can't even imagine them doing something like that. It seems like they're so much more unwilling to handle things in that way. They seem to want to inject you with things or cut you open. The way that she handled it, I was fine with.

Most of my participants, midwives and mothers, characterize a “typical” hospital birth as interventive, where the mother experiences a lack of control, lack of informed consent, and lack of respect. For most, this understanding stems from their own experience:

My first birth was a typical hospital birth. I was 19 and I was single and it was your typical hospital birth. Not good memories. For the second one, I had my second child six years later, after I got married. So that was my first homebirth. I just decided that it wasn't worth the emotional damage that hospital birth causes.

For some of my participants, including both women who birthed in a hospital and women who only birthed at home, part of what led them to homebirth was learning of or seeing someone else's hospital birth, which they deemed unpleasant or even traumatic, over-medicalized, and not what they wanted. For these women and for others, their mother's, friends', and/or female relatives' hospital experiences led them to define hospital birth in a negative way:

My sister's diabetic, so she's high risk, because of what can happen right after birth. So she gave birth in a hospital, and even though she was well-educated and had a birth plan and a supportive husband and all these things going for her, she still had a horrible experience. So I thought, if my sister, who's very outspoken, very on the ball with communicating and making sure they don't act like you're inadequate—if she can't even have an awesome birth story in a hospital, I sure as heck can't.

While these women know someone who had a bad birth experience in the hospital, and that influenced their decision to birth at home, there is an implicit or explicit acknowledgement that this is the norm of hospital experience, that many other women go through the same thing, as Carla related:

I guess it started out with my mom. She would tell me horror stories about [her hospital births...] She would always tell us how she didn't have access to us whenever she wanted. She couldn't breastfeed my sister because they gave her formula in the beginning, and that upset her stomach and caused all kinds of digestive problems. I grew up hearing about all of the problems that the hospital caused her. She even has a nightmare, I don't know if she still has it, but she had it for a long time after I was born, that she would run down the hospital halls looking for me, and they wouldn't bring me to her. So it was a traumatic experience that I've heard a lot of women have.

In addition to knowing other women's negative hospital experiences, some women explain their understanding of hospital birth as unpleasant and medicalized through reading about such

experiences, in books and online. Victoria, whose mother had two births that both unfolded in keeping with the narrative, said:

You read about it all the time. You go in with this plan, you don't know anything, they sit you down and tell you, "We're going to give you this. We're going to do this." And by the time you're done, you've had an epidural. You've had a c-section.

Wherever it originates for each woman, there was a common narrative, and one that I often see in the homebirth community, as one mother stated: "I've known enough of the horror stories at the hospital, I'd rather have a homebirth with a midwife I trust."

Midwives' own births are often similar experiences and indicative of the reasons they became midwives themselves. Reflecting homebirth mothers' collective experience, some had traumatic births:

I can remember being in the hospital [for one of my own births], they wouldn't let my husband be with me. After the baby was born, [my husband] was able to come in the room with me, but the baby was isolated. I can remember standing on one side of the glass crying, while the baby on the other side was crying because she needed her mother. So I really got into [midwifery] for my daughters, [to help ensure they had better births,] and found out there are a whole lot of people out there that felt exactly like I did. They wanted better births, better outcomes, children that are not injured because of what doctors do in augmenting labor and birth.

Others were dissatisfied felt birth should simply be done a different way:

[My first birth] was a completely managed birth, and so that was all I knew. I also had two other children with that same physician in the hospital. And really, my births were not awful. Sometimes women will come to seek midwifery care because they haven't had a good experience. [...]. But I didn't have that awful experience. But when I had my last daughter, I kept thinking, "It seems like they could do some things differently." [In a sarcastic tone, she says:] Like, maybe I could be able to hold the baby? [laughs] It was held over here in an isolette. And maybe instead of everyone standing around a box, it seems like I should be able to *maybe*, get to *touch* the baby as it was coming out. Because my physician said, and we have it on video, she said, "Don't touch her! Whatever you do, don't touch her!" right when she came out. And I wasn't traumatized or anything like that, but you know, it just seemed like there should be some way that's different that's better than this.

For midwives, then, their own birth experiences sometimes led them to birth at home and always led them to be midwives and help other women have healthy, positive births.

As explained thus far, participants described being largely influenced to birth at home by their own hospital birth experiences—which ranged in nature—from the experiences of significant

women in their lives, and/or from the narrative of generalized women birthing in hospitals. Some acknowledged that they always adhered to a different model of birth, but many at one time subscribed to a biomedical model of health and illness and began to question this perspective through their experiences and others' experiences.

Education is a key part of the process for all of the women I spoke with. Education, broadly defined, involved reading and research as well as learning from their own and other women's experiences. Participants consulted books and online resources, which was evident in many women's citing of statistics during our conversations. In addition to more formal sources of education, women recounted talking to their mothers, sisters, other female relatives, friends, and community members who had birthed; and many tell of attending other women's births as part of their journey to homebirth. For some who grew up within Mennonite communities and cultures (though most I spoke with were somewhat removed from those communities and their churches at the time of interviewing), homebirth and/or natural birth was part of the norm, though always acknowledged in relation to dominant medical institutions and practices. Some of them were birthed at home and/or they often knew other women in their churches and communities that birthed at home.

Many women attribute their negative experiences in the medical model of birth with a lack of education. They acknowledge that hospital birth is the norm in our society and that they did not question it: "Like I said, I was young. I was 19 and didn't know anything different than you go to the hospital and have a baby." Some women admit regretting their own complacency for their first and even second births, and wish they educated themselves more, or that education was included in their medical care, as it is in the midwifery care that they received. Like Eleanor above, many described experiencing some sort of intuition or feeling that birth should be different, that they did not want their births to be treated as they had been in the hospital, though it took active exploration to discover an alternative.

Ultimately, after seeking education and alternatives, nearly all of the women who first birthed in the hospital decided that homebirth was a better choice. Some women, like Eleanor, explain that in the face of experience and education, the decision to birth at home was easy:

I mean the information was: If you go to a hospital, you're exposed to so many more bacteria than if you're home; and the rarity of any kind of death or injury from homebirths; and the different cultures that have such a better infant and mother mortality rates than the United States; and the [less medicalized] way that they do birth; and the empowerment of women; and just my own personal experience, and—with what a man did to me while I was giving birth at eighteen, so vulnerable, was very—that drove me to—It was a very easy decision.

Many women started their journey to homebirth and a holistic model of birth because of their negative experiences in the hospital, as one mother demonstrated: “The three hospital births is what led us to the homebirth...” Education is a significant part of the journey that women took. Many homebirth mothers and midwives describe learning about labor and birth and thinking differently about their bodies. They came to see birth as normal and healthy and a process that they were capable of. In many ways, their journey to homebirth was a journey to the midwifery model. This model is further reflected in women’s discussions of why they chose to birth at home.

In addition to very logical and informed explanations of why they birthed at home, many women also described homebirth as very special and, sometimes, almost magical. One mother, Sally, who was dissatisfied with her first birth center birth, described her labor at home with her second in almost sacred terms: “But the pain was just there and then [my husband] was right behind me, we were in bed spooning. In the dark. In our own home. In our bedroom.” Another described the special nature of living everyday life in the house and in the room where she birthed her son: “He sleeps in the room he was born in. I think of that almost every time we go in there. ‘This is the room you were born in, where you came into the world.’” In many ways, participants connected homebirth with a sense of agency and ownership, and how this is taken away and birth is treated as almost mundane in a hospital setting, as one mother explained:

It was all on my terms. And [my homebirth] was in my house—my mom’s house. It was actually in my childhood bedroom. And I got married in that house. So I have pictures from my wedding of me and my husband in the room [on our wedding day], in that exact spot where I birthed our child. So how special is that?! It makes me mad that the hospital gets to be the place where all those memories are made. And they just spray everything with bleach, wipe it down, and bring in the next one. It’s not personal.

As demonstrated here and in many quotes above, agency plays an important role in birth for participants, and is illustrated in their journeys to homebirth, including their own birth experiences, and in women’s answers when I asked them directly: Why did you birth at home?

Why Women Birth at Home: Safety and Control

Women’s journeys to, and thus their reasons for, homebirth are complex. I will elaborate and explain these complexities throughout the following chapters. Here, I begin uncovering these intricacies by discussing responses that emerged when I asked women directly why they chose to birth at home. Participants overwhelmingly answered that they birthed at home for safety and control. I turn, with more depth, to these two dimensions now.

Safety

The most common answer given when I asked women why they chose to birth at home, and a strong theme throughout women’s narratives, was the safety of homebirth: “I chose to birth at home because I felt that it would be safer for me and my child.” Midwives echoed this sentiment when I asked why their clients choose to birth at home: “They want to feel safe.” When I asked her why she birthed at home, the response Audree gave was reflective of what other mothers and midwives told me:

Because I felt like it would be the environment that I would be the most safe. I know that birth isn’t risk-free and I felt like I was at greater risk of having a birth outcome that I didn’t want in the hospital because of all their interventions, their tendency to be heavy-handed with interventions. Versus at home, which there are risks as well, but I felt like the risk of something going wrong here was slighter. I wanted to feel safe. I wanted to, while I was laboring, feel safe. I think every woman wants that. [...] I knew that I would birth better if I felt safe and home is where I felt safest.

Though they choose it for their own safety, women choose to birth at home first and foremost for their babies. They believe that birth at home offers the safest set of birth

circumstances for their children. As a secondary consideration, they also birth at home for themselves. In popular discourse of homebirth, there is a misconception that the decision to birth at home is a selfish choice. This is certainly not reflected in the voices of my participants, as one mother explained:

Homebirthing wasn't for me only—it was for my benefit so I didn't have those terrible things done—but for my babies—I can't imagine having them go through an experience within moments of their lives, that was so traumatic.

One mother reiterates this point, highlighting the complex decision-making process that starts with consideration of the baby:

I think people think that women who have babies at home are doing it because we want to do it for us. That it's some power thing for the mother, like it's a selfish thing. In a lot of ways it is a selfish thing. There are a lot of reasons I wanted to birth my baby at home for me. But I think that we also all love our babies just as much as any other mother does. I wanted to birth at home not just for me, but for her too. I really felt like it was the best thing for my baby. And I think it was the best thing for me too, but I did what was best for my baby. My baby came first. Which is the safest thing for my baby?: To birth at home or to birth in the hospital? And even before that, [with my second], which is safer for my baby?: To have another cesarean or to have a vaginal birth? Okay, vaginal birth is safer for my baby. Now, where do I want to have a vaginal birth, which is safer for my baby? Okay, at home is safer for my baby. So now, is at home safe for me? It started with the baby, and there are a lot of benefits for me in that, but it started with the baby. And I think that's where most homebirthers start. You want the best thing for your baby first. And not that people who birth in hospitals don't do that too, but I think there's that misconception that we want to birth at home for *us*.

I first presented women's expressions of homebirth for the sake of safety at a research symposium to an audience of largely undergraduate students, most of whom likely attended not out of interest, but to earn extra-credit. I was astounded by their confused reaction to my findings. I interpreted their reaction as reflecting the hegemony of the medical model that defines birth as inherently risky. But it also led me to more fully appreciate an implicit theme in my participants' commentary—how homebirth mothers' notion of safety is rooted in the assumption that natural birth is normal and healthy. Upon reexamination of my data, I found that women always communicated this basic idea, sometimes implicitly and sometimes explicitly, as this mother did:

When [birth is] treated more like a natural thing, and less interventions are used, complications are actually prevented. To me, that's probably the biggest thing. Just treating it as what it is. It's natural, and if there are no complications, then I don't feel like I need a hospital. To me, a hospital is for problems, sick people, that type of thing. It's about going back to natural, just how it was meant to be.

For participants, natural, unimpeded birth is inherently safe, most of the time. When women and their babies are low-risk and healthy, birth will most likely be safe. Furthermore, because birth is normal and safe, intervention is usually unnecessary, unnecessary interventions on the natural process of birth create risk and harm, and hospital birth is most often interventive birth, hospital birth is understood by participants as generally risky. Another mother reiterated: "More goes wrong [with birth] when you interfere with it than when you let it take its course." Citing history and birth around the world, and sometimes God, participants stressed the normalcy of birth, and acknowledged the promise of medical technology, but the detrimental impact of its overuse.

Women valued a hands-off approach, as demonstrated by this homebirth mother:

Women have been having babies forever. As long as we've been around, we've been having babies. It seems like most of the bad things started happening when doctors and hospitals got involved. Birth is a safe thing. I read a lot of Ina May's books, but it just seemed like birth was safe and I really felt like most of the bad things that happen in birth, happen because of interventions—even if it's a vaginal exam. I always say if they keep their hands out of you and off of you, most of the time you can birth your baby. There are obviously instances where c-sections are necessary and interventions are necessary. But most of the time if they keep their hands out of you and off of you, things will be fine.

Many believed great harm is done in hospitals, but this harm is rarely attributed to the real cause—unnecessary intervention:

God designed our bodies to have babies, and most of the world and history has been birthed at home. And I'm not saying we should go back to caveman days and no medical, at all. I'm *thrilled* that there are hospitals and doctors, and I'm sure you're going to have babies that died at home that might have lived in the hospital. But I believe that there's a greater percentage of babies in the hospital die because they weren't born at home. When you really get down to it, if someone was telling the truth, there are more babies who die because of interventions in the hospitals than do at home, or have long-term health problems. [Talks about her father-in-law's birth and how he was damaged by forceps...] So there are going to be babies and mothers that die. I think it's riskier to have them in the hospital a lot of times. So the choices I made, when I had them at home, I felt I was safer at home. And I have no regrets about my choices either. [... Talks about her daughter's homebirths.] So I felt like that was how it was meant to be and it was actually safer.

Some women talked about fearing hospitals and birthing in the hospital, and this is most often attributed to medical birthing practices and the perception of harm associated with those practices, as the mother above went on to say: “At one point, it was a lot scarier to have one in the hospital to me, than it was to have them at home. So that says something about the birthing practices in hospitals these days.” Where most women in our society fear childbirth and, therefore, are likely to fear homebirth, participants, like Nina, expressed a need for skepticism if not fear of birth in hospitals:

I would tell other people, when they say I’m brave [for birthing at home], that, “You’re braver to go in [to the hospital] and let them do all these things to you, and let them interrupt that process, and hope for a good outcome.”

This understanding of hospital birth often emerges from women’s own hospital experiences, where—as discussed earlier—they described having to fight to have a natural birth in the hospital, and where they often describe being defeated. Many mothers indicated that the management of their births in the hospital resulted in physical and emotional harm for themselves and their babies. Interventions led to additional interventions, and sometimes to significant harm to the baby. One homebirth mother told of how her hospital birth was managed and the physical and emotional harm that resulted:

I had wanted to have a homebirth with him. Wasn’t really sure how to do it, I just knew that I wanted it and kind of gave into conventionality and I thought, safety, and doing the right thing. I had a very traumatic hospital birth with him. They ended up, it was the typical, I was induced, I let them induce. I didn’t really know any better. I was 25 and they told me that, I forget what the reason was, oh my blood pressure was high. And he “needed” to come out, so they “needed” to induce me, and I gave in. It was the cycle that you always read about, the induction and then the labor flounders and you need pitocin, and then you can’t keep up without pain medication, and the labor flounders, so once you have more pain medication, and then you need more pitocin, and slippery slope and it ended up that he was basically yanked out with forceps. He was very damaged. He was born with a pulse and no breathing. It was very difficult and he, two weeks later, almost died. He had infections, I think as a result of his birth experience.

Mothers and midwives problematized this process in their experiences, and many explained retroactively investigating how medical management might have led to post-birth health concerns.

They expressed frustration and highlighted immense difficulty in proving iatrogenic harm.

Another homebirth mother recounted:

When [my first] was born [in the hospital], the doctor had him due May 25th and I had been charting and had him due June 3rd, and he came June 2nd. So after he was born he aspirated fluid, or so they said, they thought he might have gotten some meconium. They took him to the nursery to do the tests and he started having trouble breathing, after he was taken from me, and they never came back to tell me. I was left for like an hour before I went out to see what was going on and found him on oxygen. And they put him on antibiotics as a preventative and never inquired about family history or allergies to penicillin, I don't even know for sure what they gave him. But when we lived in [another state], the doctor told us it was probably ampicillin, she said that was the first round that they would usually go for. And his heart rate started dropping, the whole time he was on this IV. Thankfully, the hospital messed up and he never got a full dose, but then after he was taken off the ampicillin, then his bilirubin shot up from normal to 21. And they kept telling me it was because he was overdue that all this stuff was happening.

One midwife spoke to the issues highlighted in these and other participants' experiences and, in doing so, offered a compelling reason to homebirth:

People don't realize that when you put so many interventions into a normal birth that you're causing more problems than you're solving. I've had women that used us because their baby spent a week in NICU that was completely unnecessary except for the fact that they insist she be induced. And the baby came out and had preterm respiratory problems. And the baby spent time in NICU only because of the early birth. Whereas if she had been left alone to do what her body and her baby needed to do, the baby would have been fine, and they would have gone home from the hospital in 48 hours. So a lot of [why women are birthing at home] today is coming down from either experiences that they've seen or heard about or have experienced firsthand, and they won't expose themselves to that again.

Women who have not had such an experience themselves drew from their friends', mothers', and sisters' experiences and from a larger narrative in the birth community (e.g. having read about hospital experience and/or what is referred to as "the cascade of interventions"). This narrative is often seen not only by women's experiences, but with explanations of high intervention rates and poor maternal and infant health outcomes in the U.S. And, again, such voices reiterate the value of a hands-off approach:

And I'm not against c-sections if it's necessary, but the rate that we have is too high. Compare the rate we have to other developed countries, and our infant mortality and maternal mortality rates are higher too. There has to be a reason for that. When birth is treated more like a natural thing, and less interventions are used, complications are actually prevented.

Women bolster their argument for a different way of birth with alternative systems in other countries and their corresponding outcomes:

Our maternal mortality rate is so high for a Western country. If you look at countries where more women have homebirths, they have a much better rate than we do. And I don't know how you can look at that and go, "I need to go to the hospital."

Acknowledging the structural, systematic, and institutional nature of hospital birth, in light of unnecessarily high intervention rates, and the ways in which women are vulnerable during birth, one mother, echoing popular sentiment among participants, said, "C-section rates in hospitals are so high that I didn't even want to chance it." While homebirth mothers draw on national and international statistics, midwives, like Jane, evoke a strong critique of our medical system and support for the alternative model that they practice:

If we're doing such a great job, why are our statistics so abysmal? It really makes an impression on people when I say, "Did you know it is safer for you to give birth in Cuba than it is for you to give birth in America?" And they're like, "What?!" Yeah. Statistically, your outcome and your baby's outcome, you would be better to have a baby in Cuba than you would in one of our hospitals. Straight statistics. I'm not making that up. You can look it up. There's medical and scientific evidence supporting it.

Homebirth mothers and midwives speak of the hospital as the riskier place to birth. They assert the importance of the construction of risk, safety, and fear in the medical model and go on to demonstrate a contrary understanding. Birth is constructed as inherently dangerous and risky, and a solution and a sense of safety is offered. Participants challenge the construction of birth as risky as well as the safety offered by medicine: "The hospital gives this fake net of safety feeling—that's *fake*. So I didn't have that *fake* safety net [when I birthed at home]. Oh fucking well." They express a sense of irony when explaining iatrogenic harm – again, harm caused by medical treatment itself. Many women in our society fear birth and choose to birth in hospitals because of the safety offered without considering the harmful role that medical treatment of birth may play: "We've taken birth from an event that women pass through, and very rarely goes awry, to a medical event that we are terrified of. More goes wrong when you interfere with it than when you let it take its course."

My participants communicate that, in general, women who birth in hospitals do not educate themselves to the extent that homebirth mothers and families do. They say that while some mothers who birth in hospitals might be educated, that it is not only not the trend, but that the medical model of maternity care lacks real informed consent and implicitly and even explicitly discourages mother/parent education. Though illustrations of this in my participants' and my own experiences tend to be more subtle and implicit, I can attest to being explicitly discouraged from education in my own experience. When I was interviewing an anesthesiologist at my local hospital, after asking a number of questions, I could sense she was frustrated that I did not simply accept her answers and go on my way. She told me, "You need to stop reading so much." Homebirth mothers and midwives claim this systematic lack of education puts women at the mercy of harmful medical management of birth, as one mother explained: "I don't think women know all the risks that they're taking on by going to the hospital. I think they look at it the opposite [– as safe]. So there's a lack of knowledge." Participants stressed the importance of women educating themselves, the problems of a model of care that lacks education, and the negative consequences for women receiving care within that model:

You want to inform yourself of the risks before you make that decision [where to birth]. People tend to have a sense of safety with hospitals, which they really shouldn't have, so they don't feel like they need to inform themselves. They listen to the doctor, and they just go with it.

Participants, like Luisa below, expressed a frustration with the general lack of education and assumptions of the danger of natural birth, and she spoke of frequent interpersonal struggles with those who question their decision to birth at home:

People thought we were crazy. They were like, "Is that safe? Are you sure that's safe?" Which, I really feel like that's an insult to me as a mother that I would do something that's not safe for my baby. Obviously, it's safe. I want to ask women who don't research the same question. If they choose to birth in a hospital, that's fine, but if you don't research, you don't know. I don't fault them, because I didn't research the first time. But I want to say, "Do you think that's safe, to birth in a hospital? Have you done any research on it?" If you choose to be the safer option for you, that's great. But don't assume that I'm just like, "Let's just push this baby out at the house."

One midwife provided insight into this process of fear, lack of consent, and potential iatrogenic harm in medical care and demonstrated the theme in my data that midwives have a duty to facilitate mother/family education and provide informed consent:

I was talking to one of the dads that was sort of reluctant to let his wife have an out-of-hospital birth—you know, he was worried about safety. I always say, “Dads, what are you worried about? And it’s your job to worry about your wife. You’re her protector. And so just tell me what your questions are, and what you’re concerned about.” “Well, she didn’t tolerate the pain very well last time, and she got an epidural, and I’m just thinking, ‘How are we going to do this at home?’” and I said, “You know, she had Pitocin,” and he said, “Yes, because the baby was getting too big,” or whatever, “My doctor’s going out of town,” [laughter] and I said, “Well, did anybody talk to you before they started the Pitocin to tell you that Pitocin makes contractions a whole lot harder than usual, and that has risk factors that go along with it, and that one of those is requiring pain relief because they’re much harder and stronger than what a normal contraction might be?” “No, no one told me that.” And I said, “Well did anybody tell you that that medication has the risk of uterine rupture?” and he said, “No, nobody told me that.” And I said, “Well, did anybody tell you that, it actually says in the package insert of the Pitocin, that it’s an antihemorrhagic drug and it is not to be used to induce labor, unless the risk to the baby and the risk to the mother is greater than the risk of that drug?” And he just looked at me. And I said, “You took her there to protect her, right? And already, as soon as you walked in the door, you didn’t have informed consent. And your wife was given a drug that’s dangerous, and you know it increases a lot of risks.” And he’s like, “Whoa. That’s something to think about.” And I said, “Did anybody talk to you about that epidural?” and he said, “Well, yeah, the guy came in, and said, ‘She’s going to feel a whole lot better real soon,’” and I said, “Did you hold on, and help her get the epidural?” and I said, “Yeah, and do you know what you held her for, while they did this to her?” and he said, “Well, what?” and I said, “Did anybody tell you that her blood pressure could drop out so low that it would lose circulation through the placenta to the baby and you know, it actually has many risks to it?” and he said, “No.” And I said, “Well, you took her there to protect her. So how were you really able to protect her in that environment.” And he said, “I guess I didn’t.” And I said, “That’s what I’m trying to say to you, is that, you know, birth at home is safe as long as it’s done responsibly, as long as we know our limitations.” It’s important to know your skills, but it’s even more important to know what your scope is and what your limitations are. And in this case, nothing will be done to your wife that could possibly threaten her pregnancy or her baby.

Many participants explain how childbirth has been defined as inherently dangerous and something that women (and their loved ones) should fear. Using a very sociological lens, they express that society, media, the medical establishment, religion, and law have all contributed to creating this understanding. Culture, rather than what they view as a more objective reality, shapes ideas of birth. One homebirth mother, echoing many other participants, cited culture, especially media, as problematic to our way of thinking about and, therefore, our way of “doing” birth:

I was proud of my decision [to birth at home] but frustrated with people for thinking that birth is such a dangerous event that it has to take place in a hospital to be safe. It is frustrating. As a culture, since we tend to think of birth as this extremely dramatic, screaming event where the baby is pushed out with all these people in the room and the doctor gets it out. The doctor “delivers the baby”, the woman doesn’t birth the baby. They think it all happens in 15 minutes like it’s shown on TV, I think that just characterizes their responses so much. That’s upsetting to me because they haven’t done their research, they don’t know that.

Media, in particular, was referenced often for shaping our ideas of birth and fear, and participants described how this affects women’s experiences, consequently, reifying those notions. Women, like another homebirth mother below, talked about the need for education, to dispel fear and ignorance of both pain and risk in birth:

I think that we’re very culturally taught to fear birth, that when you first get pregnant, you start watching all these birthing shows on TV. You’re like, “Oh, ‘A Baby Story!’” And you see them screaming. Okay, or a documentary on birth and they’re discussing human anatomy with you and they show this woman screaming. Or you watch movies, and everyone [birthing] is screaming, and they’re all so scared and they’re all screaming. And it hurts, and it’s painful, and it’s [screams]. And we’re all so conditioned to think that, that it plays a huge part in how we do birth. You get in there and you’re like, “Oh this is going to be hard.” And you get scared. And you don’t just allow your body to work. And I think that your mind and your body work together in sync, completely, 100%. So if you expect it to hurt, and you expect it to be scary, you send that signal to your body. So when you’re birthing, it *is*. It’s hard and scary.

A few women spoke of religious definitions of labor pain as suffering and how, upon educating themselves, they came to think differently about labor, especially pain. They redefined birth, while maintaining their Christian beliefs.:

Another book I read was called *Supernatural Childbirth*. I am a Christian, I believed that God was in control. But not all Christian women have the same views about birth. Most are so locked into this idea that the Bible says it’s supposed to hurt. But I read a book that explained it differently. And so I had the scientific, my body knows what to do, and I thought God designed it, he was in control. But I read this book that said birth doesn’t have to be painful. It’s *labor* and *work*. And it’s similar to when it says the man will labor over the soil. A man is not crying out in agony when he goes to work every day. But what the women had told me, that had had homebirth, is that it *is* work, but it’s not pain.

Another mother, who explained her process and understanding in nearly identical terms, went on to say:

Well that was completely a fabrication by a guy who translated from the original language. Really it just means hard work! So that kind of helped me realize that I didn’t have to think of it as

painful as it was—I mean it was hard, it was painful, but when I went into the pain, it became more work than pain.

Regarding law, midwives spoke a great deal about regulation in general, including the ways in which regulation is associated with both the perceptions and realities of safe birth. In short, medical hegemony has influenced law and laws regulating birth have influenced notions of risk and, therefore, fear and, therefore, perpetuated medical hegemony. While midwives spoke of potential problems of Oklahoma’s lack of regulation, they also explain that midwives generally operate very well in the state and they acknowledge the role of power in regulation and its potential danger for women and babies, as one midwife demonstrated: “We want birth to be safe. But we don’t want it to be so regulated that we can’t give people the safety and care they want—and need.” My participants view the logic of fearing birth as flawed and acknowledge that, while there is a normal and understandable amount of fear regarding birth, the medical model of birth, media, and society exaggerate the danger and, therefore, fear of birth. In doing so, medical authority of birth is strengthened.

Homebirth mothers and midwives explained the risk and safety of birth in general and homebirth specifically through a number of elements of homebirth and midwifery care. Education is an important component, which includes informed consent. (The education component speaks to the mind-body connection, a strong theme in my conversations with women, which I will discuss in detail in later chapters.) Both groups explained that homebirth is for low-risk, healthy women and babies, and how the midwifery model of care helps to ensure and maintain this low-risk status, through preventative care. While my participants unanimously agreed that birth is safe most of the time, all but one of my participants would agree that homebirth midwives are “guardians of safety” and that, generally, midwives’ skills are trusted and needed at birth in case attention is needed. (The one mother who might have a different opinion preferred her last unassisted homebirth.) In addition to education, and having a midwife,

there are also other ways that women prepared themselves and their families in the case that they needed medical attention.

All of the women I spoke with acknowledged that birth is not always safe. One midwife explained: “If you have a bad outcome, that could happen to the best midwife in the state, or doctor in the world, you know. It’s life. It’s not risk-free. There’s a set of risks at the hospital, and we try to present that, but there’s a set of risks at home.” However, participants believed that birth is safe most of the time, and they explained risk in a relative way, acknowledging risks that most people take in everyday life as well as the risk of the hospital. One mother said: “Driving is a risk, everything is a risk.” Another explained how she interpreted the risks involved with birthing at home: “And things go wrong sometimes, but it’s such a small percentage, and I knew that our midwife would be able to get us to the hospital if something happened.”

The idea that midwives will take care of mothers and their babies if something goes wrong is common. Homebirth mothers accepted a possibility that something might go wrong. They trust in the skills and expertise of midwives, and believed that, if it is something that can be helped or fixed, midwives would detect it and either address the problem themselves or facilitate transfer to the hospital, where medical experts can address it. One mother echoed many others when she said: “I felt my midwife was competent enough that if anything was wrong, she would have done something. We had a couple hospitals lined up to go to—we had all the information right there if we needed to do an emergency run. So I felt safe, I wasn’t scared at all.”

Sometimes things can and will go wrong, regardless of birthplace or care provider. At least a few women, like the mother below, expressed that if there was a birth complication that could not be helped, they would prefer to be at home:

When people ask you, “Well what if something goes wrong?” To me, if something goes wrong, and it’s something that can be saved or fixed, my midwives are going to know it and they’re going to get me to the hospital to where they can help me. But if something goes wrong, regardless if it’s at home or the hospital, and seconds really count, I don’t think it’s going to matter—it’s going to be a bad outcome no matter what.

Participants explained that when things are likely to go wrong, midwives know beforehand and/or are there to monitor during birth. Sometimes, the midwife might not be called in time or might not arrive in time to monitor mother and baby. Preparing for this possibility, many homebirth mothers, like Megan, and their partners also learned technical safety skills in the case that the midwife was not there:

I educated myself on problems and how to fix them. I'm a self-educator. [...] I wanted to educate myself on if things went wrong, what you would need to do. How long you can go without medical attention, how much of an emergency it is, and what you can do yourself without medical equipment. [...] I educated myself on what might go wrong and how the midwives would handle it, what's a good sign, what's a bad sign.

A mother who birthed unassisted particularly expressed this preparedness:

I read probably every birth book there is. And then the emergency childbirth, there's actually a little manual. My dad delivered two of my mom's babies [at home] because they came so quickly. And they used that manual, and it covers all the major crises you can have. So we got that and we did educate ourselves. My husband has gotten certified in CPR over and over again. So he was very educated with that. So yeah. We did prepare for every emergency, and we were prepared to go to the hospital if we had to.

In their discussions with me, midwives spoke a great deal about birth and risk: "We talk [with families] about the risk of postdates and other things. It's not all rainbows and fairies and unicorns and sparkly things. There is a downside to everything in life, including being pregnant and having babies." Midwives focused more on when birth is *not* safe than mothers did, which makes sense as the midwives are expected to monitor and protect safety and have the particularly important job of identifying situations that are not safe. They acknowledge the need for hospitals, stressing their willingness to transfer a mother's care when needed, while reiterating that most women do not need to birth in hospitals: "Well, I tell my clients a lot, 'I'm not here to be a hero. I try to keep you safe and do a good job. If I feel like it's unsafe or outside of my hands, I'm going to take you in or refer you out.' But on the other hand I don't want to send someone in that is having a good, safe, healthy pregnancy." While participants explained that women who birth at home generally take on more responsibility than do most women who birth in hospitals, women who birth at home still trust their midwives as experts on birth who will help them identify

problems and decide what to do if problems arise. Midwives take this responsibility very seriously, while maintaining that birth is usually safe: “I fully believe homebirth and out-of-hospital birth is safe. And safer than birth in a hospital. Unless it’s not! And then, the hospital’s the best place. But all normal women do not need to be in a hospital; your truly high-risk women need to be in a hospital.”

Participants spoke not only of the importance of physical safety in homebirth, but also of the emotional safety and respect afforded by homebirth and midwifery care. In powerful ways, some women, like Madison, described their homebirths as healing from damage of past births and other past experiences: “After my first homebirth, I basically felt like a million bucks, like I could run a marathon. I was on a high for sure, and everything went great. And it was exactly what I needed. It was just a healing experience.” They attributed the healing nature of their homebirths to various and complex elements of midwifery care and homebirth, including a lack of stress.

Another homebirth mother explained:

I think [my homebirth] exceeded expectations, because afterwards, I was just really happy, really relaxed, almost euphoric afterwards. I didn’t have that after the first hospital experience, especially, because it was so traumatic. It was very stressful, and I think the lack of stress makes all the difference.

The degree and quality of support was also important, as Millicent explained of her first homebirth:

And another huge thing is having the support. For me, I don’t think I had ever felt so loved and cared for in my life. It was almost a healing experience, I think. I had five people in the room who were totally focused on me and taking care of me and the baby. I wasn’t alone in it, I never felt alone. I never had a chance to panic for more than a few seconds, and someone would be there to comfort me.

Much of this is explained through the midwifery model of care, which will be detailed in the following chapters and includes having more personal relationships, longer visits that include assessing holistic well-being rather than quantitative measures of only physical health, and a sense of trust in midwives that they are looking out for the holistic well-being of the mother-baby unit. Judith, speaking of the job of a midwife, says: “They’re going to do everything to see to my

baby's safe arrival, but secondary, they care about me, and I'm a person." Midwives echoed the need for safety—"Our goal is for the mom to be safe and the baby to be safe. And homebirth and midwifery care promotes that."—and stressed their role in ensuring a safe environment, both for physical and emotional protection, as another midwife demonstrated:

I think that [pregnancy, labor, and birth], it's a really rich, ripe vulnerable moment. And that means, damage can be done, or healing can take place, you know? And so [women who birth at home] choose someone who they think is really going to focus on healing and wholeness and safety.

Ultimately, homebirth mothers and midwives believe that labor and birth is a vulnerable time and process for women, that women should not have to fight during this time, and that women should feel safe when they birth, wherever the birthplace is. One homebirth mother spoke to the last point:

I would not say 100% of women that they need to have their baby at home. I'm not pro-intervention, and I don't think interventions are good, but the biggest thing is that the woman needs to be able to relax. Some people can't relax at home, they feel like they need to be in a facility or they need a doctor to relax. So my biggest thing is you need to be able to relax to have a good birth. And whatever that looks like for you, this is what worked for me. And I've always just liked being at home. I just felt safe and comfortable in my home.

Participants described feeling safest at home. Audree, who has one daughter, born at home, explained: "I know that my body can give birth best if I feel as safe as possible in my environment and with the people around me that I know are supportive and trying to help me have the kind of birth that I want with the healthiest outcome." She went on to say something many homebirth mothers communicated to me, which is that health and safety are a top priority, but that a healthy mom and healthy baby is not the only important product of a good birth:

And the healthiest outcome is more than just the baby and mom living through it. The healthiest outcome is that plus a host of other things that I wanted. I wanted to be able to hold my baby right away. I wanted to decide what position I would be in. I wanted more control of the labor and delivery, not that most women don't want that, but I was aware that those things might be stripped of me if I was in a hospital setting, so I wanted to be involved in that process as much as possible.

Control

Most often, my participants said they birthed at home for safety. Nearly as often, they said they birthed at home for control, as one homebirth mother explained: “[Women birth at home] to have control. That’s basically what it comes to for all of us. We want control over our bodies and over what’s happening to us. And there’s no reason we shouldn’t have it. To have control.” Women who birth at home want control over their bodies, over their babies, and over the environment in which they labor and birth. They do not seek to control birth itself, as many of my participants would contend that you cannot and should not control birth, but they want to be involved and participatory, as another homebirth mother articulated: “I want to be able to be in control—not control in a bad way—but I want to be *involved*, actively, in my birth, in the birth process.” Mothers wanted to feel that they and those who surround them in the vulnerable time of labor and birth would do everything possible to ensure a safe and pleasant birth. Another mother reiterated: “It’s such a vulnerable time, and it’s really important what happens during that time, and I’m *really, really* glad that I had a homebirth so that I could have more control.” While I attempt, in this section, to articulate control in women’s explanations for birthing at home, issues of safety and control are intertwined for participants and I, therefore, reiterate issues of safety here as well.

There are elements of control in women’s stories that revolve around empowerment, agency, being active, and being respected. In particular, women who had hospital experiences where they felt control was denied of them emphasized control as important in their reasons for choosing homebirth. As explained previously, homebirth mothers and midwives I spoke with believed that natural birth is normal and is the safest way to birth. With this in mind, part of the control that women seek at home contrasts with their perception of being controlled in the hospital setting, often experienced first-hand, where lack of control often leads to unwanted, unnecessary, and harmful interventions. When I asked one mother, Ella, why she decided to birth at home, she says:

Control. I had control. We had control. My husband knew exactly what I wanted, and he knew that if—if I was dying, then we would go to a hospital, *if* I said, “Yes, this isn’t working, something isn’t working,” then we would go to a hospital. It wasn’t up to the hospital to say, “*You* get to have a baby.” It was, “*We’re* having a baby. *We* have the control.”

Having control was particularly important to Ella in light of her first hospital birth, where she feels she was not given education to care for herself or make decisions about her birth. While some participants describe a lack of control through a generalized narrative of hospital birth, many, like Ella, speak of their own experiences in a medical setting. Some discuss the ways in which they either willingly or unknowingly gave control over, while others explain that control was taken from them. Eleanor, whose story I recounted above, explained her hospital birth through a lens of control and agency and how it was denied from her:

I started pushing [my daughter], and I finally felt like I had some control of the situation, because I was able to push. And my doctor gave me a fourth degree episiotomy. At that point [my daughter] spilled out of me. Then they whisked her away, and then she cried. And then they injected my IV with Demerol, and so I was completely sober through the whole birth and then I went into a fog. He stitched me up, I had a fourth degree episiotomy means all the way through rectal muscle, so, he pretty much laid me open. My husband said, “If I ever find that man in a dark alley...” (laughter) because, he really messed me up. And it was almost malicious.

In discussing why women chose to birth at home, homebirth mothers and midwives express the importance of being attended by and surrounded and supported by people they know, love, trust, and have personal relationships with. The nature of the relationships described in the holistic model contributed to birthing mothers’ feelings of security, safety and control in that they felt those attending their birth had their best interests at heart and would make all efforts towards those goals at a time when the mother herself might be vulnerable. Women set this in opposition to birthing in a hospital, where they recounted being treated as cattle or as a chart, and being attended by strangers, who mothers often characterized as more interested in following protocols than helping women achieve the birth they want. One mother who birthed several times in a hospital and several times at home problematized the relationships within and the nature of technocratic care:

A huge flaw in the hospital system is that women end up birthing with strangers. Even if they know their doctor and they love their doctor, it's the nurses who are going to be [with them most of the time]. And so that's a huge flaw. And I know in the name of efficiency and money, it's never going to change. Which is why when women choose homebirth, they're making choices they have more control. They have one-on-one relationships with their care provider. The relationship with the people around you and the surroundings themselves are two huge differences between hospital and homebirth.

According to participants, more personal care, involving much more time devoted at visits and during labor and birth, promotes trust, comfort, and a sense of control, which again was nearly always contrasted with medical delivery of care as impersonal and brief where control is assumed by the doctor.:

[My midwife] listened to the heartbeat, and she monitored all the stuff you're supposed to monitor. In contrast with the hospital where you spend an average of five minutes with your doctor at every visit, it was just a completely different world. We found part of the joy of being pregnant was getting to go see [my midwife] every month, getting to have that time with her and talk about things that were important to all of us, and you know, it was just a wonderful—that whole thing was just really pleasant, and I never felt like I was being cattle-pushed through there like I did in the doctor's office. It was just a completely different—I can't even tell you enough just how different it was—just completely different. Very welcoming, not sterile at all.

Several homebirth mother participants had unassisted births—some were simply precipitous labors that were over before the midwife arrived and some were planned. My discussions of unassisted births with a few participants illuminated issues of control: “And that's why we decided to go home and do it ourselves, because we didn't want any more of that stress [we experienced in the hospital].” One homebirth mother, whose first birth, in another state, was a homebirth with midwives that turned into a post-partum hospital transfer, was compelled to have an unassisted birth with her second child. She defined her first birth as traumatic and attributed the health concerns that prompted a hospital transfer to the impatience and carelessness of her midwives:

So I had my [first] baby [at home], after a 26-hour labor, five hours of pushing, and I had a grand mal seizure and had to be transferred. And after that experience, we moved here [to Oklahoma] and I really began to think, “Okay. What went wrong?” You know, you always try to think what went wrong. And I became pregnant again when he was seven months old, and at that time I decided: I'm going to take charge of this birth.

In answering the question, Why do women birth at home?, one midwife again pointed to control and safety, and she emphasized motivations for women birthing unassisted and the importance of this for women who have been abused:

As far as homebirth, I think they want to feel some sense of control. That *they* have the freedom and *they* are managing it, and they have some sense of control about their birth in a most vulnerable, vulnerable time. And someone else is not acting like the driver. That they're able to drive it. And be in a safe place. I think that's primarily, overall, that women want to feel safe.

While there are important lessons to be learned from the reasons women choose to birth unassisted, and I do not have extensive data on the subject, from the experiences recounted to me, women choose to birth at home with a midwife and to birth unassisted for similar reasons: they want safety and control. Though they respond to these concerns somewhat differently, the concerns themselves are common ground.

Homebirth mothers ultimately wanted control to ensure a safe birth. The control participants spoke of in explaining why they birthed at home is about personal power and active involvement, but the purpose of ensuring this agency is to protect themselves and their babies – in other words, safety. When doctors manage and control birth, harmful intervention is more likely. One mother said that by birthing at home, she had control to protect the safety of her birth: “I have less of a chance of something going wrong because of something that someone else did.” Again, the safety of natural birth at home is almost necessarily set in opposition to homebirth mothers' and midwives' constructions of hospital birth as inherently interventive and, therefore, risky and dangerous. The mother of twelve, who described four of her five (natural) hospital births as relatively positive experiences, explained how a lack of mother-control in hospitals jeopardizes safety:

People may say another difference is safety, I think it's scarier to have them in the hospital. The super-germs we have nowadays. The people. You have no control over the care you receive, a nurse who doesn't wash her hands. You have less control over, if they decide to do a c-section, or forceps, or the IV, or the Pit, or whatever—all the things that cause more interventions and c-sections. Now, sure, I'm glad we have hospitals for the times when there is an emergency. But Ina May Gaskin's childbirth model has proven the percentages are much lower than we think.

And I know [our hospital here in town] has a terrible c-section rate. They have a terrible reputation for that. I'm grateful I escaped.

Homebirth mothers and midwives acknowledged the possibility of needing medical attention, but believed there was more harm than benefit to birthing at the hospital "just in case" and felt they could get to the hospital if the need arose, as one mother illustrated:

Homebirth was a really good choice for me, in that I felt like I could make the choice to protect myself in that situation and if we needed a hospital we could go and at that point I would be needing the interventions and it wouldn't be something that we were trying to avoid, it would be something that we were trying to accomplish in order to have a safe delivery, to have a safe surgery or whatever was needed at that point, you know, that's different. I felt like I was advocating for my baby and my own sense of self by having a homebirth.

A number of women directly expressed what I believe most of my participants desire or prefer, which is a female care provider during pregnancy and birth. (A few women go so far as to express that they would prefer a female provider for any form of health care.) Homebirth mothers do not only prefer a woman to care for them, but they want a woman-centered model of care. As detailed in the following chapters/sections, homebirth mothers and midwives I spoke with believe that pregnancy and birth are normal, healthy, and safe processes and acknowledge women's ability to birth. Accordingly, they desire a natural childbirth (which they define as best for the safety, health, and happiness of mother, baby, and family) and believe, due to the medicalized nature of birth in hospitals, that the best place to achieve a natural birth is home. One homebirth mother explained that her experience and education taught her this lesson: "[I learned] more about how natural birth and homebirth go hand-in-hand more readily than birthing in a hospital. Though it doesn't have to be that way, it is." In many ways, choosing to birth at home reflects an adherence to a holistic model and a desire for the care that a midwife provides.

Women's journeys to homebirth and their reasons for birthing at home most strongly implicate issues of agency and power. While these issues come to light in this chapter, they are greatly expanded upon in women's larger accounts of birth and birth models. In the chapters that follow, I articulate the nuances of the biomedical or technocratic model and the midwifery or

holistic model, as explained by participants, highlighting power relations in women's experiences of the two models through a constructivist and feminist Foucauldian perspective.

PART THREE:

POWER IN BIOMEDICAL AND MIDWIFERY MODELS OF BIRTH

CHAPTER VI

THE BIOMEDICAL/TECHNOCRATIC MODEL

VS.

THE MIDWIFERY/HOLISTIC MODEL

As I analyzed women's stories, I found that they largely explained their experiences through opposing biomedical and midwifery models of care. In all, the 41 women who spoke with me about homebirth in Oklahoma touched on, and often described in rich detail, every element of the midwifery and medical models in the literature on birth models (Davis-Floyd 2001; Davis-Floyd 2003, p. 160-161; Rothman 1991; Ratcliff 2002). These elements overlap and intertwine as they permeate women's experiences and narratives. While midwives and a small number of homebirth mothers explicitly referred to the two models of care—as in, “the midwifery model” and “the medical model”—most homebirth mothers described the models without directly evoking the language of the two models.

One homebirth mother who was training to become a midwife at the time of our interview distinguished models of care. She began with the biomedical model: “Well, you have traditional OB care, which is medical. They look at your blood pressure, your weight, and, ‘Okay, We’ll see you next month. You measure fine.’” She then addressed the role of Certified Nurse Midwives:

And then you have a Certified Nurse Midwife, most of the time it's going to be pretty similar to OB care. In some situations, you'll find nurse-midwives who have more information on dietary

things, but they are still pretty medical as far as prenatal care. They'll deal a little more with emotional issues and kind of take a more holistic approach. But they're not *trained* that way. They're trained for a medical model of care. They're *nurses* who get an additional sort of education. So they still have the same background and the same knowledge, like they're expecting things to fall out a certain way.

She also considered the role of unassisted births:

Unassisted, of course, you're on your own, and it's up to you to figure out and find the knowledge, and usually you're not going to find everything you need to know. So yeah, I have caution there for women. I don't necessarily say you shouldn't [have an unassisted birth], but you need to have the wisdom and knowledge before you attempt to take on something like that.

Finally, she turned with more discussion to homebirth midwifery care:

And of course I put the star on homebirth midwifery care. But typically, the purpose is to provide women with an all-around approach for a lot of things that, if you come to a prenatal with the homebirth midwife, what you're going to hear is diet and exercise and things that center around the whole person being taken care of, and it's not just about, "How does this baby seem to be growing?" You're going to hear a lot of, "How are you doing emotionally?" "How are life issues?" Try to work the whole picture, which makes the birth process seem more natural and part of who you are, instead of, you have a medical professional who's analyzing what you've done over the last month or telling you this is the chain of events. Once your baby comes, you're going to have to do this, and you're going to have to do that. There's not a lot of that in the homebirth scene, unless you've had issues in the past, and then there is you know, we'll be looking at this or that. But usually, it's, "We'll see how things progress on their own, because birth is normal." That's probably the biggest emphasis is just realizing that the whole person, it's a natural process to have children and it involves the whole body, and it's not a disease, and it's something that actually brings fruit, it doesn't destroy. I've heard so many young girls who come into homebirth because they are scared of the hospital and the system. But once they deliver and they are at the end of the journey, they're changed. It's a very fulfilling thing, empowering thing, to be able to do what they've done. They find it's something very normal and natural, it's something they had in them, that God put in them. And they would have missed that at the hospital.

The above participant included nurse-midwives and unassisted births in her schema.

These perspectives are highlighted by a few other participants, and some literature conceptualizes three paradigms of care (Davis-Floyd 2001) while scholars also describe a continuum of care (Cheyney 2011). Participants, however, generally referred to two distinct models—the midwifery and medical models—and this informs my organization and conceptualization of two central perspectives throughout my manuscript. While some homebirth mothers and midwives acknowledged gray areas and ways in which individuals might variously adhere to more than one

paradigm, their descriptions were fairly black and white, which, again, led me to rely on a dichotomous schematic to communicate their understandings and experiences.

When I first noticed the trend of oppositional medical and midwifery models, I thought I could analyze women's narratives and describe their viewpoints in terms of, first, the medical model and then the midwifery model. I wanted to distinguish and separate the two models. What I found, however, is that the understandings depend on one another, are not always, but very often, explained in reference to the other, and that women's experiences in the medical model often shaped their definitions of midwifery care, homebirth, and the midwifery model of care. One homebirth mother and midwife-in-training explained:

The majority of women that I know that have chosen home birth have come from the obstetric model. They have been hurt or damaged in some way, shape or form. I have met women who have done it with their first babies, and it is because of—it's not because they've come from the obstetric model, it's because their mothers have, their sisters, their aunts, their grandmothers. They knew they didn't want that.

Four important themes emerge from women's accounts of their experiences of birth and why they chose homebirth. The first deals with the ways in which the medical model constructs birth and women's bodies as pathological, while the midwifery model defines the female body and processes such as labor and birth as normal and healthy. Second, the medical model's definition of the body as a machine, where the mind and body are separated, and the mother and her health are isolated from others and society, is set in opposition to a holistic understanding of mind and body, mother and family, and mother and society. The third theme involves the tendency in the medical model to treat technology as superior to people and nature versus the midwifery model's valuing of people, nature, and wisdom. Finally, power and resistance in these two models pervades women's discussions of birth. The following four chapters are devoted to these themes, respectively, and I provide a contextual framework here.

Mother's direct and indirect descriptions of medical and midwifery models illuminate these elements as well as constructivist interpretations of meaning and experience and feminist

Foucauldian interpretations of power and resistance. One homebirth mother, Audree, provided an insightful analogy of the two models:

My family has spent a lot of times in the mountains during summers, and as a kid I would always go play on the rocks and scamper around on boulders and I loved doing that. This is my metaphor for how I felt about birthing in the hospital versus home and what I love about a more hands-off approach. I was introduced to rock climbing when I was maybe 14, and there are all these certain straps that you have to use and all this equipment and language and particular ways you're supposed to do it. And I can remember rock climbing for the first time. You go up this boulder but you go up the hardest way possible, and you have all this equipment you have to figure out first and make sure it's safe and make sure that if you fall then the equipment's going catch you, and it takes forever to go up that rock. When you get to the top you look over and you see that on the other side there's a slope that is almost perfectly flat and you could have just ran up yourself and it would have been a lot safer, a lot quicker, and a lot easier, and a lot more fun.

She then connected her understandings of the two together:

To me, the ideas of having a continuous fetal monitor going all the time and only having this kind of bed that works this way—but it's not my bed at home so I don't really know how all these buttons and charts and pumps and all these things work. When I would go rock climbing the equipment would alienate me from the mountain and from the outdoors, and when I was touring the hospital I felt the same. I felt alienated from my own body and from my own birthing process. Before I went into labor, I just felt like in my own home I would be able to find that place in my mind that knew that birth is usually safe and that my body could do it and I didn't think I would birth well without coming from that mental place. I didn't want to climb up; I didn't want to have birth the hardest way possible. I didn't want to be induced and then have the hardest contractions ever. I wanted nature's contractions that give you a break. I didn't want to be on a time frame because there is somebody else waiting behind me to get tethered in. I didn't want to wonder if the rope would catch me because I wanted to count on my own devices. I was low-risk so I expect to be able to do it and I didn't want to make me feel like I couldn't.

Along with the first mother-midwife above who described the four approaches to maternity care, Audree, through this analogy and in her interview, touched on normalizing processes of pathology, body-as-machine, and technology in the medical model, evoking illustrations of safety and risk construction; objectification of bodies and mystification of knowledge (through equipment and language); control of time, space, and movement; and normalizing judgment, observation, and examination (through monitoring, efficiency, standardization, time-tables). On the other hand, both women maintain that bodies and birth are healthy and normal, that nature offers and women possess the ability to cope with labor and to birth, and that the mind and body

are connected, and both demonstrate the midwifery model's valuing of women's agency and empowerment.

CHAPTER VII

WOMEN'S BODIES AND BIRTH AS PATHOLOGICAL VS. NORMAL

Homebirth mothers and midwives I spoke with illuminated important elements of the ways that health in pregnancy, labor, and birth can be approached. These women described, on one hand, a lens of pathology that is employed in obstetric care and, on the other, what might be considered a lens of normality employed in the midwifery model. As discussed in Chapters II and III, normalcy in the midwifery model discussed by participants is distinct from Foucault's treatment of norms and normalization. Foucault (1977) speaks of *the norm* as a rule or an ideal toward which individual bodies and behaviors are punished and corrected and *normalization* as a goal and instrument of such disciplinary processes. Norms and normalization are constraining and limiting. Alternatively, participants described holistic understandings of normalcy that involve *natural* processes of the (female) body, the *healthy* nature of pregnancy and birth, and the larger historical and global picture of birth wherein *most* women around the world and over time birthed naturally and/or at home. Furthermore, participants described a great deal of variation in what they consider normal and healthy, and *normal* is, therefore, a somewhat liberating principle. Women's discussions of pathological and normal lenses were two-fold. First, they explain that the biomedical model defines pregnancy as disease, where participants explain that they, and the midwifery model, define pregnancy and birth as normal, healthy processes. Secondly, homebirth mothers and midwives acknowledge the biomedical approach as one that attempts to obtain

physical health through detecting and treating disease, where the midwifery approach is to achieve and maintain holistic (i.e. mental, emotional, *and* physical) health and wellness proactively, using healthy lifestyle choices, preventative care, and attention to the pregnant woman's social wellbeing. According to participants, there are at least two important consequences of these foundational understandings. The first is that fear is promoted in the medical model and combated in the midwifery model. The second is that pain is constructed and treated—and therefore, experienced—differently in each model.

My participants acknowledge the ways that birth is socially constructed. They note that it varies from place to place and over time. Their stories demonstrate that these meanings often vary for one woman from one birth to the next. Participants see as problematic the current technocratic understanding of pregnancy and birth as pathological and consequential power relations, and they alternatively define pregnancy and birth as normal and healthy and describe this approach as providing agency and empowerment.

Pregnancy as Disease and Inherently Abnormal vs. Pregnancy as Normal and Safe

The homebirth mothers and midwives I interviewed all acknowledged the medical model's lens of pathology by explaining how obstetrics defines pregnancy and birth as disease and as inherently risky. One mother demonstrated: "I feel like obstetrics right now has been turned on its head, as far as, turning it into a surgical process instead of a natural birthing process. It approaches pregnancy and birth as a disease state, and that's inappropriate." Not only does obstetrics define pregnancy and birth in this way, but our entire society does: "I do think that our society thinks that birth is a medical disease that needs to be in the hands of a doctor." One midwife, who has been a direct-entry midwife and recently went to nursing school as part of her new path to becoming a Certified Nurse Midwife, talks about the general philosophy in the U.S.: "Here, we see something wrong with women's bodies. And women are taught that there's something wrong with them all the time. That's the medical community—they are looking at, 'What's wrong? What's wrong? What's wrong?'"

The origins of this belief in obstetric care can be drawn from Enlightenment thinking to the notion in the biomedical model of the male body as the norm and, therefore, the female body as defective (Simonds et. al. 2007). Through processes Foucault conceptualized as dividing practices and scientific classification, obstetrical experts defined and therefore objectified women's bodies. Scientific classification involves "the modes of inquiry that try to give themselves the status of sciences" (Foucault 1994a:326). Clearly, obstetricians have sought to, and quite successfully so, become understood as practicing a scientific profession. This rationalization has both involved the will to know (women's bodies) and the will to truth (about women's bodies and processes) resulting in greater legitimacy and significantly strengthened power. Dividing practices constitute a second major method by which individuals become objectified. In this process, women were ideologically and physically divided from others, isolated: women were defined as different than men (with men being understood as the norm) and women's bodies and social selves were at times even understood as an inversion or as opposite of male bodies; when birth moved to the hospital, women were isolated from their families, female friends, communities, and their babies. Dividing practices and scientific classification worked hand in hand in the history of birth in the United States to conceptually and physically distinguish and categorize women, to produce knowledge about them, and create them as docile bodies—and therefore, exercise power over them. In Foucault's work regarding scientific classification and dividing practices, he "offers a more complex account of normalization, as a set of mechanisms for sorting, taxonomizing, measuring, managing, and controlling populations, which both fosters conformity and generates modes of individuality, and which is at the center of an alternative picture of our history as embodied subjects" (Heyes 2007:16).

A common illustration (among my participants and among women in natural and homebirth communities in general) of the medical, pathological approach is that women are often told their bodies are too small or their babies are or will be too big to be birthed vaginally, which is actually a rare condition (cephalopelvic disproportion) (Block 2007). One mother, in

discussing reasons she birthed at home, spoke of this: ‘I’d heard so much about how you’d get in there and they’d say, ‘Oh the baby’s head is too big, you need a c-section.’ And it was a six-pound baby.” One midwife, Jane, talked about a client whom she believed had a small pelvis and the prevalence of this condition in comparison to what many women are being told:

I truly believe she was one of those moms who had one of those pelvic types that unless she had a scrawny four-pounder, she might not be able to get the baby out. But that’s only two to five percent of the human population. Then you can add another two to five percent for someone who’s been in a car accident, or had a serious break, or something that would change the pelvic shape—serious malnutrition. It’s not 40% of women. Women are being told, “Your baby’s too big.” And they go on to have a baby that is two or three pounds bigger at home. Your seven-pound baby is too big and we have to cut it out, but your nine-and-a-half pound baby fit just fine.

As a result of the belief that women’s hips and pelvises are too small to birth their babies, many women are encouraged to induce—before their baby grows any larger—and induction, ironically, increases the chances of a need for a c-section (ACOG 2002; Sanchez-Ramos et. al. 2002). Some participants were pressured and convinced to induce because of the presumed size of their babies: “I was induced at 37 weeks because they said the baby was too large, if it grew any more I wouldn’t be able to deliver vaginally. Big scare and, ‘What do we do?!’ So we induced early.” As Jane alluded, some of my participants were told by their doctors that their bodies were too small to birth vaginally, and consequently given a c-section or episiotomy, and these women later birthed a larger baby vaginally, with no need for intervention. Another homebirth mother spoke directly to this: “I’d even been told with my first one [who was born by c-section] that he had probably had a harder time progressing because my hips weren’t big enough to give birth. And then out comes this nine and a half pound baby two births later!”

Another mother experienced this pathological approach in a different way. Her build is thin and she tells me about doctors and nurses pressuring her to induce and, after her natural hospital birth, assuming she had a c-section. She told me about birthing her two children:

I birth really quickly, because—Guess what, [calls her OB out by name], I don’t need *no* help birthing my 15-inch head baby! At all! Five days after he’s fucking due! Bastard!—I did not tear, and he came out perfectly round. I remember when I had [my first] in the hospital, the nurses were like, “Oh how are you moving your legs? He’s c-section, right? His head’s too round.”

And they were judging my little body and that I had had a vaginal birth, that I had to have pushed forever and gave him a cone-head. But he literally came out in three pushes and that's literally how [my second baby] came out. And it's one push like (gruuuunt) to feel that sensation of everything pushing down and the water breaks, and another push to crown the head, and then another push to have the body. That's three pushes. Both times.

One midwife, Anita, spoke to this commonly pathologized element of birth and points to the different mindsets in the medical and midwifery models:

And I know I've certainly said to myself, "Oh wow, she has such a tight pelvis. I hope a baby can come out." And I love to be wrong! And I think that's the difference. Instead of a doctor saying, "Well see I was right." I am so glad when I'm wrong. That just shows how much our bodies can adapt. Instead of going, "Well, I knew it. I told you." Midwives don't take that attitude—or they shouldn't.

Over the history of the field of obstetrics, obstetricians have come to define more and more as risk and, therefore, have claimed more and more ground as theirs, since they technically specialize in the abnormal: they are surgeons. As many participants experienced, obstetrics today is likely to define a woman and her baby as high-risk if she is: too young, too old, too short, too fat, if she births before 37 weeks or after 40 (even this window is closing tighter), if she has multiples (i.e. twins, triplets, etc.), if her blood pressure is a little too high or a little low (often without knowing what is normal for that particular woman or without taking into consideration the social and environmental factors related to blood pressure). By establishing and making claims to knowledge of bodies and through the particular pathological constructions of women's bodies, obstetrics has made claims to risk and danger and, along with conveniently being able to exercise expertise and knowledge that address risks, has made growing claims to power. Heyes' (2007) discussion of bodies illuminates how thinking and treatment of bodies lends itself to normalization and discipline: "Fatness declaims sloth, lack of discipline, greed, and failure to moderate appetite; choosing cosmetic surgery and the look it can achieve is (not always successfully) represented as go-getting, courageous, and self-determining; those whose bodies defy neat boundaries of gender or race are often assumed to lack moral integrity" (9). In the technocratic model, bodies that are too short, too fat, too old or too young, bodies that have not

successfully birthed enough children (“unproven pelvis”) or have birthed too many children, or bodies that otherwise defy an increasingly narrow norm are deemed unfit to birth on their own and are controlled, made docile, and normalized through any number of medical augmentations or interventions.

Participants critiqued and problematized the technocratic understanding of pregnancy and birth as risky. One mother who was sixteen when she got pregnant with her first child challenged the high-risk label she was given:

And so when I went to the doctor, of course they labeled me high risk, even though that’s silly because I was the most muscular, tone, avid, healthy person. That’s the easiest birth ever for a woman. (laughs) So I steered clear of doctors my whole pregnancy after that.

Homebirth mothers and midwives define pregnancy and birth as normal and healthy processes, as one mother demonstrated: “I feel like it’s almost a natural instinct to do things the way I’ve done it. Having a baby is natural, it’s normal, it’s not a medical problem. You’re not sick.”

Participants explained that the way we think about birth impacts how we practice and perceive it:

If a woman goes into labor thinking this is a problem, she’s going to the hospital to get help for this medical condition. You have to get out of that mindset. If you grow up thinking birthing is a natural experience, it’s a normal thing, it’s not a problem, your body knows how to deal with it on its own for the most part, that’s why you can be comfortable with it. You’re not treating it as a problem. It’s just a natural process.

They actively redefine their bodies and its processes and actively resist normalization, as another homebirth mother intimated: “This is life. It’s amazing. It’s not something to hide and be afraid of and to scrub your hands before you have anything to do with this, because it’s ‘not normal’.”

One homebirth mother, who is becoming a midwife, explained that in the midwifery model:

Usually, it’s, “We’ll see how things progress on their own, because birth is normal.” That’s probably the biggest emphasis is just realizing that it’s a natural process to have children and it involves the whole body, and it’s not a disease, and it’s something that actually brings fruit, it doesn’t destroy.

In supporting the midwifery model, homebirth mothers and midwives evoke a narrative that “women were made to give birth” and that medicalization of birth fails to acknowledge this. One

midwife explained: “I get so excited when I think of women having the chance to have a birth the way God intended it. Women were not made with zippers [referring to cesarean incisions]. God did not intend for us to give birth through zippers.” Some of my participants drew upon religious understandings to make this claim (“God made us to do this”), while others claim it is a result of biology or evolution. In many cases, there was a common ground that women have given birth for our entire human history, and we (women today) can too. One participant reiterated: “People used to be born at home and people used to die at home. I would like people to know it’s normal. It can be done at home. It’s natural.”

Participants overwhelmingly communicated that, while women’s bodies are made to birth, and that they see home as the safest place to allow the normal, healthy process of birth to unfold, they acknowledge that some women should not birth at home and that sometimes interventions are needed—though much less often than they are actually administered.

I guess once I saw that it was normal and natural, I saw there was no reason to go back to the hospital. Because babies, birth and pregnancy are healthy, normal things. They’re not medical conditions. We go to the hospital because we’re sick and we need medical intervention. Pregnancy doesn’t need intervention unless there is a medical condition, and then, yes, we’re very grateful to have that available to us.

Midwives often talked about the real need for intervention. Like the homebirth mothers I spoke with, midwives believe intervention is grossly overused in our medical treatment of pregnancy and birth: “And I don’t think every mom should be at home. I don’t think every birth should be natural. But we’re not even given a chance to see who should and who shouldn’t, and trial of labors and things like that, that could make such a difference.”

One midwife, Ina, illuminated the connections that many mothers made between a model of care that aims for holistic health and wellness and the safety of homebirth:

I do believe that pregnancy and birth are normal and healthy ways of being in the world, and when women are well-fed and well-loved and well-taken-care-of, by themselves and by the people around them, that birth can go really well. Babies grow, and they’re born, and they’re healthy and happy, and of course things can go wrong. And things can go really wrong. And because when things go wrong in labor and birth, they can be so devastating, we start to swing towards thinking they’re always going to go wrong, and wanting to just be hyperactive around it because of that.

But what's real is that mostly things go really well, and mostly if things are going to go wrong you're going to have warning signs and be able to take action. [...] That's what [midwives] are. We are people who believe that women are capable of having their babies and having them safely. And so, we fit in that safe space. We help to create that safe space. And we're the ones who wave the flag when it's not safe anymore. Or moms wave the flag and we listen to them.

Here, she also demonstrates an important theme previously described regarding safety, which is how homebirth mothers and homebirth midwives distinguish between normal and safe and abnormal and the need for medical attention. Homebirth is safe for low-risk healthy women, and they generally believe that homebirth midwives and mothers have the ability to assure the health of the pregnant mother by actively maintaining health and wellness. They value this approach to health and care of the self and, therefore, problematize the biomedical approach that detects and treats disease.

Detecting Disease vs. Achieving and Maintaining Health and Wellness

A significant element of the biomedical model of health care is the lens through which this model dictates that we understand and approach health (Block 2007; Ratcliff 2002; Rothman 1991; Simonds, et. al. 2007; Wagner 2006). Using a lens of pathology, health is defined within the biomedical model as the *absence* of disease in an individual's body. Consequently, health care consists of attempts to detect, treat, and eliminate disease within the body (which will be opposed to the active effort to create and maintain health). Within a biomedical model, pregnancy and birth are understood as *at least* potentially, if not inherently, pathological. Pregnant women are constantly measured, tested, and evaluated—observed, judged, and examined—in an attempt to *detect* disease and produce docile bodies. One homebirth mother, Ella, recounts the maternity care she received during her first pregnancy with an obstetrician, which in many ways reflects this lens of pathology:

We went to the doctor, and right away, our very first appointment, a c-section was mentioned. And when I said, "No, I wanted to have a natural birth," he immediately put that little seed of doubt that, "Well, you are a short-statured woman and probably won't be able to have a regular birth." Well, then I was devastated.

She went on to discuss her retrospective frustration with a lack of health education from her obstetric care, particularly regarding nutrition. She describes herself as a bad eater and says her health declined during that first pregnancy. Consequently, operating with a lens of pathology, her doctor tested for a problem until it was “found”:

But at thirty weeks or—twenty-five weeks—they do the glucose test, and I totally passed. And then they weren’t happy with that, so they did it again, and they weren’t happy with that, so I had to do it a third time. The results were like, normal, normal, and then the third time they were not normal. I was a “diabetic”.

Once her doctor “discovered” disease he labeled her as high-risk (in relation to a highly articulated norm), and Ella described this diagnosis as a defining moment in the process of creating her as docile, a process that ended in a c-section. On one hand, Ella’s tone expressed doubt that disease truly existed. To the extent that it did exist, she expressed certainty that it could have been prevented through proper diet and taking care of herself, an effort she learned and achieved during her second pregnancy, with the cooperation of homebirth midwives.

Often, in technocratic care potential symptoms of disease are treated as all but confirmation of the existence of disease, and relentless efforts to find or create confirmation ensues, as one mother illustrated:

They did everything they could to label me as—I’ve been overweight all my life—they tried to label me hypertensive. But what it was, was when I was away from them my blood pressure was fine, and when I went there, my blood pressure skyrocketed. It really was not that high, but it was pre-hypertensive, and then they put that all over my medical records and then they wanted all these ultrasounds. They had me doing ultrasounds left and right, and non-stress tests, and *all* this stuff.

A number of mothers expressed frustration, both at the time and in retrospect, with this attitude and its resultant practices, as yet another homebirth mother recounted: “They thought I was gestational diabetic, and they tested me and tested me, and can’t find it, but it must be there, because your baby is so big.” She went on to describe frustration with constant medical surveillance, normalizing judgment, and examination: “So we just had the medical stuff creeping into every birth and we didn’t want it.” Even those who were frustrated at the time often agreed to monitoring and testing and in doing so demonstrated the ability of obstetric power/knowledge

to control individuals. Some mothers, like Madison, spoke about questioning and sometimes opting out of testing:

It started out at my doctor's office where he started asking about doing testing—blood testing for certain disorders, and I really thought, “You know, this is not necessary. This is just going to stress me out more.” I thought, “I'm healthy, I'm feeling really great.”

Ruth, who had dual care (care with both a homebirth midwife and a doctor) during her last pregnancy explained that having the “backup” care of an obstetrician had its pros and cons. Part of the downside was being pressured to test and be checked at each visit:

But what was also good [about having backup OB care] was that my midwife was so far away that I could get my blood pressure checked and check the position of the baby in town. But then he also wanted to do a glucose test, and he wanted to check my cervix *every time* I went in there, and I wouldn't let him.

All of these women share a sentiment of frustration that played a role in their own resistance to normalization. She and others described how opting out of testing was not well-received by staff at the doctor's office. Isa related:

Yes, I had an OBGYN for my first two, and very conventional. I had all of the things I was supposed to have done, and I had ultrasounds and I had this tested and I had that tested. The one thing I refused, they didn't have the AFP test, the Down's syndrome test. They didn't have that when I was pregnant with my first, but it came along when I was pregnant with [my second]. And I had decided not to have that, and I remember that being sort of controversial at the doctor's office. The nurse was astounded that I didn't want the test and was really insistent that I needed it. And I told her absolutely, in no way, shape, or form was I going to have the test. I understood that there were a lot of false positives, and my husband and I were of the opinion that we've created this baby and it will be born to us in whatever way it's born to us. And we weren't willing to terminate the pregnancy or anything else.

She went on to say:

It always seemed to me that doctors did a lot of things in an effort to control that which could not be controlled. And it even struck me when I was having my conventional pregnancies. They would test for all of this stuff, and it was absolutely pointless testing. You wanted to ask, “Well what will we do with these results?” There was a lot of information-gathering, and very little that could be done about any of it. Whereas, with the midwives, it seemed to be that they did just the things that could be productive in some way—checking your blood sugar to make sure you weren't developing gestational diabetes—things that you could really do something about, things that you could act on. Checking the baby's size you know, approximately, checking to make sure, you know, “Okay. It looks like we're a little off on the due date.” Things that would make a difference.

Participants recognize, to some extent, that information gathering on the part of medical experts is more an exercise of control and docility than an effective way to ensure the health of the mother or baby. Mothers and babies are frequently and sometimes continuously (during labor) measured and monitored. When symptoms of disease are detected through hierarchical observation and examination, normalizing judgment and biopower are exercised. Docile bodies are created through the testing alone (reifying the notion of pathological bodies and expert knowledge and authority), and furthered through the consequential actions when disease is “found”. When bodies are confirmed as pathological, as outside of the norm, they are subjected to expert power/knowledge, made docile—through medication, induction, and “assistance” in birth—and ultimately trained and normalized. Furthermore, participants described women, their families, and generally others in society as actively participating in this process. Some even described themselves as participating in the past. In keeping with constructionist and Foucauldian notions of power relations, participants explained that most Americans and Oklahomans actively seek medical care, with little or no critical reflection of taken-for-granted biomedical power/knowledge, and in participating in testing and other means of control of time, space, and movement, individuals actively create, support, and amplify their own docility and normalization.

The biomedical model aims to target, find and treat disease and physical dysfunction. Holistic models seek to proactively create and maintain health of the whole person—mind, body, and spirit. One midwife who was recently in nursing school to obtain her certification as a Nurse Midwife (after years as a direct-entry midwife) explained the challenge of working within two models of care:

For the last 15, 20, 25 years [as a midwife], all I’ve done is to think, “Okay, this herb helps *build* your blood; it builds red blood cells and helps you have more iron. This herb has the highest calcium of any herb. Red raspberry tones your uterus. High vitamin C content.” But all the meds [we learn about in nursing school]? *Anti-anxiolytic, anti-platelette, anti-...* That has been a huge mental block for me. They teach you in nursing school: “Worry! Worry about this. This is

wrong! We want to worry. We're always going to assume the worst." I have heard that over and over and over in the last two years. And that is totally different [than the midwifery approach].

Another midwife spoke to the medical approach: "I think standard of care for medical, is find out what's wrong and treat it then. Gestational diabetes, preeclampsia... Instead of acting in a preventative way, they tend to treat it as, 'We'll fix it if it becomes a problem.'" And at the point when it becomes a problem, the expert care of obstetricians is the usual solution: medication, increased monitoring, induction, c-section. As these midwives and other participants illustrated, the holistic model emphasizes proactive care that entails constantly striving to achieve and maintain health and wellness, and thus *prevent* illness or complications, rather than waiting for disease to present itself and then intervening. One mother iterated: "It's important to me to do preventative treatment rather than having to end up with interventions. That's important in our lives." Most participants explained taking this approach in all matters of health and life, in general health care, diet, and lifestyle. They subscribed not only to the midwifery model of birth but also to a holistic paradigm of health.

According to participants, health and wellness are achieved by homebirth mothers through a process of claiming knowledge and responsibility for their bodies, families, and health, working collaboratively with a midwife, becoming educated and changing behaviors, especially regarding nutrition and exercise, and addressing mental and emotional concerns as well as physical well-being. In the context that I have detailed and participants explained, this approach, which entails an important process of critique and problematization of biomedicine and culture, can be understood as care of the self, resistance to normalization and, therefore, a practice of freedom.

Every homebirth mother and midwife I spoke with talked about the importance of nutrition. Midwives monitor nutrition and encourage good nutrition as the best way to achieve a healthy mom (and therefore, a healthy baby). One midwife explained the approach at her practice:

Instead of the glucose test, the simple screening for gestational diabetes, we actually look at how the mom's doing with her own diet. So we have them tested two hours after a normal meal, and if that is out of range then we're going to move on to gestational diabetic screening.

Midwives and homebirth mothers emphasized nutrition as an everyday, preventative means of caring for themselves and their families holistically. Again, participants contrasted this approach of achieving and maintaining good health with the medical model's approach of fervently attempting to detect disease but doing little to prevent it. Participants generally described social influences on health, including diet and nutrition, and the importance of education and changing family nutrition, as the standard American diet is a common cause of disease. One midwife expressed particular frustration with American and Oklahoman culture and poor diet, and the lack of education or encouragement of proper diet on the part of medical doctors:

In Oklahoma, we don't view health highly, we have high obesity rates, we have high Type 2 diabetes, we have high adolescent obesity rates, we have MacDonald's *everywhere*. We see, in our clinic, moms that don't know how to eat everyday. Doctors say, "Well they won't do it [eat differently], so why should I try?" But they should! [...] It takes a lot of education. And doctors, if you're going to get a mom in and out of there in 15 minutes, you're not able to spend an hour on nutrition. And we talk about, not all midwives do, but most midwives talk about nutrition a lot, and we see it as a preventative measure to make a healthy mom and a healthy baby. We're not trying to judge you, we're just trying to give you the best birth possible. And we know you can have the best birth possible if you have good nutrition.

Participants explained that the lens of pathology and approach of disease detection in the biomedical model promotes fear and, consequently, strengthens expert power/knowledge. On the other hand, they described the midwifery model's constructions of birth and bodies as healthy and proactive approach to maintaining wellness as a means to combat cultural fear of birth and promote women's agency.

Fear Promoted vs. Fear Combated

The homebirth mothers and midwives who spoke with me explained that fear is promoted in the medical model, through the construction of risk and pathology, and aided by a characteristic lack of education, preparation, and support in obstetric care. In contrast, they explained the ways in which the midwifery model actively works to combat the fear

manufactured by medical hegemony in our culture. This is primarily accomplished through education, preparation, support, and family control. When birth is defined as inherently pathological and, therefore, risky, pregnancy and birth are feared. As discussed previously, my participants described a complex and powerful system through which obstetrics has, on one hand, constructed risk and created fear of birth and, on the other, to quell those fears, has created an illusion of safety in hospitals through claims to knowledge(/power) regarding risk-management. This process of risk construction and management is acknowledged by most participants as common throughout our medical system, not just in obstetrics, as one midwife explained: “Birth and death, we have become so terrified of them, because they have become so artificial, and not only do we not see natural birth, we don’t die naturally anymore either.” Participants described how, in complex ways, fear is a powerful tool for governing individuals and creating docile bodies. One midwife described this process in the hospital during birth:

In the hospital there’s so many women, we get stories all the time, they labor ten hours and they are told, “Oh, labor’s too long. Baby’s too big.” and they section them. It’s like, “Really?” Ten hours is not even normal for a first-time mom. [The average labor for a first-time mom is longer.] So there are so many fear tactics used. The mother may want to go natural, but as soon as she gets to the hospital, it’s, “Do you want any drugs? Do you want any drugs? There’s no sense in hurting,” and it’s like, well, the doctor might say, “You know, the anesthesiologist is on the floor. Let’s go hunt him down.” And they don’t want that pressure. And when the mother says, “No”, it’s, “Well, you don’t want to die. You don’t want your baby to die, do you? Right?” Well, then you’re afraid. Of course you don’t want your baby to die. So women cave to the fear. It’s not peer pressure; it’s fear pressure.

While many described completely overcoming fear, some homebirth mothers admitted being a bit fearful of either birth itself or birthing at home. The latter group explained that it was friends, family, and other external social forces that usually contributed to or created their fear, which was always overcome by participants by the time labor started (if not long before). Socially enforced fear reflects panopticism, as individuals attempt to police each other and exercise hegemonic power/knowledge. Ultimately, there seems to be an understanding that there is a normal amount of fear to be expected regarding birth, but that fear has become exaggerated by our society and by

the medical field, and that this fear is created and utilized as an instrument for biomedical power/knowledge. Another midwife explained:

Of course, first-time moms, you know, you've never been pregnant, you've never had a baby, or maybe you've had a baby or two, but this is your first homebirth, you're always anxious about the unknown. *That's* understandable. But that has shifted from a normal anxiety and a normal fear of the unknown to outright women are scared to death to have babies now, and they look at it as a horrific experience that they have to endure to get the baby.

All participants agreed that urgent situations sometimes arise in birth, no matter the setting. Participants explained that many of these incidents can be prevented with proactive health care during pregnancy and/or that there would likely be indications or warnings during pregnancy, or during labor before an emergency arose. In any case, women also described the very different ways that doctors and midwives handled such urgent situations. One homebirth mother, Judith, describes having trouble when it came time to push, and that this happened with all of her births, one in the hospital and two at home. She described this stage during her first birth, in a hospital:

But when we came to the point where we were pushing with him, his heart rate dropped, and I kept asking, "Let me get up! Let me get up!" And they just weren't listening to me, and the whole room was getting quieter and quieter because there was obviously something not right. In between every contraction, the nurse is shoving the monitor, she's climbing on top of me to push it down—because you know, he's in the birth canal—to measure his heart rate. And I'm like, "I'm trying to push this baby out! [breathless] I don't need you on top of me—Go get a Doppler! Go get something that's going to work better! Stop climbing on top of me!" Finally, as I'm on the phone, somebody's holding the phone, I'm talking to [my husband], he's in Kuwait, and everything's going nuts, and the doctor just says to me—probably the first time he's spoken to me the whole time—and he says [in deep, sort of arrogant voice], "I need to cut an episiotomy or your baby's gonna to die."

This is what is referred to as the "dead baby card" by many of my participants and other members of natural and homebirth communities. Another mother described her doctor utilizing this tool:

I was put on blood pressure medication, and I was sent to the hospital that night to be monitored all night long, and then c-section was brought up. They brought up the "dead baby" card—"Your baby's going to die, or you're going to die, during this birth, and she's going to be fifteen pounds."

Rather than a legitimate safety concern, it is most often viewed as the product of a lens of pathology and as a scare tactic to coerce birthing women into docility and to consent to

unnecessary interventions. Returning to Judith, she contrasted her urgent situation pushing in the hospital with the way her homebirth midwife handled her second birth when a similar situation arose during pushing:

[My second baby] also had trouble when it came to pushing. She got good and stuck. She had shoulder dystocia, and her cord dropped, but we had an incredible midwife who had delivered 1500-1600 babies. [...] And when it got to the point when it was scary, my midwife kept completely calm and collected. If she was scared, I wouldn't have known it. She got down with me, just like I needed, nose-to-nose, and said [in a calm, matter-of-fact tone], "We're going to push. We're going to push this baby out. We're going to push if you have a contraction or if you don't have a contraction. You're just going to keep pushing." Then all of a sudden, I feel the baby pulled completely to the side. But you know, no episiotomy, and no tearing. And her shoulder was stuck. And it's basically amazing to me [the way my midwife handled it].

Another mother similarly described her midwife's calm approach in an alarming moment of birth:

So I started pushing, and then my midwife said for me to stop pushing. And the way that she said it, I knew that it was serious. So she very calmly told me that the cord was wrapped tightly around his neck. And she said, "It's very important that you don't push." And so I just held it in and she reached up—I mean, she knew exactly what to do, I wasn't worried—she unwrapped the cord and when he came out, he was extremely blue. I mean, my husband said it was, for him, it was scary. For me, I trusted her enough to know that if there was a problem, she would have known. And she had been checking the baby's heart rate and he was okay.

So while problems arise during birth, regardless of location and care provider, the way that these situations are handled and the amount of fear involved is quite different, in the experiences of participants. The fear of pregnancy and birth described as characteristic in the medical model and promoted by our larger society is supported, according to my participants, by a lack of education, a lack of involvement, agency, or authority by the mother, and a lack of support. These elements come together to create a disciplinary technology, involving objectification of pregnant and birthing bodies and the exercise of power/knowledge, where fear is a powerful instrument of the production of docile and normalized bodies.

In the biomedical model of maternity care, the doctor is seen as the active subject, the participant with authority and knowledge/power regarding birth. The obstetrician, after all, is the skilled technician who is able to detect and treat the inherently pathological female body. Under this model of care, women are understood as and often rendered passive objects. If

power/knowledge operates effectively, pregnant and birthing women lack authority, responsibility, and involvement; they lack agency. Their thoughts and behaviors, their bodies' time, space and movement are controlled and they are rendered docile. Many participants described how receiving care under obstetricians promoted fear, because patients are left in the dark regarding what the doctor often views as likely pathologies. Since the doctor has and/or is given authority of information, he or she takes and/or is given more authority than the birthing mother to make decisions about health care delivery (e.g. interventions). In turn, when the doctor is understood as the active subject in the "delivery" room, there is not a need for the birthing mother to be educated. In fact, a mother's education and desire to actively make choices about her birth and her body are discouraged and can even lead to the doctor terminating care. Among other illustrations, one midwife told me about a mother who came seeking midwifery care late in her pregnancy:

This woman was an older woman, and she was on SoonerCare. She was going to a clinic in Muskogee, and she asked questions about things like: Could they do the exam on the baby and keep the baby in the room with her? And they finally told her, "You're asking too many questions." And they dismissed her. [They terminated her care.]

Particularly because of the notion that the relationship between the mind and body is trivial (which I elaborate upon in the next chapter), and the history and institutional factors in hospital birth, there is a lack of support, especially emotional support for women, during pregnancy and labor in the technocratic model. Isolating the mother from her friends and family and the support they provide, and immersing her in an environment characterized by fear and pathology strengthens power and makes it more efficient.

Set in opposition to the fear promoted in the biomedical model, along with the acknowledgement that this fear is now pervasive throughout society, participants described ways that fear is actively combated in the midwifery model. Homebirth mothers educate themselves, and midwives play a strongly supportive role in this education process, about bodies, pregnancy, and birth. They make plans and preparations for when things might not go well at home.

Midwives support homebirth mothers throughout their pregnancy and labor, help address their fears, assure women that they and their babies are healthy, and provide or facilitate whatever they might need to birth well. Participants explained that when they take and are given control in these ways, they see birth as normal and healthy, they feel capable of and prepared to birth, they feel supported, and they feel safe and without fear. They are empowered to critique and resist control, docility, and normalization and to engage in praxis by making active and informed decisions about their own care.

Participants acknowledged the possibility of needing medical attention during birth. Rather than describing a consequence of fear from this understanding, they described this possibility in relative perspective—that it was possible rather than probable—and they prepared accordingly. It is common, if not standard, for women who birth at home (and their midwives) to make back-up plans in the case that the need arises for medical attention, as one mother illustrated:

When I sat down with the midwife, she tracked how far the hospital was. And I had already pre-registered at the hospital just in case. So I just didn't feel like there was risk was involved. If something was going to happen, it would happen, and we would get to the hospital and we would be fine.

Her midwife explained that these preparations are not taken out of fear (i.e. to communicate that women need to fear what might happen during birth), but instead are done to alleviate fear. She showed me materials she and her clients share:

So then we have transfer sheets that they fill out. We tell them, again, "This isn't fear-based, it's just so we can actually eliminate any fear: What if something goes wrong, what are we going to do about it? We know what we are going to do about it: This is the closest hospital, this is how we get there, this is the number we call." And then this sheet over here, they fill out, and then this is what I actually give to the doctor when they transfer. That way they have all their vital information, and they don't have to pester the mom with five million questions when she's trying to have a baby.

In addition to preparation, continuous support—from midwives, doulas, partners, friends, and family—is one characteristic of midwifery care that women reiterated as very important and

comforting, and one that helps women to feel safe and in control, as one homebirth mother described:

[My homebirth] was just—it was perfect, it really was. And I completely attribute that experience to the calmness of my midwives, because they completely supported me, and made sure that I was educated, and answered all my questions, and just made me feel like I could do it, no problem. And that confidence really, really helped me to clear my mind of any worries or fears that I had.

Participants described support as incredibly empowering, and the support homebirth mothers received during midwifery care is not isolated to birth, but extends from the time care is established, throughout pregnancy, labor, and birth, and often continues to postpartum, including support in breastfeeding and caring for mother and family in what is often referred to as the “fourth trimester,” those months following birth. Women’s discussions of support demonstrate the importance of emotional as well as physical support and how my participants see the mind and body as connected (which I discuss more in the next chapter).

The most important component of combating fear—and one of the most important themes throughout all of my discussions with participants—is education. Nearly all of the homebirth mothers I spoke with described an ambitious process of education as part of their journey to homebirth. They described homebirth mothers as generally very educated about pregnancy, birth, and homebirth. (They went on to say that some women birthing in hospitals with obstetricians are very self-educated, but that the model of care discourages it and that *most* women, therefore, do not educate themselves.) For women and families birthing at home, education facilitated a mindset that I have already described regarding safety, which is that birth is normal and healthy, that overuse of interventions and other aspects of hospital birth are risky, and, consequently, that homebirth is the safest way to birth. The emphasis on education that characterizes the midwifery model acknowledges women’s agency and emphasizes critique, negation, and praxis.

Many homebirth mothers started their process of education with researching common safety concerns. One homebirth mother explained:

[Learning about] the statistics of the people who were dying back then, and the reasons, were not valid reasons for why people are going to die now. Even hemorrhaging, how long it really takes - my husband was a medic, and I met him when I was doing EMS, so I had a little bit of background - I know you're most likely not going to die in 15 minutes. A lot of times, unfortunately, if the baby is born with a serious defect, they will die in the hospital too. [...] When I read just the facts about mortality and all that stuff, when you get through the scare tactics and all that, [homebirth] is really, in my opinion, safer.

Others, including this homebirth mother, echoed this conclusion regarding safety and cite it as the product of a process of education about birth and bodies: "Just understanding how my body works, it helped to overcome some of the fear." Another mother reiterated: "I have fear of the unknown and when I educated myself, there were no more unknowns. So I had a peace."

Ultimately, participants, like Nina below, overwhelmingly spoke of education as an important means by which they actively alleviated fear surrounding childbirth and homebirth:

I know for some people they think it's scary to have a birth at home, but my favorite book was called *Homebirth*. But when I read about all of the hospital interventions, I knew that that was not for me. Just reading, and the knowledge I gained, and the education gave me complete peace of mind that birth is normal, and natural, and nothing to be afraid of, and that most complications come from interventions that they did, because the mom and baby weren't ready. But in most situations, if you truly just leave it alone, it can happen, and it works. It's normal. It's safe.

Midwives also described the relationship between education, fear, and how women cope during labor:

If they've studied or come from a homebirth family, they don't always seem to need childbirth classes. But the others with childbirth classes, they do great. And they enter birth with the idea that this is normal. And that's what we try to stress. It's uncomfortable, but it's not like pain when you hurt yourself. So they do beautifully. And if someone's there to reassure them that this is going to happen, then they're not scared. I used to love it when they would get about seven centimeters and the legs would start shaking because the baby was coming down on the ligaments. I'd tell them, "Now you may start feeling your legs shake." It's almost like I was predicting. (laughs) So if you tell them what to predict and why—it's like education puts fear of pain on the outside.

Education provided women with confidence, a sense of control, and empowerment. Midwives played a significant role in this education (and empowerment) process, and they emphasize the importance of true informed consent.

The homebirth mothers and midwives I spoke with described a model of care where pregnant and birthing women not only actively participate, but take prime responsibility for their own care. While they acknowledged that some mothers birthing in the hospital with medical care take this same responsibility and seek to educate themselves, the significance is placed on the fact that the model of care does not promote (and even discourages) this sort of agency and that most mothers, therefore, are not so active when birthing under obstetric care. Homebirth mothers generally looked to midwives for help finding information and making decisions, but they did not rely on midwives to make decisions. In fact, some mothers expressed slight frustration that their midwives would withhold their opinions on what should be done in certain situations, and some midwives discussed withholding such opinions as important to give space for mothers and families to make the decisions that are right for them. While many mothers spoke of control for the purpose of safety (discussed in the previous chapter), they also related control to empowerment—through education, participation, responsibility, and agency. One mother tied these issues together, compared the two approaches, and in doing so, echoed the sentiment of other participants:

I mean I think this whole [notion of] looming catastrophe in childbirth is very detrimental to our whole nation's practices of childbirth. And I've seen that in my own experiences, with this feeling scared, and having all this crazy stuff happen to you, versus being at peace, at home, comfortable, having everything worked out, and being comfortable around the people that I'm with. And just being in control of my environment. And having no control in my environment in the hospital—I think a lot of women have issues with losing that control and it can be scary, and that can cause labor to stop.

As homebirth mothers and midwives explained their belief that the mind and body are intricately connected, they discussed the ways in which fear affects birth. They believe, as the mother above stated, that fear can affect how labor unfolds and they insisted that fear and thinking about labor as painful suffering actually *leads* birth to be painful.

Pain as Problematic vs. Pain as Normal

Closely related to fear, in the minds of homebirth mother and midwife participants, is the way that labor pain is defined, treated, and experienced. Participants explained that fear in the medical model often leads women to experience more pain when they birth within that model, and that the lack of support and preparation for labor leave them ill-equipped to cope, which then likely leads them to request (or give in to being frequently offered) medication for pain relief. While homebirth mothers and midwives emphasized that they do not judge women who have medicated births negatively—as many themselves had medicated or interventive births in the past—they explain that natural childbirth is not only best for mother and baby but promotes empowerment of the mother and bonding for the mother-baby(-family) unit. Additionally, they express serious frustration that women who desire a natural birth in a medical setting are not only unsupported but often are sabotaged. A few years ago, there was an infamous meeting of the local Birth Connections group, where a nurse from a local hospital served on a panel discussing birth options. She bluntly stated that nurses at her hospital ignored birth plans—that birth plans were considered a joke. Some were shocked, though many were not surprised, and some even expressed that at least her honesty was refreshing. In any case, this speaks to and, for many local participants, reaffirmed a preexisting belief or suspicion about birthing under technocratic care.

Participants problematized biomedical constructions of fear and pain and explained that labor pain is accepted as normal in the midwifery model, and is sometimes not even defined as *pain*. Joan, a homebirth mother who had three quick homebirths, explained how education affected her thinking about pain and, therefore, how she experienced it:

But before [reading], I still was under the thinking that: “Okay it’s still going to be kind of painful when I have the birth, but at least I’ll be at home and I’ll be in an environment where I can better relax,” because I knew I’d be tense in the hospital, and not relaxed, and I just wanted everything to be calm and relaxing, and I thought I could do that better at home. But after I read *The Joy of Natural Childbirth* and *Childbirth Without Fear*, their whole presupposition is that it doesn’t have to be painful, that it’s being tense that makes your muscles tighten up and makes the pain come. And yes, it can be kind of different feelings, uncomfortable, intense feelings, but not truly painful. And so, those were the thoughts I went into my births with. And so that was really helpful I think.

Some participants, like this midwife while she talked about the importance of education, defined labor pain as *pain*:

And I don't really care whether they take Lamaze or Bradley, but they need something to help them manage the pain. Childbirth involves pain; I don't care what anyone says. So they can say pressure, or waves—it's not pressure or waves, it's pain. (laughter) But, you know, and I want them to have the education about what's happening to their bodies.

Homebirth mother and midwife participants explained that their mindset, achieved with education, along with preparation for labor, and emotional and physical support, helps women think of and experience labor differently, and in such a way that natural labor is possible and, for some of my participants' births, easier than they anticipated. Whether or not it is defined as pain by midwives and homebirth mothers, there was a consensus that it is normal and that education, preparation, and support are important to cope during labor. With an understanding of labor pain as normal, participants described feeling empowered, unafraid, and better able to cope with discomfort/pain.

Participants thoroughly critiqued and problematized the technocratic approach that understands women's bodies and processes as pathological. The lens of pathology in general, and the application of this lens to pregnant women, is problematic because when we look for something, or support for something, we tend to find it. When we are constantly looking for disease and pathology and "problems" of the body, we are likely to find symptoms, whether or not they are present or may actually be problems. In turn, treatment (and overtreatment) may lead to real/additional problems. Beyond all of this, utilizing a lens of pathology makes us blind to the ways in which bodily processes, like pregnancy, are normal and often healthy and the ways in which health and pathology are themselves socially constructed, varying across time and place, and from one individual to another. This approach also, even if indirectly, involves the idea that we cannot positively affect our own health; that health and illness are largely biologically determined. When we define health and illness as individually and biologically determined, and

as inherently pathological (in the case of technocratic construction of pregnancy and birth), the role of social elements are denied, most notably power.

Participants articulated how particular power relations are created and promoted in biomedical thinking and treatment of pregnancy and birth. In this chapter, supported by participants' views, I characterized those power relations as results of particular historical (and current), social processes, including pathologizing bodies and promoting fear through dividing practices, scientific classification, and the will to know. Power/knowledge in the technocratic model is further created and facilitated by an emphasis on relentless disease detection through hierarchical observation, normalizing judgment, and examination. Homebirth mothers and midwives described a lack of education, support, and preparation that objectifies women, obstructs or denies their claims to power/knowledge, agency, and empowerment. Pathological (female) bodies and disease (symptoms) are treated through a disciplinary technology, involving these power/knowledge relationships and an emphasis on detection and treatment, that produces docile and normalized bodies.

In participants' accounts of holistic care, they described the importance of education, preparation, support and empowerment through the proactive and preventative care promoted by midwifery care and homebirth. When women's bodies and processes were defined as normal and healthy, and when participants focused on maintaining health and wellness (rather than constantly fearing and searching for disease), fear was combated and they described confidence and empowerment through this approach. Homebirth mothers and midwives constantly employed critique of medical hegemony that promoted care of the self and resistance to medical control and normalization. Education and reflection facilitated critique and action and resulted in praxis, where women acted not only for themselves and their families but expressed desire for social and political change for other women and families. These elements of critique, problematization, and care of the self represent a process of desubjectification where women challenge and alter existing power relations, feel confident, secure, and capable, and constitute *themselves* as

subjects: “Women who choose to birth at home [...] want to be somewhere where they feel healthy and whole and comfortable and safe.”

CHAPTER VIII

FEMALE BODY-AS-MACHINE

VS.

WOMAN AS SOCIAL BEING

The midwifery model is a holistic, social model that emphasizes the context and production of health and illness and, in doing so, addresses the problems of the individualistic nature of the biomedical model. The homebirth mothers and midwives with whom I spoke illuminated both the ways in which the medical model of maternity care is individualistic, depersonalizing, and views the pregnant and birthing body as a machine and the ways that the midwifery model of care addresses these perceived (and experienced, lived) shortcomings through mind-body and mother-family-society connections. Technocratic treatment approaches pregnant and birthing bodies as (defective, pathological) machines, as passive objects; the holistic model understands women as complex organisms, as social beings whose minds, bodies, and emotions are interconnected in their health and functioning. Midwives are understood to support and nurture clients, who they view as active subjects.

In relaying their experiences and views of the medical model, participants described four important elements of and distinctions between the models' treatment of bodies as defective machines and women as social beings. First, homebirth mothers and midwives problematized the

biomedical separation of mind and body and a further separation or segmentation of the body itself. One of the strongest themes in my data is the belief in a deep connection between the mind and the body, which is also a key element of greater holistic models. Here, mind and body constitute one inseparable unit. The health (or illness) of one affects the other. Participants explain the importance of the acknowledgement of a mother's emotions, mental state, and personhood in care during pregnancy and birth; they express discontent with the medical model's neglect of women as holistic beings and discuss the importance of the midwifery model's approach in caring for these elements in addition to the physical elements of pregnancy and birth.

Second, participants emphasized the connection between mother and baby. Participants described knowledge and/or experience of separation of the mother and baby in the medical model, and generally described this separation as detrimental to the physical and emotional wellbeing of both mother and baby. On the other hand, mother and baby are understood to be a unit in the midwifery model. In this model, and in participants' views, they are and should be inseparable and their interests are one.

The third element distinguishing the two models regards homebirth mothers' and midwives' understanding of the mother as a social being. In participants' views, the mother and baby are seen as part of a larger family unit, which is described as being separated and weakened in the medical model and being supported and strengthened in the midwifery model. Furthermore, not only are her mind and her body connected, not only is she a unit with her baby and with her family, but participants explained that a mother is affected by her larger social environment. Once again, participants problematized the technocratic model for its individualistic approach that separates mother from family and society.

Finally, despite a very individualistic approach in the medical model, participants explained that care is generally not *personalized* in this model. Since the body is understood as a machine in the medical model, it makes sense that there is a standardization of women's bodies and processes. Women and babies are expected to have certain measurements at certain points in

the process of pregnancy and labor. Labor is seen as a mechanical, linear series of steps and stages, where time is important and deviation calls for intervention, correction, and normalization. In contrast, homebirth mothers and midwives described the midwifery model as a personalized care and acknowledged that every woman, pregnancy, and birth is different. Labor is understood as a non-linear experience, a process where time is not given prime importance.

Homebirth mothers and midwives attribute constructions of bodies as pathological machines to the exercise of technocratic power/knowledge, and they problematize the consequential denial of women's agency. Dividing practices and other disciplinary technologies work to separate mind and body, mother and baby, and mother and society and situate her in a process of standardization where she is isolated, controlled, and normalized. On the other hand, homebirth mothers and midwives explained that a holistic approach views women as normal and healthy (as detailed in the last chapter) and that women are understood and treated as social beings. Participants described a process that fosters the connections between mind and body, mother and baby, and mother and society. Midwifery care entails an emphasis on holistic and social care of the self, including personal relationships, support, education, and personalized care, and, in the lives of participants, constitutes opportunities for personal agency and empowerment as well as ethical praxis.

Mind-Body Separation vs. Mind-Body Connection

Participants described the technocratic logic that the body is the sole source of health and illness. Women are rarely acknowledged as people, as decision-makers, in this model, and their thoughts and emotions are treated as inconsequential to their health. The body itself is also segmented in technocratic care, and the vagina and uterus are the locus of attention. A hospital birth setting most often involves the draping of woman, using large, sterile paper sheets to separate the woman's face, hands and upper-body from her lower body, vagina or uterus. Lights and expert eyes focus on the baby's exit or location of "delivery". Machines that indicate "objective" measures of, first, the baby's wellbeing, and, second and separately, the mother's

wellbeing, receive secondary attention. The mother herself receives the least attention, her face, her emotions, her thoughts, her *self*—for indications of how the birth is going and how the mother is responding. Technocratic treatment of birth and birthing women reflects the philosophy that mind and body are independent, as are mother and baby and mother and environment. Many participants expressed an impersonal treatment of their own and other women's bodies by medical staff, particularly treatment and attention to their vaginas or uteruses without attention to them as individuals, as mothers, as *people*. One midwife, Susan, recalled her own hospital birth experience: "I know from my own birth, you were a slab of beef. You went up there, they yelled at you, the doctor would come in, and usually had his hand in your vagina before he ever said hello." This sentiment was touched on earlier in Judith's experience when she said that at the point of pushing her son, "the doctor just says to me—*probably the first time he's spoken to me the whole time*—and he says [in deep, sort of arrogant voice], 'I need to cut an episiotomy or your baby's gonna to die.'" (emphasis added)

Dividing practices separate the mother from society, by isolating her to the hospital, to the labor and delivery unit, and to a labor or delivery room. The dividing practices above further separate the mother from her own body, from her own baby, from her own sense of self, and demonstrate a microphysics of power with an intense ability to contain, categorize, fragment, control, and objectify. By focusing attention and action to and producing information about parts of women's laboring and birthing bodies and, in doing so, drawing attention away from her feelings, emotions, thoughts, and potential for action, the mind-body dichotomy is reified. Women are subjected to, and subject themselves to, hierarchical observation and surveillance, normalizing judgment, and examination, and their bodies are controlled through manipulation of time, space and movement. Throughout this complex process, as Foucault (1977) emphasizes, "even if [systems of punishment] do not make use of violent or bloody punishment, even when they use 'lenient' methods involving confinement and correction, it is always the body that is at issue—the body and its forces, their utility and their docility, their distribution and their

submission” (25). Through subtle means of separating mind and body, mother and baby, and mother and society, and through observing, knowing, and controlling bodies, knowledge/power is exercised to create docile female bodies.

Alternatively, a significant element of midwifery care, according to my participants, is the importance given to the interconnection of mothers’ mental, emotional, and social wellbeing. One midwife, Maria, explained: “Sometimes, what’s important is not that she measures right or that her baby sounds good, but it’s what’s going on in the rest of her life.” Again and again, homebirth mothers, particularly those who previously had obstetric care, stressed the important differences in the relationship between mother and care provider in the two models. This was often explained through the example of a routine visit to a doctor versus a midwife. Amari explained that when she goes to the midwife:

We don’t wait for two hours to be seen for 10 minutes. And it’s standard, she measures the fundus, checks your blood pressure, checks your weight, talk about nutrition—which you never hear from a doctor—and I think she cares more about what’s going on in your life and your wellbeing, mental wellbeing, than a doctor does.

Furthermore, there is a common narrative among participants that women’s bodies are made to birth and that our minds can support or be an obstacle to the birthing process. In the midwifery model, pregnant women are generally educated, prepared, and supported in a way that primes the mind and body to approach birth naturally and successfully.

I’m pretty much hands-off. I have the idea that my body knows when to go into labor. I was very against an induction. [...] I knew it was going to happen when it needed to and I didn’t have to do anything to make that happen. While I’m in labor, I learn to let go. Just get out of my own way, and let nature take over. I knew God was in control. My body knows what to do.

Participants described the ways in which women are almost sabotaged by our society and through medical care to think in ways that are detrimental to the birthing process. Women are made to think in pathological and fearful ways about their bodies and their ability to birth (as highlighted in the previous chapter), and this way of thinking affects women’s experiences of pregnancy, labor and birth, it affects our birth practices, and it affects our birth outcomes. This process

includes, from their perspective, disconnecting the mind and body and a notion that the woman's personhood is trivial, characteristics that are illustrated through impersonal relationships, lack of support, and lack of education in the medical model. Homebirth mothers and midwives distinguished the two models and stressed the importance of mind-body connection through personal relationships formed between midwives and mothers/families, continuous support during pregnancy and labor, an emphasis on education regarding health and pregnancy, and a supportive holistic preparation for labor and birth in the midwifery model. In doing so, they illuminated ways in which the model promotes care of the self and allows women to constitute themselves as subjects and agents.

Relationships

Homebirth mothers I spoke with highly valued the personal relationships fostered by the midwifery model of care. Through these relationships, as described to me, women feel known as people, truly cared about, and many say that they see their midwife as part of their family. Midwives know their clients in a deep sense. They know their names, their families, their hopes and fears, and their histories. Personal relationships in the midwifery model of care are facilitated through *accessibility and availability* of the midwife and *time* devoted to the mother/baby/family unit. Homebirth mothers and midwives spoke about the importance of a pregnant or laboring woman being able to get in touch with her midwife 24 hours a day, seven days a week. Midwives give their time to clients. Appointments are generally 30 minutes to an hour long, and longer if the mother needs to talk, ask questions, or address other issues. Ella described the difference in the care she received from her obstetrician and from her midwives:

The difference in care [between OB care and the homebirth midwives' care] was *care*. (laughter) Compassion. Empathy. Sympathy. It was human emotion versus textbook crap. The doctor, yeah, he says he cares and he says this and he says that. But he spends five seconds with you. And I waited an hour in his waiting room to spend five seconds to hear him give me a bullshit answer? Or to hear him not even listen to my question? The midwives would give me as much time as I wanted. [...] And when I left they would say, "Call me or email me if you need me." And so really, they were accountable to a degree. "If you need us, we are always here. We will

be here for you.” And then they made me be accountable for the things that, you know, I was supposed to be doing.

The personal relationships, time, accessibility and accountability of the midwifery model is in stark contrast to the ways in which women described relationships with their care providers in the medical model. Women describe a process of objectification, feeling like a chart, a number, like cattle being herded through the doctor’s office and through the birth process itself. Homebirth mothers set in opposition the availability of doctors and midwives. Where mothers can contact midwives any time of the day or night via cell phone, email, and facebook, the process to get in touch with a doctor is much more complicated and often seen as futile. Additionally, visits in doctors offices are brief, and many homebirth mothers and midwives say that there is not even the opportunity to ask questions in such a setting, much less time to discuss them, and other potential issues. One mother described the comfort and confidence she felt having a close relationship with her midwives:

I was confident that, should anything start or should I have any questions, that I could call [my midwife] at any time, which is not something you can get with a physician. There is a stark difference between going to an OB every two weeks and not being able to contact him every time you have something going on, and our midwives who are always readily available, knowledgeable, educated—it was just very comforting.

Another homebirth mother, who sought dual care during her second pregnancy, passionately described the difference in the care she received from her OB and her midwife:

[Care with the midwife] is just the *opposite* of going into an obstetrician’s office—the *complete opposite*. [The midwife] gives you *all* the power, and she has *all* the faith in you, and she has *all* the knowledge, and she’s *willing to share it*. And she *takes* the time and she *answers* your phone call and she *answers* your email, and she’s **available!** And she’s smart! And experienced. Because with a *doctor* who’s smart and experienced, well you have to cut off your left arm, and wave it up in the air, and *then* you get to talk to him—that’s how it feels. [imitating voice:] Call the office and make an appointment and we don’t have one for a month, and wait in the waiting room, and he comes in and he has this way about him, like: “Don’t waste my time, I need to put my hand in your cunt and you need to get the fuck out of here.” And there was none of that, at all [with the midwife]. So that was amazing.

The personal relationships developed in the midwifery model facilitate trust and a sense of safety and control for homebirth mothers. They see pregnancy, labor and birth as vulnerable

times where they want to be surrounded by people they trust, who know their desires, who will treat them with respect as intelligent, sentient beings, and who have their best interests at heart. These personal relationships deny technocratic mind-body separation, challenge dividing practices and biomedical power/knowledge, and nurture women as complex social beings. The midwifery model of care generally involves a process of “desubjugation,” allows time and space for critique and exercise of women’s agency, and promotes holistic care of the self.

Homebirth mothers and midwives I spoke with describe how they cherish these relationships and that sense of trust. They also describe feeling alienated and distrustful by the way women are treated and the kinds of relationships formed in the medical model of maternity care. There is an understanding that doctors and hospital staff are more dedicated to efficiency, protocols, rules and regulations, convenience, and even profit than to either the experience of the mother/baby/family unit or the safety of their birth. Even when participants discussed caring and well-intended medical providers, they express that the system is a barrier to safe and empowering birth. Rose described the intimate nature of her homebirth and the importance of the relationships between everyone present:

And there wasn’t anybody there that wasn’t in some way intimately related to me. You know, your parents, and your in-laws, and your husband, and your kids. It wasn’t a whole lot of people that you had never met before in your entire life that you were going to spend the next twelve hours with until their shift ended. It was people you had known for years and years. And your midwife, who you had gotten to know because your appointments are two hours long every time you go in and see them, rather than just the few minutes. I mean she’d spend as much time with you as you wanted to and she’d see me as often as I wanted to. I went to *her* house and she came to *my* house. It wasn’t this office somewhere that you just randomly meet and talk for 10 minutes and then go on.

One midwife talked about developing relationships with clients, which means helping them through difficult times outside of pregnancy and birth:

I’m sure not every midwife feels this way, but we’ve become involved with a lot of our families. This year, we had four different families have absolutely horrible, tragic events that, technically, had nothing to do with their birth or anything else. Their babies were long born, everything was fine with the birth, this had nothing to do with birth. One mom lost her husband. I went to go be with her in the trauma center. And it was horrible. Three months earlier, [I was at their birth]. And I’m sitting up there having to midwife her through accepting that her husband really is gone.

The mother this midwife spoke of was also a participant and independently told me about the significance of the relationship she formed with her midwife. In fact, one of the ways that she described the nature of the care she experienced in her midwifery relationships was reflected in the interactions that occurred through her life changes. She began by addressing the lack of engagement with her obstetrician:

With my OB, I would go to my appointments, the nurse would listen to the heartbeat, measure my fundus, the doctor would come in and say, “Do you have any questions? Okay. See you next time.” That was it. If I passed her on the street, she would have no idea who I am, she wouldn’t know me..

She then described interactions with her nurse-midwife in a hospital:

The nurse-midwife she sat down and talked to me. I felt like she *cared about me*. She’d come in and [ask about my children by name]. I’m sure she had it written on her chart[, my kids’ names and information about us], but she *asked*. I felt like she cared more. I felt like she knew me. If she passed me on the street, she would probably know who I was.

And finally, she spoke emotionally about her relationship and interactions with her homebirth midwife at the time of her husband’s death:

But the homebirth midwives *know* who I am. My husband passed away, and my midwife came to the hospital and sat at the hospital with me. My OB, if she saw the obituary in the paper, she wouldn’t know who he was. Same with [my nurse-midwife]. But [my homebirth midwife] was at the hospital with me. When I see her, she knows who I am. I saw her yesterday, and she gave me a hug. She knows who I am, she knows my kids. She really cares about people and not just, “I want to get home to my family.” Her clients are her family. She is excited to see them. She’s excited to see the babies and see how they’ve grown and she just really cares. [...] The [nurse-midwife], I didn’t feel like she really cared, but she acted like she cared. And she cared more than the OB. But [the homebirth midwives] care more. When I went in for my appointments, even with the [nurse-midwife], she would talk to me for a few minutes. But when I went in to see [the homebirth midwives] they would be like, “What’s going on in your life?” They really cared about *me*. The medical part of the appointment, the heartbeat, fundus, blood pressure and all that, was kind of an afterthought at their appointments, where at the hospital, that’s what I was there for.

Support

Another significant component of the midwifery model that demonstrates and reifies the belief in the mind-body connection is continuous support. Rather than having access to their care

providers once a month for a 10-minute visit, homebirth clients described receiving support, information, and answers to questions throughout their pregnancy. One mother illustrated:

[The midwives] answered all my questions. They spent several hours with me at a time, and I mean, at least two. There was never a short visit, and if there was, it was because they had a baby coming. So it was always great. I enjoyed my visits—it was very woman-centered. It wasn't much like an obstetrician's office.

When labor comes, as participants described, the standard of midwifery care is for a mother to receive continuous support, while in standard medical care a laboring woman will only very briefly see her doctor and will most often only be checked by nursing staff, who do not generally stay with the laboring woman. Margaret contrasted support in her hospital birth and her homebirth (both natural births that she characterized as positive experiences):

I like having my birth team there the whole time. With [my first birth], my birth team was my mom. And my doctor came in and delivered the baby, but [the doctor] wasn't part of my *team*. She wasn't the one standing there the whole time and being there for me. And I really liked that about the homebirth, having your midwife, your doula, whoever with you the whole time. It's not someone coming in at the last minute and catching your baby.

Participants generally explained that women often need physical support to successfully cope with the discomfort or pain of labor, but participants described that emotional, mental, and spiritual support was perhaps more important. Midwives, doulas, partners, family, and even children awaiting their new siblings provide this support. The lack of continuous care in the medical model is one reason that many mothers who want to birth naturally now hire doulas to attend their births. Even many of the homebirth mothers I spoke with had doulas, or wished they had doulas, at their homebirths to ensure that they could have continuous support if the midwife did not or could not arrive early enough in labor. Some participants spoke of difficulty in seeking, asking for, or finding social, emotional, and physical support, but they maintained the importance of such support. One mother of twelve related that one of her only regrets was that she did not seek more help and support, especially when she had a new baby—that in order to care well for others, she needed to care for herself. Rather than being constituted by normalizing processes, caring for ourselves is one way that we can constitute ourselves (O'Grady 2011). Foucault

directly challenges mind-body and other sorts of dualisms, and asserts that the self is a social product and that, in caring for ourselves and fostering a relationship with our self to itself, we constitute ourselves and can ethically care for others. Moreover, the notion of care of the self as an ethical process makes sense within a holistic paradigm, where individuals are understood as social beings, and the health and wellbeing of one affects others.

Education

As detailed previously, education is a significant component of the midwifery model that helps women to feel safe regarding birth and homebirth. The lack of education in the technocratic model of care makes sense within the context of the model's view of the body as a machine, where mind and body are separate. If the body were a defective machine, and the doctor a skilled expert, why would a pregnant woman need to educate herself? A lack of education also supports our political economy of the female body where pregnant bodies are made docile and normalized. The medical approach that treats women as bodies and bodies as objects, as machines, involves a complex process of power/knowledge that discourages critique in the aim of strengthening power. An emphasis on education in the midwifery model, on the other hand, demonstrates the belief in the connection between the mind and body, and the importance of critique, and of women's subjectivity and agency. Women I spoke with maintained that education is crucial (particularly in light of medical hegemony) to think about birth in ways that promote confidence in their bodies and their abilities. Freire (1970) describes praxis as action informed by education and reflection. He explains that reflection without action and action without reflection are each lacking and detrimental in their exercise. On the other hand, when reflection and action are combined, they have incredible transformative potential. Homebirth mothers and midwives valued critical education that promotes praxis, through reflection and action, and care of the self as an ethical practice of freedom that challenges patriarchal and technocratic power/knowledge of women's bodies and relationships with themselves and others.

For participants, then, the technocratic model's separation of mind and body works to objectify women. Through dividing practices, this segmentation works to produce docile and, ultimately, normalized bodies; it intensifies the power/knowledge of medical hegemony. The holistic model's emphasis on and treatment of the mind and body as connected, facilitated by personal relationships, continuous support, and education, contribute to women's feelings of control and safety in homebirth. In keeping with this social approach to maternity care, and furthering women's sense of control and safety, participants described the connection between mother and baby and its significance.

Mother-Baby Separation vs. Mother-Baby Unit

Women I spoke with described a separation of the mother and baby in the medical model, and generally described this separation as detrimental to the physical and emotional wellbeing of both mother and baby. According to the technocratic approach, mother and baby are separate beings likened to machines. Their needs are often set in opposition to one another. Because of these beliefs, they are often separated during pregnancy as well as after birth. Again, these dividing practices reflect particular power/knowledge relations, which are characterized as detrimental to the mother/baby/family unit by participants.

In the midwifery model, mother and baby are understood to be a unit, where one inextricably affects the other, and where the parts of the unit cannot or should not be separated. What is good for the mother is good for the baby. Specifically, the health and holistic wellbeing of the mother helps to ensure the health and wellbeing of the baby. This particular belief is connected to midwifery's emphasis on the mind-body connection and explains the attention given to optimize holistic health, especially with nutrition and preventative care. Furthermore, this facilitates care of the self, which within cultural contexts of medicalized birth and power/knowledge, might be seen as a practice of freedom.

Not only is a mother's health maintained and optimized to grow a healthy baby, but there is also a social and emotional component of the mother-baby connection. Mother and baby are

seen as a parent-child unit and the midwifery approach to prenatal care and care during and after birth are aimed at giving this relationship the best start. This includes, among various other elements, careful attention to bonding and breastfeeding. Many of the homebirth mothers and midwives relayed their sadness and anger over being separated from their babies after their hospital births. These mothers expressed such happiness, redemption, and healing in describing being with their babies under homebirth midwifery care. One homebirth mother, Luisa, who was frustrated with separation and lack of control in her two previous hospital births, said that after she birthed her baby at home:

The midwife caught her and handed her right to me. She didn't leave me at all. It all just seemed very natural. [...] She didn't leave me. [My husband] held her while I pushed the placenta out and while I took a shower. When they weighed her, I could have reached out and touched her. I was on my side of the bed, and [the midwife] was sitting on [my husband's] side of the bed weighing the baby. At one point, I was like, "Can I nurse her?" And they were like, "You do what you need to do. This is your deal."

Luisa felt physically and emotionally attached, connected, and in control after her homebirth.

Another mother, who had two c-sections and then a homebirth (and has had another homebirth since the time of our interview), described the importance of being with her child after her homebirth partly through the frustrations of being separated with her babies after hospital birth:

And as soon as he was born, I got to *hold* him and touch him, which I didn't get to do with my first two. [...] I got to *hold* him and *cuddle* with him. [...] And I held him *forever*. It wasn't like, "Oh here you go." You're handed the baby, and then they're like, "Okay, well now we have to take the baby because we're gong to go clean him up and put a little hat on him" and all this stuff. I held him until *I* was ready. I was like, "Okay, does somebody want him? Anybody? I'm ready for a shower." So I held him forever. And then nursing-wise, there were barriers at the hospital. They would be like, "Oh you can keep him in the room if you *want to*, but we really encourage the moms to go ahead and put him in the nursery, because that way it's not stressful on you." And it was kind of opposite for me, I was like, "No it *is* stressful on me [to have the baby in the nursery]. I just *had* this baby. I want this baby in my *room* with me." And so at home, he was right there. He was right there next to me, laying in this little tiny bed. And I could just pick him up. And he laid in my bed. Stuff at the hospital they would never have let me do. Just because of rules and regulations they have to abide by.

Technocratic understandings of mother and baby as separate (pathological) beings (machines), with needs and safety set in opposition to one another, reflect medical dividing

practices and facilitate an exercise of biopower that produces docile bodies. The mother-baby connection of the holistic model, on the other hand, facilitates an embodied critique of dividing practices, aids in constituting mothers' subjectivity in relation to their babies, and supports the mother in care of the self. Mothers described the midwifery practice of honoring the mother-baby connection as empowering, in contrast with the alienation they experienced and/or perceived through mother-baby separation in technocratic care.

Individualistic Approach vs. Social Approach

Homebirth mothers and midwives I spoke with characterized care and treatment in the biomedical model as very individualistic. Women are considered separate from family and social environment. As discussed above, women are even treated as separate from babies and in many ways as separate from their own bodies. Following the logic of body-as-machine, the parts and systems of the body responsible for pregnancy and birth are not usually acknowledged as being connected to or impacted by other systems or parts of the body; and, again, the mind and body are separate. At the two significant breaks in the Western episteme that Foucault identifies (1970), we see, respectively, the impetus for the organization of a field of obstetrics and obstetrics coming to hegemony, especially in the United States. Fragmentation and objectification of, and the will to know, female bodies that is characteristic of the technocratic model can be connected with these periods of history, which are also important landmarks of Modernity itself.

Participants described an alternative, holistic and social understanding of pregnant and birthing women: Women are influenced by and part of family and society; as discussed above, they see mother and baby as one unit and that mind and body are interconnected. The woman's pregnant and birthing body is a healthy organism, and maintaining overall health of the mother ensures health of the baby, as parts and systems of the mind and body are interconnected as well. In ways, we might understand the midwifery model and understanding of women as social beings as a disillusionment with and response to Modern ways of seeing the body, individual, and society.

The Importance of Family

Birth is not just an experience that affects a birthing woman—though arguably it affects her uniquely—it changes the whole family. One important element of the midwifery model is an emphasis on the mother as part of a larger unit. Family is emphasized in this model, particularly more so than in the medical model. Many homebirth mothers and midwives stressed the importance of family in their pregnancy and birth experiences and how they saw family separated in medical care and bonded through midwifery care. Several mothers spoke directly to homebirth and midwifery care in the way that it improved or strengthened their relationship with their husbands, empowered both the mother and her partner, and partly empowered the mother through garnering respect from her husband. While this can and does happen in medical settings under technocratic care, building the family relationship is distinctive in the midwifery model because it is an explicit goal of this model of care, as described by participants. The extent to which it happens in hospitals is often unintentional; family bonds in the medical model of care are more often a product of the nature of birth itself rather than (or even despite) medical treatment of families. One mother, whose husband passed away since the homebirth of their last child, particularly valued the ways in which midwifery care and homebirth brought them together:

Having a homebirth, it did something for my marriage, that having a baby at the hospital didn't do. He didn't hold our babies in the hospital right away. He didn't feel comfortable. But [with our last baby], he held her while she was attached to the cord. I cut her cord. But he bonded with her faster than with our other kids, because he was in charge—well, he wasn't in charge, *I* was in charge—but he was more in charge than he was at the hospital. They were on his turf. It brought us closer, like our relationship with each other. It did something that hospital birth didn't do.

The importance placed on strengthening the family unit in the midwifery model is related to agency. In this model, the family is active, and the goal of the midwife is not to *do* the work of birth but to help the family do the work of birth. Participants described that at an ideal homebirth, and in many of their own homebirths, the mother is the active subject and the family works together to bring a new member, while the midwife serves and often stays in the background when not needed. The mother-baby unit is important, as a part of this larger family unit.

Participants explained that in the typical hospital birth, the doctor is active and the mother is, most often, a docile body to be delivered of a baby. The partner may be present or acknowledged, but it is not the goal of the medical model to enhance or improve the relationships between family members. Often men are left out of the birthing process in a medical setting, and may even be treated or feel like they are in the way. Though they may not play an active, constructive role in the medical process of birth, one midwife explains how men are often manipulated by doctors and hospital staff and, consequently, do play an important (taken-for-granted) role in convincing otherwise reluctant women to consent to intervention. Thus, women's potentially most-trusted ally and invested partner often becomes an instrument to their own docility. One midwife explained:

I include men, because men are so excluded and manipulated in the American birth scene. And they inadvertently end up manipulating their wives and girlfriends because if a doctor goes to a mother and [plays the death card]. If they can't get her to cave, they go to the dad. [...] Then they have two people to worry about. And I love men, but they're not as strong as women are emotionally. They're not, I'm sorry. So they've got that extra stress, of: What if something happened?! And so men put pressure on the women [along with friends, mothers, anyone else], and they end up with augmentation. [...] Women get manipulated all the time. [She goes on to explain that doctors don't tell patients the risks, and they manipulate patients into doing what they want to do.]

An important narrative among midwife participants involves their responsibility in building the family relationship:

I find a lot of fathers wanting to be involved. That means a lot, because he's bonding with that child. And his wife's bonding with him. She's not bonding with the doctor. And midwives, they feel close to us, but we're more there for support. And that's what I always tell my apprentices: It's not about me, it's about the family. We always get the family involved as much as possible.

As another midwife, Elizabeth, demonstrated, midwifery care gives ownership to the family, promotes their agency, and aims to strengthen relationships between partners/parents:

And also, something that I love that's one of my favorite things of being a midwife is watching the couple have the experience of growing closer together throughout their pregnancy and then during their birth being able to work together as a couple and realize this is their baby and *their* pregnancy. And yes, it's very important for the woman and something that is empowering to her in that she's responsible for it in one sense. But on the other hand, she is very vulnerable and it's so nice if she can have that support from her husband and care from him and him realizing how much he can help her and how much he can be a part of this baby as well. Especially during the

birth as far as the support and the dad being her main support, and then him just using that time to really affirm the wife and support her postpartum as well.

In keeping with a social approach, midwives acknowledged life beyond birth and signified, through telling their philosophies and experiences, the opportunity and desire to positively impact and empower the family through the care they provide during pregnancy, birth, and postpartum.

Yet another midwife illustrated:

We try to keep it family-oriented. [...] But you know, it involves the family, and we really support the dad being involved. And that is a little bit different than what I saw in childbirth twenty years ago. The midwife—we were the doula and the patient advocate, and I mean, I've spent hours in one woman's face, breathing and rubbing, and I still do a lot of that, but not like I used to, because we want the dads to do it. We want the sisters and the moms involved, and we want to build the family unit, because we're important to them, but the family is going to be with them the rest of their lives. And there are times in our life, like birth and death and crisis, when we bond with the people around us. That's how you know who your friends are. The bonds you build during birth—you don't get anywhere else. It's like the bond when somebody dies. That's a bond or a release that you don't get in any other experience in your life. So I think homebirth keeps the unit in the home, and it belongs to them, and it empowers women, and it empowers their men. You know, the stronger their woman feels—if he's a good, supportive husband—it's going to strengthen them, because they've done something really powerful together, in their home, with their children in the next room or at the end of the bed.

Strengthening families not only results from supporting the mother and her partner through midwifery care; involving children in the prenatal and birth process was extremely important for participants. Homebirth mothers and midwives described siblings being welcome and included at prenatal appointments. Midwives, like Susan, described ways that they engaged children in prenatal care:

We have women who come in here with their children, and we let the little ones hold the Doppler. The last one that kind of sticks in my head, it was a little guy that, he would come in, and when I was done with his mom, *he* would climb up on there, pull his shirt up, so, and I would listen to his heart so he could hear something.

As one mother explained, participants felt very strongly about the importance of children being included, respected, and actively involved:

The thing that I like the most with [my homebirth midwife] has been being able to invite my family. You go to her home. She has an office and it's professional, but [she's not treating] a disease, it's not a hospital, it's not whitewashed everything. It's personal and it's normal. I think

the best part is being able to bring the kids and if they make a little noise, it's fine. They get to listen to the baby's heartbeat and everything. I wouldn't trade that, that's phenomenal.

Children are involved in life with a new baby/sibling after birth, and so it makes sense that they should be included in preparing for the new family member as well. In addition to bringing them to prenatal appointments, homebirth mothers talked with and otherwise educated and prepared siblings for birth and having a new sibling. Some mothers had children present or in the house during their homebirths and others sent children with grandparents or other family, but brought the older siblings back soon after the birth. Including siblings is important for most homebirth mothers because birth means not only a new person, or a new child for the mother, but a new member of a greater family unit. The inclusion of partners and children are not only special to homebirth mothers and midwives, and important in building a stronger family unit, but it also speaks to the idea that pregnancy and birth are normal. It is not something to be kept from children, or something that they should be shielded from. One mother of five, whose last two children were born at home, explained how having children involved in prenatal care and present for the birth or right after the birth normalizes birth for the siblings:

For us, we've been able to have the kids present at the birth, and I think that increases bonding between siblings. They're so in love with them. It shows them, this is just a part of family life. My kids, my nine-year-old has asked no questions about girls and all the stuff that goes with that, and I've talked to other people, and they're like, "What? Your child hasn't asked any questions?" And I'm like, "No, but he's been present at two births. So I don't think he really has any questions." (laughs) You know, it's just natural.

The significance of other children in prenatal care and birth, then, reflects a desire for continuity and connection, as another homebirth mother intimated:

Including the whole family in the birthing process was huge. The whole family was a part of that process. It wasn't like I went away with daddy and we came back with a new baby, which is the way things are done now, and so, I just really loved that. That was so important.

One homebirth mother, Isa, described the presence of her children immediately following one of her homebirths as an important time of connection for the family and invigoration for her after an arduous labor:

But I remember hearing this thunder of footsteps on the stairs, it sounded like cattle. Apparently, [the midwife] had gone outside and said, “Who wanted a baby brother?” So I hear this [screams like an excited kid], all these feet coming, and the door just flies open, and all of my other children just spilled into the room. And they were just so happy and just so excited and I remember at that moment, I reenergized.

A Social Approach

Midwives commonly discussed the importance of giving homebirth clients space to talk about what is going on in their lives—what’s going on at work, at home, with family, financially. In turn, homebirth mothers spoke of appreciating this aspect of care, as it constituted more thorough care and tended to their holistic wellbeing. Midwifery care, as previously described, includes dedication of quality time, serious attention, and personal relationships. Providing attention to various areas of life, with the thorough care of a midwife is an important aspect of helping homebirth mothers to achieve holistic wellness. One midwife exemplified this holistic and social care:

The care that we give, we’re visiting with the whole family. We know the whole family dynamic. We know if the father actually lives at the house. We know if abuse is really going on. We see what’s in their pantry. We see the whole social picture of everything that’s going on. The whole family, the mother-in-law, and others. We put our name on a birth certificate and we really know that this is the baby’s dad. We know what’s really going on.

Another midwife, Anita, related the significance of personal relationships between midwives and clients/families to our postmodern condition, where we are fragmented, isolated, and separated from one another. Midwifery care allows for connection and community: “And I think we desire that collaboration. We used to be much more intertwined in our lives. I have to say, I don’t know my neighbors. We don’t have that support. So to have a midwife, it’s that neighbor, that person that we can talk to that makes the community a stronger place.” Participants explained that women are social beings and detailed the benefits of a social and holistic model of care. They also described in detail, through their understandings and often through their own experiences, the detriments of an individualistic, biomedical model of care, including inadequate care, alienation, isolation, and objectification. Because participants understand pregnancy and

birth as normal and healthy, and stress the interconnection of their relationships with their children, family, and society, they challenged biomedical dividing practices and maintained the importance of fostering both care of the self and social relationships during pregnancy and birth.

Standardization vs. Personalized Care

Homebirth midwives and mothers I spoke with described a process of standardization in the biomedical birth system and personalized care in the midwifery model. Through their personal accounts of prenatal care and birthing and working in medicalized settings, they described elements of what Ritzer (2012) calls McDonaldization. These elements are efficiency, calculability, predictability, and systematic control. On the other hand, midwifery involves a great deal of time and effort made to care for women, quality of care is emphasized, care is personalized or customized for individual women's needs, and pregnant women claim and are given freedom and control.

Obstetric care is efficient, seeking to provide care for great numbers of patients while minimizing time and effort expended. As demonstrated through previous accounts of women's medical experiences, physicians see relatively high numbers of patients each day in their clinics, provide limited care, and extend minimal time to patients, maximizing labor and profit. Homebirth midwives see relatively few clients and seek to offer a great deal of time and energy to each client. Appointments are long and most midwives seek to be available throughout pregnancy—every day of the week, and any time of the day or night, not just at appointments—and to provide continuous care during labor. Many homebirth mothers' birth stories incorporated the value of continuous support during labor, and this was highlighted by lack of continuous care from their doctors in hospital births.

The biomedical model entails treating women and their bodily processes in very calculable ways. Quantity is emphasized over quality, and quantitative measures of the birth process provide the primary, if not sole, indication of progress and safety. Medical professionals tout this efficient and impersonal mode of assessing labor and birth as scientific and objective

and, in doing so, both reify obstetrics as a scientific discipline and claim exclusive knowledge/power regarding women's bodies. The impact of this emphasis on quantity over quality is that more patients can be "seen" and *known* and, therefore, *subjected*, but the quality of care they receive also suffers—and greatly, according to participants. Many I spoke with explained that this is one point at which safety is put in jeopardy in the medical model. One midwife, in discussing the importance of mind-body connection and holistic care, incorporated the importance of time and qualitative assessment of health:

We spend a lot more time with women. And we also look at them holistically. It's not just about the woman. You are more than just blood and bones. I have no doubt that if you came to my house and if you'd gotten here and if you got in an argument with your mother-in-law, if I took your blood pressure, it would be higher. But if I had only seen you for five minutes, I would be charting that down and saying it was a problem and that we need to fix it. Instead of talking to you, and finding out that this was going on, and letting you calm down for thirty minutes and talk about it and taking your blood pressure again. So I think that's the big difference in midwifery, too, is that we look at a person holistically. We don't try to separate the mind and the body. It's all interconnected. They put in their body, what they put in their mind.

While most midwives take measurements of pregnant women's bodies (e.g. blood pressure, fundal height, heart tones), as demonstrated throughout this chapter, measurements of the body are not the sole or even primary means of assessing women's (and, therefore, babies') health. In approaching women's health as constituted by the connection between mind and body, mother and baby, mother and family, and mother and society, and approaching babies' health as largely dictated by the mother's well-being, midwifery care values subjective knowledge and intuition and views empathetic care as best.

Predictability and uniformity are also dictated in the technocratic handling of birth. Viewing the body as a defective machine, labor is understood as a mechanical, linear process. Stages of labor are neatly defined and conceptualized as separate, linear, and calculable. Notions of calculability facilitate claims of predictability and desires of efficiency: time and presumed objective measures of women's and babies' bodies are paramount in medical management of and claims to *know*—and, therefore, exercise power/knowledge over and make docile—bodies and

birth. In technocratic maternity care, the hospital is as an assembly line or factory, where those who deviate from standardized notions of normal labor and birth are judged against the norm. They are ranked, deemed broken or failed and, not coincidentally, medical experts are prepared to “fix” the “problem,” to correct individuals toward the norm. Participants described the hospital as sterile, impersonal, and as a generally unsupportive environment. As demonstrated throughout this chapter, participants described in rich detail that the midwifery model involves personalized and holistic care. Participants often explained that every woman and each pregnancy and birth is different. There may be patterns and consistencies to collective women’s labor and birth experiences, but there are also inconsistencies and unpredictable changes that can be healthy and normal. Homebirth mothers and midwives directly and indirectly challenged narrow biomedical understandings of normalcy and, therefore, challenged normalizing technocratic processes. Homebirth mothers and midwives may notice and keep record of time during births, but time is not a determining factor in the assessment of progress and health. Labor was sometimes described as following linear or “textbook” fashion, but participants also acknowledged labor as a potentially non-linear *process* and *experience*. Participants, like Susan, a midwife, critiqued medical claims to “stalled labor” and “failure to progress” as objective and inevitable deterministic indications for medical intervention or “delivery”:

NARM has been keeping statistics since 2001 or 2002 and they’re finding out that women stall out at a certain time, regularly. It’s usually at four centimeters, seven, nine, nine-and-a-half. And, when women stall, that’s usually when doctors say, well you’ve been at this for two hours, let’s get you augmented.

Acknowledging the less-than-predictable nature of labor and the varying personalities and needs of laboring women, midwives offer personalized care. When I asked what she does for women in labor, one midwife, Anita, said:

It depends on what they need. Sometimes, some women need to be the cat in the closet. They need to be by themselves, maybe with their husband, and then someone coming in and saying, “Oh your baby sounds so wonderful!” Just to know that everything is going the way it should. That reassurance. Because in labor, you are in your own world, but those gentle reassurances that: This is okay. Everything I’m feeling is okay. Because you kind of feel out of control, because

your body is doing things, and doing such hard work. And we're not used to that. If I have a headache, I take a pain pill. [laughs] But in labor, it is a totally different experience. I think that some women need that; some women need their hand held the whole time, they need help through *every* contraction. Some women just need someone to just not talk to them, they just want your presence. They don't want you in the other room, they don't want you talking to someone else, they just need your presence. So you have to adapt to whatever a mom needs at that moment. You're there to safeguard and give her what she needs, whatever that may be, which changes per birth, per time. Sometimes a mom wants to run away from contractions, so you're helping bring her back to realize why she needs to feel and experience that and let go. And some moms, they have no fear, and so they can just do it. I wish I could say, I do this every single time, but I don't, because it just depends. Some moms I do no vaginal checks, and some moms need that check to know that they're progressing and not doing this for nothing.

Finally, medical birth practices seek to control everyone involved, though pregnant and birthing women are arguably most controlled and, consequently, suffer the most in this process of standardization. Medical management of birth entails a strict control of time, space, and movement characteristic of biopower or microphysics of power described by Foucault (1977). Biopower works to control and normalize physical bodies, but perhaps more importantly controls individuals more wholly through panopticonic observation, surveillance, normalizing judgment, and examination. Our particular biomedical power/knowledge works in such a way that pregnant women birthing in hospitals most often render themselves docile. To varying degrees, women are participatory in biomedical power/knowledge and control of time, space, and movements and therefore in the transformation, utility, and docility of their own bodies. In contrast, homebirth mothers and midwives explained that pregnant women birthing at home most often claim control over their time, space, and movements. Midwifery care and homebirth provide freedom rather than constraint and allow women to "desubjectivate" themselves and constitute themselves in different ways. The home as the site of birth reflects the values of midwifery: the home is a nurturing, personal, and comfortable environment where women have control and responsibility.

And [the midwife] did everything that we had talked about before that we had wanted. And she was very, as hands-on or hands-off that you asked her to be on different things. She was just right on. It wasn't like there was a right way to do it. It was just, "What's *your* way to do it? We'll do it that way."

The elements of efficiency, calculability, predictability, and control are interconnected; they demonstrate the ways in which the birth process has been standardized in our technocratic system and facilitate the interventive and normalizing care that results from using a lens of pathology. These efforts glaringly reflect the notion in the biomedical approach that the body is a machine, and that there is a separation of mind and body, mother and baby, and mother and society/environment. This individualistic and authoritative management of birth controls birthing women and limits their agency and freedom. In the midwifery model of care, rather than a standardized, McDonaldized, normalizing approach, there is an emphasis on people as holistic and social beings, personal relationships, and quality of care; there is a lack of predictability, and a process of giving control to, rather than taking it from, pregnant and birthing women. Homebirth mothers described having friendships with their midwives and many even described their midwives as family. Ruth demonstrated this intimacy, along with elements of gendered power/knowledge relations, and reflected the ways that many other participants viewed the differences in relationships in the two models, as she recounted meeting with her homebirth midwife. They met at a friend's house because they lived a distance from one another, with the friend located between:

We are sitting on my friend's couch. She doesn't even measure me, and she doesn't even want me to pee in anything. She doesn't have the (thump-thump thump-thump thump-thump) thing—the doppler. She's just sitting with me, like *being* with me. And then she lays me down and she feels the position of the baby. But she's massaging my baby. And she massages my baby to sleep in the womb. And puts me to sleep. *She puts me and my baby to sleep. With. Her. Hands.* And she was just like—she drove an hour and a half to put me and my baby to sleep with her hands. What the fuck? What OB would ever do that? That's so far from any realm of any way a man would ever treat a woman who's pregnant—even a woman who's an OB, she would be *trained to not think* like that, *act* like that, *be* like that. *Cherish* that. It would be beaten out of her. And so it was just like I had picked this pure woman who just had no influence at all from any male obstetrical way of being, and she massaged my baby to sleep inside of me. And it was amazing. That was a spiritual experience. And then as I was driving home, I was like—Oh! She wanted to see me because she was going to be with me when I have my baby. And she wanted to see and touch me. Because she was going to take care of me. And she wanted to let me know that she was going to take care of me.

Intimate, personal, and trusting relationships are fostered through the midwifery model of care, and, furthermore, participants explained that more time and the midwife knowing the mother holistically translates into more thorough and, therefore, better health care:

I don't want to risk anything being overlooked. I knew it was a personal experience with the midwife. They treat you like family, and they care what they're doing, they'll spend an hour with you. When you go to the OBGYN, you are in and out, and you're a chart. It's not like they don't care, but at the end of the day, you're a chart almost.

Standardized biomedical power/knowledge and practices of efficiency, calculability, predictability, and control represent a powerful disciplinary technology that objectifies, controls, and normalizes pregnant and birthing bodies. For participants, technocratic separation of mind and body, mother and baby, mother and family, and mother and society alienates, objectifies, and disempowers women. Hierarchical observation, normalizing judgment, and examination, involving dividing practices, quantitative and “objective” measuring and monitoring, and strict control of time, space, and movement produce docile bodies and intensify biomedical power/knowledge. Technocratic normalization of female bodies occurs not primarily through physical means but instead, and possibly more importantly, through a conceptual machinery that is internalized and reified. Standardized medical care, then, embodies biopower's complex ability to govern individuals and constitute them as subjects of power/knowledge.

The holistic model's emphasis on the interconnection of mind and body, mother and baby, mother and family, and mother and society facilitates personal relationships, continuous support, and education, and contributes to women's feelings of control and safety in homebirth. As described by homebirth mothers and midwives, the midwifery model of care provides quality care, a dedication of time, emotion, and energy. Adhering to the midwifery model entails recognition of a wide range of normal variation in women's bodies, social needs, and processes, and midwives provide personalized care to respond to these variations. Holistic understandings and practices of women as social beings—rather than female bodies as defective machines—foster self-education and critique of hegemonic normalizing practice and power/knowledge. In

turn, participants described the midwifery model as promoting praxis and embodied resistance to objectification and normalization. Midwifery care acknowledges women's subjectivity and agency, seeks to empower women, and encourages care of the self as a practice of freedom. The role of technology and nature is, literally and figuratively, instrumental in the operations and power/knowledge relations in technocratic and holistic models of maternity care, and is, therefore, the topic I investigate in the next chapter.

CHAPTER IX

THE SUPREMACY OF TECHNOLOGY

VS.

THE SUFFICIENCY OF NATURE

A third notable theme in both my participants' discussions of birth models and the literature on birth (Davis-Floyd, Ratcliff 2002) is the emphasis on technology in the biomedical model and on nature in the midwifery model. Interrelated with previous themes, the supremacy of and reliance upon technology is suitable within a technocratic model that uses a lens of pathology and understands bodies as defective machines. In particular, the body is seen as a machine to be monitored and measured, observed, known, judged, examined, controlled, and normalized. When bodies do not follow a predictable and uniform course, intervention is deemed necessary and bodies are corrected towards the norm. The belief in the sufficiency of nature also makes sense within the respective context of the holistic model: women's bodies in general are normal, that pregnancy and birth are normal, healthy processes, and that women are social beings affected by their context.

In describing their experiences and the opposing models of birth, homebirth mothers and midwives articulated at least three interrelated components of the tensions between technology and nature. Where medical management of birth is the hallmark of obstetric, biomedical

maternity care, watchful waiting is a goal in the midwifery model. Accordingly, technological intervention is rarely withheld in the biomedical model; in the holistic model, a hands-off approach is preferred and, when warranted (which is much less often than claimed in the technocratic model), midwives utilize natural, less invasive techniques. On the relatively rare occasion that midwives deem technological interventions (e.g. episiotomies) necessary during a homebirth, informed consent is very important for midwives and mothers I spoke with. The third component is biomedicine's recognition of the importance of machines over people versus the prime importance of people in the holistic model of care.

From the perspectives of homebirth mothers and midwives, biomedical power/knowledge and experts use technology to objectify women and reify notions of bodies as pathological machines. Reproductive technology is an essential component of a disciplinary technology that employs hierarchical observation, normalizing judgment, and examination to produce power/knowledge about, govern, and ultimately normalize women. Participants described the disempowering ways in which they experienced biomedical technology in the management of their prenatal care and births under obstetric care. Homebirth mothers and midwives problematized the use of technology in the biomedical model and explained that wisdom, watchful waiting, and an honoring and deference to pregnant women's needs and intuition are hallmarks of the midwifery model of care that, in both practice and philosophy, not only empowers women to make decisions, but truly gives women authority and control.

Medical Management and Intervention vs. Wisdom and Watchful Waiting

As the lens of pathology dictates, doctors and medical staff anticipate disaster at every birth. In an attempt to preemptively detect illness and abnormality (as broadly defined in this model), medical experts conduct tests throughout pregnancy, and assert their findings as justification to correct bodies toward the norm—through practices that reinforce biomedical power/knowledge, such as induction, scheduled cesarean sections, and other measures of caution and intervention. Once induced or when a pregnant woman is otherwise “allowed” to go into

labor, she is constantly measured and monitored. The measurements taken are used to help determine if the laboring woman is conforming to the narrowly defined, linear, uniform, predictable, “normal” process of labor and birth. When women’s measurements stray, experts usually recommended intervention, often with a dose of fear. One hallmark of obstetric care, then, is the active, technological management of birth and women’s bodies—the idea and practice that not only do women often need intervention to aid them in “delivering” their babies, but that a woman must be monitored and measured along the way to determine when (usually not *if*) intervention is needed. Technology makes medical management of birth possible, and in many ways reifies technocratic philosophy and practice. Through claims of knowledge about bodies, biomedical power is exercised over women, and this power/knowledge is facilitated and intensified through hierarchical observation, normalizing judgment, and examination. Technological medical management, then, represents a disciplinary technology that works to produce docile and normalized bodies. Through social interaction, ideologies, and institutions, society establishes the understanding that birth should be managed and so, in ways, women (and men) are primed to expect and often desire this sort of care; it is also often reified from the onset of prenatal care with a medical birth attendant. One midwife explained:

[At the local hospital], most of the doctors are known to schedule the induction right at the very beginning [of a pregnancy]. You’re just starting with them and they will tell you your approximate date for induction. Because they don’t respect that, [letting birth happen naturally], they don’t do that, they want the controlled birth. This whole idea of controlling birth goes back so far. It’s just disgusting, that progression of, we’ve slowly made [birth] worse, not better.

Homebirth mother and midwife participants saw medical management of birth as problematic for a number of reasons, including that managed birth and intervention are often detrimental to the health of mother and baby, and that this kind of care is often alienating and disempowering for the mother and family. As discussed previously, participants believed that natural birth is the safest way to birth. They described medical management as interfering with normal, healthy birth processes, by disrupting the mind-body connection and often leading to a

cascade of interventions. This cascade generally involves one intervention in labor or pregnancy that leads to another, which leads to another, and often ends in intervention in birth itself. For instance, a very common path of the cascade of interventions is induction of labor, which may involve stripping of the membranes or introduction of synthetic oxytocin, or Pitocin. Pitocin mimics natural oxytocin, which brings on contractions of the uterus, but Pitocin is known to produce stronger and more regular contractions than oxytocin naturally produces. Having stronger contractions and less rest between them is likely to be difficult for a laboring woman to cope with and, in response, she might be offered or seek pain relief with an epidural. Epidurals generally render women unable to stand, walk, or choose birth positions that are potentially more conducive to birthing (squatting, for instance, there are many benefits of squatting and it is thought to open the pelvis by up to 30%); epidurals also have the potential to slow contractions and, therefore, the progress of labor and may also prevent women from feeling their bodies and their babies as they attempt to push their babies through the birth canal. Less effective pushing is often augmented, in turn, by the use of vacuum or forceps. Quite often, however, if the baby is not ready for birth, mothers do not progress enough for the use of vacuum or forceps and birth by cesarean section is deemed necessary. At any point in the process, if monitors indicate fetal distress, which is a risk that many interventions carry, cesarean is also likely. Additionally, medical research shows that electronic fetal monitoring is likely to indicate fetal distress when it is not present (Enkin 2000; Goer 1999; Wagner 2006), which is problematic because it is often the source of information indicating need for c-section. One mother described her first two labors in the hospital as a cascade of interventions beginning with inductions and ending in c-sections:

My first one was with an obstetrician, and I was asked to induce two days after my due date. So I did. That sounded exciting, that the baby was coming. And I was in labor for about 22 hours. And I was given an epidural halfway through just because I was like, “Yeah give me an epidural.” Because at this point I had had Pitocin, so then had an epidural, which then slowed down my contractions, so I got more Pitocin, and then baby went into fetal distress. So they were like, “We have to go ahead and go get him, his heart rate’s dropping.” And at that point, you know, you’ll do anything, it doesn’t matter. He was a c-section. And then my second one was a c-section as well, but I asked to VBAC. They let me try but only for about six hours and then they said I

wasn't progressing. Which I also told them that my due date was wrong, but they won't change it, or they wouldn't there. So they had me induced again, and then I ended up in another c-section.

Not only are obvious technological interventions a part of this cascade, but homebirth mothers and midwives I spoke with explained the philosophy and practice of medical management as a process of normalization. Interventions that initiate the cascade are often unnecessary. For example, how can medical experts justify medical need for induction when it is scheduled at a mother's first prenatal visit? Furthermore, participants maintained that medical staff rarely fully disclose risks of interventions. Almost one in four women experience complications from epidural, including temporary or long-term paralysis and potentially serious drops in blood pressure (Goer 1999; Leighton and Halpern 2002; Lieberman and O'Donoghue 2002; Mayberry and Clemmens 2002; Wagner 2006). Again, using a lens of pathology arguably leads us to find disease whether it truly exists or not. From detection to treatment, women are objects of knowledge/power in an approach of medical management and are transformed into docile bodies through technocratic philosophy and practice.

Cervical checks are one illustration (of many) that reflects a philosophy of medical management of birth and the ways that knowledge gained from technocratic procedures may have more to do with the exercise of power than improving health outcomes. Cervical dilation and effacement as very poor indicator of labor onset or progress (Lothian and DeVries 2005) yet medical birth professionals commonly perform cervical checks at the end of pregnancy, if not throughout pregnancy and very frequently during labor. In my own experience, where I consented after coercion to a cervical check, my cervix was found to be effacing, or thinning, around 22 weeks. In medical thinking of pregnancy, according to the notion of bodies as defective machines, and the processes of pregnancy, labor, and birth as predictable, uniform, and calculable, a woman's cervix remains thick and closed until labor begins. I was told that I likely had an "incompetent cervix" that would not hold my twins to term. The specialist encouraged me to get steroid shots to help my twins' lungs develop in case they were born prematurely, and to

get a cerclage, a stitch in my cervix to keep it closed. (The cerclage came with the risks of puncturing the membranes, initiating labor, and infection.) My obstetrician wanted me to have an appointment every week and to check my cervix at each appointment. After only two or three appointments, and a great deal of researching both medical literature and critical birth literature where I confirmed the useless nature of cervical measurements and found that stimulating the cervix could actually initiate further thinning or dilation, I began to refuse checks. Still, my obstetrician continued to assert the desire or need to perform checks. In an attempt to see eye to eye with my doctor, I asked him what he hoped to gain from cervical checks. Why did he want to measure my cervix?: “To have information.” And while he acknowledged that the information had limited practical value, he insisted it was still worthwhile—for the sake of *knowing*. At each visit, the nurse would want me to prepare for a vaginal ultrasound—in the early days instructing me to get ready without truly *asking* and later learning to ask if I would consent to it that time—but I refused. While we do not have the information of the progression of my cervical effacement and dilation, we do know that I went into labor naturally, with twins, at more than 41 weeks.

The mother above spoke of cervical checks in telling me about her first homebirth after two cesareans (her second hospital birth was an attempted VBAC). She said after spending time in her living room with her family and midwife during labor, eating and laughing and watching movies, she felt it was time to move to the bedroom and labor with her husband:

So I'm sitting [in my bedroom] on this big green bouncy ball and watching a movie, and my midwife came in. And this was the first time that she'd ever checked me. I remember at the hospital being checked from like 36 weeks or 38 weeks on or something crazy like that. And I remember in the hospital being checked every couple of hours, maybe every hour. I mean, it was crazy. So this was the first time she checked me and she said, “Alright, well you're at a nine.” And I was like, “Serious?! Sweet!”

Her excitement and relief is set in opposition by participants to how frequent cervical checks affect women, how they make women feel about their bodies and their abilities to birth in standardized ways.

Participants acknowledged iatrogenic harm as a real problem resulting from medical management of birth. Iatrogenic harm is that which is inflicted as a result of a doctor's actions or as a result of medical routine or protocol. Instead of attributing harm to management, however, medical experts and staff (and consequently many mothers and families) attribute harm to the dangerous process of birth itself and/or the pathology of women's bodies. Ironically, then, the harm done *through* the practice of medical management of birth is often used to justify the need for such care and intervention. Isa, like other mothers I spoke with, attributed her baby's health problems after birth to interventive care itself, while medical staff did not support this notion:

I was 25 and they told me that, I forget what the reason was—oh, my blood pressure was high. And he “needed” to come out, so they “needed” to induce me, and I gave in. It was the cycle that you always read about, the induction and then the labor flounders and you need Pitocin, and then you can't keep up without pain medication, and the labor flounders, so once you have more pain medication, and then you need more Pitocin, and slippery slope and it ended up that he was basically yanked out with forceps. He was very damaged. He was born with a pulse and no breathing. It was very difficult and he, two weeks later, almost died. He had infections, I think as a result of his birth experience. Of course, nobody's going to tell you that that's why—it was just a “big mystery” and no one would ever quite say, but he ended up in pediatric intensive care two weeks later—very serious situation.

Homebirth midwives and mothers emphasize iatrogenic harm as a result of the philosophy and practice of medical management. In turn, they stress the ways in which a hands-off approach implementing wisdom and patience often ensures safety, as one midwife demonstrated:

A lot of hospital births, they get in a hurry to deliver the placenta. And pulling the placenta causes a lot of the hemorrhages. I think that's something most of the midwives have realized, that if you back off, you let that cord quit pulsating, and after a while, we gently tug on it, but we don't pull on it. That causes the hemorrhages.

One mother explained her view of the important differences in obstetric and midwifery care through the different approaches of medical management versus watchful waiting and indicated how these approaches shape the birth process itself:

The doctors are always right there monitoring, anything, the slightest problem, they want you to lay down in the bed, which of course might stop the contractions. And then, “Oh, well you're not having contractions, let's give you Pitocin. Well, you can't handle the pain, you need an epidural. Then, oh, you need a c-section.” It just snowballs. And with my midwife, she sits back and she watches. And it's no big deal, it's normal. Go with the flow.

Another homebirth mother recounted someone else's birth in a way that highlights the values of watchful waiting and gentle birth and the potential (if not inevitable) dangers of active management of birth:

And I had a friend that had a friend whose baby died. It died the next day, and she randomly caught the baby at the house, because it was a gentle, sweet little birth. The baby just slithered out. They held her up and named her and got her on the mom's chest and she breastfed and they took pictures and pictures and pictures and pictures, and the next day she stopped breathing. [...] They knew exactly what to do and they took her to the hospital. [There was a problem with the baby's heart], so how she lived as long as she did was because of [her gentle birth]. If she'd had a hospital birth she would have died in labor. They have pictures of her sister looking into her soul; they were looking into each other's eyes. [They wouldn't have had that had she had a medicalized birth.]

Even homebirth mothers who never birthed in a hospital incorporate a narrative of iatrogenic harm and how their experiences might have been different under medical management at the hospital. One mother, who birthed her first child in a birth center and her second at home, said of her second labor: "So we just waited and waited, and I didn't progress. Which I'm sure in the hospital if it didn't progress, they would start intervening, so I'm really glad I didn't go to a hospital for this one." When I asked one midwife why women choose to birth at home, part of her answer had to do with agency, management of birth, and the way that it affects women emotionally: "They don't want their dignity taken away from them. They want to be in charge of their labor. At the hospital, they will tell you, 'We will manage your labor.' And a lot of times that's what they do, they augment it so they can deliver on their time-table."

Throughout the history of obstetrics, obstetricians have claimed expertise of high-risk or complicated births. They are trained surgeons; they are not well-trained in normal, natural birth (Gaskin 2003; Wagner 2001, 2006). Over time, obstetricians, through mechanisms described previously, have defined more and more as risky and, therefore, within their domain. When proponents of natural birth and homebirth see intervention rates, they see a problem; but in the context of obstetric training, philosophy, and practice, high intervention rates are seen as normal. When increasing numbers of women are deemed high-risk, and birth itself is defined as

dangerous, high rates of technological intervention are expected. As a result, and no doubt a factor that perpetuates these trends, many doctors and nurses have seen few natural births. Participants discussed negotiating with their doctors when requesting a natural birth and being surprised to find that their doctors admitted having little to no experience with natural birth. Mothers who birthed naturally in the hospital before deciding to birth at home often spoke of medical staff buzzing about and gathering to see a natural birth, because it was so rare. One mother, Lillian, who transferred to the hospital for her first birth because she thought labor was stalling (though she recounted retrospectively that she should have just stayed at home a little longer), had a natural birth in the hospital and explained: “And then when my son came out, it was really good to see, because a lot of the nurses had not seen a natural birth before.” And another mother who had multiple home and hospital births related: “And my fourth baby, I remember the doctor, when it was time to push, like 10 people came in the room, nurses, because they wanted to see a natural birth. It was so unusual for someone to birth without an epidural. Which is really sad when you think about it. That’s really sad that it was [such a big deal].”

A lack of belief in the mind-body connection, along with high numbers of patients creates a situation where doctors and nurses are either not experienced or able to devote the time needed to helping women cope with labor. Very often, this results in women requesting and/or otherwise being encouraged to accept, and receiving epidurals, even when they planned or wanted a natural birth. Medical management lends itself to the overuse of intervention, which, as demonstrated, leads to increasing opportunity for iatrogenic harm. Some participants, like Matilda, questioned even midwives’ skills or attributed harm (e.g. tearing) to their practice: “I didn’t feel she was bad at handling problems, but I feel like she wasn’t as good at preventing them. And maybe that’s just my personal experience. [...] But I tore really bad, and she never suggested I do things to prevent that.” Most homebirth mothers’ criticism of midwives was similar to Matilda’s in characterizing their midwives as too medicalized or not holistic enough. Such criticism of midwives existed only to a very small degree relative to critiques of doctors, nurse-midwives in

hospital or birth center settings, and other medical personnel. Of the few mothers that expressed some dissatisfaction with their midwives, flaws were attributed to the midwife, rather than the model of care or any other aspects of the practice of homebirth. Participants criticized individual doctors and nurses, but generally in a way that acknowledged systematic problems in philosophy and practice. Sally was one of the women who expressed dissatisfaction with her midwives. Though she felt that her midwives (first at a birth center, then at home with her second) were more interventive and medicalized than she wanted, her idea of hospital birth was that it would have been much worse:

But what I won't do, I really feel strongly about, is not telling [women considering homebirth] that you could have the same type of birth in a hospital. That's what some people say. They'll go, "Well you can still do kind of both." Well you really can't. You just really can't. Cause I couldn't even at a birth center—I couldn't even at my own home. I had bong water [herbal mixture], stripped membranes; they knew the sex of the baby, asking me if they should leave, asking me if they should break my water. I still had a homebirth that was still *awesome*, but I had a lot of stuff [that was medical, that was not what I wanted], so imagine the hospital, what I would have had.

An approach of management of birth is reflected not only in regular or constant measuring and monitoring (e.g. regular cervical checks, electronic fetal monitoring, watching the clock), but intervention rates and patterns and birth statistics also reflect this approach. Medical management not only happens in labor and delivery rooms, in the lived experiences of individual women; it is systematic. It is how we *do* birth in this country, and in Oklahoma. One midwife spoke to this and how change must also take place systematically, rather than at the level of the patient alone:

The state of maternity care in America is appalling. And I think it's very significant when you have radio and TV spots, PSAs, from the Oklahoma State Department of Health going, "Don't let your doctor induce you before 39 weeks." They have to start a public campaign to inform people not to let their doctors pressure them?! [She is referring to the "Every Week Counts" initiative.] Who's talking to the doctors?!

Not only are general intervention rates high (national, annual), but statistics show increasing rates of interventions, such as c-sections and inductions, during the week, at peak hours (before dinner

and before bedtime), and before holidays, demonstrating that some element of convenience must play a role (Curtin and Park 1999; Wagner 2006). One midwife, Jane, demonstrated:

There's no way anybody's going to convince me that c-sections are not being done for selfish reasons. Even ten years ago, before this trend was so entrenched, babies were born every day of the week and every hour of the day and night. You got your babies on Sunday, you got your babies at 3 a.m., you got your babies whenever. The most popular day across this nation is now Tuesday. There are now more babies born on Tuesday than any other day of the week. And virtually every facility, if you look at their statistics for delivery, there's a peak around 4:30 to 6:30 and there's a peak at 11 o'clock. The first one is, "I want to get home for dinner." And the one at 11 is, "I want to get to bed at a decent time." And that, again, is statistically provable. That's not my opinion. There's no way anyone can say, "We are not interfering with the natural process." In my career, babies are born all the time. They are born at night—more of them are born at night than during the day. And they are born on Sundays and they come on Tuesdays and they come on Fridays. And they come on Christmas, and they come on Thanksgiving, and they come on Easter, and they come on my kids' birthdays. And they come every other day of the week. And they come whenever.

From the perspective of those subscribing to a holistic model, intervention rates and patterns are one indication of the extent to which the technocratic model exerts control over birth in the U.S. Homebirth midwives explained that they attend birth any day of the week and around the clock, because—as they explained—birth happens at any time. Jane continued:

You're always on call. You're going to get called on the holidays, you're going to get called on your kids' birthdays. You can be in the middle of making love or fighting, and if the phone rings, you're going to go. The phone rings, and mom goes, "They're three minutes apart. You better get here." You don't have time to finish what you're doing. It doesn't matter what you're doing, you have to leave. You walk out of your kid's birthday party, or you show up after Christmas has already been done, because you've been gone all night. It happens. It's very demanding, it's very hard, physically.

While homebirth mothers and midwives alike stressed the need for large-scale change—in our thinking and handling of birth—they acknowledged the challenges in achieving this goal.

Another midwife spoke of the systematic problems and how difficult they are to address:

You look at the World Health Organization. They have no power. They've directed to have this lower c-section rate. No one's listening. I know my dad [a long time ago], when they were bringing back VBACs, he was on a committee to bring the c-section rate down. It's back up where it was before, or probably beyond. But it just shows you how the trust of birth is gone. The fear of lawsuits is high. The thought that the c-section saves all, and it shows you've done everything you could do, in court. And all these doctors want to control it. Because they're afraid. So few of them ever see natural birth in the hospital, that they don't know what it is.

Midwives and homebirth mothers described increasing awareness of the systematic growth in interventions and the ways that management of birth creates a cascade of interventions leading to c-section. This awareness, along with recognition of the challenges of fixing “the system”, were cited as a major reasons that many women choose homebirth, as one midwife explained:

I asked one client, when she first called, “Why do you want to have a homebirth?” And her response, which has become very common over the last few years, is, “I don’t want to automatically end up with a c-section. And if I come to you, and I do have to go to the hospital, and I do end up having a c-section, I’m going to feel like I probably needed it more than if I just go to a doctor. Every woman in my office that was pregnant in the last year, saw the same doctor,” who by the way has a reputation around here for being midwife-friendly, “every one of them got a c-section.” She said, “You can’t tell me that all four of the women that I work with that got pregnant needed a c-section—*needed* a c-section.” Usually, when women come in and tell me about their first birth, and especially if it’s the “normal” American birth: they got induced, they broke their water, it didn’t happen, and they say, “It’s taking too long, you’re water’s been ruptured, you’re baby’s getting stressed out, it’s time for a c-section.” So that would be the story. Or, “I started contracting and I went to the hospital, they got me on Pitocin because they said I wasn’t going fast enough, and then the baby went into distress, and then I got a c-section.” Or some variation on those two themes. They were either induced or augmented, it didn’t go great, and they had a c-section.

This midwife, who has practiced in Oklahoma for more than 20 years, described being shocked when she began noticing this trend and went on to explain that even though cesareans are major surgery that, from accounts of her clients, many women are not given a justification for their surgeries:

I’ve had three women lately who’ve come in who had a c-section with their first baby. When we get to the part where I ask, “Why did you have a c-section? What was the indication? What happened in your birth that they decided you needed a c-section?” These women have looked at me and said, “I don’t really know why I got a c-section.” And I’m thinking, “You didn’t even get the lie—that probably wasn’t true anyway?!” And they’re looking at me not knowing what happened: “I was in labor, I was doing this and doing that, and the next thing I know, the doctor and the nurse came in. The doctor said, ‘We’re going to do a c-section.’ And the nurse started prepping me. And I don’t really know why I got a c-section.” And I would ask, “Did they talk about the baby being in distress?” No. “You’re blood pressure didn’t shoot way up?” No, no. In other words, the doctor decided it was time. Time to have a c-section.

The growth in cesareans is, again, also reflected at the systematic level, in Oklahoma’s labor and delivery wards. One midwife discussed seeing an uptick in business and staff at the office where she gets her oxygen tanks refilled. She asked one of the employees, who told her:

“Every hospital in the area has remodeled their OB ward, and every one of them has expanded how many ORs they have for c-sections. They’re not regular ORs, they’re for c-sections. They don’t do other operations there.” She said, “Every one of them has at least doubled their c-section rooms, and one facility went from four c-section ORs to 12.”

Participants’ understandings of medical management of birth and iatrogenic harm highlight power/knowledge relations and exercise or denial of women’s agency. Power/knowledge is made greater by the seeming neutrality of medicine and, as Foucault saw it, “the real political task in a society such as ours is to criticize the working of institutions which appear to be both neutral and independent; to criticize them in such a manner that the political violence which has always exercised itself obscurely through them will be unmasked, so that one can fight them” (Foucault, in Rabinow 1984:6). Homebirth mothers and midwives I spoke with diligently questioned not only medical institutions but also generally questioned other institutions and other elements of culture and relations of power/knowledge.

In opposition to the panopticism of technocratic care, homebirth mothers and midwives had an understanding, from their own experiences and/or in their philosophy of birth, that women often need privacy in order for labor to progress most effectively. Many mothers, like Emma, told me about wanting to be left alone at some point in their labor:

I struggled there in the hospital for a little while because the nurses were coming in and checking on you, wanting to put me on the monitor and then they’d let me off. It was the middle of the night so I didn’t see my midwife yet. [...] Finally, there was, I guess, some nurse shift change or something. And so for some reason, because they were changing nurses, we didn’t see anybody for like two hours. We had brought our exercise ball and so I remember using that in the room a lot, and I progressed a lot in that time, without the disturbance of anybody, and so I was able to deliver him quickly.

While it is common for midwives to acknowledge the need for privacy, the practice of medical management of birth aims for complete observation and surveillance and necessarily allows for little privacy, as one homebirth mother and midwife-in-training explained:

There are good doctors out there who are natural-minded, who provide women with a decent hospital birth. But there’s nothing that’s going to replace having your baby in your own environment. One thing that we talk about kind of laughingly in the homebirth setting: Babies weren’t created in the public view, they were created in a bedroom. And that’s really the place for them to come forth, is from the loving environment that they were created in. And I just think that

it's kind of, it seems silly to say, it's kind of light-hearted, but I think it's really true. We don't give birth very naturally in the eyes of people and hooked up to monitors and seeing everything we're doing.

In questioning panopticism of medical management, the male clinical gaze and will to know, with its effects of objectification and normalization, participants problematized the technocratic philosophy and approach itself, as one mother demonstrated:

A lot of women now question [our medicalized birth system] and want to go back to being natural. So I don't know if, I guess it kind of is a resistance to modern medical technology. Or just taking a step back, if that makes sense. [...] It's good that medical technology has been able to save so many lives and made the progress it has, but there are some things it doesn't need to meddle with. If you're not sick, you don't need a doctor.

Homebirth mothers and midwives described a belief that nature knows best and that midwives hold a valuable wisdom of normal birth. Accordingly, birth can and does happen at any time, and we should have patience to let birth unfold naturally. Midwives facilitate this process through asserting wisdom, watchful waiting, and trust in nature. Midwives do not ignore or neglect mothers—participants explained that they generally provide very personal and comprehensive care—but they practice patience and, in doing so, provide space for women to exercise agency over their bodies and the process of birth. One midwife articulated this well:

[T]he hallmark of good midwifery care is being able to do nothing. Being able to be humble enough to sit on your hands and let someone do their work and do it well, in a safe space that you've helped to create, *and* being able to see when you need to put your hands on, and being able to do it well and competently and quickly. So it's like, you wait, you do nothing, you rub her back, you tell her she's doing wonderful, you wait, you do nothing, you rub her back, you tell her she's doing wonderful, you see a problem, you act *immediately*, and you know exactly what to do. And that's a tricky, tricky balance to strike, because we're so in the habit as people of sort of showing off our skills or doing things we're good at, that to stay proficient in a skill can feel like, then you want to use it. But in midwifery, the trick is to stay proficient in your skills and use them as little as possible.

The personalized care and woman-centered approach participants described also reflects care of the self and embodied resistance. Women generally described a process of “desubjectification” that challenged normalizing biomedical processes. Midwives employed wisdom, watchful

waiting, and trust in pregnant and birthing women, and thereby supported clients to constitute themselves as women and as mothers throughout their pregnancies and births.

In contrast to medical management of birth and intervention, homebirth midwifery is characterized by a reliance on wisdom of normal birth and an approach of watchful waiting. Homebirth mothers and midwives I spoke with described a kind of wisdom that midwives use in caring for pregnant and birthing women. When midwives and mothers/families deem action appropriate, natural, normal, or common-sense approaches are taken first, as one mother explained: “Instead of starting an IV on someone who’s dehydrated, she drinks water. Well, yeah! It’s awesome.” Midwives’ wisdom is, in many ways, common sense; but it is also not *just* common sense; it is very logical, rational, and evidence-based. Instead of administering Pitocin to induce labor or to make it progress faster, a midwife might suggest first waiting for labor to happen on its own. If midwives make suggestions, they are generally to take natural approaches at encouraging what may already be happening in the body—taking a walk, nipple stimulation, having sex, and so on. Ruth contrasted the way the same post-birth condition was handled in the hospital and at home:

[My husband] had fears [about having our second child at home] because with my first one, after I gave birth, I turned white and I dropped a lot of blood at once. I don’t hemorrhage, but I turn white and I pass out. Which happened with both of my children. In the hospital, they started an IV, laid me down, and waited for my BP to go up. But they do it in a way that’s like [yelling], “We’re saving her life! And it’s crazy! And she’s about to die! And you need to get out of the way! I need to do this! It’s my job and I’m important!” And that freaked my husband out and he thought I almost died. But I didn’t. And when the same thing happened to me at home, they gently laid me down and started having me sip water and eat stew. And that was it. So when [my husband] knew that everything that they did for me at the hospital in that moment when he was so afraid, when he knew that [my midwife] could do for me at home, he was relieved and comfortable with the homebirth.

Watchful waiting is not simply sitting and doing nothing, as the midwife above alluded. On the contrary, watchful waiting involves wisdom, informed by the intimate knowledge midwives have of birth and of the individual woman they are assisting. It involves knowing and respecting when they do and do not need to act. Continuous support and care is both a source and

a reflection of midwives' wisdom. Discussed previously as an important element of the personal relationships developed between midwives and their clients, continuous support during pregnancy and labor allows midwives to know women intimately. When women receive this support, they seem to think quite positively about labor and their ability to cope with pain and discomfort during the process of labor and birth.

Participants also described midwives' wisdom and watchful waiting as a display of experience, a deep kind of knowledge and understanding, in knowing or suspecting how a woman feels or what a woman might need, while she is pregnant and especially while she is laboring. Midwives described trying to stay in the background, so that birth can belong to the woman and the family, but they also remain keenly aware of the mother and baby—it is their job, after all. In providing continuous support during labor, midwives are attuned to qualitative indications of labor and when changes take place—in the sound a mother makes, in the look on her face, her demeanor, her focus, and so forth. Homebirth mother, Jeanne, recounted her own mother's surprise at the wisdom and attention of Jeanne's midwife:

And [my midwife] leaves you alone. In fact, with [my first homebirth], [the midwife] sat in the living room with my mom and [my first child], who was about two at the time. And she just left me and [my husband] alone and just let me labor. My mom had asked her a question about it, and the midwife said, "You can always tell, they get a certain moan or groan or something when it's time." And my mom said within a few minutes I started making that noise, and [the midwife] was like, "Okay. Time for me."

Homebirth mothers recounted being left alone to labor and even thinking that midwives were not keeping track of them, but found otherwise when labor or needs shifted, as Rose described:

I remember she would be sitting there [during labor] and I would think she wasn't paying attention while it was going on, and then all of a sudden she'd go, "Okay, wait. That sounded different that time. Tell me what's going on." And I remember, within like two minutes of that, I was pushing. I mean, she was just phenomenal.

Power/knowledge relations in the medical model of maternity care involve panopticonic observation, normalizing judgment, and examination. Following a philosophy of management and an approach of intervention, medical experts frequently if not constantly measure and

monitor bodies, and judge and act upon bodies when they do not conform to standardized notions of normalcy. Through these methods, women are often alienated and objectified and interventions render them physically docile and perhaps more importantly, the conceptual machinery of the technocratic approach renders them docile in ways that they internalize and participate in, as the panopticon aims. Where medical management puts importance on measuring and protocol, creates the provider as an active subject, and objectifies the birthing woman, midwives' watchful waiting reflects trust in the birth process, trust in women's bodies to do the work of labor and birth, and puts women at the center of this process, as active subjects. Midwives are keenly attuned to women during labor, understanding and responding to their particular physical, social, and emotional needs. The holistic model, as described by participants, emphasizes subjectivity of birthing women and in many ways represents resistance to normalization and practices of freedom. Subjectification/desubjugation is facilitated and/or reflected by a focus on people—especially birthing women and the mother/baby unit—in the holistic model, while docile and normalized bodies are the product of a focus on technological intervention and machines in the technocratic model.

Machines vs. People

Machines and monitors are valued, trusted, and relied upon in the biomedical model. Actions, often interventions, are based on technical, “scientific,” and “objective” measures. Personal relationships and listening to and communicating with women are valued in the holistic model, and actions, such as comfort measures and other ways of attending to women's needs, are based on body knowledge and intuition. Medical experts measure, monitor, and intervene, while machines play an important role in the process of constituting women as docile subjects of power/knowledge. Those subscribing to the holistic model maintain that an emphasis on people, on *women*, as complex social beings promotes “desubjugation,” care of the self, and empowerment.

Midwives and homebirth mothers told me that very few doctors today practice a very basic skill, which they referred to as “laying of hands,” as it seems few doctors or nurses know how to palpate (or to feel with their hands) to find a baby’s position. Midwives, like Sloane, expressed particular frustration with this: “I’m finding out so many doctors don’t even do hands on, they don’t palpate, they don’t do fundal height, which I think is crazy.” Instead, medical experts use medical technology to monitor the baby’s position at many visits, if not each visit, as another midwife critiqued. She maintained that ultrasounds can be useful and that many of her clients choose to have one or more scans during the course of their pregnancies but that ultrasound is overused in biomedical practice:

The new thing now, with ultrasounds, is that they’re doing serial ultrasounds—every visit, for low-risk, singleton pregnancy, *every* visit. And I don’t agree with that at all; there’s just no reason why you can’t put your hands on that mom to see where that baby is. But they scan them, and say, “Oh, we’ve got to find out where the kid’s at.” Well it’s right here under your hand. (laughter)

While medical experts tout the wonders of ultrasound (Filly and Crane 2002), much research suggests that measures from ultrasounds are inaccurate, routine use is ineffective in producing healthier mothers and babies, and radiation from ultrasound technology is at least potentially hazardous (Block 2007; Colman et. al. 2006; Lothian and DeVries 2005; Wagner 2006). Whichever is the “truth” (which in my assessment is more likely to be the latter), their use is widespread in biomedical “treatment” of pregnancy. They are not only coming to be used at many appointments, if not every doctor’s visit, for the purpose of determining position—despite a lack of support for such use, even in the recommendations from the American College of Obstetrics and Gynecology (2009)—but they are used regularly to create measurements of the mother and baby that are considered scientific and objective. These measurements, then, when viewed through a lens of pathology and standardization, are used to determine what interventions may need to be utilized. Ultrasound measurements are often the mechanism through which women are coerced to consent to normalizing interventions.

Ultrasound technology produces one-dimensional representations of complex, multidimensional, and ever-changing bodies. These representations are then interpreted by individuals who are trained but, nonetheless, human; the measurements are therefore subject to not only human error, but the fact that humans cannot and generally do not produce objectively exact, consistent measurements. Despite evidence that ultrasound measurements are (at least potentially) inaccurate, within the technocratic model such readings are treated as tested diagnostic tools. The pathological notion of small pelvises and big babies (cephalopelvic disproportion), introduced earlier, is legitimated and reified through the use of ultrasound technology. Due dates, a measurement that in itself is problematic are also often “determined” by ultrasound technology, where participants stress that due dates are only estimations and that birth dates are actually determined by babies, assuming that labor starts when they are ready to be born. Many homebirth mothers I spoke with knew their conception date and recounted arguing or otherwise struggling with doctors who claimed that they had a different, more accurate, due date according to “objective”, scientific ultrasound measures. One mother told me about her struggle with her obstetrician, who provided dual care during her pregnancy:

There were discrepancies among the dates, because I *know* when I had sex. And I *know* when I got pregnant. But he did an ultrasound on me at 20 weeks and changed my due date. And so according to [the doctor], I gave birth to my second child at 43.5 weeks, but he was actually 40 weeks and 5 days. So I went into the obstetrician’s office with them saying, “Oh my gosh! You’re 40 million weeks! Are you going to induce?” And [he] knew - he could look at his chart and think I was a 100 weeks pregnant, and it did not matter - he knew I wasn’t going to be induced. And he would say, “Well, I just have to say this, that my recommendation would be to induce you.” And I said, “I know! But I know when I got pregnant!” And he just didn’t hear it. Does not matter - I am not knowledgeable about my own *fucking* body, about a dick that went *in me* and put a baby *in me*! He knows more about that than I do.

Though biomedical power/knowledge claims safety and measurement as the primary functions of ultrasound, there are also other important functions of the technology (Sawicki 1991; Simonds et. al. 2007; Treichler et. al. 1998). One involves the notion that ultrasound provides the opportunity for parents to bond with and get to know their baby better. Ultrasound imaging separates the mother and baby in order to bring them together—bringing the baby from inside the

mother, actually dependent upon and part of the mother's body, outside of the mother onto the screen of the ultrasound machine. This technology, then, is a physical manifestation and reification of the biomedical philosophy of mother-baby separation. Determining the fetus as a person separate from the mother, which includes the anthropomorphizing of body movements (e.g. The baby is waving!), brings the focus on the baby and away from the mother—she is rendered docile. Through examination, involving human interpretation of ultrasounds, knowledge and facts, and therefore, power, are produced as part of a disciplinary technology that is easily used to normalize. From a Foucauldian perspective we can understand ultrasounds as a means of surveillance, normalizing judgment, and examination that is used in the exercise of technocratic power/knowledge. Ultrasounds operate in ways that palpating and intuition can not or do not. Through a one-dimensional image on a monitor, women are fragmented from their uterus, from their baby; they are measured, evaluated, and judged in relation to a narrowly defined norm; they are categorized and classified in terms of their potential pathology and deviation from the norm. Biomedical experts use ultrasound information to know women and babies, to judge them in relation to other women and babies, and to therefore exercise power over them, to transform them, to make them useful, to make them docile. Technology, such as ultrasounds, is all the more useful to power/knowledge because it is assumed to be neutral and objective. This perceived neutrality allows power/knowledge to operate more efficiently and effectively. Rather than producing objective facts or information for the sake of ensuring health and safety, the most important (and taken-for-granted) function of technology is that it magnifies power/knowledge. Reproductive technology, like the ultrasounds, operate as disciplinary technologies in that they:

operate primarily ... by producing new objects of knowledge by inciting and channeling desires, generating and focusing individual and group energies, and establishing bodily norms and techniques for observing, monitoring, and controlling bodily movements, processes and capacities. Disciplinary technologies control the body through techniques that simultaneously render it more useful, more powerful and more docile. (Sawicki 1991:83)

Participants described the ways that technology alienated them during their hospital births. One mother, Rose, described being surrounded by strangers and machines at the hospital and that machines were a source of stress:

I remember I had one that would beep the baby's heart beat, and one that would beep my blood pressure, and there were so many beepings going on and I remember going like, "Oh my gosh! There are so many beepings!" And if one of them started to go up or down or the wrong way, this alarm would go off, and then like six people would come in. And I remember, seriously, they all came in, but no one would tell me what was going on because they said they had to tell the doctor first. I remember asking, "What's going on? What's going on?" And they were like, "We have to talk to the doctor first." And I said, "But it's beeping really loud!" It was nerve-racking.

The holistic model's valuing of nature and women promotes care of the self, women's agency, and subjectivity. As participants explained, the pregnant woman is understood as the best source of information regarding her own body and, because mother and baby are one, the mother knows her baby better than a machine could. Her intuition, knowledge about her body, and emotional connection to the baby are, in most cases, superior to information provided by technology. Since midwifery care is woman-centered, the personal relationships fostered in the midwifery model of care entail listening to and communicating with women and valuing their knowledge and intuition. (This also reflects the importance of the mind-body connection in this model of care.)

One homebirth mother's account of midwifery care reflects an emphasis on women as sources of information and indications of their wellbeing:

The midwife did great, she kept me calm through it and helped calm me down when I was freaking out during it. I wouldn't trade her for the world. And the one thing she told me when I was having [my second], she said towards the end, when it's getting close to time, she'll ask women, "How do you feel about it? What are your feelings? What are your dreams?" She said a lot of times women will have an instinct that something's not right, that something's not happening right. And they're right. She said one time, she had a lady who kept dreaming about hemorrhaging, so I think she was finally like, "Okay you need to go to the hospital," and it ended up that the mother did have some kind of problems with hemorrhaging or something. So she truly listens because the mother has that sixth sense or instinct going on.

With cooperation from her partner, family, midwife and others, pregnant women are empowered and empower themselves to listen to their own instincts and make decisions. The qualitative indications of labor and wellbeing used by midwives are qualities that machines cannot detect,

measure, or understand, nor can they be known or well-responded to by medical staff that checks women frequently but briefly through collecting physical measurements of the woman's body. Instead of using a monitor for contractions, midwives watch, observe, and listen to the woman herself about how far apart contractions are and how strong they are felt. If a woman knows when she conceived, the care in the midwifery model acknowledges that her account of conception and estimated due dates is more accurate than an ultrasound estimate. If a laboring woman feels the need to change positions, move locations, or even transfer care, this is honored and respected under the holistic model.

Gwen's experience of homebirth reflects the importance of people over machines:

[The midwives] were very professional. After I had the baby and came out of Labor Land, [I noticed] they had oxygen tanks in there. I didn't notice it [before]. They had all kinds of stuff that I didn't even notice. It's like they slipped in unnoticed, and they're very good at—it's like ninja midwifery—they're very good at what they do.

Not only were the midwives respectful, but they gave Gwen a personal kind of care that did not put machines at the forefront of her labor and birth. This is in stark contrast to not only my participants' experiences of hospital birth, but necessarily to any woman's experience of birth in a hospital. Even a woman who births naturally in the hospital cannot avoid the presence of machines in the room, in the hallways of labor and delivery floors. Machines and monitors are ready "just in case" they are needed. Even when women are not continuously monitored, some monitoring is "required" by hospital protocol and there is always an emphasis on the clock.

Technocratic practice, ideology, and technology all come together to form a seemingly infallible (hegemonic) system that conditions women to distrust and fear their bodies and its processes. Technology objectifies women, often through personifying babies, and reifies notions of bodies as machines and women's bodies as pathological. Reproductive technology is an essential component of a disciplinary technology that employs hierarchical observation, normalizing judgment, and examination in the exercise of biopower and the government of women. This microphysics of power produces women as objects of knowledge and, therefore, as

objects of control. From the perspectives of homebirth mother and midwife participants, what results from this process, which they explained through medical management of birth, intervention, and the importance of machines over people, is a prime environment for the normalization and disempowerment of women.

Meanwhile, the holistic model of care involves seeing birth as normal and healthy, women's bodies as capable, the mind and body connected, and the woman as part of mother-baby, family, and social units. Accordingly, wisdom, watchful waiting, and an honoring and deference to the pregnant woman's needs and intuition constitute a model of care that, in both practice and philosophy, not only empowers women to make decisions, but truly supports women in claiming authority and control. Critique of technology and valuing of women as subjects promotes care of the self, which, in the next chapter, I will articulate as practices of freedom and embodied resistance to normalization.

CHAPTER X

POWER AND RESISTANCE

IN BIOMEDICAL AND MIDWIFERY MODELS OF BIRTH

As I started conducting interviews for my dissertation research, I was unsure of the role that power would play in women's decisions to birth at home and, therefore, in my writing about homebirth. My critical perspective, and my personal experience, along with a great deal of literature, points to the importance of power in society and social interaction and in birth place and models of maternity care specifically. I also deeply respect and seek to understand and include the variety of reasons for choosing to birth at home and various interpretations of birth experiences. What I found is that some homebirth mothers and midwives spoke directly of power and agency. Many others, however, did not directly speak of power, and I left our interviews thinking that power might not be a significant theme of my findings. I worried about how to mend my own perspective of birth as a site of power, and some women's emphasis on power in their experiences, with the lack of power-talk in others' interviews. However, upon coding, analyzing, interpreting, and reflecting on women's accounts and words, I found that even women who did not directly speak of power and agency did so in more subtle ways. Homebirth mothers and midwives spoke of power through lived experience as well as through broader views of culture and power/knowledge relationships. Women articulated power through discussions of control, authority, agency, empowerment, and resistance.

Participants primarily spoke of power through their own experiences within medical and midwifery models of care. Perhaps most evident here is the point of control. The control that women talked about in explaining their reasons for birthing at home is intensified through the understandings of the technocratic and holistic models detailed in previous chapters. The philosophy and practice of these models significantly shape the ways that women can experience and exercise control during pregnancy and birth. The control that homebirth mothers seek (and homebirth midwives help provide) is not selfish, the control is not only about calling the shots during birth and is not only about the important aspect of safety. While birthing women's control in homebirth is very much about safety, control in homebirth (or any birth) is also about an exercise of authority and agency over and rights to one's own body, birth, and baby. Participants, to varying degrees, spoke of a sense of empowerment gained from birthing at home. Most, if not all, of the women I spoke with discussed a confidence that resulted from homebirth, a confidence that women gain in themselves and their bodies that they feel far beyond birth—a confidence they feel as women and as mothers. Many homebirth mothers and midwives also took a broader, more sociological view of birth and discussed culture and power/knowledge relationships on a wider scale, and most of these women also described ways in which they resist cultural and medical hegemony not only through homebirth but in other areas of their life as well.

Although an important theme throughout this dissertation, in this chapter I aim to tie together elements of power/knowledge in technocratic and holistic models articulated in each of the previous chapters and incorporate more of women's own accounts of power and empowerment as I investigate homebirth as a means of subjectivity and resistance to medical hegemony and, for some, cultural hegemony.

Power and Agency in the Biomedical and Midwifery Models

Here, I revisit the elements of the biomedical and midwifery models, with an emphasis on the ways in which the model's elements, practices, and philosophies situate the exercise of power/knowledge. I then discuss the ways that women specifically spoke of control and

empowerment in the two models of care, as well as their emphasis on agency as expressed through their accounts of action and authority.

Power and Agency in the Biomedical Model

Technocratic constructions of pregnancy as disease and women's bodies as pathological, perpetuate and reflect men's power/knowledge. Men's ability to create women as the Other involves defining women as mentally, physically, and/or morally inferior (de Beauvoir 1949; Said 1979). Othering is often facilitated through the use of pathology and communicated in subtle but powerful ways. Ruth described her first prenatal appointment with her obstetrician:

I already knew I didn't want an episiotomy, I didn't want an induction, I wanted to have a natural birth, because it appealed to me and my personality. So I *told* him these things. And he...smiled, and nodded, and said "uh-huh, uh-huh". And *then* he proceeded to tell me that he had actually never *attended* a birth *without* an epidural in place, but that we would *learn about it together* [cheerful, condescending voice]. And that really scared me. But his attitude was positive [so I thought, "Maybe this will work out."] ... He stood up to leave and was by the door, and he just had his eyes roll up and down my body one time (Ruth demonstrated, and looked up and down my body in a quick and subtle but confident and intimidating way), and then he said, "Well, we'll probably want to induce you a little early so that head doesn't get too big for you." And then he *smiled* at me. And...I felt really unsafe at that moment. And I felt really panicked. And really violated. And really demeaned. And it was such an extreme (punches her fist into her hand as she says extreme) feeling, but it was just like, no one could tell from the outside. I just...something just (she snaps) in me, in that moment. And I never went back there. *Ever*. Because he did *not* listen to me, and he did *not* think I could do it. And he was looking at *my* body, judging me, and my ability as a woman.

As Ruth explained, power/knowledge is sometimes exercised in subtle ways, through methods that are likely not questioned or challenged by many in our society. Power/knowledge is exercised through observation, judgment, examination, through tiny seeds of doubt and small but significant steps to control, docility, and normalization. Rather than admitting a lack of ability to care for her in the ways she might need, or attend the kind of birth that Ruth wanted, or even referring her to someone who might be able to better attend her birth, the obstetrician symbolically (in Ruth's own interpretation) patted her on the head and attempted to settle her down. Then, when she seemed resigned to that arrangement (that they would "learn about it together"), in a way that seemed very subtle and kind, he told her she would not be capable of

birthing the way she wanted. By judging and defining Ruth's body and her ability, the obstetrician exercised power/knowledge over her in a way that she experienced as extreme and violent. Among mother participants who had obstetric care, midwife participants' accounts of common obstetrical practice, and among many other women I have spoken to regarding their experiences, this is a common experience. Doctors often schedule induction early in pregnancy, if not at the first prenatal visit, and, when they do not, there is a common narrative that care providers leave the subject alone until the last trimester and then push the matter. By that point in pregnancy, many women feel unable or uncomfortable switching care providers and either feel bullied into procedures (like induction) or spend their last pregnant weeks and months fighting medical management.

A lengthy and often subtle process of pathologizing and management constitutes (pregnant) women as Other. This process is facilitated through a manufacture of risk and fear and through dividing practices, scientific classification, and the will to know, and it involves control of knowledge and truth and, therefore, power. Biomedical power/knowledge is further created and facilitated by an emphasis on relentless disease detection through hierarchical observation, normalizing judgment, and examination. In both detection and treatment, (pathological) bodies and disease (symptoms) are treated through a disciplinary technology that makes docile and normalizes. Fear—as participants described—makes the experience of labor pain worse and that, along with a lack of personal support from medical personnel, leads many women to seek medication for pain. The administration of medication during labor most often renders a woman unable to leave the bed and, therefore, physically passive and dependent. Significant at each part of the process, participants claimed an objectification and denial of agency that involved a lack of education, support, and preparation. Women described biomedical efforts to control their bodies, thoughts, and decisions, to make them docile, and to normalize them.

When the body is viewed as a machine, separated from the mind, a woman is not valued as a person. When the mother and baby are treated as separate and often detrimental to one

another, fear and coercion are easily used to create power/knowledge relations that disadvantages pregnant and birthing women. Understanding the mother in a vacuum—apart from her family, environment, lifestyle, and society—obscures the sources of and, therefore, the solutions to pathology that a woman can address herself. Consequently, she must rely on the doctor as the expert to supply medication or intervention, which she is often mis- or under-informed about. Approaching a woman's body as a machine dictates the view of her pregnancy and labor within a narrow, standardized form. Progress in pregnancy and labor, again, is set apart from the woman's emotional or mental being, apart from her relationship with her baby, apart from her family, environment, and social world. Dividing practices and standardization set the stage for a process that is most concerned with efficiency, technology, institutional protocol, and action on the part of trained experts. As a result, the pregnant and birthing mother is devalued as a person, objectified, controlled, and disempowered as a potential agent in the process. Homebirth mothers and midwives discussed the body-as-machine approach as problematic in a number of ways. Women talked about feeling herded like cattle through prenatal visits and labor and “delivery”. Most striking were the accounts of women not just feeling that their emotions were neglected, but feeling degraded, violated, and even abused, and they related this to a lack of caring about the patient as a whole person (mind, body, and soul).

For participants, women are objectified through technocratic dividing practices that separate mind and body, mother and baby, mother and family, and mother and society. These dividing practices work to produce docile and normalized bodies and intensify hegemonic biomedical power/knowledge. Standardized biomedical care that includes ideals and practices of efficiency, calculability, predictability and control represents a powerful disciplinary technology that combines power/knowledge and objectification of pregnant and birthing bodies. Strict control of time, space, and movement operates not primarily through physical means but instead, and possibly more importantly, through a conceptual machinery that seeks to render them docile. Quantitative and “objective” measuring and monitoring constitute panopticonic observation,

normalizing judgment, examination, and, ultimately normalization. Standardized medical care, then, embodies biopower's complex ability to govern individuals and constitute them as subjects of power/knowledge.

The third significant element of the biomedical model explained through the experiences and voices of participants is the models' particular use of technology. Constant biomedical measuring, monitoring, testing, and treatment puts into practice and reifies the philosophies of pathology and body-as-machine. This practice both reflects and perpetuates patriarchal technocratic control, authority, and power/knowledge in maternity care, as reproductive technology is an essential component of a disciplinary technology that employs hierarchical observation, normalizing judgment, and examination in the exercise of biopower and the government of women. Doctors and experts with knowledge of medical machines become authorities, giving the pregnant mother limited information at best. A system has been created, then, where doctors use privileged knowledge of machines and measurements, and are, therefore, considered more qualified to justify decisions about the care a woman and her baby receive. Consequently, women are objectified and disempowered, controlled and made docile. Homebirth mother and midwife participants report how one kind of technology or intervention leads to another, a cascade of interventions that necessarily involves doctor agency and control and places the health of mothers and babies at risk. In so many words, they describe a paradigm and a model of birth that seeks to and is often successful in controlling, making docile, and normalizing pregnant and birthing women. Participants further described that these processes are not limited to birth or maternity care—that they permeate society and impact women in all social and power/knowledge relations, as individuals, as mothers, and as citizens.

Power and Agency in the Midwifery Model

In the midwifery model of maternity care, pregnant women assume primary authority over their own bodies. The model assumes women's bodies and the processes of pregnancy, labor, and birth to be normal and healthy, alleviating fear and empowering women. Emotional

and physical support, along with the expectation of normal kinds and amounts of discomfort, assures women that it is within their own ability to cope with labor and birth. Homebirth mothers and midwives constantly critique medical hegemony while advocating care of the self and resistance to normalization, including praxis through education and action. These elements represent a process of desubjectification where women feel confident, secure, and capable.

Eschewing the body-as-machine metaphor of the biomedical model, the holistic approach used in the midwifery model understands a woman as a complex social being. Midwifery care entails attention to suit a particular woman's unique needs. This woman-centered approach combines a recognition and respect for the connections between mind and body, mother and baby, mother and family, and mother and society, to create a comprehensive delivery of care that strives to entirely meet the needs of a pregnant and birthing woman. Empowerment can flourish when a woman feels healthy, whole, confident, and supported. The midwifery model promotes praxis that sets the stage for embodied resistance to objectification and normalization, as midwifery care acknowledges women's subjectivity and agency, seeks to empower women, and encourages care of the self as a practice of freedom.

Homebirth mothers and midwives generally rejected biomedicine's reliance on technology and instead found nature and intuitive ways of knowing sufficient. Midwives' watchful waiting reflects trust in the birth process, trust in women's bodies to do the work of labor and birth, and involves putting women at the center of this process, thus reifying her as the active subject. By honoring and deferring to pregnant women's needs and intuition, the practice and philosophy of the midwifery approach supports women to make informed decisions about their bodies, their babies, and the processes of pregnancy and birth, to create themselves as subjects, and to empower themselves. It promotes participants' care of the self, reflecting practices of freedom while resisting the biomedical model's imposed technology and normalization.

Control and Empowerment

In addition to the aspects of control discussed previously, particularly the aspect of ensuring safety, participants also related control and empowerment. Many homebirth mothers talked about homebirth as providing them with a great deal of confidence, that it was an empowering experience: “I just really believe it’s an empowering thing for women, it’s what we’re made to do.” Some women also indicated that, in a way, the confidence and empowerment garnered from homebirth should not be understood as so special because that is just the way that birth should normally happen:

[My second birth, my first homebirth] didn’t have as much of a monumental impact on me. It’s more like I was just getting the payoff of all that work, all that research, having that birth in the hospital that was so triumphant but so frustrating. It was almost like just easy. It didn’t have any—“Oh wow, I did that, it’s awesome.” I look back at it and say, “Yeah, I fucking did that. That’s how it fucking goes.”

Others, like Isa, below, describe an incredible sense of empowerment garnered from birthing at home, particularly in light of past negative hospital experiences:

I remember feeling after my first homebirth, that I was pretty damn close to superwoman. And that wasn’t *why* I had her at home [...], but the *effect* afterward was that I thought, “Wow! I can do *anything*! I did that, and I can do *anything*.” It was just a tremendously empowering experience and the polar opposite of what hospital birth, especially my first one, had been like for me—that [birth] was disempowering and almost abusive.

Homebirth mothers who had a negative past birth experience particularly expressed the gravity of empowerment through homebirth:

And it was very good for me. And it was amazing. I mean, the best day of my life. If there was one day I could relive, it would be the day of her birth. Because it was that good. Just so *empowering*, and you feel so *strong*, and you’re just like: I did this. The midwife didn’t do it. My husband didn’t do it. I did this completely by myself. And you just heal from the pain of the past birth—you just heal.

Several homebirth mothers and midwives described the enabling nature of homebirth for husbands and partners, indicating that it helped strengthen their bond as a family unit. Luisa explained:

At the hospital, he felt like he couldn’t say, “She doesn’t want you to do that.” We were on their turf. Here, if they had done something, which they didn’t, but he could have said, “Don’t touch

her like that.” I think he felt like he could stand up for me and for her more so than he could at the hospital.

Many homebirth mothers and midwives emphasized how empowerment comes not just from birthing at home, or naturally, or even vaginally, though these elements are certainly described as empowering by participants. They explained that empowerment comes from the care they received, which defined and treated them as authorities, as capable, as respected, loved, and supported, and not only allowed them but encouraged them to exercise agency. One mother, who is a doula and plans to be a midwife one day, elaborated on the importance of care over the birth itself and stressed the importance of agency, of being actively involved:

I am an advocate for homebirth, but also an advocate for natural birth, and an advocate for *women* to get the birth that *they* want—even if it’s an epidural birth or a cesarean birth. [...] Because it’s not about the baby coming out your vagina. It’s about going through it and surviving it and being strong at the other end. [...] I was able to give myself the credit for what I had done. [...] I think all women can take that away from it. But the more power that women give over and the less they think about it, the more power is taken away from them. Because it’s something that happened to you, not something you did.

Another mother’s story particularly displayed the gravity of this concept—that empowerment comes at least as much from the care and respect given as the kind or place of birth. She described her first birth as a traumatic and unnecessary cesarean section. Her second birth was an attempted VBAC at home that turned into a transfer to the hospital and a decision to have a repeat cesarean. When she decided to transfer to the hospital, she chose to travel over an hour to avoid the hospital in her town, where she had been treated so poorly at the time of her first birth. She described the care from the nurses at her second birth:

They were kind of like midwives, because they were—you know, *caring*. They would come and help me wrap [my son], or you know, they would ask me if I needed help to take a shower or go to the bathroom, or things like that in the beginning. And...it wasn’t gross for them. I was still a human, someone who had just had a major surgery; whereas before, the nurses at [the hospital here in town, where I had my first baby,] were like, [in a disgusted tone] “Oh God. I have to change your bandages,” or “I have to change your padding underneath you because you’re bleeding.” And then, [at the local hospital], after my c-section I couldn’t lift myself up very well when I was still numb from my boobs down, from the spinal. And I remember one nurse just gave me this—just, sigh of disgust. She was just like, “Gaw...” and then another one when she came in to check my wound—this was with the first birth, she said, “Oh, okay. I gotta lift your ‘apron of

fat' real quick." And I was just like, "Oh my God. I've never heard it called an apron of fat. Thank you. Now I feel even more disgusting." [At the hospital where I had my second baby] I was still respected to a degree and they're like, "Okay. Let me look at your wound... Oh, that looks so nice! It'll heal so well." They were so positive. And I think, maybe it's because they work around midwives. And they know that compassion does better than, you know, BS and being mean to your patients. Your patients will heal faster if you're nice to them.

This mother's account highlights the differences in mind-body separation versus mind-body connection in the technocratic and holistic models of care. She described feeling alienated and objectified after her first birth. After her second, which occurred in a hospital—though she attributed the difference to the influence of nurse-midwives there—she described being treated with respect that she went on to explain as contributing to a process of subjectivity.

The importance of care in the midwifery model is further reflected in the recent motto of the Oklahoma Midwives' Alliance: *It's in the care, not the catch*. When asked about the contributions of midwifery care, another midwife, Anita, explained what other participants echoed:

I will say this, moms who have midwifery care, even if they end up in the hospital, they do not feel like something was *done to them*, that they didn't have a chance, or that there was no choice. They realize the why's and the how's and the what's. Because it wasn't just scheduled, done, or out of their control.

Those who had a negative past birth experience seemed to focus more on the empowering potential of homebirth. Experiences and interactions shape the ways in which we view and interact with the world, so it makes sense that, in light of a negative or traumatic birth experience, that a positive homebirth would be viewed as particularly healing, empowering, and restorative. One mother, Matilda, explained that her mother's traumatic first birth experience led her to birth the rest of her children at home. Matilda said her mother paved the way for her to have both of her own children at home. When I asked her if she saw homebirth as empowering, she said she had never thought of it that way, but went on to explain how she could see it that way, especially for other women who had a bad birth in the past. Luisa related how her negative hospital birth experiences shaped a new path and understanding of birth:

Birthing at home really changed me. It gave me a lot more confidence as a mother than I had before. It changed our marriage; it made our marriage a lot better. The homebirth didn't do it as much as the c-section did. The bad experience made me want the good experience. Having had the bad experience is what makes me want to educate other women. I don't know I would necessarily feel that way if I hadn't had a bad experience. I'm sure I wouldn't have had a homebirth if I hadn't had a traumatic first birth. Most women are like, "Lay me on my back, hook me up to an epidural, and tell me when to push." That's what I would think birth is [if I didn't have the experience I did], and I'm thankful that I now know that's not what birth is.

In discussing or presenting the empowerment that participants described to others outside "the birth world," more than once someone questioned to what extent that all mothers are empowered, simply by giving birth—in any way and setting—by becoming a mother. The question became: Is it homebirth that is empowering, or is it birth itself? While I agree that many women can garner some degree of confidence and empowerment through giving birth in any way, I do not believe that many women who have birthed in a hospital feel empowered to the extent that my participants do. There seems a qualitative difference in a woman who births at home and describes herself as "superwoman" and says that she can do absolutely anything after having done this—and a woman who feels some amount of control by determining that her birth will be a c-section, thus allowing or directing the doctor to deliver her baby surgically on a chosen day and time. Participants described their homebirths as giving them confidence as women and as mothers, and that they carry this empowerment into the rest of their lives. Choosing an elective cesarean clearly has the potential to provide women a sense of control in their births, in dictating the path it will take, but the potential empowerment is limited to the birth. Additionally, all but two of the homebirth mothers who birthed in a hospital described hospital birth, to varying degrees, as disempowering or at least as distracting or inconvenient to the way that they wanted to birth and as, therefore, a barrier to empowerment. My findings indicate a considerable element of empowerment specific to homebirth and homebirth midwifery care.

Agency: Action and Authority

The concept of agency captures well participants' descriptions of empowerment arising from the holistic approach, and the disempowering or problematic elements embodied in the

biomedical model of care. In particular, the two interrelated aspects of agency emphasized by mothers and midwives are action or the role of being the active subject (versus passive object) and having (or not having) authority and responsibility.

In a model that is characterized by managed care, where doctors and hospital staff monopolize expertise, and they read the measurements from the mystified machines that determine if a woman's potentially defective body needs intervention to "deliver" her baby, the locus of knowledge, action, and control—and consequently power—lies with those doctors and nurses (and machines). As one mother described her medicalized hospital birth: "they had the monitors strapped on like 15 minutes out of every hour, so I had to stay in bed and I couldn't get up and move around. And there are just not as many restrictions at home." She is restricted to the bed, prohibited from eating and drinking, and she is monitored often, if not continuously:

When we went to [the hospital], the nurses were like, "Yeah these beds are uncomfortable, we're going to try to get you in and out of here as soon as possible. You *can't* get up. You'll have monitors and IV's and this is what you're going to do." And everything I had read said that laying on your back was the worst thing possible, you shouldn't do it. I talked to them and said I don't want an IV, I don't want a fetal monitor the whole time, and they were like, "You're at the wrong hospital." Like it wasn't an option to have it that way. [...] You're not drinking, you're not eating, you're laying on a bed, you're not allowed to get up, you're not allowed to do anything. [...] There would have to be something really wrong for me to end up there.

When a hands-off approach is used that defines and treats birth as normal and healthy, and something that a woman's body is capable of, when her needs are central and taken care of, the birthing woman is the active subject, the locus of control and action. In the midwifery model, the laboring woman determines what she does. She is the authority of time, space, and movement. With the support of her midwife (and often from her partner, doula, or other members of her birth team), the woman does what she feels is needed. She moves when and how and where she feels best; she eats and drinks as she likes. On one hand, the doctor, the nurses, and the technocratic institution exercise control over the laboring body, and in many ways, directly or indirectly, control the labor itself: *The doctor delivers*. On the other, the laboring woman controls her own body, and takes action on her own, with the support and cooperation of her midwife: *The woman*

births. One mother, in discussing her birth attendants' responses to her births, demonstrated the differing values of birthing women's agency in biomedical and midwifery models:

Once you push your baby out in your house, you're like, "There is nothing that I can't do. I can do *anything*! Because I just did that." It's very empowering to know that I did it. And I really feel like *I* did it. At the hospital, I kept saying after [my second birth, my first VBAC], "We did it! We did it! We did it!" I was saying it to my husband, like, "You and I did this!" And the nurse-midwife kept saying, "Yes. You did," in a tone like she was thinking, "Okay, you did it. Great. Get over it." Here [at home] I felt like we did it, and [the midwives] were just as much in awe of the fact that we did it. [...] It was just very empowering. I won't go back to the hospital to have a baby, as long as I have a normal pregnancy. It's just a lot better at home.

Regarding authority in the two models, homebirth mothers and midwives emphasize critical education and informed consent. The doctor and the midwife are both defined as experts by their respective clients. One important distinction, however, is that in the holistic model an effort is made throughout the course of care to share responsibility and authority between the pregnant woman and her midwife. Education and informed consent are two important ways that women are given authority in this model. In the technocratic model, as participants described, authority rests with doctors and is created and supported through a complex process involving medical hegemony, patriarchy, cultural constructions of women's bodies as pathological, manufacture of risk and fear, and the use of technology.

Homebirth midwives and mothers I spoke with explained that, where education and informed consent are essential to the midwifery model of care, there is a lack of education and informed consent in medical care. They explained that education and informed consent are critical for a woman to understand what is happening with her body and her baby and to be in a position to make decisions about her birth, her body, and her baby. Being educated and informed allows women to claim authority and responsibility. For homebirth mothers and midwives, this includes questioning expert advice (including midwives' advice) and mothers educating themselves to make decisions:

Since most of my friends haven't gone the homebirth route, I do think they tend to trust what the doctor tells them to do. The doctor says, "You need to take this pill," they take the pill. They don't question it. They don't research it to see if it's safe, or what the side effects are. So I worry

about my friends sometimes. I think that's so common to put your trust in your doctor and I think you should definitely question a lot.

On the part of the midwives, facilitating critical education and providing true and full informed consent are vital to supporting the pregnant woman and her family to share authority and collaborate in decision-making. Homebirth mothers and midwives alike characterized patients' lack of informed consent and a resulting lack of authority in the biomedical model. One midwife explained:

The AMA has made a big deal being worried about universal health care and (sarcastic voice), "You and your *doctor* need to be making these decisions." Gag me. The only one making real decisions is your doctor, *especially* in OB care because they bank on you not knowing a lot. They know they always have the wild card: "You don't want anything to happen to your baby, do you?" That's the wild card they can always pull out, and that's an easy push. When they approach you with that card, nine times out of ten you're going to fold and go, "You're right. I don't want anything to happen to my baby." Of course you don't! You spent all this time growing and nurturing [your baby], and someone approaches you saying that?! And the problem is that mothers and babies and families are suffering for it. And dying for it.

Again, participants emphasized that the important thing about birth is not necessarily that a woman births at home, or naturally, or vaginally (although these are ideal for my participants); instead, it is perhaps most important that the birthing woman is active in the process—that she is given and claims responsibility. One mother, a doula, illustrated:

I know a mom who had a cyst and she had to have a cesarean, but she had to go through that—she had to go through learning that she had the cyst, and learning that she couldn't birth vaginally—because she wanted to. And then she had to have the cesarean and recover from it. And she did that. She chose that. That was her path. It wasn't passive. The doctor wasn't just like, "You have to have one," and she was like, "Okay. Whatever. Do it." She thought about it. That's the difference.

Related to a lack of informed consent, participants problematized the lack of education in the technocratic model. They explained that women are capable of understanding and making their own decisions, but that they are not allowed to do so under paternalistic obstetric care. One midwife, Anita, explained:

Most moms are intelligent enough, and they want to be told, "If you eat this, it will cause this, and this is why it happens." It goes back to feminism: Give us the knowledge and we'll do it. Don't treat us like, "Oh sweetheart, it will be okay. Just take this." I think that's what women are trying

to run and scream from. I think they're tired of that. They want the knowledge; they want the information; they want to make decisions for themselves. So give them the information so they can make the decision for themselves.

As Anita alluded to, mothers and midwives related a lack of education and informed consent in the medical model to the larger issue within that model of pregnant women not having authority.

One mother explained how authority operates as a product of biomedical power/knowledge in the obstetrician-patient relationship to render women docile:

Because they don't even ask and they don't even give you informed consent. There is no explanation like: Okay. He's going to put *his hand* in *your vagina* and he's going to do it for this reason. Or: He wants to; can he? [There is] none of that. So it's like this very subtle build-up to: You don't have a choice, we're not going to give it to you, and you don't know the right answer, that's why you don't get the choice.

Participant after participant described the midwifery model in contrast to problematic elements of the medical model. This often included elements of agency, including authority, involvement, and informed consent: "With the doctor, you are the patient and they are the expert, and you don't really have a chance to be informed or involved. You don't need to be." Pregnant women's authority within the holistic model is further reflected in midwives' philosophies. One midwife explained:

My philosophy is that I am a hired consultant. I have a certain amount of knowledge, a certain amount of experience, and a certain skill set, I've worked hard to gain, but that's all it is. The moms that I serve—I encourage them to listen to their own body, to do their own research, to know what they want and what they don't want, and that ultimately everything is their decision. I don't make decisions for them. I tell them what I know, tell them how I think and what I observe, and then they need to make a decision. So I really think that birth belongs to the mother that's having that baby. It's not mine. And so, I'm just there to support her in what she wants to do.

Another midwife, Maria, reiterated women's ownership of the process and emphasized her role in keeping with the meaning of midwife—"with woman":

Midwives should work *with* the women they're with. I mean, that's what midwifing means, "with-women." I assume that everybody comes to our practice looking for the same outcome we are: a healthy mom and a healthy baby. And so we don't need to be combative. You know, say you're a vegetarian. I'm not a vegetarian. I think meat is good for you. But you don't. You took care of yourself, you ate what you needed to eat, because you were doing what you believed to be the best thing for your body and your baby. Why would I suddenly know what would be better for you more than anybody else? So, I think that as long as we're working as a team, that it works out

really well. I hear women say things like, “My doctor let me...” and I’m thinking, “Why would he ‘let’ you do anything? You’re supposed to be on the same page. I’m not ‘letting’ you go to forty-two weeks. I’m not ‘letting’ you be a vegetarian, you just are.” So I think when we work as a team, it works better, instead of trying to make somebody be what you need them to be. [...] I think midwives become more a part of a family, a group, than somebody who thinks they’re your authority and are telling you what to do.

Medical Hegemony vs. Homebirth as Resistance

Homebirth mother and midwife participants explained many reasons for preferring midwifery care and homebirth. They value the personal relationships and support midwives offer, and feel empowered by understanding their bodies as normal and healthy and by being authorities on their bodies. Throughout women’s narratives, this understanding is set in opposition to technocratic understandings and experiences of women as pathological and disempowered. In this section, I explain how homebirth is, in many ways, a response to medical hegemony. I then discuss homebirth as an act of resistance and some of the impacts of this resistance described by participants.

Homebirth as a Response to Medical Hegemony

Understanding power/knowledge relationships in the technocratic and holistic models illuminates agency and resistance in women’s choices to birth at home. Homebirth mothers and midwives described their own and others’ reasons for participating in homebirth, at least in part, as a preferred alternative to birthing in a hospital, particularly within a technocratic system. Despite their varying adherence to a holistic model—or perhaps more accurately reflecting their adherence to a holistic model—homebirth mothers and midwives described in great detail a complex understanding of medical hegemony, including obstetric care. This is a starting point for understanding homebirth as a challenge and resistance to medical hegemony. Participants described, in different language, homebirth and care with a midwife as an exercise of agency, as praxis, and as the creation of culture. Not only did participants describe personal empowerment through homebirth, then, but also expressed a knowledge and an optimism regarding social change. Though the data here limit me from speaking to the practical possibility of such change,

it does reveal a crucial ability to critically question society, disciplines, and power/knowledge relations.

Participants acknowledged the dominance and power/knowledge of the biomedical model in our society, in their peers' lives, and even in their own lives in the past. Many women discussed education in contrasting the two models of care and described, as previously discussed, a lack of education in obstetric care. The lack of education in the medical model of maternity care, however, is not a true *lack* of education. While it is accurate that women under obstetric care in the U.S. are generally not directly taught or encouraged to seek out education about their bodies, the process of birth, proper nutrition, the risks and advantages of various birthing options, and so forth, women are, in fact, actively being taught something very significant and powerful. As Foucault explained, "It seems to me...that the real political task in a society such as ours is to criticize the working of institutions which appear to be both neutral and independent; to criticize them in such a manner that the political violence which has always exercised itself obscurely through them will be unmasked, so that one can fight them" (Foucault, in Rabinow 1984:6). As patients of the biomedical model, and as members of our culture and society, pregnant women receive a particular kind of normalizing education, an education in the ways of appropriate participation—of passivity and docility—as patients and as citizens. Participants described and problematized this education as teaching fear (fear of bodies, fear of birth, fear of pain, fear of ever-present danger and risk), doctor authority, pathology, lack of confidence, need for technology, and more, promoting the effective exercise of medical power/knowledge and control. This education is certainly a part of the technocratic delivery of care, but is also reflected throughout our society, at all levels, from interaction to institution. The ideology, practice, and institutionalization of medical hegemony is supported through all of our social institutions, including media, religion, and politics. The recognition that medical hegemony is intertwined with our social structure and culture makes the case of homebirth even more interesting and significant. Subscribing to a model that questions and often fundamentally challenges medical

(and cultural) hegemony, homebirth mothers and midwives described subjectivity, empowerment, care of the self, and the promotion of women's agency in midwifery care and homebirth.

Through objectification, control, and commodification of women's bodies and actions, obstetrics claims subjectivity/knowledge/power and the ability to best deliver a valued product (Davis-Floyd 2003). In the Oklahoma City area, there are currently billboards that feature a set of hands holding a baby. The only words that appear, aside from the name of the hospital being promoted, are "WE DELIVER." This has been the object of discussion and frustration among many Oklahoma City homebirth clients, midwives, and advocates, including some participants in my research. This advertisement can certainly be viewed as a cultural text that reflects the claims of biomedical birth professionals: Doctors and other hospital staff are the active subjects ("*We* deliver.") in a process of freeing (the origins of the word *deliver* are "to set free") a product (baby) from the mother (whose lack of visual representation can be interpreted as a lack of subjectification) which can be understood as a commodity if for no other reason than the fact that it is being clearly advertised as such. Ultimately, this reifies the hegemonic ideology in our current social arrangement that birth is a service which medicine owns and supplies to society as a cost—financial and otherwise—to birthing mothers and families. Participants and other members of the natural birth and homebirth community clearly acknowledge this message and express an oppositional one that women are the active subjects of birth—that *they* do the work, that a woman's health and wellbeing are integral and intertwined with that of her baby. Homebirth mothers and midwives always highlighted issues of control and agency, especially when comparing the two models:

[The midwives] were good with just being real, and you know, really giving the woman the empowerment she needed, to have her birth, and her body, whereas the doctor kind of—it was *his*, and you know, it was *his* procedure, and *his* thing, and his office, and you are just you know, honored to be here.

Participants also expressed frustration in frequent if not continuous encounters and battles with this (hegemonic) ideology. A mother who birthed her only child at home stated:

I was proud of my decision but frustrated with people for thinking that birth is such a dangerous event that it has to take place in a hospital to be safe. It is frustrating. As a culture, since we tend to think of birth as this extremely dramatic, screaming event where the baby is pushed out with all these people in the room and the doctor gets it out. The doctor “delivers the baby”, the woman doesn’t birth the baby. They think it all happens in 15 minutes like it’s shown on TV, I think that just characterizes their responses so much. That’s upsetting to me because they haven’t done their research, they don’t know that.

In this context, I—along with most of my participants—define homebirth as an exercise of agency and an act of resistance. What explains women’s departure from social structure and their consequential exercise of agency? As discussed when relaying women’s reasons for birthing at home, many were disappointed to varying degrees with their previous hospital experiences. These women wanted to birth unimpeded; they tried birthing in the hospital and they were tired of fighting. Many of these women who described fighting at the hospital felt defeated and undermined. Others, who technically had the outcome they desired—that is, a natural birth—were disappointed by having to fight, and felt their experience was tarnished by the conditions of the technocratic birth experience. One homebirth mother recalled:

I had already experienced [the way hospitals handle birth], I had already had a taste of it twice. I didn’t want it. I wanted a natural childbirth in the hospital—they weren’t willing to give me what I wanted. So, I bucked the system and said, “This can be done in a different way.” And I found somebody who was willing to do it.

Other participants were part of communities or families that understood natural birth and even homebirth as normal, viable options. These women were less inclined to offer resistance as an explanation for their own birth experiences, likely because homebirth was defined as more normal and perhaps even taken for granted as normal. On the other hand, many of these women explained that their communities (e.g. Mennonite communities) were generally distrustful of and often resistant to mainstream cultural norms and institutions. These homebirth mothers still explained the important distinctions between the medical and midwifery models, and to varying extents agreed that homebirth can be seen as a challenge to the biomedical model. One homebirth mother, who was influenced by Mennonite culture, stated:

A lot of women I know that do homebirth, they don't have the same kind of entertainment. We don't watch a lot of TV. And I think that helps when you're not constantly seeing what's out there. It doesn't flood your mind all the time. I just think it can get to you after a while, unless you're really strong and independent. I had that advantage, that I was, you can think of it as sheltered, but in some ways it's a freedom. You can think outside the box. You don't have to be the status quo.

In many ways, we have created a system that controls our behavior and our life experience, though we must take responsibility because we participate in and reify this process regularly. Some women indicated an early understanding of the system of standardization and control and normalization. Others wish they had known sooner. Women from each of these groups decided at some point to birth in the hospital because they had a sense that, for some reason, their experience could be different. They either thought they would have the ability to control the situation, or had faith in their doctor, or faith in the generalized "experts" of birth. Ultimately, however, many of my participants described coming to a point when they determined they could not fight the system and decided, instead, to leave it or proactively avoid it (for those who birthed their first at home). A homebirth mother intimated:

I think that women need to be where they can feel safe and maybe for a lot of people that's in the hospital, it just wasn't for me. I think a lot of people are freaked out by hospitals, I'm not. My dad's a doctor, so that's not my response to the hospital itself. It doesn't scare me. I'm not afraid of doctors, but right now, in the culture of obstetrics, I am. I don't know if afraid is the right word... I am *disgusted* by how they use their power to control how babies are born, even though their [clients] want something different and probably could have something different. I really hope it changes.

Homebirth as Resistance to Medical Hegemony

In addition to the two elements of agency discussed in the previous section (action and authority), there are other elements of agency at play in terms of resistance, which are illuminated when understanding homebirth in the context of structure and agency. Participants, in one way or another (and usually in multiples ways, which I will discuss briefly) described departing from a rather deterministic structural process of socialization. Homebirth mothers and midwives acknowledged this top-down process and how influential it is. However, they also described resisting rather than reifying cultural practices and philosophies, creating themselves in new

ways, and at the same time individually and collectively creating and reifying alternatives.

Through choosing to birth at home and to attend births at home, these women are not simply choosing to birth or support birth in an alternative location. They subscribe to and participate in an entirely different paradigm and model of care that defines women and pregnancy and birth in ways that are necessarily oppositional to dominant power/knowledge relations. The empowerment participants described gaining from midwifery care and homebirth affects women on a much larger scale than “just” in terms of birth and seems to facilitate particular constructions of identity.

I entered into thinking about homebirth as resistance very carefully and cautiously. Early on, I began to see patterns in interviews that led me to define women’s homebirth as resistance, and started asking what women thought about that characterization. While there is a general agreement among participants that the concept of resistance accurately characterizes homebirth, this characterization was given with some qualification. As I analyzed and evaluated women’s stories, the ways in which they communicated their journeys and experiences, and their in-depth descriptions and responses to technocratic and holistic models of care, I absolutely came to define homebirth as a means of resistance. I often heard about this from homebirth mothers and midwives in terms of what they thought characterized women who birth at home, as this midwife articulated:

[Women who birth at home] tend to be independent I think, in the sense that they are going against the mainstream. [...] There’s a willingness to disobey, and that’s one of the things that I think is most important. When it comes to our bodies and our health and our wholeness, there’s such a pressure to be obedient patients that we just don’t speak up, about our intuitions, or our own sense of what’s healthy for us, or you know, our own history, or just other questions that we have. [...] There’s a willingness not only to be disobedient but just to be impolite, in the sense of saying, “No, that’s not actually what I want. That’s not actually how I want this to go. I don’t actually want that intervention. I have the right to refuse this, that, or the other.” Just a willingness to be impolite. And when you’re in front of someone in a white coat, it’s really hard to be impolite.

While all participants agreed to the characterization of homebirth mothers as independent, and they included that they are generally critical and self-educators, and most participants agreed that

homebirth can be understood as resistance, they sometimes hesitated in coming to this latter conclusion, and there always qualified this characterization, as Audree argued:

I do think it resists the culture by trying to say, “No midwives are better at this than doctors.” Our medical system is just a cluster of specialties and midwifery is one of those. Really they just need to be included. They were ousted at one point and they just need to be brought back under that umbrella. If we put so much stock in specialty medicine, this is exactly what that is. So in some ways I think of it as resistant, and in other ways I just think the current model is just obsolete.

Homebirth mothers’ and midwives’ challenges were often grounded in explanations of the holistic model, where normal birth is usually healthy and safe, where birthing in a hospital meant unnecessary interventions, and where medical interventions often lead to a cascade of interventions, consequently causing unnecessary harm. One homebirth mother, Margaret, stated:

When it’s treated more like a natural thing, and less interventions are used, complications are actually prevented. To me, that’s probably the biggest thing, just treating birth as what it is: It’s natural, and if there are no complications, then I don’t feel like I need a hospital. To me, a hospital is for problems, sick people, that type of thing.

Participants embraced the resistant or rebellious nature of homebirth to varying degrees.

Many explained that homebirth was simply the best choice for their families (and their clients’ families, in the case of midwives), and, again, the ideal way to approach pregnancy and birth.

The larger context of resistance was a secondary consideration. A homebirth mother recalled:

I think it’s just that different way of thinking. I’ve read articles that say women are birthing at home because they’re trying to be rebellious and trying not to be controlled by society. I don’t really think that’s it. I don’t think I’m rebellious. But I just wanted to do what was best for us. And [my son] is perfect.

Most participants, however, directly incorporated resistance of medical hegemony and, therefore, agency into their explanations for why they birthed at home. One mother who birthed her only child at home discussed her decision:

[Birth is] a special moment for me and my family. It shouldn’t be treated like a business. So I wanted to resist that. If anything, I might be resisting the culture that the hospitals and everything have created, in the sense of scaring women and teaching them that they couldn’t birth on their own. I think everyone deserves that special moment. I was resisting that and resisting them telling me what I could do.

Not only did they acknowledge agency and structure, though in different language, and the top-down process of socialization that sociologists emphasize, but when participants qualified homebirth as resistance, their explanations were also incredibly sociological in nature, as a homebirth mother demonstrated:

I definitely agree that it is cultural resistance. Our culture is trying to send messages that our bodies don't know how to birth and that they're not enough. That it's safer to cut than to push. That it's better to not feel pain than to endure it and to work with it. Certainly in America, we think of hospital as being the safe place. But hospitals have people we don't know with backgrounds we don't know and super bugs. Insurance companies driving the policies rather than science or the health care providers. And to find a provider that's not a doctor, I think that resists our culture.

In talking about their homebirth experience, and in qualifying homebirth as a challenge to the medical model, participants discussed three sociological elements. First, they explained that homebirth was not a simple rebellion. Instead, they described agency as active and informed participation, as praxis. The result of homebirth praxis, for participants in this research, was often an empowerment of the birthing mother and the family unit. Audree stated, "As far as whether I feel like a big rebel. I don't. I don't want to sound cocky but I just felt like I was gathering information and making an informed choice." Related, when women define their bodies differently, they defy norms and disciplinary practices. In doing so, and in relying on a caregiver that also rejects normalizing processes, and by birthing in a manner and location that opposes the need for medical knowledge and expertise, women might be understood as engaging in "anti-authority struggles" (Foucault 1994a).

Secondly, participants emphasized context. In the context of U.S. social structure, culture, and society, homebirth is oppositional. Medical hegemony is an important element of this context. In a larger context of humanity, participants explained natural birth and homebirth as normal. Around the world both currently and throughout human history, midwifery care and homebirth have been and continue to be widespread and even normal. Homebirth is the norm over time and place. The medicalized birth system is, relative to humanity and birth itself, out of

the norm. Participants not only acknowledged this, but also discussed problems of the medical model as reflective of larger society and other social institutions, as one homebirth mother illustrated:

Actually the crazy thing is, all the people out there who think we're crazy, *we're* the ones that are doing it like it was meant to be. And so really, it's trying to do things as they were meant to be done, rather than I'm going to do it my way kind of thing. But because we're such a culture of sheep herding, everyone follow what everyone else is doing, we're so peer-dependent in our culture, that anyone who chooses to be different, it's looked at as resistance and rebellion. But what these families and mothers are doing, in my opinion, are just following their instincts and their heart. And our culture doesn't [do that]. And that's why it looks so counter-cultural. Because everyone else does everything without question. All their mothers-in-law, and sisters-in-law, and cousins, and aunts, say, "Oh, you're going to want drugs." And, "Go to this doctor." And all this kind of stuff. And women, just like sheep, obey. [...] In our culture people are not taught to think. [...] So it's a symptom of our culture, that everyone is taught to conform and don't make waves and you'll be fine. [...] They believe everything they see on TV, they believe everything politicians tell them. They're being good citizens because they're manageable. [...] So those of us that make different choices because we're thinking for ourselves, we are seen as a problem.

This contextualized understanding of agency illuminates participants' discussions of authority and regulation. Participants clearly defined authority as ideally lying with the birthing mother or family. It is from this perspective that legal regulation of homebirth is understood as sometimes detrimental, and as a mechanism that undermines women's authority over their bodies and birth. Regulation over homebirth midwifery is further problematized by its reliance on biomedical power/knowledge of birth and bodies. One midwife explained resistance to regulation and why some women are inclined to birth or attend birth in ways oppositional to law and regulation:

To try and draw parameters around what's acceptable and not acceptable is a hard thing to do, and when you start trying to do that you get people that really, on a case-by-case basis could fit inside the box, but because of the parameters that you've written, technically they don't. And so they miss out on the opportunity to have the birth that they really want. And then you force people to start breaking the law—because that's what they do, when people don't agree with the law, and it's not a law that's going to hurt anybody but themselves, they break it. They don't abide by it. It's different when we're talking murder, or stuff like that, but even things like speeding which has the potential of hurting lots of other people—if somebody doesn't agree with the speed limit, they don't go the speed limit. Having more laws doesn't make people more complacent, it makes them more angry. (laughter) And, so when you start trying to tell a woman, "Well, because you're over thirty-five," and "Because you've had more than six children, [and other common reasons dictated by regulation] I'm sorry, honey, but you can't have your baby at home," she thumbs her nose at you and says, "What are you going to do about it?" And then that puts everybody in an awkward situation. The midwife has to make a decision between this client whom she loves and cares for,

or her license with the state, who she really could care less about. But it's a matter of being legal or not legal. And then also, it makes them more reluctant to seek help when help is really needed. And I think that's the big [problem].

Finally, contributing to an understanding of homebirth as feminist agency, praxis, and resistance, participants described homebirth as an active creation—of culture, of a new (and old) concept of normal birth, of power/knowledge—rather than an act that is solely meant to oppose hegemony or existing cultural norms. One mother indicated: “It doesn't feel like resistance, it feels like progress.” While participants acknowledged social structure's influence on individuals, particularly medical hegemony's influence of women's thinking about bodies and birth, most were very optimistic about the long-term potential for grassroots change through critical education and collective movement through women's individual birth choices. However, there was an optimism and vision of potential for change through educating women and through the collective movement through women's individual birth choices.

Only one participant, a midwife, directly expressed that change can only happen from above, from the level of structure and institutions:

[The birth system] won't change just because some women are leaving. [As a midwife,] *I'm* not going to change anything about that in Oklahoma. Some women are going to make a decision that [hospital birth is] not okay with them and they're going to come to me for that reason. Midwives won't be the one to save birth in Oklahoma. What will is when Oklahoma steps in and says, “We're not going to pay you for [overmedicalized birth] anymore.” And I can see that the Health Department is already gearing towards that. I think they did it in the seventies as well. I mean, they came and told [doctors and hospitals] the c-section rate was too high, and Medicaid came in and said, “If you go over seventeen percent, we're not going to pay you,” or “We're not going to pay any more than we would for a vaginal birth.” And so all the sudden, the c-section rate drops and VBACs go up, and you know, that kind of thing. That's what is going to have to happen here for it to change. Women aren't going to change it.

Though she was skeptical of the potential for individual women or midwives to forge change, she believed that there was an impetus for change from Oklahoma's Health Department:

I think the Health Department is gearing up towards it, with their programs, the commercials that they're running now, about how your baby is a masterpiece, not to let your doctor induce you before thirty-nine weeks for certain. But not being induced at all is a better idea. So, yeah, absolutely. I think that the Health Department is where the information is being collected about the c-section rate, not to mention it's connected to who's paying for those c-sections when it comes to SoonerCare. Also, they have a new committee at the Health Department that is

reviewing every newborn death in Oklahoma and they're sending a caseworker to the provider of the baby that died and they are coming that person's records to see what kinds of things are in common. I mean, they're doing their own research. What kinds of things are in common with these babies? And I bet you what they're going to find is that intervention in birth for unnecessary reasons—perfectly healthy women going in for inductions. So I think that's where it's going to come from. It's going to come from our Health Department.

While other participants may hold similar beliefs, no one expressed it directly in this way.

Instead, most participants emphasized a need for both structural and cultural change as well as change in women's exercise of authority and agency. Homebirth mothers and midwives generally seemed to believe more in the potential of change from below than in the chances that our birth system would change from within. Participants' optimism, then, was often expressed in discussions of resistance, through explanations of homebirth as a creation of culture. Millicent noted:

I would like to think we are going towards something. And it does involve not blindly following and be willing to stand up and be different. [...] I want to call it something more like *creating* culture. I don't believe we can necessarily change the world. But I also see that culture can change and perceptions can change. [...] I want the more positive way of going *toward* something more holistic. [...] We can't change the whole world, but we can start where we are.

In challenging medical hegemony within the structure of labor and birth, respondents emphasized questioning others as well as themselves, educating themselves, and being active in maternity care. They saw birth as normal and as a creative active agency that perpetuated informed participation. Homebirth mothers and midwives constructed practices as an active creation of culture, and opportunity to embrace personal power—rather than an act solely meant to oppose hegemony or existing cultural norms themselves. Their efforts present a challenge to dominant biomedical birth systems, embraced as praxis and empowerment intended to benefit their health and that of their children, families, and communities.

Impacts of Resistance

Two themes emerged from homebirth mothers' and midwives' discussions of resistance in regards to the impacts of resistance. The first is that, in addition to the empowerment that mothers gained from midwifery care and from their births, many experienced a degree of

empowerment that stemmed from successful resistance. Related, the second theme involves the ways in which they described resistance in one area of their lives, including but not limited to homebirth, empowered them to reject cultural norms or normalization in other areas of their lives.

As discussed in various ways thus far, many of the homebirth mothers and midwives who spoke with me gained empowerment through their homebirth experiences, as Bridget demonstrated: “It is nice to be able to stand up and say, ‘You know what? I didn’t follow the assembly line. I didn’t go and have this hospital birth and have all these problems. I had my baby at home in the bathtub and I loved it!’” Participants explained that empowerment comes from rejecting the fear of pathology and understanding their bodies as normal and healthy, from being supported in their relationships with their babies, families and society, from taking control of their health, their births, and their babies, from being *given* that control and authority by a chosen care provider, and generally through the exercise of agency in their births. For some women, part of this empowerment was also described as a result of successful resistance, as one midwife explained:

I think you find a lot of women are definitely a little more independent, or independent thinkers, or you know, just have something inside of them where they’re okay with going against the norm. Sometimes you get the women that are really timid about it, but because they want this experience they’re willing to go against some family pressure or you know, just the society. And usually by the end of their pregnancy, especially after a successful birth, it’s amazing to see how much it empowers them.

Internalization and socialization is a key component of social construction and reification. It is through these processes that objectivated power/knowledge comes to influence or become part of subjectivity. “Identity is, of course, a key element of subjective reality, and like all subjective reality, stands in a dialectical relationship with society. Social processes shape identity. Once crystallized, it is maintained, modified, or even reshaped by social relations” (Berger and Luckmann 1966:173). Macro-sociological phenomena, such as social structure, organization, and history, all shape subjective reality and, thus, identity. In the case of pregnancy and childbirth, this is particularly relevant to the identity of pregnant and birthing women. The

hegemony of the obstetric model in our society influences the identity of women—their experiences, their sense of self, body, and agency. Our particular social reality and, as I have demonstrated, power/knowledge relations tend to create women as passive, fragile, inherently broken and dangerous machines. This reality is maintained through a number of mechanisms, one of which is language. Though I would be interested in how my participants' experiences and identities compare with those who choose to birth differently, it is clear that the homebirth mothers and midwives I spoke with incorporated homebirth, in one way or another and to various degrees, into their identities and descriptions of themselves. They also described the potential (and sometimes inevitable) disempowering influence of the ideologies and practices of our medical birth system on birthing women in our society.

The empowerment that my participants garnered from their homebirth experiences and their experiences of midwifery care, along with other complicated ideologies, choices, and social processes, contributed to an interesting phenomenon I found in getting to know my participants. For the majority of homebirth mother participants (only two women said this did not characterize them), homebirth was not the only thing that they did in their lives that was outside of the norm. For nearly all of these women, there were other areas of their lives in which they chose holistic, “alternative,” and/or potentially culturally resistant ways of doing things. For instance, though not all participants do all of these, most do some of the following: breastfeeding, including extended or full-term breastfeeding, not circumcising, cloth diapering, co-sleeping, not vaccinating or vaccinating alternatively; many practice attachment parenting, homeschooling, sometimes conducting church in their homes, and many choose to do things differently with their diet, like being vegetarian or vegan or eating organically and/or locally. For some, homebirth was the first step in this direction, and for others it was a natural progression of what had begun in some other way. Regardless, many seemed to have this lifestyle, identity, or set of practices within which homebirth fit well and made a great deal of sense. Midwives also acknowledged this trend with many of their clients. When I asked about this phenomenon, one midwife said:

Yeah. I think that's very real, and very true. And I think it goes along with them being women who are willing to go against the grain, willing to be a teensy bit disobedient, willing to have their parents look at them funny when they change their baby boy's diaper [because he is not circumcised]. Willing to kind of stare some things in the face, and also women who have resources for accessing information, about how to make choices. I mean they're women who are making choices rather than just falling in line. And *we* are people who like to be a little bit different, like there's something satisfying about that. There's an identity piece to it, too.

One mother described this occurrence as a result of empowerment from her homebirth, especially in light of her first disempowering birth:

Well, after I had my son, I had terrible postpartum depression, and I felt really guilty that I couldn't do it right. He was separated from me for a very long time after birth. And [we had] awful problems. So after having her, there's nothing I can't do. After having done that, like I don't get overwhelmed with situations that come up. If I could have done that, there's really nothing I can't do. Because I feel like, that is the triumph of my life, is having her. My son's birth was probably the worst day of my life, and then this was the best. And I wish I could have given that to him. But I think that it makes me way more confident and more self-assured. It changes the woman that you are, and it is becoming mother like that, when you can do it all by yourself, it just changes everything in your life.

Another midwife explained how she saw this phenomenon taking place:

Once people start looking into homebirth, whether they've got much of a background in more holistic healthcare or not—even just based on some of the recommendations that we make—dietary changes or things like that, even if it's not a big one, it could start that progression down that path. “Maybe we do need to do this. And we have a baby coming now, so maybe we need to change that. And how are we going to feed our baby when the baby starts eating?” So I think it does make a lot of people start to rethink different things. Maybe this is part of a whole rather than, you've got homebirth and then whole food eating. These things become integrated into a whole life rather than: you've got this, separate from this, separate from this.

Homebirth was not always the first area of their lives where homebirth mothers acted against the norm, though for some it was. A homebirth mother described the progression in her life:

Dating and timing the unfolding of any number of other unconventional things that my husband and I have decided to do, I think a lot of that *stemmed from* the homebirths. It was empowering to *both* of us to the extent that, well if we can choose to have our babies this way, what other choices can we make? You don't have to have the baby in the hospital, well you don't have to send the baby to school when they are five. You don't have to send the baby to school when they're five, you don't have to eat the crap diet you were raised on. For us, [the homebirth] was the beginning of a much greater level of awareness, of experimentation with alternatives. We have gone pretty far fringe since the homebirths. I think maybe it was the way we always were but it was empowering to have this very visceral, firsthand experience of making this pretty radical choice and realizing what that could do for us, opened up so many more possibilities. It's really, I think it's changed our lives to a very great extent, because it's not that the homebirth was just magical and made wonderful things happen. But we started to think about it more, from that point onward.

When I asked how homebirth fit into the larger picture of their lives, many participants explained this element of identity, in different words, and that it often had to do with both adherence to a holistic model—not only regarding birth, but in their larger lives—and function of agency, freedom from normalization, and resistance. Matilda explained:

[Choosing to birth at home] seems like very much a part of me and the way I like to do things. I like things down to earth, and comfortable, and natural. [...] I think a lot of women [that birth at home] are more independent, they don't struggle with the same level of peer pressure [that most women do].

One midwife discussed why she decided to birth at home by explaining that it was part of her identity:

Because it's what I do. I mean, by the time I decided to birth at home, I'd already been doing this work for a couple of years, so it was just normal for me at that point. Why would I be a homebirth midwife who still went to a doctor and had babies in the hospital? (laughter) I think that [my midwife partner] and my hooking up was just kind of the way it was meant to be, I mean, a God thing, because I never—I spent my whole life trying to be normal. I would never have sought this out, and I can't imagine—I don't feel like it's what I do. It's just who I am. If somebody calls me with a pregnancy question, I can't not answer it. If somebody needs help, I can't *not* go. [...] I mean, if somebody needs something, that's what you do. You take care of it. So I think it's just who I am. That's why I have babies at home, because that's who I am.

While most participants adopted a holistic model and seemed to embrace resistance to and critique of dominant ways of doing things, at least two women said that this did not characterize them. All of the mothers and midwives I spoke with, however, emphasized questioning others and themselves, problematizing existing knowledge/power relations, educating themselves, and being active in maternity care, other forms of health care, and other areas of life.

CHAPTER XI

CONCLUSION:

POLITICAL ECONOMY OF BIRTHING BODIES

Women who birthed at home described a journey to holistic care and homebirth that often involved technocratic care and fighting to birth naturally in a medical setting. Through these experiences and the experiences of other women, participants questioned medical hegemony and technocratic constructions of birth and bodies and sought to educate themselves regarding alternatives. Homebirth mothers birthed at home for safety and control. The safety of homebirth is grounded in particular understandings of natural birth as safest for mother and baby, interventive birth as harmful, and hospital birth as interventive. Homebirth mothers and midwives stressed the important role of critical education in midwifery care and described a lack of education, informed consent, and agency in the medical model of care. Acknowledging this, women birthed at home for control—control of their bodies, births, and babies. This control is ultimately a way for mothers to ensure physical and emotional safety of their babies and themselves.

Homebirth mothers and midwives, while occasionally articulating overlap or inconsistencies, overwhelmingly described oppositional biomedical/technocratic and midwifery/holistic models of care. Participants described and problematized biomedical constructions of women's bodies as pathological and as defective machines where mind and body

are separated, as is the mother from herself (physically and ideologically), from her baby, her family, and society. Alternatively, women conceptualized, in keeping with a holistic understanding, women's bodies and birth as normal and healthy. Homebirth mothers and midwives saw the mind and body as connected and asserted the interconnectedness of women with their own bodies and selves, with their babies, families, and society—they described women as social beings. Participants further problematized biomedical management of birth, overuse of interventions, and the supremacy of technology, and associated these with the pathological and bodies-as-machines elements of the biomedical model. In contrast, they spoke passionately about midwives' watchful waiting, wisdom, and valuing of people—particularly the pregnant woman herself.

Foucauldian and constructivist perspectives provide significant theoretical opportunity to address the construction and practice of knowledge/power and the political economy of bodies in experiences of birth, institutions of birth, and the multidimensional exercise of (bio)power. Historical and contemporary biomedical dividing practices and scientific classification regarding women's bodies and birth lays the groundwork for objectification, control, docility, and normalization. Within this context, women's bodies are disciplined into docile and normalized bodies through technocratic and patriarchal disciplinary technologies, involving the control of knowledge and panopticonic domination of time, space, and movements of the body. Homebirth represents a challenge to normative medical hegemony through the active creation of agency, empowerment and practice of alternative birth models. Homebirth mothers and midwives clearly exhibit the kind of critical questioning and problematization of taken-for-granted reality and legitimated disciplines that facilitate constructivist exercises of agency and Foucauldian care of self and practices of freedom. Where the docile female body can be understood as a product of the power/knowledge relations of the biomedical model of maternity care, the midwife-supported, active female body described by participants as characteristic of the midwifery model might be

read as a text of embodied female (and feminist) resistance to normalization and medical hegemony.

This research considers homebirth in Oklahoma from the perspective of homebirth midwives and women who have given birth at home, seeking to understand how homebirth mothers characterize and respond to our society's hegemonic birth system, its power, ideology and practices. I argue that from the perspective of homebirth mothers, the decline of birth at home and associated midwifery was no accident or inevitable evolution of birth practices. Instead, it was an orchestrated effort, facilitated and made possible by the exercise of power/knowledge in the patriarchal biomedical system. Respondents indicated significant manifestations of power/knowledge and control facilitated by technocratic practices, which are rooted in conceptions of pathology and birth as representative of illness, a woman's body as machine and reliance on technology. Biomedical professionals asserted expertise and authority, limiting women's knowledge/power and informed consent throughout the birth process.

Homebirth mothers articulated narratives of empowerment, knowledge and control in the philosophy and practice of the midwifery model and homebirth. They understood their bodies and bodily processes as normal and healthy and they emphasized the connectedness of mind, body, and spirit as well as that of mother, baby, family, and society. The midwifery model's woman-centered approach was viewed as superior to the biomedical model for the ways in which the midwifery model calls for and even requires shared responsibility and claims to knowledge/power. Set in opposition to the biomedical model, participants valued the sufficiency of nature and intuitive ways of knowing over the reliance on and authority of technological information. Homebirth mothers and midwives perceived themselves as active and informed agents engaged in the dynamic creation of decisions benefiting themselves, their children, their families, and communities. This agency and creation were understood as a kind of praxis, as the journey to homebirth was often explained as a consequence of a process of education and

reflection, involving action and empowerment in their own lives as well as hope for greater improved maternal and infant health, female empowerment, and social change.

Providing insight into how social constructions and individual realities challenge powerful institutional structures and adding theoretically and empirically to a growing body of sociological and anthropological work on women's health and reproduction, this research supports and adds to existing literature regarding birth models as well the systematic and lived inequalities in women's health care. Through lenses of Foucault, constructivism, and feminism, emphasizing power/knowledge and bodies, I assert that the discipline of obstetrics, often viewed as a neutral and objective discipline with the purpose of ensuring safe birth for American women, operates more importantly as a means of governing and normalizing female bodies and citizens. Understandings developed in this research contribute specifically to applications of Foucault's work to gender, power/knowledge, and embodied resistance. Second, in the feminist research tradition, this research contributes to knowledge constructed from the perspectives of women, drawing on women's voices and experiences, and providing illustrations of the ways that some women seek agency by controlling their bodies, identities, and experiences. Participants expressed a desire to voice their thoughts and experiences and an enthusiasm for collaboration and action for social change. Finally, I speak directly to how individual practices are shaped by and may challenge powerful social structures. Women's accounts of homebirth and midwifery care were set in opposition to experiences and understandings of disempowerment and dissatisfaction with biomedical care and hospital birth. These understandings of the biomedical model were instrumental in women's complex journeys to homebirth and greater holistic understandings of health and wellness. Homebirth mothers and midwives elucidated how adhering to the holistic model and birthing at home involved opposition and resistance—in both thought and action—to hegemonic biomedical power/knowledge. Through this resistance, women engage in feminist praxis and demonstrate Foucauldian care of the self and practices of freedom.

Not only does my research contribute to the historical record by providing accounts of homebirth in Oklahoma, it offers an avenue to build awareness of midwifery care and homebirth options. This work illuminates the necessity for women—in Oklahoma and elsewhere—to inform themselves and consider various reproductive choices. In the long term, research such as this may contribute to improvements in maternity care in Oklahoma and beyond encouraging care providers (including, but not limited to, medical care providers, such as obstetricians and nurses) to: (1.) critically evaluate their own practices and the care they provide and (2.) inform and improve support of pregnant and birthing women and their choices. Further research on this topic may lead to the empowerment of women and men—including midwives, doulas, partners, friends, and family—who support and assist women in having healthy, respectful, and empowering births in any setting.

Future studies may seek to understand the experiences of homebirth midwives and mothers in a variety of ways. Homebirth midwives spoke in detail about policies and regulatory factors influencing midwifery practices. This issue deserves further exploration and is of consequence to intersectionality, access to midwifery care and alternative options for birth. In this vein, future research may examine the ways in which race, class, ability, sexuality, and other social positions shape and are shaped by birth models, ideologies, and practices. Furthermore, future research might investigate how women seek to challenge medical hegemony from within the medical birth system and examine dynamics of resistance and progress in the homebirth and midwife communities as well as the creation of alternative movements. The decision to birth at home seemingly encourages the opportunity to embrace other oppositional life decisions that would be an interesting focus of research, including varying strategies regarding food and nutrition, education, health care and immunization. Finally, in keeping with Foucault's approach, and that of many Foucauldian feminists, it is worth examining the potential for normalization within holistic models which homebirth mother and midwife participants described as very empowering.

There is clearly wisdom to gain from examining and understanding the experiences and motivations of homebirth midwives and women who birth at home. Perhaps one of the most important lessons is that we must address the problems of our biomedical birth system. So often discussions of home and hospital birth lead to a “debate” over homebirth—primarily its safety. Rather than attacking practices that affect such a minority of the population and how they might need to change, addressing the medical system that 99% of the population of birthing women in the U.S. experiences is more productive. Homebirth mother and midwife participants advocated for homebirth, but also placed great emphasis on the need to problematize and reform biomedical philosophy and practice. In particular, they recommended incorporating holistic care into obstetrics and hospital birth as well as greater collaboration between holistic and biomedical care providers. Several midwives and homebirth mothers directly offered the Mother-Friendly Childbirth Initiative (Coalition for Improving Maternity Services 2013), particularly its “Ten Steps to Mother-Friendly Care,” as a framework for improving our birth system. Participants desperately want change, for themselves, their sisters, and their daughters: “That’s the biggest thing: We need to change our attitude toward birth—in Oklahoma, in the United States, in the world.”

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APPENDICES

APPENDIX A: INTERVIEW SCHEDULES

Interview Guide for Homebirthers

I want to talk with you today about your experience with homebirth, your decision to birth at home, and your midwifery care. But first, would you mind introducing yourself?

How many births have you had? Where did each birth take place?

(If both hospital and homebirth, at some point ask what accounts for the differences between experiences. How do you feel about these differences? What did you learn?)

Tell me about your experience of being pregnant.

How did you feel – physically, emotionally? How did others respond? In general, what was being pregnant like for you?

How did you learn about midwifery care and homebirth?

Can you describe your prenatal care?

What were visits like? What procedures were conducted? How did you feel about/during these visits?

How did you (or did you) educate yourself or otherwise prepare for labor, birth, and postpartum?

Tell me about your decision to birth at home.

Why did you decide to use a midwife? Why did you decide to birth at home? How did friends and family respond? How did that affect you or your decision?

Tell me about your labor and birth.

What did you do? What did others do? What were your expectations and how was your experience different than you expected?

Please describe for me how you think about your body. (What do you think is the role of the mind and the body in birth? What is the relationship between the two?)

Describe your knowledge about and relationship with your body.

Can you explain to me how your experience of birth fits into your life? How has it shaped you, your perspective, etc?

Can you characterize women who have homebirth? Is there something you think they have in common?

...Advice for someone considering homebirth?

Is there anything special you would like others to know about what you have learned about being pregnant and giving birth? Is there anything we didn't talk about or anything else you think I should know about homebirth?

Interview Guide for Midwives

Why did you decide to become a midwife?

Please tell me about your education and training. (Certification, apprenticeship, etc.)

Can you tell me about the first birth you attended?

How many births have you attended?

Can you describe your relationship to your patients?

Tell me about homebirth in Oklahoma.

What is the legal status of direct-entry midwives in Oklahoma?

How do you feel about this status? What do you see are the advantages of this status?
Disadvantages? (Potential question areas: backup physicians, insurance, etc.)

How would you describe the role of direct-entry midwives in Oklahoma?

What, in your opinion, is the role of a midwife at a birth?

What do you think birth will be like in the future?

How do you envision the future of midwifery in Oklahoma?

APPENDIX B: IRB APPROVAL

Oklahoma State University Institutional Review Board

Date: Tuesday, July 05, 2011
IRB Application No AS1141
Proposal Title: Birthing Resistance: The Social Construction of Homebirth in Oklahoma

Reviewed and Processed as: Expedited

Status Recommended by Reviewer(s): Approved Protocol Expires: 7/4/2012

Principal Investigator(s):

| | |
|----------------------|----------------------|
| Katie Worman Ross | Stephen M. Perkins |
| 409 Murray | 431 Murray |
| Stillwater, OK 74078 | Stillwater, OK 74078 |

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

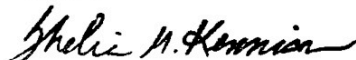
The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 219 Cordell North (phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,



Shelia Kennison, Chair
Institutional Review Board

VITA

Kathryn Worman Ross

Candidate for the Degree of

Doctor of Philosophy

Thesis: SPEAKING OF EMOTIONS: A FEMINIST SOCIOLOGICAL ANALYSIS
OF WOMEN'S ABORTION NARRATIVES

Major Field: Sociology

Biographical:

Education:

Completed the requirements for the Doctor of Philosophy in Sociology at Oklahoma State University, Stillwater, Oklahoma in May, 2013.

Completed the requirements for the Master of Arts in Sociology at Middle Tennessee State University, Murfreesboro, Tennessee in 2007.

Completed the requirements for the Bachelor of Science in Sociology and Psychology at Jacksonville State University, Jacksonville, Alabama in 2004.

Experience:

Instructor, University of Central Oklahoma, 2012-2013

Graduate Teaching Associate, Oklahoma State University, 2007-20012

Graduate Teaching Assistant, Middle Tennessee State University, 2006-2007

Professional Memberships:

MidSouth Sociological Association, American Sociological Association