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Homebirth as Systems-Challenging Praxis: Knowledge, Power, and Intimacy in the Birthplace

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In this article, I examine the processes and motivations involved when women in the United States choose to circumvent the dominant obstetric care paradigm by delivering at home with a group of care providers called direct-entry midwives. Using grounded theory, participant observation, and open-ended, semistructured interviewing, I collected and analyzed homebirth narratives from a theoretical sample of women ($n = 50$) in two research locales. Findings interpreted from the perspective of critical medical anthropology suggest that women who choose to birth at home negotiate fears associated with the "just in case something bad happens" argument that forms the foundation for hospital birth rationales through complex individual and social processes. These involve challenging established forms of authoritative knowledge, valuing alternative and more embodied or intuitive ways of knowing, and knowledge sharing through the informed consent process. Adherence to subjugated discourses combined with lived experiences of personal power and the cultivation of intimacy in the birthplace fuel homebirth not only as a minority social movement, but also as a form of systems-challenging praxis.

Keywords: *homebirth; power; systems-challenging praxis; midwifery; pregnancy; anthropology, medical*

In the United States, institutionalized racism and biomedical hegemony heavily structure access to maternity care and the extent to which women might exercise the right to choose where and with whom to give birth (Davis-Floyd & Johnson, 2006; Kitzinger, 2005; Wagner, 2006). Cultural and political–economic factors, and to a lesser extent scientific research, determine what constitutes safe birthing options and appropriate care providers. Wagner (2006) and De Vries, Benoit, van Teijlingen, and Wrede (2001) argue that a unique set of historical and political–economic factors have produced a virtual monopoly by U.S. physicians over the process of childbirth, even though a large body of literature now exists that supports midwifery care both in and out of hospital (OOH)[1] as a safe and viable option (Anderson & Murphy, 1995; Durand, 1992; Janssen, Holt, & Myers, 1994; Janssen et al., 2002; Johnson & Daviss, 2005; Murphy & Fullerton, 1998; Rooks, 1997; Schlenzka, 1999). The United States and Canada are the only two high-income nations in the world in which highly trained surgical specialists (obstetricians) still regularly attend normal, healthy, low-risk mothers in delivery (Wagner, 2006). The overt dominance of high-tech obstetrics is both unusual from a global maternal and infant health perspective, and extremely powerful insofar as unquestioned authority structures construct reality, making a limited number of birthing choices seem reasonable.

In this article, I examine the processes and motivations involved when a small minority of women in the United States (only about 1% to 2%) reject the cultural norm of obstetrician-attended hospital birth and choose to deliver at home with a midwife. Using a grounded theory approach and data collected though participant observation and open-ended, semistructured interviewing, I explore the ways women negotiate the fear associated with the "just in case something bad happens" argument that forms the foundation of hospital birth rationales. I argue that the processes of challenging established forms of authoritative knowledge and valuing alternative ways of knowing, combined

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with embodied experiences of personal power and a deep desire for intimacy in the birthplace, fuel homebirth not only as a minority social movement, but also as a form of systems-challenging praxis (Singer, 1995). The explanatory models grounded in participants' narratives and analyzed from the perspective of critical medical anthropology claim an alternative value system, while providing a contemporary critique of dominant, U.S. obstetric approaches that, after 20 years of "mother- and baby-friendly reforms," are arguably still overly interventive, hypermedicalized, and fraught with unequal relations of power (Kitzinger, 2005; Wagner, 2006; WHO, 2004).

Theoretical Perspective

Critical medical anthropology (CMA), a theoretical and practical paradigm within the larger field of medical anthropology, is based on the notion that health itself is profoundly political (Navarro, 1984) and that power relationships, like those that characterize U.S. obstetrics, are foundational variables in health-related research, policy, and programming (Baer, Singer, & Johnson, 1986; Singer, 1990). The mission of CMA is expressly emancipatory as it aims not simply to understand, but also to change oppressive and exploitative patterns in the health arena and beyond. Proponents of CMA see their approach as essential in postcolonial research insofar as it helps to overturn the tendency for conventional medical anthropology to serve as a "handmaiden to biomedicine" (Greenwood, Lindenbaum, Lock, & Young, 1988).

In an effort to more explicitly delineate the ways CMA might be applied beyond superficial systems-maintaining approaches that tinker and patch existing health care systems, but fail to recognize underlying power structures that serve oppressive ends, Singer (1995) has distinguished two disparate categories of social and health reform. The first, "systems-correcting praxis," involves the conscious implementation of material improvements, but avoids substantial alterations to the fundamental structures of social relations within institutions. Systems-correcting praxis often results in measurable material gains as in improved access to biomedical care, but it is also vulnerable to cooption by dominant forces. Singer (1995) argues that although systems-correcting practice tends to obscure causes of suffering and sources of exploitation, the second category, "systems-challenging praxis," explicitly attempts to unmask sources of social inequities and to advocate for permanent changes in the alignment of social power. Systems-challenging praxis converts medical problems into social and political issues—a process that Singer claims is essential to health improvement through enhanced democratization and the elimination of demystification. In the article that follows, I apply Singer's concept of systems-challenging praxis not to my work as an anthropologist and advocate, but to an interpretation of the actions and motivations of a small minority of U.S. women who choose to birth at home with midwives.

Methods

For the purposes of this study, I utilized a modified grounded theory approach (Glaser, 1978; Glaser & Strauss, 1967, Strauss, 1987), following the methodology proposed by Charmaz (1990, 2000). After receiving institutional review board approval for the ethical and noncoercive treatment of research participants, I interviewed a voluntary sample of 13 women in a Pacific Northwest college town during the autumn of 1998, asking them to share the stories of their homebirths and what made them choose to deliver outside the hospital. I transcribed their narratives and then analyzed them to produce an initial coding system based on commonly recurring themes. After completing this first set of interviews and finding that all of the women faced enormous social pressure as a result of what was often a long and arduous process of exploration leading to the decision to deliver at home, I refined my research question: Given the pervasiveness of hospital delivery, the widespread cultural perception that homebirth is unsafe, and the institutionalized constraints that severely limit insurance reimbursement and access to physician backup when necessary, how do some U.S. women arrive at the decision to birth outside the hospital?

The second stage of my research utilized more focused interviewing and participant observation of new client consultations, prenatal visits, home deliveries, and postpartum checkups with a practice of four midwives and their clients in a Midwest college town. The goal was to explore in more detail the initial categories generated during preliminary interviewing. I interviewed an additional 37 women during this phase of the research between December 2000 and January 2002, relying on theoretical sampling and concept saturation (Glaser, 2001) to guide the process of recruitment. I attempted to include women from as many social, religious, reproductive

histories, and educational backgrounds as possible, and stopped interviewing only when I felt that no new information regarding theory construction was being supplied.

Ethnograph, a text-based research tool that facilitates the identification, coding, and quantifying of themes from interviews (Phipps, 2001; Weiner, Swain, Wolf, & Gottlieb, 2001; Westfall & Benoit, 2004, was used to help identity and mark the location of key conceptual categories in transcribed interview texts and field notes. Interview categories were then developed and translated into a schema or model that mapped participants' responses and formed the foundation for my interpretations. After data analysis was completed, a summary of my findings was returned to participants and discussed in focus groups through a process often referred to as "member checking" (Charmaz, 2006), or reciprocal ethnography (Lawless, 1992). The process of returning to communities for comment and critique not only allows for further elaborations of categories and refinement of theoretical constructs, it also promotes reliability and validity in qualitative research (Barbour & Kitzinger, 1999) because participants have the opportunity to disagree with findings.

Study Sample

All of the women interviewed in this study engaged in prenatal, intra-, and postpartum care with direct-entry midwives (DEMs) and began labor intending to deliver in their own homes.[2] DEMs are midwives who bypass nursing school and enter directly into midwifery training through one or more of several possible educational routes that include formal accredited schools, distance learning programs, informal study groups, lengthy apprenticeships with senior midwives, and/or internships at high-volume birth centers (Cheyney, 2005; Davis-Floyd, 1998). Direct-entry midwives work at home and in independent, freestanding birth centers (i.e., not affiliated with hospitals), and occupy a highly marginalized position vis-à-vis the obstetrical hierarchy. The legal status, training requirements, and processes for certification and or licensure of DEMs (where available at all) vary significantly by state.[3] Thus, homebirthers[4] and the direct-entry midwives who attend them (especially in "illegal" states), might be described as "hidden populations"—or groups that reside outside of easily accessible clinical and institutional settings (Klassen, 2001; Singer, Scott, Wilson, Easton, & Weeks, 2001). As a result, time-intensive and relationship-oriented ethnographic approaches like participant observation and serial, open-ended interviews have proven essential for eliciting the context-embedded, insider perspectives of systems-challenging groups like homebirthers (Davis-Floyd, 1994a, 1994b; Klassen, 2001).

Results

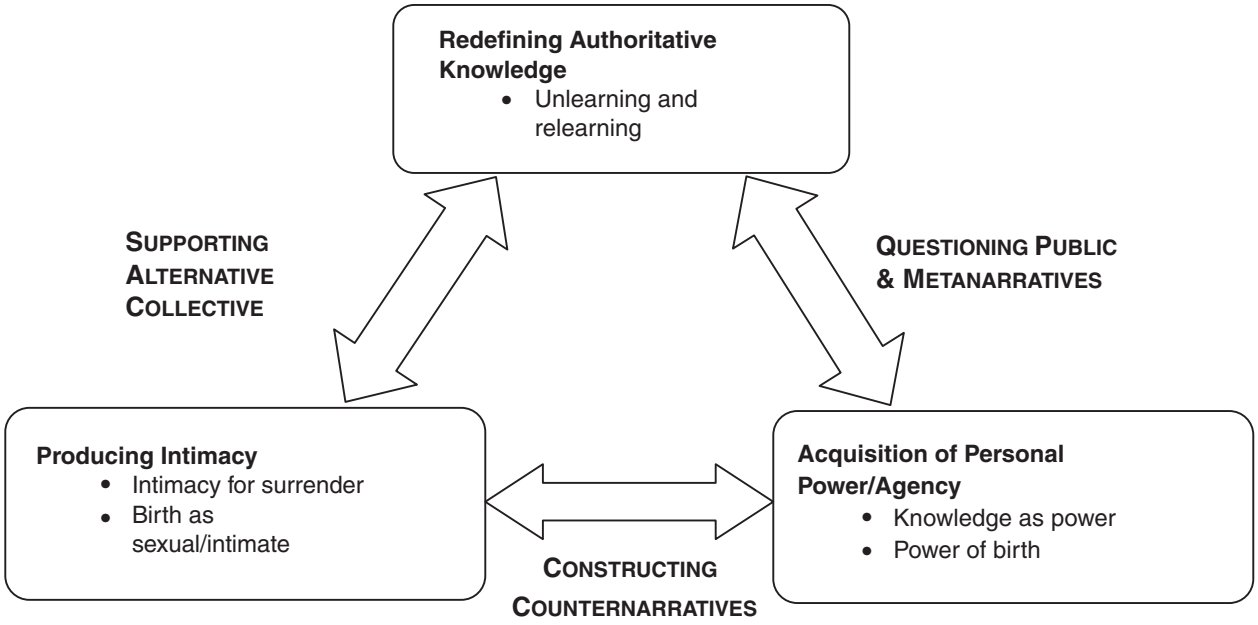
In listening to women's stories, it soon became evident that, although there was considerable variation in the details of how each pregnancy and birth unfolded and in how each woman and her family arrived at the decision to birth at home, several themes were repeated in many or even most of the narratives. Using in vivo coding, I identified three predominant themes: (a) redefining authoritative knowledge; (b) embodying personal power/agency, and (c) creating connection/intimacy in the birthplace, as key theoretical categories in participants' narratives. Figure 1 diagrams the connections between these themes and their related subthemes as they emerged from analysis.

Redefining Authoritative Knowledge: Challenging a Limited Repertoire of Childbirth Narratives

Somers (1994) has proposed several categories of narrativity, three of which—ontological, public, and metanarratives—are essential to my discussion of homebirth stories. Ontological narratives are individual accounts constructed through social interactions that order events and allow individuals to define themselves as social actors. Public narratives are stories that are professionally, or as in the case of childbirth, medically defined and held by social units larger than the individual. Metanarratives communicate culturally constructed expectations and refer to traditions in which individuals and their social relations are "embedded as contemporary actors in history" (Somers, 1994, p. 619). Guided by these distinctions in narrative form, I identified the first conceptual category, redefining authoritative knowledge, and three associated subthemes: (a) unlearning and relearning; (b) valuing embodied knowledge, and (c) engaging in informed consent, that help to explain the processes women participate in as they begin to challenge accepted public and metanarratives of obstetrician-attended hospital delivery.

Unlearning and relearning a new authoritative knowledge. Participants constructed ontological or individual homebirth narratives, in part, as responses

Figure 1
The Cultivation of Knowledge, Power, and Intimacy in Homebirth as Systems-Challenging Praxis



to a limited repertoire of public and metanarratives and as a means of challenging what Jordan (1993, p. 152) has called "authoritative knowledge"—or the knowledge on the basis of which decisions are made and actions taken "either because they explain the state of the world better (efficacy), or because they are associated with a stronger power base (structural superiority), and usually both." One participant explained why she chose to deliver her first baby at home even though her family threatened to disown her:

> When I got pregnant, I was not going to be like all of my friends. You know the story. . . . They go overdue by a couple of days, go in for an induction that doesn't work, and they end up with a C-section. Then they're in too much pain and too depressed to nurse, so they have to find a support group to process their feelings of victimization. I didn't know much, but I knew I didn't want that. You're not supposed to say this in our society, but I'm not totally convinced that obstetricians really know what they're doing.

For this mother, the decision to birth at home is embedded in a refutation of a public narrative (the medical model of childbirth)[5] and a challenge to obstetricians as indisputable experts.

Women in this study also contested established hospital narratives, in part to help resolve a lived discontinuity between culturally defined birthing practices and their own experiences (or those of close friends or family). MacIntyre (1981) and Miller (2000) have discussed the difficulty of maintaining a sense of personhood and social continuity through major life transitions like childbirth. Under such conditions, the construction of birthing narratives might facilitate the process of making sense out of "biographical disruptions" (Bury, 1982, p. 169) or feelings of uncertainty and unpredictability that arise during birth as a transformative process. However, as Miller (2000) has noted, there is also the potential for an overt clash and consequent irreconcilability between individual and public or metanarratives during periods of change. Experiences with childbirth might produce a logical disjunction between what Mishler (1984) calls the "voice of medicine" (the technical details of disease and treatment) and the "voice of the life world" (the social relationships and the experiences of the individual). Participants clearly articulated these discontinuities in their efforts to ascribe meaning and justification to their choice to deliver at home with a midwife. One mother explained this process in relationship to her

previous hospital delivery and the logical and embodied discontinuities that experience produced for her:

> My hospital birth was horrible. My husband had to fire the doctor in the middle of pushing because he was insisting on giving me a C-section. . . . It was so hard, because I knew that if I just had more time, I could do it. . . . We got a new doctor and I delivered vaginally after two hours of really difficult but triumphant pushing. . . . With our second baby, there was no way we were going to subject ourselves to that kind of torment. . . . I wanted a midwife that I could trust, who believed in me and my ability to birth, and that is what we got with our homebirth.

For women to begin to challenge powerful and widely accepted hospital birth metanarratives, and to move into the realm of social action either by giving birth at home or by becoming alternative birth activists, many described first passing through what was often a long and arduous process of "unlearning and relearning." Women sought a new, authoritative knowledge as they "hungered for new information" and a "new way of seeing childbirth," especially as they attempted to "make sense of what happened the first time" in a previous hospital delivery. Alternative birthing knowledge was acquired though the Internet and books on midwife-attended birth, as well as through more informal knowledge sharing networks where women actively sought out midwives and other homebirthers who were willing to share their stories. One first-time mother explained,

> When I got pregnant, I realized that I really knew very little about what to expect. So being an academic, I started reading everything I could get my hands on—books, Medline, mothering magazines. Knowledge acquisition was all I focused on for the first few months of pregnancy. . . . As I got more into the literature, it was really a process of unlearning and relearning. I had to replace all of those images from sitcoms where women are eating dinner in a restaurant and they suddenly go into labor and start screaming in pain while their husband runs around frantically. . . . Through reading, but also by talking to midwives and other homebirthers, I started to realize that as a healthy woman with a straightforward pregnancy, it was very likely that my birth would not be a terrifying emergency.

Homebirth mothers discussed overcoming their own fears of birth and their decisions to deliver with midwives outside of the hospital, despite "what if" scare tactics as a result of this knowledge acquisition process. One-on-one discussions with midwives were particularly important during this process. As one participant explained,

> I had read all about the safety of midwives and homebirth, but I was still scared on some level. I couldn't really let all of my socialization go, and I was worried that something would go wrong. That lasted until I met my midwife. She was so confident and capable! Having seen all of those successful homebirths really put her in a different place, and she was able to put my fears at ease and help me know I could do it [birth at home].

All of the women in the sample faced skepticism and accusations of "selfish irresponsibility" and "unnecessary risk-taking" from friends and family members who were not supportive of homebirth. Many noted that although their own process of unlearning and relearning was challenging, it did not compare to the difficulty of convincing their detractors. As one participant lamented,

> When I told my doctor I was thinking of having a homebirth, he said "Cool, and while your at it, don't bother with a car seat." . . . He totally discounted me even though I had printed out a full bibliography of over 100 studies on the safety of planned homebirth for low-risk mothers.

After experiencing and articulating an embodied discontinuity between public and personal narratives of childbirth, participants narrated a process of moving or working through a "journey" of unlearning and relearning that enabled them to start assembling new narratives that more closely modeled their lived realities. These reformulated narratives commonly value new sources and definitions of knowledge. Two in particular—embodied knowledge and informed consent—were discussed in detail by participants from a variety of social and demographic backgrounds.

Embodied knowledge. Although the acquisition of formal and informal knowledge through books and story sharing played a role primarily during the prenatal period, intuition, or "body knowledge," was discussed almost exclusively in the context of labor, delivery and the immediate postpartum periods. Mothers mentioned multiple forms of, or terms for, concepts like instinct, intuition, and embodied knowledge as a means of describing knowing that was not intellectual, rational, or

logical, but more bodily and experiential.[6] One first-time mother explained,

> My labor was taking forever and at one point I just started high stepping around the house. . . . I was lifting my knees up to my chest with each step. I didn't really realize I was doing it at the time, but it just felt right and pretty soon after doing that I started to feel like I had to push. . . . Afterward, the midwives said it was really good that I had done that because the baby's head was tilted to one side, and by doing that, I was shifting my pelvis and encouraging the baby to move her head. . . . I just think it's really amazing that my body knew what to do. I wasn't conscious of it, but my body knew. . . . I have a lot of respect for myself, for my body because of that. What if I had had an epidural? How could I have listened to my body?

Participants who discussed nonrational forms of knowledge also reported relying on childbirth education classes, books, the sharing of birth experiences with other women, and discussions with midwives as important sources of information. Thus, homebirthers rely on and value multiple forms of knowledge during the childbearing year, and these are often seen as complementary. As one a first-time mother explained,

> Education took much of the fear out of birth for me. But when it came down to it, I couldn't birth my baby with my brain. I had to go into my body and find what I needed to give birth.

Davis-Floyd and Davis (1997) have analyzed the roles of intuition[7] and more rational, logical, or ratiocinative ways of knowing about birth from the perspective of homebirth midwives. Davis-Floyd and Davis argue that within holistic models of midwifery care, intuition is covalued along with biomedical testing and more quantifiable ways of rational or logical knowing. Occasionally, midwives rely on intuition as a primary source of authoritative knowledge—a revolutionary act in a society that grants legal and conceptual legitimacy only to ratiocination. Similarly, participants in this study tend to value multiple forms of knowledge without seeing nonrational ways of knowing as secondary or inferior to more rational/logical forms of information. In asserting the value of intuition or "body knowledge," homebirthers are claiming multiple, legitimate forms of authoritative knowledge. In doing so, they implicitly challenge the (over)reliance on technology and hypervaluation of scientific ways of knowing that they believe characterize more medicalized approaches to childbirth.

Informed consent. In addition to claiming the value of embodied knowledge, participants challenged public or metanarratives of hospital delivery in connection with the desire for "better informed consent." Homebirth stories rely heavily on notions of information sharing and the coconstruction of knowledge by midwife, mother, baby, and often the father or other family members as a means of contesting the role of obstetrician as absolute expert in hospital deliveries. Prenatal care with direct-entry midwives entails discussing options for prenatal testing and interventions in substantial detail, encouraging mothers to ask questions and exploring the individualized pros and cons of procedures. In the over 500 prenatals that I observed, information sharing comprised the vast majority of the 1 to 1.5 hours that each visit lasted. Homebirth clientele are also provided with numerous handouts and encouraged to do their own research on common procedures like ultrasound and amniocentesis.

Interviewees deeply value shared decision making with their midwives and partners, and as a result often feel that they are able to make knowledgeable choices about whether to use specific technologies and interventions. Participants, as a rule, argue that "true informed choice is not possible in mainstream, hospital birthing care." As one mother who had a hospital delivery with her first and a home delivery with her second child explained,

> I really liked the co-decision-making process we had with the midwives. You know that you can't just surrender your body and say, "You make all of the decisions for me. You get this baby out." We were really involved in making choices about our care. . . . It makes sense that you get informed and make decisions about your pregnancy and birth because isn't that what you are going to have to do when you are a parent? The hospital might get a baby out for you, but they surely are not going to follow you home and help you raise it! Learning about birth was my practice for learning how to parent.

Through the identification and voicing of discontinuities between experience and desire, the quest for reconciling versions of alternative birthing knowledge that honor embodied and experiential ways of knowing, and the coconstruction of authoritative knowledge via informed consent, women who choose to birth at home with midwives create new realities and explanatory models around childbirth. These new realities are constructed through overt challenges to public and metanarratives, as well as through direct

action when women choose to birth at home as an act of resistance and systems-challenging praxis. As families refuse participation in socially prescribed hospital birth practices, they effectively undermine unequal power relationships between doctor and reproducing woman as patient—an essential step in eliminating the mystification that Singer (1995) argues so frequently functions to maintain the status quo by obscuring inequalities. Belenky, Clinchy, Goldberger, and Tarule (1986) identify such a transition from dependence on external authorities (public and metanarratives) to reliance on subjective knowledge or the "inner voice" (ontological narratives) as a major developmental transition marked by a sense of personal strength and power where women become their own authorities.

Personal Power/Agency: Living the Powerful Body and the Construction of Counternarratives

The acts of challenging a limited repertoire of public and metanarratives and of claiming a new authoritative knowledge are closely tied to a second key conceptual category incorporated in homebirth narratives—the acquisition of personal power and individual agency. As women narrate the parts of their stories that describe the actual labor and delivery, passionate subplots emerge that emphasize the clash between public narratives and the lived experience of birth at home with midwives. Women's stories identify discontinuities, question the dominant paradigm, and eventually explicitly claim an opposing story or counternarrative as real (Miller, 2000). These counternarratives contain three distinctive subthemes related to personal power and agency: (a) knowledge as power, (b) empowerment as embedded in the intensity of labor and delivery, and (c) power as healing.

Knowledge as power. All of the women interviewed discussed knowledge acquisition in connection with a sense of personal empowerment and agency, or the ability to affect the course of their pregnancies and births through choice and direct action. Participants explicitly claimed knowledge as a form of power, while asserting that withholding knowledge and/or limiting definitions of what counts as "legitimate" knowledge is disempowering. As one second-time mother explained,

> In the hospital, the doctors and nurses are the experts and you are perceived to know very little, which actually might have been the case with my first baby. I felt like I never got very good explanations for why I was doing certain tests. . . . With the midwives, they spent most of their time with us sharing knowledge and asking me what I thought. . . . They said I was the expert on my body and my baby. I mean, can you see how that is a very different kind of message? Knowledge is power and in the hospital I didn't have the knowledge, so I didn't have the power.

In claiming the interconnections between knowledge and power, women are echoing Foucault's argument (in Gordon, 1980) that knowledge and power are actually synonymous terms. Knowledge/power as a single, self-referential concept expresses the inseparable nature of knowledge and power insofar as a discipline's knowledge claims directly increase the power of that discipline. Because society, via its representatives (governments, bureaucrats, educators, and so forth), acknowledges the power of some groups (obstetricians) and limits that of others (direct-entry midwives), social structures functionally determine who holds the knowledge, and therefore, the power. This, Foucault argues, leads to dominant and subjugated discourses that, from the perspective of homebirthers, can be seen as the medical and midwifery models of care, respectively. Through the acquisition of knowledge and the lived experience of personal power in birth, women who choose to deliver at home with midwives claim a subjugated discourse as real and, in doing so, reject the implicit claims of the dominant discourse or public narrative that backs hospital birth.

Foucault's (1979; Gordon, 1980) critiques of modern disciplines, and the ways they induce submission by promising rewards for compliance and punishments for noncompliance, are also relevant to homebirth decision making. With reference to the medical establishment, and childbirth in particular, hospital birth offers the rewards of safety, health, and pain relief (Fahy, 2002). When mothers reject the disciplinary power of obstetrics by birthing at home, they are viewed (and view themselves to some extent) as susceptible to the punishments of pain, death, and disability. Herein lies the power of social sanctioning, for a mother who is seen as accepting pain, death, and disability, especially for her infant, certainly violates the social parameters of what constitutes a good mother. Through the process of alternative knowledge acquisition, homebirthers challenge whether contemporary U.S. obstetrics truly offers health and safety, and by extension, the absence of death and disability, while questioning whether the pain of

childbirth is something to be avoided. One mother who had had three babies at home explained:

> I of course grew up hearing the story that birth is inherently dangerous and unbearably painful and that I would need to go to the hospital to have a safe delivery. But after meeting a homebirth midwife and doing a lot of my own research when I was pregnant, I decided that that wasn't necessarily the case. . . . I also questioned the whole epidural thing. . . . We are taught that epidurals take away the pain, but really they take away all of the sensations including the power and the pleasure of birth. I wanted to feel my baby be born. Everyone thought I was crazy and irresponsible, but because I didn't see the pain of birth as a marker of danger or as something to be avoided, the hospital didn't have much to offer me.

Power as embedded in the intensity of labor and delivery. In addition to knowledge as power, homebirth narratives are woven with stories and subplots that communicate the enormous and often overwhelming personal power many experience as a result of the intensity of their birthing experience. A sense of exaltation and extraordinary accomplishment pervades all of the narratives, and several of the women interviewed described the moment of delivery or the sensation of first touching their newborn as ecstatic.

Midwives refer to the feelings of exaltation that many women express after a homebirth as "Superwomen Syndrome," and argue that it forms the foundation of empowered parenting and successful breast-feeding. Empowerment is the express goal for each delivery and it is seen by DEMs as integral, and not secondary, to a healthy mother and baby. One participant described the immediate postpartum experience by saying,

> When I saw her and held her, I knew what I had done. I had created a new life—a whole new person and I was overjoyed. . . . I mean I had birthed with no medications, no interventions and without anyone telling me what to do. I felt like I could do anything, which was good because parenting turned out to be very hard work!

It is important to note that participants located the source of personal power differently. Although all described power in connection with the acquisition of knowledge, as well as the lived experience of birthing, the religious women in the sample were careful to explain that the source of the power was their relationship with God and not something that they uncovered in and of themselves. Birthing and parenting in power can mean finding one's own internal power or tapping into the power of the divine, though, for the participants in this study, both were accomplished by avoiding the medical establishment. When women choose to birth at home with DEMs, they see themselves as effectively evading unnecessary and even harmful medical surveillance and manipulation—what Foucault (1979) calls the "panopticon of disciplinary power."

The panopticon, literally the observational tower found in prison yards, is a concept used by Foucault (1979) to illustrate how social surveillance, or what he called the "gaze," is central to the operation of power. Foucault (Gordon, 1980) argues that once individuals internalize the notion that they might be observed at any time and, in the case of pregnant women, that their bodies have become "public property" and are continuously subject to the gaze of "natal panopticonism" (Terry, 1989), individuals often become their own observers and enforcers, thereby turning themselves into "docile subjects." Docile subjects comply with the demands of the establishment willingly, and thus, power structures remain invisible until they are overtly challenged (Foucault, 1982).

Foucault (Gordon, 1980) argues that disciplinary power like that held by the medical establishment cannot operate without the panopticon or the continuous social surveillance of the gaze. Homebirthers, in refusing the gaze of medical surveillance, effectively undermine the authority of the medical establishment, reject the docile body, live the empowered body, and arguably, engage in systems-challenging praxis through enhanced democratization of the birthplace. Homebirthers' stories narrate attempts to avoid medical surveillance and insofar as women see themselves as successful, they construct an embodied reality that is not portrayed as docility, but instead as personal power. As one woman who had delivered both of her children at home explained,

> After my homebirths, I just do not believe that women need all of these interventions or that 30% of us cannot get our babies out vaginally. I can see now that it is more about controlling women and maintaining the hospital as an institution. Do they even realize that they are beating us down, disempowering many of us in the process? If they did know, would they care?"

Such explicit critiques of underlying power relations, combined with the overt refusal to work within

established institutions, situate homebirth as systems-challenging praxis.

Power as healing. The women who spoke of their homebirths as empowering relative to their previous experiences with hospital deliveries also claimed the power of birth at home to heal the scars of past "medical abuses." A participant who successfully completed a vaginal birth after Cesarean (VBAC) at home remembered,

> I screwed around in support groups and counseling for two years over my C-section. I was so upset. I couldn't even close my eyes without remembering what it felt like—all of that pulling and tugging, knowing my insides were open and that my baby was being cut out of me. I had a nagging feeling even then that I just needed more time and that I could do it if they supported me. . . . Anyway, after the first few weeks of grieving the experience, people lost their sympathy and were like, "Well, you have a healthy baby. You need to get over this." And let me tell you I tried. . . . But I had no outlet for that anger, that feeling of violation. . . . So, when I got pregnant again, there was no question for me. I wanted a midwife and a homebirth. . . . I delivered at home after a 4-hour labor and 20 minutes of pushing that I loved every second of. . . . My home-born baby was also a full pound and half bigger than my C-section baby. And the doctor had said my pelvis was inadequate. Whatever! I can tell you this. That birth healed me. It redeemed me. . . . I got my power back and I felt nothing but triumph.

The acquisition of knowledge as power combined with the lived experience of birth at home with midwives leads some mothers to lose faith in a medical establishment that they come to see as disempowering at best and damaging, harmful, and victim-producing at worst. What women describe as "blind faith" in modern obstetrics is replaced with anger and resentment when hospital deliveries lead to unnecessary interventions. Successful homebirth heals and restores faith, but a faith in birthing bodies and babies and not in the medical establishment or the benefits of hospital delivery. This transformation is commonly narrated as embedded in, and unfolding through, direct action—that is, through the embodied experience of the power, ecstasy, and personal accomplishment associated with homebirth. In addition, the knowledge and empowerment participants claim, what one mother called the "gifts of homebirth," do not end with labor and delivery. Many of the women who discussed power or empowerment in some form also made an explicit connection to parenting. As one participant said very pragmatically, "You know, it's good to have those feelings of extraordinary power to call on when they start waking you up every 2 hours to nurse and your nipples are sore and you are so tired you think you might die." For participants in this study, the power of homebirth and the faith the experience can engender is not a one-time event; it is deeply connected to their identities as mothers and to their perceptions of parenting following delivery.

Producing Intimacy in the Birthplace: Support for New Public Narratives

A third conceptual category that emerged from homebirth narratives involved discussions of the value of intimacy or connectedness during prenatal, intra-, and postpartum care. In explaining why they chose home over the hospital for place of delivery, participants emphasized a desire for intimacy that they believed was lacking in the hospital. Women discussed this desire for intimacy through three particular subforms or subthemes: (a) intimacy as necessary for surrender, (b) birth as intimate/sexual, and (c) intimacy as a prerequisite for disclosure during the prenatal period. All of the women interviewed, with one exception,[8] described their experiences of homebirth care as meeting and even exceeding their expectations for intimacy. Furthermore, the sense of connection produced in the birthplace (whether between midwife and woman, and/or mother, child, family, and friends) was narrated as essential to the development of social support networks that helped sustain the new family, especially in the early months of parenting. The intimacy generated through the homebirth experience and the networking so often provided by midwives created a supportive space for women to develop their individual counter-narratives into collective or social/public narratives. Such "strength in numbers" plays a vital role in sustaining homebirth as systems-challenging praxis.

Intimacy as necessary for surrender. Participants expressed a deep desire to create intimacy and a sense of personal connection in the birthplace primarily because they see trust between mother and midwife as the foundation of midwifery care. Trust is, in turn, constructed as "essential for a safe and empowering birth" as the former enables mothers to feel "comfortable enough to surrender to the power of contractions."

Participants explained that if they could establish a relationship of trust and intimacy with their care provider before labor's onset, they would then be better equipped to cope with the pain of labor. "Feeling safe" during the birth "releases fear," which is believed to make the pain of labor more bearable. One mother said, "Knowing I was safe and that the pain didn't mean something was wrong made it all manageable." Intimacy, trust, feeling safe and the ability to surrender are viewed as intertwined and essential components of a positive home delivery.

Midwives use the in vivo code "laborland" to help explain what happens when a woman and her attendant are able to create a "safe, intimate, and trusting space." When a birthing mother is confident that "someone trustworthy is guarding" her and "watching out for her and her baby's well-being," she can "let down her guard," "hear her inner voice," and "fully surrender to birth." Laborland is a metaphysical place that midwives believe all (or almost all) mothers go to "to uncover the power to birth." It is located deep within each woman, though not all find it during labor because medications that dull pain and the "fear of letting go of the conscious mind" can prevent some from inhabiting laborland. Midwives acknowledge that a mother is in laborland when the latter acquires "a far off look," "stops communicating during the contractions," and becomes "primal" (read intuitive) in her "birthsong"—the sounds mothers make to cope with the intensity of contractions and pushing.

Participants who had experienced both home and hospital births emphasized the differences between attempting to deliver in the hospital under the watchful eyes of "intimate strangers" and the sense of safety and the ability to surrender that came with knowing their care providers well. Some women also explicitly connected the decrease in the number of distance-producing interventions and technologies utilized during their deliveries at home with the production of intimacy and their consequent ability to surrender to labor. One mother explained,

> My midwife told me about the importance of getting out of my conscious mind, letting go and surrendering to birth. I know what she means now after having my third baby at home. . . . It was dark and quiet except for the sounds of my birthsong and the heart tones, and I felt so safe. For me, birth feels like a "back of the cave" experience, almost like I need to be inside a womb of safety myself, and that kind of intimacy is what I got at home. . . . In the hospital you cannot go there, at least I couldn't. I mean just all the asking you what you're allergic to and that automatic blood pressure cuff thing and then the IV pole. You cannot just let go when you are attached to so many tubes. You really have to think okay, what is attached to me where, and how can I get over there without yanking something out?

Birth as sexual and/or intimate. Some of the women who discussed the importance of intimacy and trust as prerequisites to surrender explicitly made a connection to the second subtheme in intimacy narratives—birth as sexual and/or intimate. A participant who had had one hospital and two homebirths explained that just as she would have had difficulty engaging in sexual intercourse with strangers looking on, so she felt the need to labor in the presence of people she felt an intimate connection with:

> Birth is a really sexual thing you know. I mean it's the same hormones. And listen to the sounds you make when you're laboring—it sounds like sex! For me it was so like that . . . you know how if you're having sex and someone just barges in or even if they knock and come in quietly, you really get out of your rhythm? (*laughing*) It's pretty much over until you can get the mood back. Well, that was sort of how my hospital birth was for me. I would get this great labor pattern going and then every time they came in to check me or poke around, it was gone. It was an uphill battle . . . but at home I knew the midwives were close by watching over us. They made this really intimate space where I could just contract and moan and push and do my thing.

Intimacy as a prerequisite for disclosure. Women who discussed the value of intimacy, trust, or connectedness with care providers also explained that as they got to know their midwives well, they were more likely to disclose information that was pertinent to their care. In the telling of her homebirth story, one woman, for example, shared how she had experienced extreme cravings for potting soil and coffee grounds during her pregnancies, a phenomenon known as pica.[9] Although this participant had not felt comfortable telling her obstetrician about these cravings, she shared them willingly with her midwife because she felt they had a "more equal relationship" and that she was less likely to be judged:

> I told her about my craving and she was so amazing about it. She said, "Isn't it really cool how our bodies let us know when we are missing something we need?" She said my cravings were my body's way of

> letting me know I needed more of some specific nutrient and that it was probably iron I was lacking. She got me on these liquid vitamins and sure enough—no more cravings.

Like the thematic categories of knowledge and power, intimacy was also tied to parenting. The women who discussed the intimacy of their homebirths explained how the setting of the birth contributed to increased intimacy with their partners or husbands, and ultimately with their babies. Fathers are generally very actively involved in prenatal visits and labor support at homebirths, and women frequently discussed the value of this participation in terms of cementing the parental relationship and encouraging investment in the child. As one mother explained,

> I think having him [her husband] at the birth, rubbing my back, holding me while I pushed, and just seeing what I went through to birth our baby, it changed us as a couple. I feel like we really entered into this lifelong endeavor very committed to each other and to this baby. . . . The intimacy and the power of our birth really brought us together.

Davis-Floyd (1992, 1994a, 1994b), in her various analyses of American birth models, focuses on connectedness and intimacy as the most fundamental values undergirding midwives' more holistic approach to birth. This connectedness, she and others argue, exists in opposition to the medical model of birth that is predicated on separation—separation of "milk from breasts, mothers from babies, fetuses from pregnancies, sexuality from procreation and pregnancy from motherhood."[10] "The warm exchange of breath and sweat, of touch and gaze, of body oils and emotions, that characterizes births in which there is intimate connection between the mother and her caretaker has given way in the United States to the cool penetration of needles, the distant interpretation of lines on a graph" (Davis-Floyd & Davis, 1997, p. 315). Like the midwives who attend them, participants in this study profess the value of connection and intimacy. As one participant explained: "I'll take the pain, the power, the pleasure, the intimacy of an unmedicated birth over an epidural any day. I didn't want a sterile, white-washed, 'Oprah on the television in the background' birth, thank you very much!"

The intimacy experienced and valued as essential in homebirth explanatory models affirms and sustains individual counternarratives even in the face of social sanctioning and ostracism. The sense of connection through common cause and shared experience provided in homebirth networks further facilitates the development of alternative, collective, or public narratives. This social support enables women to face detractors and often to become articulate and outspoken critics of the unequal power relations and "obstetric abuses" that they argue still plague medicalized models of birth today. The value of the social support provided in these groups, as well as through online communities, cannot be underestimated. One participant explained,

> After I go visit my parents and listen to them joking about how "out there" I am, you know because of the homebirth and the fact that I plan to nurse him for two years and we use a sling and on and on. . . . I have to go back home and reconnect to my community, so I don't feel like I'm crazy or a bad mother. I know what I'm doing is right for me and my baby, but sometimes the cultural pressure is just too much to handle alone.

The intimacy developed in these groups builds on the sense of connection experienced during the delivery and plays a role in keeping women's individual and collective counternarratives from being completely subsumed by the power of mainstream obstetric metanarratives and discourses.

Discussion

In response to consumer demands for more humane birthing practices, many hospitals in the United States now offer birthing rooms with floral wall paper, wooden beds, lovely cabinets that hide medical equipment until the time of delivery, and champagne and lobster dinners for postpartum celebrations. Women who choose to birth at home with midwives expressly reject these attempts to create more home-like and less institutionalized environments in the hospital, often referring to them as "superficial efforts," or as one woman put it "interior decorating obstetrics." Participants argued that because the U.S. cesarean section rate has continued to rise each year,[11] even while modifications have been made to make hospital rooms more family friendly, these changes are ultimately a façade that function to obscure the underlying belief that women

are incapable of birthing without obstetric management. Thus, homebirthing families reject systems-correcting praxis or those behaviors and interventions that Singer (1995) has argued provide some measurable gain, but do not challenge underlying structures of power. Homebirthers see such systems-correcting changes as vastly insufficient and even insulting, as they "trick women into thinking they represent a more woman-centered or holistic approach to birth." They call instead for the comprehensive transformation of an obstetric establishment they see as overly expensive, invasive, and disempowering.

An examination of theoretical categories grounded in women's homebirth narratives and analyzed from the perspective of critical medical anthropology reveal three integrated conceptual themes: knowledge, power, and intimacy. These themes help to explain the processes and motivations involved when women bypass mainstream obstetric care and give birth at home with direct-entry midwives. Findings suggest that women often begin with a process of unlearning and relearning, where they acquire new knowledge and consequently begin to question the validity of mainstream public and metanarratives. As they come to value additional forms of authoritative knowledge that include embodied and intuitive ways of knowing, mothers displace physicians as the unequivocal or sole experts in the birthplace. When women adopt more egalitarian forms of knowledge sharing and production, they contribute to an unmasking of covert sources of power at play in technocratic birth settings—a critical component of systems-challenging praxis.

The women in this sample formulated critiques of the dominant obstetric model through the exploration of alternative and subjugated knowledge sources, and articulated counterevidence for the "just in case something bad happens" argument that forms the foundation of hospital birth rationales. These commonly involve the express desire to experience the sensations of labor without medication, as well as overt challenges to the claim that obstetrician-attended hospital birth is safer than home delivery with a trained midwife. The development of counternarratives helps to reconcile disparities between dominant discourse metanarratives and women's own lived experiences of pregnancy and birth, and often stimulates a transition from faith in doctors and hospitals to faith in birthing bodies, babies, and midwives. As women move into the domain of direct action, their critiques of the medical model of birth are embodied in the lived experience of delivering at home. Personal power, agency, and for some women the healing they experience as they are transformed by the power of unmedicated delivery, further affirms their belief in, and advocacy of, new ontological counternarratives. These counternarratives assert a reality where women's bodies function exquisitely despite the absence of major technological interventions.

In avoiding the medical gaze and relying on social relations for assistance through the challenges of the childbearing year, intimacy is generated in the birthplace between midwife and mother, mother and babe, and mother and partner/family. This sense of community and connectedness often extends to encompass larger homebirth support networks as women seek out other like-minded mothers, usually with the help of their midwives. Through community formation, women find strength in numbers, as well as a continued sense of connection that affirms and sustains new ways of seeing and living birth and early parenting. Social support also prevents minority, homebirth voices and their alternative social and public narratives from being completely subsumed by the power of institutionalized birthing models and social pressures for conformity.

What remains unclear from this research is what happens to women and families when plans for an unmedicated delivery at home with a midwife go awry because of complications that arise during the prenatal, intrapartum, and/or postpartum periods. A major limitation of this study is the voluntary nature of sampling, which might have increased the likelihood that women with extremely positive birth experiences would seek out participation. A more comprehensive analysis of transport or transfer of care narratives might help to delineate the ways knowledge, power, and intimacy are negotiated when the pregnancies and/or deliveries of intended homebirthers do not go as planned. How, for example, do women who end up requiring the technologies and interventions provided by obstetricians in the hospital view their bodies, their midwives, and their relationship with the medical establishment? How do women face the "I told you sos" of pro-hospital birthing friends and family members? Do mothers who transfer care to backup physicians abandon components of homebirthing ideals, like the value of listening to the body or of informed consent? Or do they find ways to contextualize their experiences as exceptions holding true to the tenets of midwifery and homebirth models of care? These questions require further study.

Finally, it is important to note that women's homebirth narratives suggest a linearity of process that, in reality, might not have moved smoothly from knowledge acquisition to personal power and agency through direct action, and on to the development of new personal and social counternarratives grounded in an intimate network of midwives and homebirth activists. Hyden (1997) has argued that narratives are not only multilayered and open-ended, but that they are also temporally ordered. As women attempt to make sense of their experiences through storytelling, they order and structure events according to a chronology that does not necessarily reflect the progression of events and processes as they were/are lived. The motivations and personal journeys that women give voice to in their homebirth narratives are ongoing processes—ones they revisit continually as they face new detractors and work to construct, voice, and live homebirth as a minority social movement and systems-challenging praxis.

Notes

1. Out of hospital (OOH) refers to home and independent or freestanding (not connected to a hospital) birth centers.

2. Three of the 50 women interviewed were transported during labor for nonemergent complications.

3. See http://www.mana.org/statechart.html for the current legal status of DEMs by state.

4. "Homebirther" or "homebirth mama" is an emic, in vivo code used by participants to reference a group of women who share a similar value system that emphasizes the importance of unmedicated, midwife-attended birth at home; long-term, on-demand, and exclusive breast-feeding; cloth diapers; the use of slings; cosleeping; and often, but not always, delayed or selective vaccination. I use it occasionally in this article in an effort to vary my word choice, but do not mean to assert that participants are unidimensional, with the desire to give birth at home as their only social characteristic.

5. See Rothman (1991) and Davis-Floyd (1992) for discussions of medical/technocratic and midwifery/holistic models of care.

6. I follow the distinction between ratiocinative processes, or the process by which individuals reason methodically and logically, and intuition, or nonlogical, nonmethodical cognition that is based on the experience of deep cognitive processes that occur without awareness and cannot be logically reproduced or explained, as utilized by Davis-Floyd and Davis (1997) and Laughlin (1992, 1993).

7. Davis-Floyd and Davis (1997) use the *American Heritage Dictionary* (1993) definition of *intuition* as "the act or faculty of knowing or sensing without the use of rational processes; immediate cognition."

8. Part way through my research, it became obvious that all of the volunteers were overjoyed with their experiences of birth at home—a finding I was expecting given the literature on midwifery care and postpartum satisfaction ratings (Hunter, 2002; Rooks, 1997). As a result, I actively sought out two women who were rumored to be critical of their midwives and homebirth experiences. One did express disappointment in the connection, or rather the lack thereof, that she felt with her midwife at the actual delivery. She was careful to note that while the level of intimacy was much better than what she would have expected in the hospital, she felt that her midwife was too interested in having fun with the assisting midwife and that "she wasn't completely present" for her.

9. Pica is a craving for substances not normally considered food items, such as dirt, ice chips, and laundry starch. See Wiley and Katz (1998) for an overview of anthropological perspectives on dietary cravings in pregnancy.

10. Excerpt from Barbara Katz Rothman's Plenary Address, Midwives' Alliance of North America Conference, New York City, November 1992, as cited by Davis-Floyd and Davis (1997, p. 315).

11. The Cesarean section rates in the United States for 2004 (final) and 2005 (preliminary) are 29.1% and 30.2%, respectively, up from 24.4% in 2001 (Hamilton, Martin, & Ventura, 2007). See also www.cdc.giv/nchs/birth.

References

American Heritage Dictionary of English Language (3rd ed.). (1993). Boston: Houghton-Mifflin.

Anderson, R. E., & Murphy, R. (1995). Outcomes of 11,788 planned home births attended by certified nurse midwives: A retrospective descriptive study. *Journal of Nurse Midwifery, 40*, 483-492.

Baer, H., Singer, M., & Johnson, J. (1986). Introduction: Toward a critical medical anthropology. *Social Science and Medicine, 30*(2), 95-98.

Barbour, R. S., & Kitzinger, J. (1999). *Developing focus group research: Politics, theory and practice*. London: Sage.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). *Women's ways of knowing: The development of self, voice, and mind*. New York: Basic Books, Inc.

Bury, M. (1982). Chronic illness as biographical disruption. *Society of Health and Illness, 4*, 167-182.

Charmaz, K. (1990). Discovering chronic illness: Using grounded theory. *Social Science and Medicine, 30*, 1161-1172.

Charmaz, K. (2000). Constructivist and objectivist grounded theory. In N. K. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed. pp. 507-535). Thousand Oaks, CA: Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.

Cheyney, M. (2005). *In transition: A biocultural analysis of homebirth midwifery in the United States*. Unpublished Doctoral Dissertation. Eugene, OR: University of Oregon.

Davis-Floyd, R. (1992). *Birth as an American rite of passage*. Berkeley: University of California Press.

Davis-Floyd, R. (1994a). Mind over body: The pregnant professional. In N. Sault (Ed.), *Many mirrors: Body image and social relations in anthropological perspective* (pp. 204-233). New Brunswick: Rutgers University Press.

Davis-Floyd, R. (1994b). The technocratic body: American childbirth as cultural expression. *Social Science and Medicine*, *38*(8), 1125-1140.

Davis-Floyd, R. (1998). The ups, downs and interlinkages of nurse- and direct-entry midwifery: Status, practice and education. In J. Tritten & J. Southern (Eds.), *Paths to becoming a midwife: Getting an education*. Eugene, OR: Midwifery Today.

Davis-Floyd, R., & Davis, E. (1997). Intuition as authoritative knowledge in midwifery and homebirth. In R. Davis-Floyd & P. Sven Arvidson (Eds.), *Intuition: The inside story*. New York: Routledge.

Davis-Floyd, R., & Johnson, C. B. (2006). *Mainstreaming midwives: The politics of change*. NY: Routledge.

DeVries, R., Benoit, C., van Teijlingen, E., & Wrede, S. (Eds.). (2001). *Birth by design: Pregnancy, maternity care and midwifery in North America and Europe*. New York: Routledge.

Durand, M. (1992). The safety of home birth: The farm study. *American Journal of Public Health*, *82*(3), 450-453.

Fahy, K. (2002). Reflecting on practice to theorise empowerment for women: Using Foucault's concepts. *Australian Journal of Midwifery*, 15(1), 5-13.

Foucault, M. (1979). *Discipline and punish: Birth of the prison.* NY: Vintage Books.

Foucault, M. (1982). The subject and the power. In H. Dreyfus & P. Rabinow (Eds.), *Beyond structuralism and hermeneutics*. NY: Harvester Wheatsheaf.

Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: The Sociology Press.

Glaser, B. G. (2001). *The grounded theory perspective: Conceptualization contrasted with description*. Mill Valley, CA: The Sociology Press.

Glaser. B. G., & Strauss, A. L. (1967). *The discovery of grounded theory*. Chicago: Aldine.

Gordon, C. (Ed.). (1980). *Power/knowledge: Selected interviews and other writings 1972-1978 by Michel Foucault*. NY: Pantheon Press.

Greenwood, D., Lindenbaum, S., Lock, M., & Young, A. (1988). Introduction theme issue: Medical anthropology. *American Ethnologist, 15*(1), 1-3.

Hamilton, B., Martin, J., & Ventura, S. (2007). *Births: Preliminary data for 2005*. *National vital statistics reports.* Hyattsville, MD: National Center for Health Statistics.

Hyden, L. C. (1997). Illness and narrative. *Sociology of Health and Illness, 19*, 28-69.

Janssen, P., Holt, V. & Myers, S. (1994). Licensed midwife-attended, out-of-hospital births in Washington state: Are they safe? *Birth, 21*(3), 141-148.

Janssen, P., Lees, S., Ryan, E., Etches, D., Farquharson, D., Peacock, D., & Klein, M. (2002). Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia. *Canadian Medical Association Journal, 166*(3), 315-323.

Johnson, K. C., & Daviss, B. A. (2005). Outcomes of planned home births with certified professional midwives: Large prospective study in North America. *British Medical Journal, 330*(7505), 1416.

Jordan, B. (1993). *Birth in four cultures: A crosscultural investigation of childbirth in Yucatan, Holland, Sweden and the United States* (4th ed.). Prospect Heights, Illinois: Waveland Press. (Original work published 1978)

Kitzinger, S. (2005). *The politics of birth*. Edinburgh: Elsevier Butterworth Heinemann.

Klassen, P. (2001). *Blessed events: Religion and home birth in America*. Princeton: Princeton University Press.

Laughlin, C. (1992). *Brain, symbol, and experience: A neurophenomenology of human consciousness.* New York: Colombia University Press.

Laughlin, C. (1993). Fuzziness and phenomenology in ethnological research: Insights from fuzzy-set theory. *Journal of Anthropological Research, 49*, 17-37.

Lawless, E. (1992). I was afraid someone like you . . . An outsider . . . Would misunderstand: Negotiating interpretive differences between ethnographers and subjects. *The Journal of American Folklore, 105*(417), 302-314.

MacIntyre, A. (1981). *After virtue*. London: Duckworth.

Miller, T. (2000). Losing the plot: Narrative construction and longitudinal childbirth research. *Qualitative Health Research, 10*(3), 309-323.

Mishler, E. (1984). *The discourse of medicine*. Norwood, NJ: Ablex.

Murphy, P., & Fullerton, J. (1998). Outcomes of intended home births in nurse-midwifery practice: A prospective descriptive study. *Obstetrics and Gynecology, 92*(3), 461-470.

Navarro, V. (1984). A critique of the ideological and political positions of the Willy Brandt report and the WHO Alma Ata Declaration. *Social Science and Medicine, 8*, 467-474.

Phipps, H. (2001). Carrying their own medical records: The perspective of pregnant women. *Australian and New Zealand Journal of Obstetrics and Gynecology, 41*(4), 398-401.

Rooks, J. (1997). *Midwifery and childbirth in America*. Philadelphia: Temple University Press.

Rothman, B. K. (1991). *In labor: Women and power in the birthplace.* New York: W. W. Norton and Company. (Original work published 1982)

Schlenzka, P. (1999). *Safety of alternative approaches to childbirth.* Unpublished Dissertation. Palo Alto: Stanford University.

Singer, M. (1990). Reinventing medical anthropology: Toward a critical realignment. *Social Science and Medicine, 30*(2), 179-188.

Singer, M. (1995). Beyond the ivory tower: Critical praxis in medical anthropology. *Medical Anthropology Quarterly, 9*(1), 80-106.

Singer, M., Scott, G., Wilson, S., Easton, D., & Weeks, M. (2001). "War stories": AIDS prevention and the street narratives of drug users. *Qualitative Health Research, 11*(5), 589-611.

Somers, M. R. (1994). The narrative constitution of identity: A relational and network approach. *Theory and Society, 23*, 605-649.

Strauss, A. L. (1987). *Qualitative analysis for social scientists*. NY: Cambridge Press.

Terry, J. (1989). The body invaded: Medical surveillance of women as reproducers. *Socialist Review, 19*, 13-43.

Wagner, M. (2006). *Born in the USA: How a broken maternity system must be fixed to put mothers and babies first.* Berkeley: University of California Press.

Weiner, E., Swain, G., Wolf, B., & Gottlieb, M. (2001). A qualitative study of physicians' own wellness-promotion practices. *Western Journal of Medicine, 174*(1), 19-23.

Westfall, R. E. , & Benoit, C. (2004). The rhetoric of "natural" in natural childbirth: Childbearing women's perspectives on prolonged pregnancy. *Social Science and Medicine*, *59*, 1397-1408.

World Health Organization (WHO). (2004). *Beyond Numbers: Reviewing Maternal Deaths and Complications to Make Pregnancy Safer.* Geneva, Switzerland: Author.

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