CHOOSING RESISTANCE: SOCIAL POWER AND ALTERNATIVE BIRTH CARE IN SONOMA COUNTY, CALIFORNIA

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by

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San Francisco, California

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CERTIFICATION OF APPROVAL

I certify that I have read Choosing Resistance: Social Power and Alternative Birth Care in Sonoma County, California by Jessica Lee Dailey, and that in my opinion this work meets the criteria for approving a thesis submitted in partial fulfillment of the requirement for the degree Master of Arts in Anthropology: Sociocultural Anthropology at San Francisco State University.

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Childbirth in Western societies is subject to near-total medical surveillance and control. The power of the dominant medical institution is such that alternative forms of pregnancy, birth, and neonatal care, such as midwife-attended intentional out-of-hospital birth, are often devalued, distrusted, and delegitimized. This thesis explores how choosing alternative forms of prenatal and birth care can be understood as a form of resistance to the biomedical model of birth and the institution of allopathic medicine. This thesis will also explore the ways in which social and economic factors mediate access to different reproductive options, and how medical decision-making can also be understood as an expression of both social position, and of individual and group identities and value systems.

I certify that the Abstract is a correct representation of the content of this thesis.

Chair, Thesis Committee — Date: July 16 2019

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"…and then a week before our big wedding in Sonoma, we were at Burning Man and randomly ran into a homebirth midwife who lived in Santa Rosa. And we're like, 'Hey, well, we're getting married next week and, like, probably going to have a baby soon,' so she gave us her card and went on to deliver all three of my babies." Willow[1] is a homebirth mother. She is describing to me how she made the decision to give birth to her children at home, instead of in the hospital. Before her fortuitous encounter with a midwife at Burning Man's Playa, Willow said that she had seen the film "The Business of Being Born," which touted the benefits of homebirth. Willow's mother, whom she described as being "into natural, holistic stuff," had also given her a book about midwifery.

Willow tells me that she and her then-fiancé are people who often go against the grain: "We don't necessarily have to do what everyone else did. Let's look at the information and then make our own decision." They felt that mainstream conceptions about pregnancy and birth were unnecessarily medicalized and fearful. "The things that made a lot of sense to us, were around the idea that hospitals are for sick people and pregnancy is not a medical condition in that way, and that it's a natural process." Willow tells me that she also doesn't trust "Big Pharma" or medical institutions in general. She

[1] Willow's name, and all names used for research participants throughout this thesis, are pseudonyms

didn't begin vaccinating her children until they enrolled in kindergarten. Even then, Willow didn't follow the full immunization schedule as recommended by her doctor, preferring instead to opt for only the vaccines she thought necessary, which were administered to her children on a delayed schedule of her choosing.

We are drinking sparkling lemonade spiked with ginger and lavender. The coffee shop where I am meeting Willow is trendy among groups who identify as counter-cultural or alternative. I meet with and interview several of my informants here, throughout the course of my fieldwork. Mismatched tables, chairs and couches are strewn in a haphazard manner among shade trees, unkempt herbs, and flowering plants which overgrow their containers. Windchimes and colored fabric decorations hang in the branches above, stirred by the occasional breeze. The majority of one side of the building is a graffiti-style mural in pastels and jewel tones. The resulting impression of this locale is whimsical, inviting, and visually vibrant—A comfortable respite from the heat of the August afternoon.

Demographically, the coffeeshop is also an overwhelmingly white space. Although there are Black faces painted on the mural wall, the baristas and the majority of the customers are light skinned. Willow is white, too. When I ask her how she identifies herself racially at the end of our interview, she laughs awkwardly and changes the subject without answering. This sudden reticence is surprising to me. For the better part of an hour and a half, Willow has talked to me in great detail about her thoughts, opinions, and

lived experiences around pregnancy and birth. She has been friendly, and forthcoming, even to the point of showing me photographs on her phone of herself giving birth. She is enthusiastic to describe why her decisions to opt for homebirth, and the care of a midwife, were well-informed, beneficial, and ultimately, correct.

Willow is 35, and the mother of three young children, all of whom she gave birth to at home. She paid $5,000 for each homebirth—a rate she describes as discounted owing to the close friendship she developed with the midwife she met at Burning Man, and the amount of business generated for her as Willow convinced her friends and sisters to have homebirths of their own and recommended her services. In addition to paying her midwife, Willow retained her Kaiser insurance throughout her pregnancies. When I asked if accessing this form of care posed her hardship, she told me "I'm thankful that my husband was on board, or that I have control of the money, and that my family was supportive." The issue, as she saw it, was not the cost of homebirth, but whether one's family was supportive of choosing it. "I know some women have to fight," she explained: "I also have friends who could afford a home birth, but their husbands refuse to pay for it because they think it's too risky or they just don't know. They just don't think it's a good use of their money." Willow had taken my question about economic costs and reoriented it in her response—framing the issue of paying for homebirth as one of social acceptance, rather than access. Having enough money to cover the cost of care wasn't a concern—instead, the difficulties Willow saw arising with having to pay $15,000 in the space of

three short years were the potential for her choices to be criticized or opposed by her family and social circle. She felt lucky that this hadn't been the case for her: "I didn't have pushback from my family. Like, I also don't have a family that was, you know, against the idea of homebirth, or against breastfeeding or… Like, some women are fighting totally an uphill battle. I didn't have to convince my husband, you know, any more than just educating him."

This thesis tells a story about the alternative birth community in Sonoma County, California. The research I conducted involved interviews with practitioners, both medical and non-medical, who provide pregnancy and birth care outside of the socially dominant biomedical model. I also spoke to women who chose or desired these forms of care. My analysis of interview content looked for major themes in informants' descriptions of their motivations for choosing alternative prenatal and birth care. I found that the women I spoke to often opted for alternative forms of medical care as a means to refuse, or deny, biomedical control over their bodies and experiences with birth. It also became apparent that my research participants' attitudes about the processes of birth, the nature of medical institutions, and individual care-seeking choices can all be understood as expressions of a specific set of ideologies and value systems particular to this group. Additionally, the demographic makeup of my study population—majority white and affluent—is a key component of their care-seeking choices. This thesis interrogates what it means for a

socially and economically powerful group of people to actively choose a non-dominant form of medical care.

During the fieldwork phase of this project, I conducted fourteen ethnographic interviews over a period of five months in the Summer of 2018. After my original plans for performing participant observation at a local birth center fell apart due to the sudden firing of the individual who was my main point of contact there, I began emailing local midwives and asking if they would like to be interviewed on the subject of alternative forms of birth care. To my delight, I was met with prompt responses indicating interest.

My first two interviews were with midwives who I had emailed, and who had enthusiastically agreed to participate in my research. At the end of both interviews, I asked them if they knew of anyone else I should speak with, and they both sent me in the direction of other women who had something interesting to say about birth. Lucy, the second midwife that I interviewed, made a post about my research in a private group on social media for self-described "hippie moms." These were women who lived and advocated varying degrees of alternative philosophies and lifestyle choices. I began receiving messages from women who wanted to talk about their homebirths, their experiences as doulas or prenatal yoga instructors, and various other thoughts and opinions they had about pregnancy and birth in general.

One characteristic I found that my informants had in common was considerable enthusiasm for sharing their particular worldviews. I often got the sense that they were

trying to educate, or persuade me, of various things: that the medical institutions attempt to quash knowledge about efficacious treatments outside of allopathy, that vaccines were a poisonous sham, that the hospital often does more harm than good—in short, that the world was not what it seemed and that that which is popularly accepted as mainstream belief or practice needs to be questioned and often rejected, especially where medicine is concerned. Accordingly, these informants' medical decision making often favored alternative forms as a means to evade biomedical care, and they were keen to describe the benefits of their choices. Throughout the course of my fieldwork, the women I spoke to often told me about the various alternative techniques that they used, some of which I had never heard of—that colloidal silver can be taken orally as an antibiotic, that a clove of garlic inserted vaginally will cure a yeast infection, that healing crystals are most efficacious when tucked into one's bra, close to the heart. My informants often encouraged me to try these things for myself, assuming that I, like them, wanted to distance myself as much as possible from mainstream medical care. Despite their zeal for alternative forms of medical care, not a single mother I interviewed went without health insurance, or the care of a biomedical physician, even while receiving care from alternative practitioners during their pregnancies.

The women who I interviewed were also quite privileged—they belonged to socially powerful sectors of society. Most of them were white, affluent, and married. Many of them were highly educated, holding graduate degrees, or professional

certifications in the realms of psychology, nursing, or prenatal yoga instruction, for example. Along similar lines, the birth care providers, both medical and non-medical, were often reluctant to talk about race or socioeconomic class among their clients, but when pressed, would portray their "typical" client as white, mid-thirties, married, and, as described after some uncomfortable hedging by Linda, a doula and prenatal yoga instructor whom I interviewed in July: "people who can afford to pay out of pocket." Because midwifery and homebirth are medically marginalized forms of care which exist outside of the dominant institution, they are seldom covered by insurance and are often quite expensive.

To address theoretical and ethnographic themes which were relevant to the fieldwork I conducted, my research also included a foray into a large body of literature. Much vital research has been done concerning pregnancy and birth care, and associated power dynamics, within the field of medical anthropology, and also from scholars of social thought more broadly. I draw from these works to discuss the various themes connected to what it means to choose alternative forms of birth care in contemporary US culture, within the specific population that I interviewed. I found that the three main broad areas of inquiry which were pertinent as context to my own analysis were the highly medicalized nature of US childbirth, and the natural birth movement as a shift towards demedicalization; the profoundly imbalanced power dynamics inherent in biomedical birth care and how choosing alternative forms of care can be understood as a

means to disallow biomedical control over the body; and how medical decision-making can be understood as an expression of both class position and group identity. The contents of this thesis are organized around these three main themes, each of which constitutes one of the three chapters to follow:

The Historical Medicalization and Demedicalization of US Childbirth

In order to understand the social landscape within which my informants made their care-seeking decisions, one needs to consider how biomedical birth-care, and hospital birth, came to be popularly accepted as standard and socially expected. To this end, this thesis draws on sources which discuss the history of childbirth in the US, focusing on its medicalization, and subsequent modern movements to demedicalize.

Chapter One follows the historical narrative that has taken birth in the US out of the domestic spaces of the home, and the care of the midwife, and placed it instead inside of the hospital and into the hands of the obstetrician. The rise of hospital birth in the late-1800s as the dominant model of care ceded control over childbirth, and the parturient body, to the (typically male) physician, and this corresponded to the centralization and consolidation of medical authority and power which occurred during this same timeframe (see Dye 1980; Starr 1982). The popularization of hospital birth signaled also a change in public understandings of the birth process. Birth began to be both medically and publicly understood as inherently dangerous and flawed—a framework which legitimized medical

control and contributed to the power of the biomedical model of birth, and its popular conceptualization as a logically necessary and beneficial intervention. This remains the case to this day, as evidenced by the fact that in 2016, 98.4% of all live births in the US occurred in the hospital (Martin et al 2018, supplemental table I-4).

Hospital birth remains the mainstream practice in the US. However, beginning in the 1960s, and corresponding to other countercultural social movements, midwifery and homebirth began to be increasingly used. Between 1970 and 1977, the rate of intentional-out-of-hospital birth in the US more than doubled, predominantly among the white middle class (Kline 2015, 530). The dramatic increase of homebirths among middle-class white women helped shift the popular social perception of the practice away from a low-cost yet risky alternative for economically marginalized segments of the population towards an informed, voluntary choice which gave more affluent subjects a greater degree of autonomy and control during the birth process. This history is especially relevant for the women who participated in my research, since Sonoma County, with San Francisco and Berkeley only a short car ride away, served as a hub of social movements to get away from the city and back to the land during the 1960s and 1970s. Echoes of these counter-cultural social movements are still very present in contemporary Sonoma County, as evidenced by my informants' referring to themselves as "hippie moms."

Because of the intrinsic connections between the dominance of the biomedical model of birth and its social and historical contexts, this project includes a discussion of

the history of hospital birth in the US, and the emergence of the natural birth movement as a response to some of the problems associated with it. Just as the shift towards in-hospital birth defined parturition as a medical event, the holistic style of care associated with the natural birth movement moves towards demedicalization by foregrounding the social, emotional, and experiential aspects of birth. Presenting a social history of the emergence of hospital birth as the dominant standard of care provides this thesis with important context for its discussion of what it means for a modern-day economically and socially advantaged population to choose non-dominant forms of care.

Medical Power and Control During Childbirth

This thesis also explores the clash between medical authority and individual autonomy and control, both bodily and ideological that can occur during labor and birth. During the course of my interviews, many research participants told me that their decisions to opt for alternative forms of prenatal and birth care served as a means to avoid, or disallow, biomedical control of their bodies. The nature of hospital birth is often described as dehumanizing because it subjects the pregnant female body to near-absolute medical surveillance and control, and because it foregrounds the biophysical processes of parturition as medical events at the expense of the social and emotional components of labor and birth (see for example Davis-Floyd 2004). Since the imbalanced power dynamics characteristic to the biomedical model of birth loomed large in the decision-

making processes of the women I spoke to, this thesis includes a review of literature relating to medical authority and control over the parturient body. In order to address the broad topic of medical control over the parturient body, and choosing alternative care as a means to resist medical authority, the works I review in chapter two are divided into three main discussion sections: 1. Medical authority over female reproductive processes; 2. The technocratic rituals of biomedicine in US childbirth; 3. Resisting biomedical power by rejecting it.

Much important scholarly work has been done addressing medicalization, and medical practice, as instruments of power and control. The dominance of the biomedical model of childbirth care is largely a product of the hegemonic nature of biomedicine itself. In order to address the broad theme of medical power over bodies, this thesis draws upon some of the theoretical work of Michel Foucault. Foucault's work describes how the practice of medicine behaves as a focal point for societal power over bodies—one of the avenues by which states pursue their prerogatives to improve or maintain the health of their populations (Foucault 1997, Foucault 2004). The broad movements of power which address themselves to a population's overall health often result in political support for a dominant, normative form of care—which in turn becomes standard and socially expected (Foucault 1997, 246-253). Moving from Foucault's premise of regularizing medical care to consider the specific issue of childbirth, hospital birth under the attendance of an obstetrician is the socially dominant form of care. Because pregnancy

and birth are subject to extreme medicalization in the US, childbirth care cedes control over the parturient body, as well as authority over knowledge around birth, almost entirely into the hands of the institution of biomedicine, and its representative, the obstetrician. In this thesis, I draw on the work of Foucault to explore the dominance of the mainstream form of birth care, in relation to the marginalized form—midwifery—which was preferred by my informants.

In her body of work, medical anthropologist Robbie Davis-Floyd has interpreted mainstream medical care around birth in the US as a series of technocratic rituals (see Davis-Floyd 1994; Davis-Floyd 2004; Davis-Floyd 2018). Davis-Floyd writes that absolute faith in science and technology forms the central cultural ethos in the US, which is expressed in the birthing room through biomedical mutilation of the natural processes of birth, and the substitution of technological prostheses in their place. Davis-Floyd's reading of biomedical birth care in the US holds true in many ways, and many critiques of allopathic birth care have centered around the overuse of technological and surgical interventions during birth, and the understatement of the possible harm they might cause in the biomedical literature (see, for example, Wendland 2007).

Chapter Two presents literature which explores the issues of medical power and control during childbirth and medical care more broadly. It includes a review of literature which addresses the theme of choosing alternative, or non-dominant, forms of care as a means to resist medical power. Because of the extremely medicalized nature of

biomedical birth care, many scholars have argued that seeking alternative forms of birth care can be understood as a reaction against the social power wielded by the dominant medical institution and its normative model of birth (see Cheyney 2008, Craven 2005, Davis-Floyd 1994, Davis-Floyd 2004, Davis-Floyd 2018, Macdonald 2006, Miller 2009, for example). I found that among my informants, the rejection of biomedical prenatal and birth care served as a means to avoid feeling disempowered and out of control of their bodies. Opting for alternative forms of birth care allowed them access to a birth experience they found preferable because it foregrounded the social and emotional components of birth. By challenging the popular belief that hospital birth is necessary in order to avoid risk during childbirth, the choice to opt for homebirth, or the care of a midwife, can be understood as an expression of resistance against medical power and authority

Medical Decision-Making as Expressions of Class Position and Group Identity

This thesis also addresses itself to the issues of privilege and social power, and their relationship to the medical decision-making processes and the "hippie mom" identity characteristic of my study population. Throughout the course of my fieldwork, I found my research participants to be mostly white, affluent, heterosexual and highly educated, which is in keeping with demographic trends in the region of Sonoma and

Marin counties. These informants made decisions to opt for alternative medical care from positions of marked economic power.

To address this, I make use of the theoretical framework of stratified reproduction. In their classic edited volume *Conceiving the New World Order: The Global Politics of Reproduction* (1995), anthropologists Faye Ginsburg and Rayna Rapp introduce this term, and present essays which discuss the ways in which access to reproductive care, resources, and experiences are mediated by social factors such as gender, class and race. As Ginsburg and Rapp argue, conception, pregnancy and birth take place in a hierarchy where reproductive options are disproportionately available to those who are in positions of social and economic power—that social factors outside of reproduction itself have profound impacts on which forms of reproduction are popularly considered to be acceptable or even celebrated, and which are problematized even to the point of becoming criminal. In this thesis, I use the framework of stratified reproduction to interrogate the connections between my informants' privileged class positions and their care-seeking decisions around pregnancy and birth—and how seeking alternative birth care while still retaining access to biomedical care, should it be needed, can be understood as a function of economic power.

Literature that makes use of the theoretical framework of reproductive stratification in large part does so to interrogate the ways in which reproduction among groups of socially, economically, or medically disadvantaged people becomes

problematized. Examples of excellent ethnographic work concerning stratified reproduction in US culture include: Khiara Bridge's book *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* (2011), which explores the negative consequences of race on women who depend upon public healthcare for prenatal and birth care; Kelly Ray Knight's book *Addicted. Pregnant. Poor.* (2015) which documents the lives of drug-addicted women in San Francisco's Mission District; and Ellen Lewin's essay "On the Outside Looking In: The Politics of Lesbian Motherhood" (1995), which presents the particular set of social issues negotiated by lesbian mothers. All of these examples address how groups who are marginalized by dominant culture have their experiences with conception, pregnancy and birth problematized in one war or another.

Fewer works have addressed how experiences with reproduction and reproductive care are different for more privileged sectors of society. One exception is Ellen Lazarus' essay "What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth" (1997). In this essay, Lazarus interrogates the connections between socioeconomic class and birth in America, by comparing the content of interviews she had conducted during two separate studies in the 1980s—one which followed fifty-three indigent women through their prenatal care, and one which addressed itself to childbirth experiences of middle-class women (1997, 139). Lazarus describes that in the context of hospital birth women tended to value having control of the social and emotional aspects of labor and birth, and while lower-class women might have

valued those things as well, their own choices were so limited that what mattered most to them was simple continuity of care. The women in my research echoed this finding—they often explained their choice to seek out alternative care to me in terms of improving the experience of labor and birth in a way that felt more emotionally fulfilling than hospital care. With my own writing, however, I move one step beyond Lazarus' observations, and suggest that with greater degrees of social privilege individuals are able to access not just increased control over their birth experiences within the same system, but the ability to opt out altogether while still maintaining access to the rejected care model. The women with whom I spoke were able to access a care model which foregrounded the emotional and social components of birth to a greater degree than does the biomedical model, while retaining their insurance and access to the hospital, should they need it, because of their privileged socioeconomic positions. Therefore, in this population, the choice to opt for alternative forms of prenatal and birth care, and (partially and conditionally) resist the biomedical model, can be understood as a function of economic power and social privilege.

Medical decision-making can also be understood as a means to project one's identity and belonging to a particular group. In the third chapter of this thesis, I discuss my informants' medical decision-making preferences using the motif of "hierarchy of resort." This term comes from the work of Romanucci-Ross', whose book "The Hierarchy of Resort in Curative Practices: The Admiralty Islands, Melanesia" (1977)

explores how medical care-seeking decisions can be expressive of social dynamics at work within a group. In the case of my research participants, I found that their first resort for care was usually whatever form was perceived as non-allopathic, non-institutional or alternative. In addition to alternative forms of birth care, my informants often made use of other non-dominant forms of medical care beliefs about medicine. Informants told me about their use of techniques such as reiki, energy healing through crystals, and aromatherapy, and that they preferred these to biomedicine in most cases. Many of them believed that mainstream medical institutions, doctors, and pharmaceutical corporations, were deceptive and untrustworthy. I found espousing some degree of anti-vaccine belief to be relatively common among these informants, even among the midwives I spoke with.

As a group, the women I spoke with believed themselves to be at-odds with societal institutions, such as "Big Pharma," the government, and mainstream medicine. Accordingly (and somewhat paradoxically), they leveraged their social and economic advantages to reinforce their identity as nonconformists resisting social power, and to strengthen their bonds as a group. As I discuss in chapter three, the hierarchies of resort employed by my interview participants expresses a group identity that valorizes counterculture and resistance to medical authority, and also of belonging to a special community with certain expectations of alternative philosophy and lifestyle choices.

One of my research objectives, before I began my fieldwork, was to determine whether I could find any discernable patterns in self-reported ideological motivation for choosing alternative forms of prenatal and birth care. Analysis of interview content revealed twelve major themes in women's motivations for their reproductive health care choices:

1. Birth and the Female Body Are Safe
2. The Biomedical Model is Not As Safe as it Seems
3. Keeping Concurrent Biomedical Care is Necessary—"Just in Case"
4. Midwifery/Alternative Models Attend to the Social Aspects of Birth, are Holistic, and Individualized
5. Midwifery Offers "True" Informed Consent
6. The Biomedical Model Mitigates Choice and Personal Control
7. The Standards Used By The Biomedical Model Erase the Individual, the Emotional, and the Social
8. The Biomedical Institution and its Physicians (Wrongly) Control Medical Knowledge
9. Alternative Medical Decision-Making as an Expression of Alternative Identities
10. Choosing Alternative Care Because of a Negative Experience with Biomedicine
11. "Natural" as Superior
12. Alternative as the "Educated" Choice

I explore each of these themes in more detail in the Findings Chapter of this thesis. The majority of women I spoke to chose to seek out the midwifery model of care as a means to refuse, or deny, biomedical control over their bodies and their experiences of childbirth which they described as coercive and dehumanizing. Choosing alternative forms of prenatal and birth care can also be understood as a demonstration, and reinforcement, of class position, group and individual identity, and shared value systems. The informants I spoke to leveraged their powerful social positions in order to reinforce strongly held values and beliefs by rejecting the dominant model of medical care. For this population, resistance against medical authority can be partially understood as a form of privileged expression—an exclusive means to broadcast belonging to a group that valorizes alternative philosophies, countercultural lifestyle choices, and distrust of institutions. This thesis explores what it means for a socially and economically privileged group of patients to actively seek out a medically marginalized form of care—and how my informants' choices to avoid biomedical control over their bodies during birth, while simultaneously expressing their identities as "hippie moms," is made available to them by their powerful social positions. The group of women with whom I spoke chose to avoid biomedical care as much as possible because of their distrust of medical and pharmacological institutions—paradoxically leveraging their economic power to reinforce their identities as individualistic resistors of social power. In a period when US society has recently

experienced serious outbreaks of preventable diseases—such as measles or pertussis—due to vaccine refusal in groups demographically similar to my own study population (see for example Phadke, Bednarczyk, Salmon, and Omer, 2016), interrogating the social motivations behind avoidance of biomedical care is relevant and timely. In the case of my study population, high levels of social and economic privilege allowed for reproductive care-seeking decisions to be made not only to control the experience of labor and birth, but also to express something about one's beliefs, and one's belonging to a group. This thesis argues that for the "Hippie Moms" of Sonoma County, California, opting for alternative forms of birth care can be partially understood as resistance to medical authority over birth, but also—and perhaps more importantly—can be interpreted as a means to reinforce their identities, values, and beliefs about themselves as a community.

Medicalization and Demedicalization: From Home to the Hospital, and Home Again

Introduction

This chapter discusses the history of childbirth in the United States, focusing on the medicalization of birth that accompanied the rise of hospital birth and obstetrical biomedicine as the dominant model of care, and the subsequent shift towards demedicalization that is associated with the natural birth movement. In order to situate my later discussion of alternative birth care choices in contemporary Sonoma County, I will explore the history of birth care in the US in terms of its medicalization, as well as discussing modern movements, such as the natural birth movement, towards demedicalization. The rise of modern obstetric practice shaped popular perceptions about what kinds of birth and birth care were thought of as normal or desirable. To this end, I will trace the history of the hegemonic practice of hospital birth in the US by demarcating four main periods in US history. The earliest period, *pre-medicalized* birth, took place prior to the 1800s when birth care was primarily administered by a midwife in the home, and was understood as a social, rather than medical, event. The second period, the *medicalization* of birth care, occurred during the 1800s when birth, though it still took place in the home, shifted away from the midwife and into the care of the biomedical physician. The period of *hospitalization* began in the early 1900s, when hospital birth began to become the most popular form of care. Finally, what I am calling the period of *demedicalization* began in the 1960s and 1970s, with the emergence of the natural birth

movement in the US and the shift towards demedicalization it is associated with. I will discuss this last period as a social reaction to the dominance of the biomedical model of birth, which pregnant women had largely accepted prior to that point. It is important to note that the dates with which I have defined the four periods I will discuss are not absolute, given that of course there existed individual differences in practice, circumstance, and decision-making, but rather indicate large-scale trends in the United States as a whole. Exploring the historical establishment of what forms of birth care are dominant, and socially desirable, in the US, and how they came to be that way, provides for this thesis important context for a discussion of what it means for a contemporary cohort of patients to choose non-dominant forms of birth care. As I will discuss in chapters two and three, seeking out alternative forms of birth care can be understood to function both as a means of denying biomedical control over the birthing body, and as an expression of strongly held group values and beliefs.

Home

> *"I think a large number of people who are looking for that support are just looking for support in the way that we used to be able to provide it, I don't know when... Back in the old days, or in different cultures. I mean, I tell clients all the time, you're just paying for your village."*
> -Linda, 48, Homebirth Mother, Doula, and Prenatal Yoga Instructor

Childbirth in the geographic region known as the United States took place among Native American populations for centuries before the arrival of European settlers, but

birth care as it exists today primarily reflects shifts in childbirth practices and associated values that began among white settler communities (McCool and Simeone 2002, 736). Childbirth in the colonial United States took place in the domestic sphere (Dye 1980, 98; McCool and Simeone 2002, 736). Until the late 1800s, and the onset of the period of medicalization, when care during childbirth shifted into the domain of the biomedical physician, birth typically took place in the home, surrounded by female friends and family members, and attended by a midwife (McCool and Simeone 2002, 736; Dye 1980, 98; Thomasson and Treber 2008, 79; Leavitt 1986, 36-38). The period in which US childbirth occurred in the home—which I will be referring to as the pre-medicalized period during the years prior to 1800—both paved the way for the later shift towards hospital birth, and also still echoes through contemporary social conceptualizations of labor and birth. It was against a backdrop of birth in the home that the medicalized model of birth care first developed. Modern movements towards demedicalizing birth often call up the pre-medicalized period as a reference point for imagining care which treats birth as a social, rather than medical, event.

During the course of my fieldwork, I noticed a tendency towards romanticizing the past. The positive aspects of the pre-medicalized period of birth care provided both a historical background, and an ideological justification, for the shift away from the extremely medicalized allopathic model of birth. Giving birth in the domestic space of one's home, with a midwife and one's family in attendance, was sometimes described as

a restoration of the ways in which birth care was carried out in the past. For some of my informants, such as Linda, above, the move away from medicalized birth models harkened back to what they understood as the halcyon days of birth as a social event which foregrounded female camaraderie and support, close social bonding, and the emotional experience of welcoming a new member into one's family.

There are some flaws in the historical narrative about birth care in the US. Knowledge about birth in the pre-medicalized period is largely available to historians through contemporaneous letters and written accounts. The historical sources on childbirth in this early period of US history contain inherent biases. The narrative provided by the historical record is not exhaustive; parts of the history are inaccessible, and the accounts which remain largely represent the dominant experiences. For example. as noted by historian Nancy Schrom Dye in her essay concerning the history of childbirth in the US, although historians record that the vast majority of births in the US were attended by midwives until the 1800s, very few materials exist that shed light on the practitioners themselves (1980: 99). Factors such as literacy levels, social class, and race among midwives during this time remain something of a mystery, as do birth experiences from non-white or lower-class communities (1980: 98-105). We know from examples such as Gertrude Fraser's exploration of the disappearance of African American midwives in the American South (1995) that marginalized communities historically possessed their own birth practitioners and forms of care. Unfortunately, the birth

practices of non-dominant groups often are left out of accounts of the history of mainstream biomedical birth and midwifery. The discussions of majority childbirth practices which follow are not necessarily representative of the experiences of all US women, and especially not of those from marginalized communities. Instead, the experiences which are disproportionately represented in the historical records are those of married white women from the upper and middle classes (Leavitt 1986, 7-9).

Colonial American women in the 1700s gave birth in a fashion that was culturally patterned off childbirth practices in England at the time (McCool and Simeone 2002, 736). Birth typically took place in a woman's bedroom, where she might be surrounded by female friends and family members, attended by a female midwife, and perhaps also a female nurse. If a family were affluent enough to afford his services, a male physician might also have been available on an on-call basis, in case of emergencies (McCool and Simeone 2002, 736).

After the birth took place, the new mother remained in her bedchamber for a "lying-in" period, in which she recuperated and spent time with her child while still surrounded by her supportive network of female companions (McCool and Simeone 2002, 736). In this sense, labor and childbirth in the US during this period were predominantly social, rather than medical, events. Birth was embedded in the domestic sphere of life and created a space for the strengthening of close social bonds and the expression of care along the lines of a supportive female community. Likewise, birth

practitioners during this time employed a non-interventionist approach—unless labor was not progressing normally and required some form of medical assistance, the role of midwives and other birth attendants was primarily understood in terms of offering reassurance and emotional succor to the parturient woman (McCool and Simeone 2002, 736).

As Dye notes, however, it is inaccurate to imagine US childbirth during the pre-medicalized period in an idealized way (1980, 99). Even though the experience of childbirth during this time carried with it the positive characteristics of emotional support and reinforcement of intimate bonds among one's female social network, it was also fraught with danger. Preparations taken in advance of labor during this period were often understood as being synonymous with preparation for death (McCool and Simeone 2002, 737). Preparing for confinement (a period of imposed isolation in the final stage of pregnancy) often included such measures as writing letters to loved ones, arranging care for one's infant in the event that the mother should die and her offspring live, and putting one's financial and spiritual affairs in order (Leavitt 1986, 20-22).

Historian Judith Walzer Leavitt describes the possibility of maternal or neonatal mortality and morbidity during this time as "the shadow that followed women through their childbearing years" (1986, 20). Leavitt's account of childbirth in the US from the 1700s through the 1800s describes how maternity and mortality were popularly understood as intimately connected—with every pregnancy, even young and healthy

women carried within their bodies the terrifying potentialities for stillborn infants, life-altering injuries and infections, and of course, death (1986, 20). Intense fear of injury and death colored women's birth experiences, and continued to shape popular perceptions of birth until long after maternal and neonatal mortality rates began to decline in the 1800s (McCool and Simeone 2002, 737). As I will discuss in a later section of this chapter, desire for increased safety during childbirth was one driver of the increased medicalization of birth in the US during the 1900s.

The fear of death during childbirth during the 1700s was also accompanied by dread of the uncontrollable pain that accompanied labor and birth. Dye notes that the terror that was popularly associated with the period of confinement was such that labor and birth were often regarded with superstition (1980, 99). The mortal terrors of death and pain were commonly combined with perceptions of childbirth as a point of vulnerability to malevolent supernatural forces, such as witchcraft or demonic interference (Dye 1980, 99). The connections drawn to the supernatural can be understood as an extension of religious values that had their roots among the Puritan communities of the US colonial period, which framed the terror of childbirth as a divine moral punishment meted out upon the female gender.

Sociologists William Ray Arney and Jane Neill, in their essay analyzing changes in perceptions of labor pain over time, write that before birth became medicalized it represented "a crisis, physiological and moral, through which women were destined to

pass by virtue of their place in the natural order" (1982, 3). The "place in the natural order" which women were understood to occupy was one of subordinance. Pain during labor and birth took on a moral characteristic—known as the "Curse of Eve," childbirth was understood as the penalty visited on women for Eve's role in the Fall (Arney and Neill 1982, 3). The severity of pain, then, and a woman's success in coping with it, became indicative of her moral character and standing in the sight of God. As I will discuss in a later section, with the medicalization of birth the socially constructed ontology of labor pain shifts away from an indication of the displeasure of the Christian God and into the role of a foil to effective medical technique—an obstacle to be eradicated at any and all cost through medical intervention. Later movements to demedicalize birth also correspond to a shift in the meaning of labor pain. With the rise of the natural birth movement, pain took on a revelatory capacity once again. Instead of signifying the displeasure of a divine entity, for proponents of natural birth, pain in labor becomes indicative of the normal functioning of the biophysical processes of parturition, which are regarded as healthy and ultimately positive.

Pain and death during childbirth were sources of significant dread for US women, then, prior to the 1800s. The confinement room was a place of female social support and expression of care, but it was also an environment of grave peril, both for one's body and one's soul. The endangerment and vulnerability inherent to childbirth can be woven into the broader life narratives which were typical for women at this time. The majority

experience of adult life for a woman in the US was marked by subservience, both to God in the spiritual sense, and to one's husband (or other male family members) in the pragmatic schema of day-to-day life (McCool and Simeone 2002, 736). Women primarily existed within the domestic sphere, and among the labor required of them, reproductive work was paramount.

Fertility in the US through the 1800s was high, and after marriage (which typically took place in one's late teens or early twenties), bearing and raising children became the predominant duties of the typical woman (Leavitt 1986, 14). In her book about the history of childbirth in the US, Leavitt describes the experience of a New England woman, Mary Vial Holyoke, who married into a wealthy family in 1759 at 22 years old (1986, 14). Over the following 23 years of her life Holyoke experienced 12 full-term pregnancies, from which only three of her children survived (Leavitt 1986, 15). In addition to the surfeit of maternal grief that these numbers imply, it is also clear that Holyoke spent the majority of her adult life either pregnant, recovering from delivery, or breastfeeding (Leavitt 1986, 15). Although Leavitt notes that Holyoke endured more pregnancies than her average contemporary, to our modern standards the difference is slight, given that at the end of the 1700s white American women bore an average of seven live children (1986, 14-15). Leavitt's arguments illustrate a kind of circular social logic, in which the limitation of the female life experience to domestic duties, pregnancies, and child rearing in effect left women at the mercy of the biological

processes of reproduction—and in turn, the female body being claimed by an endless cycle of conception, birth, postpartum recovery, and breastfeeding provided justification for the relegation of women's lives to within the domestic sphere.

The expression of support and love among networks of female peers during labor and birth was a source of solace against the arduous experience of near-constant pregnancy, child care, and subservience to one's husband and male family members (McCool and Simeone 2002, 736). It is this experience of togetherness and mutual caring that encouraged the persistence of what clinical educators William F. McCool and Sara A. Simeone describe as the *Social Childbirth Philosophy* well into the period in which midwives were beginning to be replaced by male physicians as desirable attendants (2002, 736). The social childbirth philosophy conceptualized birth, pregnancy, and the processes of labor as social rather than medical. This perspective allowed both for the foregrounding of the emotional aspects of reproduction, and for the reinforcement of one's place within a supportive social network.

The idea of childbirth as a space for the expression of love and support, originating as it did in the pre-medicalized period, still echoes through modern conceptualizations of birth. For my informants, there seemed to be a common understanding that the midwifery model of care was older than, or had existed prior to, the biomedical model. Linda, the 48-year-old doula, yoga instructor, and homebirth mother whose quote I included at the beginning of this section, described this outright,

telling me that the supportive services she offered as a doula were only the modern iteration of what she believed was once ubiquitously available to women during labor and birth. By hiring a doula, her clients were "paying for [their] village" in the sense that they were leveraging money to provide themselves with social and emotional support that might have come from one's community during "the old days." Linda expressed regret that money needed to be exchanged in order to access the emotional assistance and encouragement that she viewed as necessary and important during labor and birth, and told me that while "it's sometimes awkward to receive payment for this work, I need to because I have a family to feed."

One of the main allures of alternative prenatal and birth care that was described to me by mothers I spoke with who chose or desired them was the sense of individualized social and emotional support that it offered. For example, Lydia, a 34-year-old mother of one whom I interviewed for a little over an hour and a half on July 30th, 2018, described what she loved about her midwife's care: "…she paid attention to me as a whole person instead of just like the data, right? Like, I wasn't just numbers on a page to her. She really took into account my whole lifestyle." Lydia's midwife provided care in a way that addressed both the biophysical data related to her pregnancy (the numbers on a page), and the individual circumstances of her life. In the Discussion chapter of this thesis I will further explore how the alternative care models that many of my interviewees found so attractive foreground the emotional and social aspects of pregnancy and birth. Proponents

of the modern natural birth movement—both my study population in Sonoma County and possible others elsewhere in the US—often tout care for both the medical and emotional aspects of birth as one of the primary benefits of homebirth. The perceived connection between midwifery and desirable social support can trace historical origins to this pre-medicalized period. That the more negative aspects of reproduction and female life experiences in general that were associated with childbirth in the US prior to the 1800s seem to have been mostly forgotten perhaps speaks to the complicated ways in which social memory can reconstruct the past, and create meaning in the present (see, for a number of examples Climo and Cattell 2002). To my informants, choosing alternative forms of birth care called up idealized conceptualizations of childbirth as a social, rather than medical, event –characterized by emotional bonding, togetherness, and expressions of love and care.

Hospital

> *"There's so many people that think that if you're going to have your baby in the hospital, nothing can happen to you."*
> - Diana, 37, practicing midwife

Returning to the historical narrative of childbirth in the US, I will now discuss how the dominant form of birth care transitioned from midwife-attended homebirths, to hospital births attended by a biomedical physician. The periods of medicalization and hospitalization of birth care, from the early 1800s through the mid-1900s, are important to understand because they provide a means to understand how hospital birth became the

dominant form of care, and how this reflected changing social beliefs about what was appropriate, important, or desirable during birth. The informants whom I interviewed made choices about their own birth care amidst a cultural landscape where hospital birth was socially deemed necessary and expected. I discuss the establishment of the biomedical birth model as dominant to provide context for what it means to choose non-dominant forms of care.

At the turn of the nineteenth century in America, male physicians were rising in popularity as birth attendants. Increasing numbers of physicians travelled to England for medical training, where they learned to consider midwifery as a component of medical science, and attendance at birth to be a key part of medical practice (Dye 1980, 100). As a result, the figure of a male birth attendant, or physician-accoucheur, began to gain social traction as an acceptable choice (Leavitt 1986, 38). In the decades following the American revolution, affluent, urban white women began actively seeking the aid of trained physicians, both for childbirth and prenatal care (Dye 1980, 100). Following the turn of the nineteenth century, this trend blossomed into what can now be understood as the beginnings of both the establishment of the social dominance of the biomedical model of birth, and the consolidation of medical control over the processes of pregnancy and childbirth. The social redefining of birth as a medical event coincided with changes in both birth practice and culture, as well as shifting popular beliefs about what kinds of

risks were acceptable during childbirth, including a reframing of labor pain as something which must be eradicated through medical intervention.

The "New Midwifery," or "New Obstetrics" that American physicians brought back from Europe and subsequently folded into American medical practice was much more interventionist in nature than had been the case previously in the US. As I mentioned in the previous section of this chapter, prior to the 1800s childbirth philosophy in the US was largely non-interventional. The primary role of the midwife was understood to consist of providing reassurance. Only during very abnormal labor might she leverage techniques such as the administration of medical herbs (ergot was used to strengthen contractions during a labor stall, for example) or the performance of an external version (a hands-on technique in which the practitioner repositions an abnormally presented fetus through forceful manipulation of the pregnant woman's abdomen) (Leavitt 1986, 38).

By contrast to the mostly-passive midwives, the physicians who came back from England trained in the New Obstetrics made use of interventions at nearly every turn. Male physicians borrowed the use of ergot from their midwife predecessors, and administered it to parturient women in much higher quantities in order to speed labor (Dye 1980, 102). The dubious (to our modern sensibilities) practices of bleeding and purging (via enemas or emetic substances), as well as high doses of opium and laudanum were thought to calm lengthy, painful labors (Leavitt 1986, 39-40). Forceps came into

widespread medical vogue in the early 1800s, and their use allowed physicians to take control during the final stage of labor by mechanically extracting the neonate and circumventing the need to push (Thomasson and Treber 2008, 79).

The change from mostly-non-interventionist to highly interventionist approaches to childbirth care brought with it an increase in iatrogenic effects. The use of forceps, which began occurring on an almost indiscriminate basis in the US during the early-1800s, particularly ran the risk of causing injury and introducing pathogens to the body (Dye 1980, 102). Before the advent of Germ Theory, physicians would use the same pair of forceps on multiple women, and sometimes during autopsies as well, without any sterilization or hygiene measures in between (for an account of these practices and an early attempt to address them see Holmes 1843). It is therefore not surprising that puerperal septicemia, or childbed fever, became vastly more prevalent in America after 1840 (Thomasson and Treber 2008, 79).

By the beginning of the 1900s, nearly 50% of all births were attended by physicians (Thomasson and Treber 2008, 79). This influx of new obstetrical patients was not evenly distributed among socioeconomic classes—the majority of middle-and-upper-class white women were attended by physicians in their homes during childbirth, whereas poor Southern black, immigrant, and otherwise socially marginalized women relied heavily on midwives (Thomasson and Treber 2008, 79). In turn, physicians were eager to deliver babies, given that providing obstetrical services to wealthy patients provided an

important keystone upon which to build a successful medical practice (Thomasson and Treber 2008, 79). We can take from this that incorporating birth into the auspices of biomedical practice had financial incentives for the practitioners themselves. Accordingly, the medical profession began to claim control over birth care, and therefore over the reproductive female body, as a means to shore up its own economic and authoritative social power.

US women turned, in increasing numbers, to the services of the physicians-accoucheurs during the 1800s. Physician-attended birth would have been desirable for women in part because of its association with membership in the prestigious upper classes. The ability to afford home-visits from a male physician was available disproportionately to the more affluent segments of society, and that in itself granted medicalized birth a degree of desirability in that it demonstrated high social status. Matters of financial and social prestige, however, only yield part of the picture as to why women resorted to physician-attended birth rather than cleaving to the ministrations of midwives which had, up until this time, been standard and expected. After all, the rise of the New Obstetrics, as it was practiced, was incompatible with the Social Childbirth Philosophy espoused by midwives. Instead of serving as a space which fostered close social bonding and community support, birth under the care of a male physician was secluded and private. Physicians banned female relatives and friends from the birthing room, both because the increasing privatization of family life throughout the 1800s made

of birth a challenge to modesty, and also because having supportive visitors in attendance could undermine the situational authority of the physician himself (Dye 1980, 102).

What might have then prompted the affluent white women of 1800s America to so easily abandon the rituals and practices of childbirth which provided for them a respite from the physical, social, and emotional demands placed on women at this time? The answer is, of course, quite complicated, but a significant motivating force which led these women to readily accept male physicians into the birthing room was the popularly held belief that they could make birth safer and less painful. As I discussed in the previous section, the potential for pain, injury, and death during labor and childbirth created a pervasive sense of dread which underpinned women's reproductive years. The technologies and techniques of the New Obstetrics were understood to promise an escape from the mortal terrors and chronic anxieties created by the risks of childbirth that plagued women during their fertile years, a conceptualization that the physicians themselves actively fostered and encouraged.

Physician accoucheurs had access to medical training and knowledge that was forbidden to women at the time (Leavitt 1986, 39). Midwifery was rooted securely in practical knowledge and the familiarity of female rituals, whereas male physicians brought with them the advantage of prestige associated with formal learning (Leavitt 1986, 39). The combination of the higher social status that physicians as a group were rapidly accruing throughout the 1800s (Starr 1982, 54-59), the perceived potential for

safer and easier labors through the uses of forceps, opium, and anesthesia (Dye 1980, 102), and popular belief that the ever-increasing scientific knowledge of the birth process promised further practical and technological advances in managing labor in the future (Leavitt 1986, 39) contributed to women's impressions that physicians knew more than midwives about the birth process, and moreover that birth attended by a physician was the desirable choice. To my thinking, the perceived superiority of physicians as birth attendants that emerged during the 1800s was key to the social framing of Western biomedicine as sole arbiter of knowledge about birth and birth care. Maintaining control over knowledge related to birth contributed to the largely unchallenged and near-complete control that came to be leveraged over the reproductive female body by medical institutions, and by proxy obstetricians, as I will discuss in the following chapter.

The production and control over authoritative knowledge also carries with it the advantage of granting legitimacy to a particular knowledge system, and devaluing its competitors. Medical anthropologist Brigitte Jordan's discussion of authoritative knowledge (1997) describes how in a situation where there exists more than one way of knowing and understanding, one system often gains dominance over the others. A particular knowledge system might overcome its competitors either because it is more efficacious at explaining and interpreting the world, or because it is structurally associated with a more powerful base of adherents (Jordan 1997, 56). Jordan relates that it is often a combination of these factors that leads to the production of authoritative

knowledge, and that the garnering of power by one knowledge system lends it legitimacy, while simultaneously devaluing its competitors (1997, 56).

Jordan's framework of authoritative knowledge serves as an effective way to understand the rise of biomedicine as hegemonic in US culture. US medicine in the 19th century was characterized by the growing authority of biomedical care, and the gradual delegitimization of alternative forms (see again Starr 1982, 54-59). Regarding pregnancy and birth care specifically, the rise of physician-attended birth during the period of medicalization was paralleled by the decline of the once-dominant form of midwife-attended birth. Midwifery in the US was marginalized swiftly, confined as a practice first to poor, black and immigrant communities who couldn't access a male physician (Thomasson and Treber 2008, 79). Towards the turn of the 20th century, as reforms in medical education and technological advances continued to consolidate medical power, midwifery declined even further (Dye 1980, 103-104, McCool and Simeone 2002, 737-738). Biomedical practice at this time was being professionalized, and physicians were establishing ever-more-strict entry requirements into medical schools, professional networks, and medical practice itself (Dye 1980, 103). Midwives, by contrast, had no system of formal training, and often were solitary, serving rural or isolated communities (Dye 1980, 103). Their lack of formal training denied midwives access to knowledge about technological and practical obstetric advancements, such as anesthesia or the use of forceps (Dye 1980, 103).

Around 1910, professional medical societies in the US began to agitate politically for the restriction of midwifery as a practice (Dye 1980, 104; McCool and Simeone 2002, 738; Davis-Floyd 2018, 166-167). Framing midwives as inept, uneducated, and dangerous, these movements were mostly successful. Many states outlawed midwifery altogether, and other states imposed regulations and requirements that the majority of practicing midwives were not able to meet (Dye 1980, 104; Davis-Floyd 2018, 167). The eclipse of midwifery, and the installment of modern obstetrics as arbiter of what constituted a normal, safe, or desirable birth can be understood in terms of the relationship between social power and legitimacy, and control over the production of authoritative knowledge. Medical institutions and their practitioners were, as I've noted, making their brand of medical knowledge more exclusive and difficult to acquire, and in doing so, they delegitimized competing forms of knowledge, such as midwifery (Thomasson and Treber 2008, 84). Legal and political measures which supported obstetrical practice at the expense of parallel forms of care such as midwifery further reified the biomedical model of childbirth care as socially normative.

The extent of the social authority wielded by biomedical physicians at the turn of the 20th century is evident insofar as their seizing control over pregnancy and birth was largely unopposed (Starr 1982, 50). Even in the face of increased rates of iatrogenic illness associated with physician-attended birth (Thomasson and Treber 2008, 79), and notwithstanding the moral opposition to male physicians infringing upon the female

modesty that was so important at the time (Dye 1980, 101; Leavitt 1986, 40-41), people allowed, and even welcomed, the rise of obstetrical biomedicine. Sociologist Paul Starr, in his expansive social history of medicine in the US, notes that "well-to-do women had come to accept the physicians' claims of superior skill. No protests were registered at the time physicians took over obstetrical practice" (1982, 50). The decline of midwifery spelled the end of the *Social Childbirth Philosophy,* and precipitated the advancement of what McCool and Simeone call the *Medical Illness Model of Birth* of pregnancy and childbirth, which frames the processes of birth as inherently dangerous and flawed, and necessitating medical intervention (2002, 738). The social establishment of biomedical obstetrical practice as superior paved the way for the US shift towards hospital birth that began in the early 1900s.

The advances in medical power and authority over the birth process during the 1800s paved the way for the shift in practice which carried childbirth away from the home, and into the halls of the hospital. Prior to the 1900s, hospitals were dirty, terrifying places that were often run by religious charities, and served only those who had no other options (Thomasson and Treber 2008, 79). Accordingly, hospital birth was extremely undesirable, and the only women who gave birth in hospitals were the homeless, or those who couldn't access in-home care for other (largely socioeconomic) reasons (Thomasson and Treber 2008, 79). At the turn of the century, however, the role of the hospital began to change.

The early 1900s saw many advances in the professionalization of medical practice (Dye 1980, 103). Innovations such as Germ Theory, improved hygiene measures, and advancements in medical technology improved health outcomes (Thomasson and Treber 2008, 80). The increases in social power and authority gained by physicians during the late 1800s and early 1900s contributed to establishing biomedicine as an institutional practice, and made of the hospital the primary locus for medical education and the growing centralization of the medical profession (Thomasson and Treber 2008, 80, McCool and Simeone 2002, 738). Hospitals transitioned in the early 1900s from charitable or religious institutions which tended the destitute, the dispossessed, and the insane, to state-of-the-art facilities which provided highly-trained medical care to affluent members of society (Starr 1982, 145-146). Correspondingly, hospital birth began to become socially desirable during this time.

Many women were motivated to give birth in the hospital in the early 1900s because it was widely perceived as safer, and also because it was associated with greater comfort and convenience than homebirth. Popular perceptions that the hospital offered a superior place to give birth were reflected in popular women's magazines from this period. In the October issue of Ladies' Home Journal from 1923 (see figure 1), an article which discusses the costs associated with obstetrical care urges women that it is worth the price, claiming of hospital birth that "in so many instances it is easier and safer that I would urge every prospective mother to consult her doctor about its advisability" (Baker

1924, 212). Elsewhere in the article, the author argues that "The fact the we are not using our present hospital facilities to anything like their full extent is all wrong…There should be such a [maternity] hospital in every county" (Baker 1924, 212). The article concludes with the moralistic imperative "Cost what it may, a child is worth anything we may be asked to pay for it" (Baker 1924, 213). One of the major undertones of this article is the idea that a "good" mother will do whatever necessary—pay whatever necessary—to protect her precious child, and the best and safest care available during birth could be found in the hospital.

Physicians at the time reinforced the perception that hospital births were safer, often denigrating the parallel practice of homebirth and continuing to portray midwives as poorly trained and incompetent (Thomasson and Treber 2008, 84). In their analysis of the rise of hospital birth Economists Melissa Thomasson and Janet Treber note that hospital birth during the early 1900s was more profitable for individual physicians (2008, 82). Thomasson and Treber speculate that the increased medicalization and the large number of interventions which became commonplace during hospital birth may have been connected to physicians' desire for financial benefit (2008, 84-85).

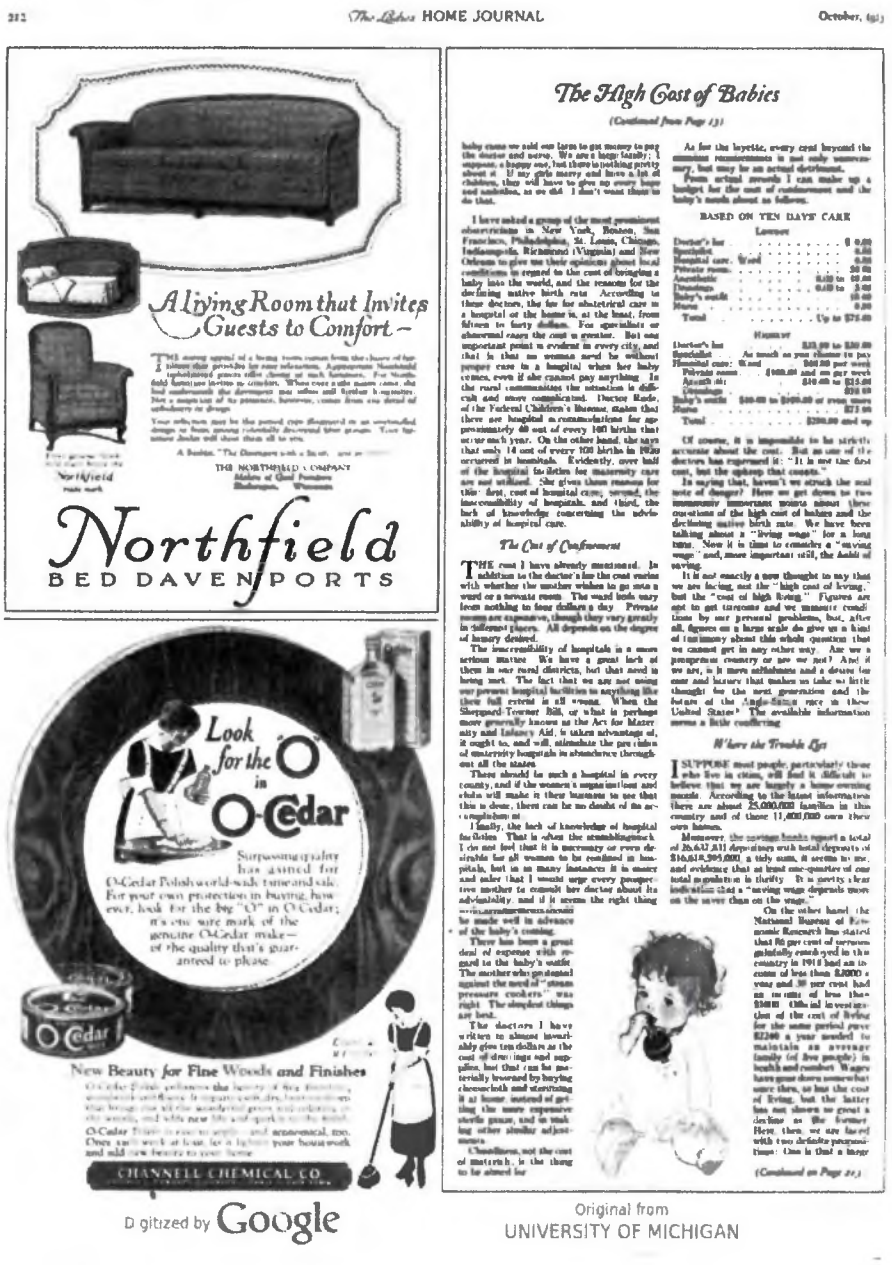

Figure 1: Page 212 of The Ladies' Home Journal, October 1923 (The Hathi Trust Digital Library, 2018)

Interestingly, despite social perception that hospitals provided safer births, rates of maternal mortality during childbirth remained static during this time period, and deaths caused by puerperal septicemia, or childbed fever, increased (Thomasson and Treber 2008, 84-85). Increased rates of postpartum infection may have been related to the higher incidence of surgical birth interventions (e.g. episiotomy, or the surgical widening of the birth canal) employed by physicians in hospitals (Thomasson and Treber 2008, 86). It wasn't until the 1930s and the combined advent of increased regulation of instrumental delivery technique, improved standards for obstetric hygiene practice, and widespread adoption of Sulfa drugs, that the maternal mortality rate began to decline (Thomasson and Treber 2008, 86-87). The medicalization of childbirth, and the shift from home to hospital, is therefore better understood in terms of economic factors, medico-institutional power, and social values, than as purely a measure of increased safety. Hospital birth, the medicalized model, remains dominant in the US today, and the logic of medicalization shapes which practices related to birth are deemed desirable, appropriate, and socially acceptable.

Modern conceptualizations of birth in the US are still flavored by the largely unquestioned assumption that the dominant form of care -- hospitalized birth attended by an obstetrician -- provides the safest and most efficacious form of childbirth. Particularly to the practitioners who participated in my research, the commonly held idea that the hospital is the only safe place to give birth presented an obstacle to their own practice.

Diana, whom I quoted at the beginning of this section, a 37-year-old midwife who had been practicing for eight years (though only five of those years had been licensed), described what she saw as a social stigma around giving birth at home. "There's a lot of shame around it, and it's really interesting. I had a couple that, they both were ER nurses, and they didn't tell any of their colleagues that they were having a homebirth." The weight of social judgement hung particularly heavily on this couple, Diana explained, because they worked within the very institution that was largely understood to provide the only viable option for a safe birth.

Diana expressed to me quite clearly throughout the interview that the majority views about the risks of out-of-hospital birth were false, and that in fact she believed the biomedical model of care was actually more risky than commonly believed: "Unfortunately we're seeing that now the maternal and infant death rates for our country, we are far down on the line, and it just goes to show you that you're not safe just because you're in the hospital, you know?" Diana continued: "…to me, birth is as safe as your practitioner is paying attention… You know the recent research that's coming out about the maternal infant death rates and how poorly we are doing as a country, you start to look at how well are those people being taken care of? And that's not to say that all those women or babies could have been saved, but as a midwife I really believe if you paid more attention, if you gave a little more care, I think a lot of things would be caught."

Profound distrust of dominant medical institutions, and the hegemonic epistemological constructions associated with them, provided a common theme that bound many of my informants together as a group. When I asked Diana if she would be able to describe what she thinks of as a "typical" patient in her homebirth midwifery practice, instead of thinking in terms of demographics or economic class, she jumped right into describing ideologies:

> They're aware of the fact that what the hospital, or what the medical system says is not always the right way… They, most of them, appreciate the hospital and they are glad that it's there, and things like C-Sections and things that can be lifesaving, but they really believe that there's a gross overuse of the medical system and the medicalization of birth, and they really just want to bring it back to the fact that we've been doing this for since the beginning of time and this is how we're all here. And they have an innate trust in their body and the process that, you know, despite a few things here and there like, this really will work. Birth will work. The baby will be born, and you don't have to mess with it a whole lot. And that, I would say, that's the common thread between all the couples is that they know that this works. The birth process works. And they trust it and they just want it to be kind of left alone. (Diana, interview with author, June 27th, 2018)_

The implication of this statement is that the reverse is true within the biomedical model—the birthing body is untrustworthy, and moreover, *birth doesn't work*, and requires medical intervention. It was interesting to me, as well, that Diana here expressed the idea that birth *as it should be* was a natural process that women have engaged in "since the beginning of time" (a view which was expressed to me multiple times, from various informants). The allusion to historical depth to shore up the legitimacy of natural birth as a practice is perhaps a reaction against historical establishment of biomedicine as the

dominant form of care. As I have shown in this discussion, hospital birth and the associated popular understanding that it offers a safer form of care became socially dominant even before the assertion of improved safety was actually true. The relationship between the social ascendency of medical institutions and the control over knowledge production was so powerful that hospital birth became hegemonic despite not actually providing greater safety. Medical control over labor and birth are often understood to be necessary and desirable. The logic of medicalization that established medical authority over birth is still woven through modern understandings about risk and safety during pregnancy and birth. Popular conceptualization of the inherent riskiness of childbirth create an ideological stumbling block to movements towards demedicalized birth care, even when not necessarily supported by statistical evidence (see, for example, Cheyney and colleagues' 2014 paper about care outcomes for planned homebirth).

One of the perceived risks of childbirth that biomedical care attempts to control is pain.The use of analgesic intervention to alter the experience of labor and birth can be understood as an extension of medicalization, and another avenue for technological control over the birth process. Along with hospitalization, the *Medical Illness Model* of birth gave rise to an interventionist standard of practice among physicians, and techniques such as the use of episiotomies, forceps, and anesthesia, became and continue to be commonplace obstetrical practices (Dye 1980, 106). Physicians and hospitals were perceived to offer greater safety—and this meant not only protection from injury and

death during childbirth, but also the mitigation of normal labor pain. Among other things, the use of analgesic and anesthetic measures during childbirth became routinized as standard practice in most hospital-based birth care, and this prevalence shaped social expectation of their use (McCool and Simeone 2002, 738).

In their discussion of the changing conceptualizations of labor pain throughout history, Arney and Neill observe that the technologies and practices of obstetrics can be interpreted as measures of domination (1982, 3). When birth is framed as violent and dangerous, obstetrical medicine becomes a weapon with which to combat the hazards and risks associated with it (Arney and Neill 1982, 3). The rituals associated with obstetric management of birth are centered on the efforts of the physician to "deliver" a largely passive pregnant patient, and this is reflected in the technologies associated with birth, such as delivery beds, which "…were designed to immobilize patients so that they could not move their obstetrically important parts from the view of the operator" (Arney and Neill 1982, 3). Labor pain poses a significant challenge to the medical management of birth, and so historically birth practices in the US were connected to the development of analgesic technologies as well, from ether, to chloroform, to twilight sleep, all the way up to what the most popular form of pain relief in childbirth currently—epidural anesthesia, an injection of analgesic medication directly into the spinal cord which is intended to completely numb and immobilize the lower extremities from the waist down (Sell, Rothenberg and Chapman 2012, 200).

As of 2013 in the United States, epidural anesthesia was employed in 58% of live births, making it the most commonly used analgesic measure employed during childbirth (Holck and Camann 2013, 412). Widely understood to be a "routine" choice for a labor analgesia, epidural use continues to increase in the United States and other first world nations, such as Australia (Newnham, McKellar, and Pincombe 2016, 22). The ubiquity of epidural use, and its social construction as an inherently "safe" technology, speak to dominant values present both in Western societies, and in the culture of Western biomedicine itself.

The drive to mitigate physical pain associated with childbirth through intervention, at any and all cost, reflects values within the biomedical community, and these both inform and are influenced by the values of US culture in a wider sense. Newnham, McKellar and Pincombe attribute much of the discourse on this subject to the technological rationalism they see as foundational to the US cultural worldview (2016, 25). Technological rationalism is posited in this work as a sort of convergence of technological determinism and rationalism—a system of belief in which all progress is the end result of reason, all progress is framed as positive, and all associated technologies are neutral by-products of society's endless march towards the better-than-today future (Newnham, McKellar and Pincombe 2016, 26). It follows, then, that technological interventions are not only attractive, they are necessary—in a worldview that frames every scientific advance as innately beneficial, every new technique and technology to be

developed must also be inherently superior to whatever came before. From this premise, the use of analgesic technologies, such as epidural anesthesia, will always be understood to be desirable, and this way of understanding the issue is termed by Newnham, McKellar and Pincombe as the "pain relief as progress" paradigm (2016, 26).

The use of epidural anesthesia is one example of the social framing of obstetrical measures and technologies as being innately beneficial, regardless of the possible harm they may cause. The largely unquestioned social framing of the logic and efficacy of the medicalized model of birth has been explored in a number of works of social thought. For example, medical anthropologist Claire Wendland by explored increasing rates of cesarean section surgery by reviewing what she describes as a proliferation of indications for their use in obstetric literature in the US (2007). Wendland found that even though cesarean deliveries had been consistently found to correlate to increased pain, negative feelings about the birth experience, and maternal emotional distress that could continue for years, these data were seldom included in studies on cesarean outcome (2007, 222). Instead, evidence-based studies focused only on short-term biophysical complications, such as major hemorrhage or maternal death, as markers of negative surgery outcomes (Wendland 2007, 223). Wendland posits that defining negative birth outcome in this way erases the experiential aspects of birth, and frames maternal grief, distress, and emotional pain as unimportant (2007, 223).

Wendland arrived at the startling observation that in all the biomedical studies she canvassed, none of the authors treated the cesarean section itself as inherently harmful (2007, 223). Unintentional injuries such as hematomas, lacerations, or broken bones were addressed as risks in the literature, but the intentional surgical wound was never considered as majorly detrimental, even in cases of elective, or prophylactic, cesarean (2007, 223). Wendland describes the "unmarked" status, or invisibility of the surgical wound to researchers, as being an expression of the absolute faith in medical technology that is a hallmark of US culture (2007, 224; see also Davis-Floyd 1994). The use of medical technology is often understood by the biomedical community as inherently beneficial and superior to the natural processes of birth, even when the advantages of intervention are contested and uncertain (2007, 224). Therefore, cesarean delivery is assumed by the biomedical community to be an equal alternative to vaginal birth, and the surgical wounds created during the procedure are not understood as a form of harm (Wendland 2007, 223-224).

Under the *Medical Illness Model of Birth*, the modern iteration of birth in the US is generally dictated by the medical technology associated with it, the institutional policies of the hospitals where it takes place, and political interventions that control things such as mandatory minimum length of stay in maternity wards (McCool and Simeone, 2002, 742-743). Although modern American women tend to believe they have a choice in how they give birth, the terms of that choice are actually dictated by medical

providers, institutions, and technologies (McCool and Simeone 2002, 743-744). The social landscape of US birth is then largely one of institutional and technological control.

I will further discuss the issue of control over the parturient body in the next chapter of this thesis, but for this chapter's purposes, what is at issue are the historical events and trends which have established the largely-unopposed perception that hospital birth is normal, beneficial, and socially desirable, and that biomedical obstetricians and their care models are the logical and superior choice. Choosing otherwise, then, as the informants I spoke with did, becomes a countercultural act. The movement towards alternative birth choices, popularly referred to as the "natural birth movement," has its own particular history -- as I will discuss in the next section.

Home Again

> *"I'm not sick. I am pregnant. Those are two totally different things. I don't need death and dying care, I am just going to have a baby. That's how this entire earth has been populated over and over again, not just by human women, but by every species on this planet that is mammalian. I mean... and how many of them die in the wild? Not as many as you think."*
> -Lydia, 34, mother of one, stay-at-home mom

Examining the history of childbirth and associated care in the US shows us that the rise of the biomedical model of birth is inextricable from the hegemony of biomedicine over other forms of care, and its social establishment as arbiter of medical science, and medical knowledge. It is interesting, then, that the US has also been home to

a significant social movement towards demedicalizing birth care. My informants understood themselves to be part of the natural birth movement, which has strong historical ties to the area of California where I conducted my fieldwork. In this section, I will explore the reemergence of homebirth as a socially acceptable care option, from its inception up until the present day.

Beginning in the 1960s, and corresponding to other countercultural social movements, midwifery and homebirth began to reemerge as forms of care that were actively sought out and chosen. The natural birth movement developed as a corollary to the hippie counterculture that developed and flourished in the 1960s and 1970s and in large part centered on the San Francisco Bay Area. Because of its proximity to San Francisco and Berkeley, and the subsequent 'back to earth' movement that led to an exodus of counter cultural folk leaving the city for countryside, Sonoma County became associated with these movements during the 70s, when it was home to famous communes such as Wheeler Ranch and Morning Star Ranch(see Miller 1999, 51-56).

This history still echoes through contemporary local culture in Sonoma County and the surrounding region, and countercultural elements such as commune-like living arrangements, organized protests, and (often quite successful) shops which sell items associated with alternative philosophies, medical care, and spirituality are still relatively commonplace. The alternative birth community who participated in my study can be understood as part of the modern iteration of the natural birth movement which began in

the 1960s and 70s as a reaction to the coercive nature of medicalized birth. The particular local culture and group identity espoused by my informants can also be understood as related to their particular medical choices, which I will discuss in the third chapter of this thesis.

The genesis of the natural birth movement has been the subject of some scholarly inquiry. In an article written in 1980, certified nurse-midwives and clinical educators Kathryn A. Patterson and Vicki L. Peterson explore what they call the "alternative birth center movement" that was centered around the San Francisco Bay area. In their writing, they frame two social movements as connected to the natural birth movement in normalizing out-of-hospital birth—the feminist movement, and the consumer movement in healthcare (Patterson and Peterson 1980, 23). The ascendance of feminist philosophy in the 1960s encouraged women to take control over their reproductive processes, rather than submit passively to medical authority, which was by nature male-centric and patriarchal (Patterson and Peterson 1980, 24). What Patterson and Peterson describe as the consumer movement in healthcare allowed patients to leverage a degree of control over their healthcare by "shopping" for the experience they desired, thus undermining medical authority somewhat, and influencing the availability of alternative forms (1980, 24).

The shift towards demedicalizing birth can also be understood in terms of the popular culture associated with it. Medical historian Wendy Kline traced the emergence

of the natural birth movement through an analysis of popular publications that were associated with it (2015). According to Kline, Ina May Gaskin's *Spiritual Midwifery* (1975), Raven Lang's *The Birth Book* (1972), and Rahima Baldwin's *Special Delivery* (1979) all hit the market concurrently with a boom of counterculture lifestyle advice books which encouraged the reader to simplify their life, live in the moment, and be in touch with a more authentic version of the self (Kline 2013, 533). Gaskin, Lang, and Baldwin's books questioned the safety and efficacy of hospital birth, and instead gave advice on how to have a "natural" childbirth in one's own home (Kline 2015, 529). These publications asserted that out-of-hospital birth was a viable option, arguing that birth was not something to be addressed with dread, but rather a "transformative, consciousness-raising event to be celebrated" (Kline 2015, 530).

The mass popularity of publications in this vein indicate a shift in the epistemological underpinnings of what constituted a "good" life, and what experiences were desirable, normal, or acceptable. If we return to Brigitte Jordan's discussion of the connections between social power and the production of authoritative knowledge (1997), it can be understood that the resurgence of more socially oriented childbirth philosophies posed a challenge to the dominance of the biomedical model of birth. By reframing the processes of pregnancy and birth as innately normal and safe, the natural birth movement pivoted away from the *Medical Illness Model* of birth that is associated with biomedical obstetrical practice (McCool and Simeone 2002, 738).

Kline's article states that between 1970 and 1977, the rate of intentional out-of-hospital birth in the US more than doubled, predominantly among sectors of the white middle class (2015, 530). The dramatic increase of homebirths among middle-class white women helped shift the social perception of the practice away from a low-cost yet risky alternative for economically marginalized segments of the population towards an informed, voluntary choice which gave more affluent subjects a greater degree of autonomy and control during the birth process. By the time the next highly popular book about natural birth, Rahima Baldwin's *Special Delivery*, was published in 1979, countercultural "pockets of consciousness" concerning the practice of midwifery as a viable alternative to the biomedical model were becoming more mainstream (Kline 2015, 553-554). In what Kline describes as the "triumph" of midwifery in the late 1970s, several states implemented laws which regulated midwifery by outlawing the practice of lay midwifery in favor of practitioners with more medical training, thus normalizing it somewhat as a socially acceptable modality of birth care (Kline 2015, 555).

Along with changing the acceptability of alternative forms of care, the natural birth movement also reoriented understandings of labor pain. Medical historian Jacqueline Wolf writes that Ina May Gaskin, whose midwifery school known as "The Farm" became synonymous with the tenets of the natural birth movement, encouraged women to have analgesia-free labors and births (2009, 138-139). Gaskin's childbirth philosophy held trust in women's bodies as paramount, and her writing and speaking

encouraged women to embrace the experience of childbirth, including pain, as a "sacrament" or "spiritual experience" (Wolf 2009, 138-139). From this point of view, pain is redefined from an opponent of medical care that must be defeated by obstetrical analgesic technique to an indication of normal, healthy, biological processes that can be potentially spiritually uplifting.

The women that I interviewed in Sonoma County could be described as belonging to the modern iteration of the natural birth movement. Although Wolf describes the social influence of the natural birth movement as having waned by the 1990s (2009, 167), many of the major philosophical tenets associated with it, such as a belief that birth and the female body are safe and trustworthy, and that pain is a normal part of labor that need not be feared, were reiterated to me during interviews. In the Sonoma County alternative birth community, adherence to alternative beliefs and questioning authority were valued components of a particular group identity, and so it makes sense that their choices around birth care mirrored these values. I will discuss how medical care-seeking decisions can act as expressions of group identities and beliefs in the third chapter of this thesis. The following chapter will concern itself with a more in-depth discussion of birth and parturient body as a locus of societal and medical control, and also as an avenue for resistance.

Medical Power and Childbirth: Who Controls the Parturient Body?

Introduction The biomedical model of birth is often described as coercive and dehumanizing in that it subjects a pregnant woman's body to near-absolute medical authority. During the course of my interviews, many of my informants articulated their decisions to opt for alternative forms of medical care as a means to avoid, or deny, biomedical control of their bodies, and instead retain that control for themselves. The profoundly unbalanced power dynamics intrinsic to biomedical care were therefore a major factor in the ways the women of the Sonoma County alternative birth community made medical decisions. This chapter will explore the issues of medical power, and resistance against it, in the context of childbirth. I present a review of ethnographic scholarship, and related works of social thought, along three main themes: 1. Medical authority over female reproductive processes; 2. The technocratic rituals of biomedicine in US childbirth; 3. Resisting biomedical power by rejecting it. In order to address the issues of authority and control, this chapter includes an analysis of how social institutions, such as medicine, leverage power over the physical body.

The Coercive Care of Biomedical Birth

> *I think that what I find is... let's say in like an OB-GYN or doctor setting, I would say that that model is much more—for better or worse, and this is even without, necessarily, judgment—but I would say there's more of a philosophical approach to try to control the process. I would say, therefore there's more likely to be intervention in order to ensure safety.*

> -Brigit, 40, homebirth mother of two, doula, pregnancy life coach/provider of "integrative counseling and coaching for pregnancy, birth and postpartum"

In the previous chapter, I presented a social history of childbirth care in the US. Doing so provides context for the medical decision-making processes of my informants, by exploring historical shifts and changes in mainstream styles of birth and prenatal care which still echo through contemporary perceptions about birth. Hospital birth, established as the standard of care in the late 1800s, is associated with highly medicalized way of addressing the processes of parturition. The biomedical model of birth remains the dominant form of care, as evidenced by the fact that in 2016, 98.4% of all live births in the US occurred in the hospital (Martin et al. 2018, supplemental table I-4). Medicalization, or the process of "defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it" (Conrad 1992, 211), draws certain facets of human life experience under the auspices of medical authority. Much attention has been paid to the connections between medicalization and control, either over targeted groups, or individual bodies by scholars within the social sciences. In this section, I will review literature which explores how birth in Western societies can be understood as a significant locus for the expression of medical authority.

Birth and associated care in contemporary Western societies are highly medicalized, and this renders them subject to high levels of medical control. Sociologist

Peter Conrad's 1992 review article "Medicalization and Social Control" addresses the theme of medicalization as an avenue for increased medical hegemony over human social spheres. The processes of medicalization have historically been focused on drawing more and more issues into medical frames or definitions. Accordingly, much of the interest in medicalization from the perspective of the social sciences has focused on nonmedical problems becoming (sometimes inappropriately) redefined as medical ones (1992, 211). Both natural life processes, and behaviors that are socially classified as "deviant" (such as alcoholism, madness, eating disorders and compulsive gambling, just to name a few) have been medicalized (Conrad 1992, 212-213). Life processes that have become medicalized include aging, sexuality, death, and of course, childbirth (Conrad 1994, 213).

Childbirth in particular is, in Western societies, subject to near-complete medical surveillance and control (Conrad 1992, 216). In fact, in his discussion of the degrees to which human problems can be understood as medical ones, Conrad cites only childbirth and death as examples of conditions which we know to be fully medicalized in contemporary Western societies (1992, 220). The extreme medicalization of pregnancy and birth, both female biological processes, can be partially understood as connected to the social and historical marginalization of the female gender in all cultures, and throughout all time, which Sherry Ortner (1974) describes so successfully. Female identities, issues, and bodies are more vulnerable to oppression and the caprices of societal power, and it follows that specifically female biological processes are themselves

also particularly vulnerable to subjugation and medical control. Conrad alludes to this point briefly, stating that "women may be more vulnerable to medicalization than men," and describing how women's life processes, particularly concerning reproduction, are more likely to be medicalized than men's (1992, 222).

The narratives created by medicalization involve a discursive relationship between the genesis and dominance of medical knowledge, and the social power of medicine and medical practitioners. Anthropologist Kirsten Barker's article "Ship Upon a Stormy Sea: The Medicalization of Pregnancy" (1998) analyzes the role played by medical rhetoric around pregnancy and birth in the rise of Western medicine's social authority and centralized power. To explore this theme, Barker performed an analysis of a medical text called *Prenatal Care*, which was widely distributed to pregnant women in the first half of the twentieth century. The document was meant to function as a sort of handbook, which women could refer to throughout pregnancy for guidelines and help making decisions about their care, and for warnings about potential complications (Barker 1998, 1068). As one might expect, *Prenatal Care* heavily stressed the need for medical supervision throughout pregnancy and birth as the best way to avoid illness or injury to the mother or her unborn child (Barker 1998, 1069).

Barker compared versions of the document from 1924, and the revised version from 1935 (1998, 1069). Barker's study found that over time, instructions given to

pregnant women became longer, more detailed, and solicited greater medical control over the body. Barker also makes note that although both texts describe pregnancy and birth are natural events, they were heavily soaked in rhetoric which emphasized the potential pathologies associated with them (1998, 1069-1070). The 1935 pamphlet even went so far at one point as to invoke a host/parasite metaphor to describe the caloric and mineral needs of the fetus (Barker 1998, 1070). Increased framing of pregnancy and birth as potentially pathological emphasizes the idea that medical intervention is necessary—and reinforces medical authority over the actions and body of the pregnant woman.

The perceived need for medical help to decrease risk and improve health outcomes during pregnancy and birth is one of the primary social drivers behind high levels of medical authority and control associated with them. Looking beyond childbirth specifically, it is salient to my discussion to consider a larger theoretical framework around the preservation of health as a rationale supporting medical power. The ways in which societies cultivate the health of their populations has been written about extensively by Michel Foucault in his broad concept of biopower, or biopolitics, if one is thinking about the specific means leveraged by the state. Foucault describes a governmental style that emerged post-Enlightenment as the inverse of the older style of government—what Foucault calls the power of the sovereign (1997, 240). The right of the sovereign is essentially the right to kill; Foucault lectured that the older ways in which states intervened upon the bodies of their constituents can be neatly summed up as

the right to either "take life or let live" (1997, 241). Foucault describes that the new set of state prerogatives, which did not replace the power of the sovereign but rather exists alongside it, can be likewise and conversely described as the power to "make live and let die" (1997, 241). What Foucault means by this, and what became a typical exercise of state power in the years following the Enlightenment, is that governments set about trying to improve or maintain a certain equilibrium in the biological functioning of their citizens *en masse*—making live means to make healthy, and states do this on the scale of populations (1997, 244-245). Biopolitical interventions, then, play out upon individual bodies in the name of the health of the many, and in so doing they address the population as a kind of biological collective or "body with…many heads" (Foucault 1997, 245).

The concept of biopower seems, perhaps, nebulous, but it is something that people living in Western societies are quite familiar with. We see it in immunization requirements for public schools, the speed-limits we are meant to follow when we drive, the ubiquitous access we have to sewer systems, to hospitals, to clean drinking water. We expect our hunger to be fed, the spread of contagion to be halted, our canned foods to be free from pathological bacteria. The prospect of our bodies being kept safe by societal rules and interpositions is so commonplace that it becomes all but invisible. Biopower is self-enforcing—as in panopticism, another concept delineated by Foucault, wherein it doesn't ultimately matter if anyone is in the tower because we are all surveilling ourselves (see, for example, Foucault 1995, 195-228) —biopolitical authority over bodies

is augmented by social expectations of it, and popular belief in its necessity and goodness. Biopower, as it pertains to medical care, is meted out through powerful, centralized medical institutions which are supported (and their would-be competitors delegitimized and sometimes criminalized) by a slew of political interventions, such as laws governing the licensing and behavior of physicians, for example. As pertains to pregnancy and birth care, we see these kinds of interventions in examples such as the sometimes-fraught legal status of alternative forms of care, such as midwifery (see discussion of Craven's article, below). The dominance of the mainstream form is augmented by both politico-legal measures, and the largely unquestioned social logic that hospital birth provides the safest, most efficacious, and most desirable form of care.

Foucault's idea of "regularizing life" (1997, 449) means that the medical practice which is both supported and regulated by the state (here allopathic biomedicine) employs a depersonalized interpretation of biological processes, such as aging, illness, or birth, and a one-size-fits-all method for addressing them. In effect, the mechanisms of power at work here reinforce the perception that there is a "correct" form of medical care, that is efficacious, socially expected, and normative. The particular ways in which Western biomedicine is practiced concentrates power (particularly power over medical decision-making) in the hands of the physician, inasmuch as physicians act as a sort of representative for the medical institutions that employ them.

The biopolitical shaping of childbirth care supports the authority of medicine over the process of birth, and the commonly-held social perception that the normative model of care, hospital birth under the care of an obstetrician, is the only acceptable option. Political and legal discourse often support the biomedical model of birth at the expense of competing models, such as midwife-supported homebirth. Medical anthropologist Christa Craven's article "Claiming Respectable American Motherhood: Homebirth Mothers, Medical Officials, and the State" (2005) explores what happens at the intersections between medical discourse about what kinds of care are appropriate for individuals, and state discourse about what care practices are acceptable for its citizens (2005, 194). In this article, Craven analyzes the debate around several bills that were presented in the state of Virginia in the early 2000s which centered around the legalization and licensure of direct-entry midwives (DEMs), or non-nurse midwives who specialize primarily in homebirth (2005, 195). Craven argues that the rhetoric around decision-making that might lead mothers to choose either homebirth, or hospital birth, frames mainstream choices as "acceptable," and alternative choices as "pathological" because of how each group responds to risk (2005, 200-201). Mothers who chose biomedical birth were framed as supporting the "commonsense" logic that doctors and hospitals make birth safer, and thus were lauded for their "respectable" attitudes about risking their babies (Craven 2005, 199-200). The decisions of homebirth mothers, on the other hand, were describes as "pathological." Craven describes how at certain points throughout the debate

women who chose homebirth were likened to mothers who leave their newborn alone at home while they go to the store, people who decide to use drugs, and perpetrators of violent child abuse (2005, 201-202). At one point, the riskiness of childbirth at home is described as analogous to driving a car without brakes (Craven 2005, 199). Medical officials, by linking homebirth mothers with socially problematic identities such as child abusers or drug addicts in their rhetoric, place them outside of what's described at the "normal" spectrum of US maternal choice-making and experience, where normal implies a willingness to accepts biomedical management of birth as the only means to responsibly reduce risk (Christa 2005, 200). The framework that Craven describes is a stark example of the entrenched authority of the institution of biomedicine being upheld through political means—which serves to further reinforce biomedical control over the processes of birth in order to avoid potential negative health outcomes.

The idea of avoiding risk and improving health outcomes during childbirth provides one of the main rationales for the dominance of biomedical birth care—but taking biophysical health as the only measure of safety tends to erase the psychological and emotional damage that can take place during childbirth, often due to biomedical interventions themselves. The medicalized nature of mainstream birth care, and its problematic tendency towards coercion and control, was often acknowledged by my interview participants. Brigit, a doula and "integrative wellness counselor" who provides various supportive and spiritual services to her clients during pregnancy, birth and

postpartum, described different understandings of birth in the biomedical and midwifery models of birth care. The ethnographic quote with which I opened this section describes Brigit's thoughts about biomedical care: "There's more of a philosophical approach to try to control the process," Brigit said about hospital birth, and biomedical physicians. "And I would say, therefore there's more likely to be intervention in order to ensure safety… I do not see any maliciousness in that at all. That actually it's a paradigm that the medical model of care is in. It's how can we make sure that you're safe, you and your baby… So that model of care, there is much more of a tendency to try to manage… And therefore, there is more intervention and so there's less tolerance for just letting things be." Brigit continued to describe that the more medical tests are administered during pregnancy, the more tendency there is to intervene further in order to avoid potential complications—there is a sort of snowball effect that takes place. Medical authority over the pregnant body reinforces itself through the positive feedback-loop of medical testing, leading to preventative interventions, leading to the need for further testing. According to Brigit, midwifery takes a gentler approach: "As opposed to in a different paradigm, a midwifery model of care is much more of, like, we're going to trust the birth process and the baby's going to stay in as long as it needs to stay in. And so, we're going to avoid intervention. Or if we do need to intervene, we're going to do it as gently as possibly with acupuncture or massage."

Because of the discrepancies between the two styles of care, Brigit continued, she sees more of a need for doulas in the hospital setting than during homebirths. Doulas provide emotional support that helps defend pregnant patients from the dehumanizing, impersonal, controlling environments that are typical of the biomedical style of birth care. People hire doulas for homebirths, too, Brigit told me, "but there, more often, I find they're feeling like they're getting the care that they would be getting from a doula a little bit more from the midwives."

According to Brigit, the care of a midwife tends to be more attuned to the social and emotional aspects of labor and birth, and so having emotional support from a doula is less critical than it might be for a woman laboring and giving birth in the hospital. In the hospital, the narrative is that biomedical control is necessary throughout the process in order to avoid the frightening, damaging, or deadly problems that could potentially arise, and many of Brigit's clients found biomedical rhetoric to be emotionally harmful. The care of midwives, according to Brigit's experiences with her clients, creates less of a power imbalance by attending to the patient as a whole person, instead of as a constellation of potential biophysical pathologies: "And I think there's sort of a… A recognition that fear has an influence on the process. That actually there is that mind-body connection and that through the mind-body connection… any emotions have an effect on the body. And so there, there's often just more… a holding of that as a truth, and therefore then being less likely to use information that would induce fear, [they] would

probably try to like, soothe fear." What we can take from this remark is support for the idea that allopathic physicians, and the mainstream model of birth care, is reinforced through the idea of fear—fear of risks, complications, and potential damage to a mother or her baby—and the only way to remain safe is to accept the care, and authority, of an obstetrician in the hospital. The approach which values biophysical safety at all costs can, however, erase the emotional and social components of labor, as well as minimize potential harms caused by the interventions themselves.

Lucy, 33, a practicing homebirth midwife and homebirth mother of two with whom I spoke, mentioned a disturbing anecdote about obstetrical care, and its construction of which risks are acceptable: "I talked to an OB who said that he never gets in trouble for doing a C-section. He could get in trouble for not doing it, though." The idea was that if something went wrong in labor, her OB acquaintance would be questioned, and perhaps reprimanded, for not performing a cesarean section, or not performing one soon enough. Lucy recounted what the OB had told her: "if the baby comes out and is doing good, [the OB's] like: 'Good thing we did it, your baby's fine.' And if the baby is not doing good, it's like, 'Good thing we did it, your baby was not doing fine'... So [the OB]'s like, 'I win every time I do a C-section.'" It is clear that major abdominal surgery, with potentially life-altering consequences for the mother, is not inherently harmless (see Wendland 2007). That an OB-GYN might discuss performing cesarean surgeries in this nonchalant way demonstrates the value systems

inherent to biomedical understandings and practice around birth, and their foregrounding of certain types of risk (risk of death, risk to the institution) at the expense of others (risk of emotional trauma, for example). The women I spoke to made their care-seeking decisions around pregnancy and birth contrary to popular conceptions that biomedical birth care was the only safe and viable option. A major theme that I encountered during my fieldwork was that informants opted for alternative forms of care in order to avoid feeling like their bodies weren't under their control—to avoid the loss of personal autonomy that they associated with hospital birth and biomedical care. Therefore, my informants' medical decision making can be partially understood as a reaction to the unbalanced power dynamics intrinsic to the biomedical model of birth.

Knowing and Doing—Technocratic Birth in the US

> *"And I was thinking to myself that no one's looking at her...She's having a baby and everybody's looking at the monitors. The nurses would come in, they go straight to the monitor... There's like a disconnect, like they're not actually focused on her."*
> -Kirsten, 38, prenatal yoga instructor, homebirth mother of two; describing a friend's experience giving birth in the hospital

The control wielded by medical institutions over pregnant and birthing bodies can be understood as an extension of the social dominance of biomedical knowledge in the US, and indeed most Western societies. In the previous chapter, I discussed the historical

establishment of hospital birth as the dominant model—a process that was intrinsically connected to the social construction of biomedicine as the sole arbiter of knowledge around reproduction. The shift that took birth out of the home, and brought it into the halls of the hospital, also changed the way birth was understood. Labor and childbirth were no longer social occasions relegated to predominantly female domestic spaces, but instead medical issues that necessitated specialized care. The process of medicalization, in this case, involved interconnected processes of increasing biomedical control over the reproductive female body, and establishing biomedical, scientific knowledge about birth as authoritative. This section will discuss the connections between medical knowledge and power, both in a broad theoretical sense, and then tying that theory to specific birth experiences in US culture using medical anthropologists Robbie Davis-Floyd's discussion of the technocratic body. I will begin this section by returning to Foucault for a discussion of how dominant discourses shape practices—in this case, medical practices. I will then narrow this concept down to focus specifically on US culture, and birth care practices—and how the positivist thought and valorization of science and technology dictate the technocratic nature of birth care in the US, which has been much interrogated by Davis-Floyd. Finally, I will present the lived reality of technocratic birth care by discussing relevant ethnographic examples from my own fieldwork.

The way that birth care is practiced reflects discourses of knowledge within a given society. Returning to Brigitte Jordan's concept of authoritative knowledge (1997),

the rise of obstetrical practice as the dominant form of birth care paralleled obstetrical understandings about birth, neonatality, and the female body becoming socially accepted as standard and true, while eclipsing competing forms of knowledge. We know from the theoretical work of several important scholars, Michel Foucault chief among them, that knowledge and societal power are mutually constitutive such that they are ontologically inextricable one from the other (1980). Dominant discourses dictate formations of practice that, in accordance with the historical and political contexts which shaped them, come to define what knowledge is popularly accepted as normal or true, and therefore what is enacted socially (Foucault 1980, Foucault 1991). In simpler terms, the forms of *knowing* and *doing* that become dominant in a given place and time both reflect and reinforce the beliefs and practices that are themselves also dominant. Scientific biomedical knowledge is often considered to be the only "true" form of medical knowledge in Western cultures, therefore our ways of administering medical care are deeply entrenched within positivist ways of understanding the world. This is true for care around birth, as well, where biomedical ways of thinking about childbirth are popularly accepted as "common-sense" or true.

Biomedical understandings and modes of thought are rooted in the history which produced them. In his monograph *The Birth of the Clinic* (1994) Michel Foucault describes the development of the medical profession in relation to the rise of positivism in the late 1700s and early 1800s. Modern medical practice can trace its lineage to the

post-Enlightenment reorganization of Western knowledge, according to Foucault, which brought with it the social construction of empiricism as the only true means to understand and engage meaningfully with the world—resulting in the characteristic biomedical perspective Foucault calls the "medical gaze" (1994, xi-xii). Concurrently with establishing this iteration of medical knowledge around the body and its pathologies, the medical gaze began to divide the human form into its separate systems, separate empirical sources of medical data—and in so doing divorced the individual from both her body and from relevance within the medical sphere of inquiry and care. The restructuring of medical knowledge that Foucault writes about has profoundly influenced the modern practice of Western biomedical care around pregnancy and birth.

Foucault's "medical gaze" can be seen in mainstream practices around birth care in the contemporary US. Biomedical physicians tend to address parturition as a series of potential symptoms that need to be dealt with through pharmacological or surgical intervention. When birth is addressed in this way, the medical gaze can be understood to divide the parturient body into a series of processes and organs—a contraction, a uterus, a hormone shift—which erases any sense of the individual, the emotional, or the social. In accordance with Foucault's writing, biomedical control over the processes of reproduction, and birthing bodies, reflects the positivist world views and value systems characteristic of Western societies.

Medical intervention and its associated technologies (sometimes referred to as "technomedicine") are often valorized over the biological processes of parturition, in accordance with the popular social perception that they are safer, less painful, and more desirable (Davis-Floyd and Sargent 1997, 7). The biomedical model of birth care in Western societies, and especially US society, tends to be dehumanizing in that it objectifies the patient by interpreting the body as a series of mechanical processes, and labor and birth as a constellation of symptoms to be dealt with through medical technologies and interventions (see Davis-Floyd 1994, Franklin 1995 etc.). Medical care in US culture reflects an absolute faith in medical technology, so much so that technocratic thought has been described by certain scholars as the central mythology of our culture. The technocratic nature of US birth care creates a significant avenue for the expression of medical control over birth and birthing bodies, and profoundly shapes the clinical experiences many women have with hospital birth. Much of the work of medical anthropologist Robbie Davis-Floyd addresses technocratic birth care in the US, and some of the issues associated with it. Davis-Floyd writes about discord between individual experiences and the biomedical, or technocratic model of birth care, and the prominent role of medical technology during birth which functions as an extension of the central role of technology in modern Western culture (1994, 1125). Referencing Peter C. Reynolds' work *Stealing Fire: The Mythology of Technocracy* (1991), Davis-Floyd argues that absolute faith in technology, and particularly medical technology, functions as

the central mythos within Western societies, and is in turn reflective of heavily positivist Western conceptualizations of reality (1994, 1125). Davis-Floyd writes that the technocratic model of birth is dependent on a set of rituals which transform the naturally occurring into the man-made, and thus improve it (Davis-Floyd 1994, 1125; Reynolds 1991).

Davis-Floyd describes that the technocratic rituals of biomedical practice can be understood as a violent, two-step process—at the first stroke rendering dysfunctional a natural feature or function, and the second amending or replacing it with technology (1993, 1125). Allopathic birth care follows a pattern of *mutilation* and *prosthesis*, then, as physicians disrupt the biological processes of birth via technological intervention, and then augment or replace them via synthetic proxy (Davis-Floyd 1993, 1126). The technocratic mutilation of the process of parturition is achieved through its dissection into different measurable components, such as the stages of labor or degrees of cervical dilation. The course of childbirth is also further figuratively disassembled through the use of standardized diagnostic measures, such as ultrasound and internal electronic fetal monitoring, intended to determine whether events are proceeding in a "normal" fashion, as defined by the medical institution (Davis-Floyd 1993, 1127).

When birth is deemed to be progressing in an abnormal or hazardous way, it is addressed with the prosthesis of medical technology. These prostheses can take the form of pharmacological or surgical interventions, such as prescribing the medication Pitocin

to augment the force of contractions, or the performing of episiotomies (surgically cutting through the perineum or surrounding tissues to artificially widen the birth canal) (Davis-Floyd 1993, 1127). In the case of Cesarean sections, biomedical technology completely replaces the biophysical event of parturition with a surgical procedure, thus functioning as a complete technocratic disruption and reconstruction of a natural process (Davis-Floyd 1993, 1127). The power of the technocratic mythology in Western societies is such that Davis-Floyd describes debates within medical literature over whether prophylactic Cesarean sections (Cesareans which aren't medically indicated but rather performed by choice) ought to be offered to all patients as standard practice, regardless of individual circumstance (1993, 1127).

The technocratic nature of birth care in the US, and the social dominance of biomedical knowledge about birth, strongly colored the perceptions many of my informants had about mainstream birth. Kirsten, whom I quoted above, a 40-year-old yoga instructor and homebirth mother of two, described assisting her friend during labor in the hospital. Her friend was having her second hospital birth. Kirsten described to me how her friend's first pregnancy and birth had been at a relatively young age. The friend had not done any research for herself about her medical care options before entering the hospital in labor. She had trusted her doctors to know what was best for her.

Kirsten described an intense, long, labor, during which her friend was frightened and exhausted, and ended up accepting the epidural anesthesia that was offered to her.

Although the epidural relieved pain, the complete absence of sensation it engendered created feeling of being disconnected from the experience of birth that Kirsten's friend described as unpleasant and alarming. In addition to being emotionally fraught, both Kirsten and her friend believed that the epidural had lessened her ability to control her body during second stage labor (i.e. the pushing stage). "I remember when the baby just like shot out of her [laughing]. Just came out really fast!" Kirsten, and her friend, felt that the birth might have done less damage, and perhaps have required fewer stitches afterward, if her friend had been more physically aware and been able to control the degree of force with which she bore down.

When Kirsten's friend became pregnant for a second time, she decided beforehand to labor without pain medication, in hopes that she would feel more connected to the birth process and her body. As it happened, labor stalled once they arrived at the hospital), and Kirsten's friend ended up needing intravenous Pitocin (a synthetic form of the hormone Oxytocin) to augment the force of her contractions and speed labor. "She brought snacks. She was eating snacks like pretzels. And the nurse came in and said, 'Oh, you're eating. Maybe that's why the baby's not coming.'" The nurse told her friend to stop eating, and Kirsten felt it was ridiculous, and perhaps not in her friend's best interests.

Even with contractions that were now extremely painful, Kristen's friend had been trying to labor without pain medication. Her attempts to manage her labor pain by

walking were impeded by IV tubes, wires, and sensor cables attached to her arms and a band around her belly, which physically encumbered her to the point that she finally collapsed on the bed and wept. Despite saying repeatedly that she absolutely did not want pain medication, the friend was nonetheless repeatedly, and sometimes forcefully, offered epidural anesthesia by the nursing staff. In Kirsten's words: "…she's in pain and she's in active labor and she's having to explain herself when she's already set the boundary and they're crossing over it. And I was just like, this just doesn't feel right."

Kirsten was deeply troubled by what she perceived to be overuse of medical technology, lack of attendance to her friend's emotional state, and general powerlessness over her body that her friend had experienced in the hospital. She described to me that being present for her friend's hospital births is what made her decide that she wanted homebirths for herself. To my thinking, there are several things going in in Kirsten's story that are telling about the ways childbirth is largely *known about* and *done.* We can see clearly that medical knowledge is dominant over the patient body, even over the friend's bodily self-knowledge: attempts to manage and care for her own body during labor, by eating or walking around, are either made too difficult to continue or actively shamed and discouraged. One of the messages that can be read in this situation is that a laboring patient must defer to the authority and superior knowledge of the biomedical practitioners, or else risk negative outcomes (thus the nurse insinuating that the friend's labor stall had been somehow caused by eating pretzels without approval).

The technocratic rituals of US birth care that Davis-Floyd has described for us are also present in Kirsten's story. As Davis-Floyd described, Kirsten's friend's labor was riddled with various biomedical interventions and augmentations. The technocratic *prostheses* are the augmentation of labor with Pitocin, the simultaneous devaluation of the friend's knowledge of her own embodied experience and replacement of her senses with sensors—a band around her belly to monitor contractions, another around her arm to monitor blood pressure. In the quote that began this section, Kirsten described that the medical staff were more focused on the monitors attached to her body than they were on her friend. What better expression of the technocratic control over the birth process, and the subsequent erasure of the social and emotional aspects of birth, than a woman so encumbered with medical equipment that she can't even walk at will, being cared for by nurses who breeze past her as she weeps on her bed to tend instead to the technological equipment which monitors her? The process of birth has here been *mutilated* into a series of symptoms, stages, and biophysical events, surrounded by technocratic rituals. The individual, in all her embodied, social, and emotional aspects, is erased. The experience of hospital birth can be disempowering and dehumanizing, and therefore, it can be argued that choosing alternative forms of birth care can be understood as resistance against the imbalanced power dynamics ubiquitous to the biomedical model of birth care.

Resistance Through Choosing

> *I actually really hated my Kaiser doctor. She was not the OB, she was the nurse practitioner and she was just this very crass... I think that she was, if I'm going to be honest, unhappy with the amount that I knew about my own body... I mean I had questions that she was kind of annoyed that I even understood or knew about, and she would answer them, and I would question her answer and she would become defensive.*
> - Lydia, 34, mother of one, stay-at-home mom

The previous sections in this chapter have touched upon some of the entrenched power imbalances in prenatal and birth care in contemporary US culture, where birth is subject to near-complete medical authority. Physicians, and medical guidelines, occupy a position of power when it comes to birth, wielding control over both medical decision-making and the parturient body. When individuals seek care outside of the mainstream form, it can be construed as a form of resistance to the social power of Western biomedicine, and a rejection of its control over the body and experience of pregnancy, birth, and postpartum. This section will explore some examples from the anthropological literature of alternative birth care choices as resistance, and contrast my own findings from my fieldwork among the Sonoma County alternative birth community.

The concept of resistance to medicalization and medical authority has been interrogated by the field of medical anthropology as a means to better understand how individuals act with agency within the framework of the cultural hegemony of biomedicine. . Medical anthropologist Byron Good, in his collection of lectures on

anthropology and medicine (1994), discusses some of the ways in which resistance has been addressed within the discipline. Good writes that there has been a tendency within certain works that address the hegemony of biomedicine and its representations of illness to cast patients as passive victims of oppression (1994, 58). In response to James Scott's famous ethnographic work *Weapons of the Weak: Everyday forms of Peasant Resistance* (1985), and following Foucault's famous quote "where there is power, there is resistance," (1978, 95-96), there has developed a body of scholarship which addresses agentive social behaviors, activities, and practices which resist medical power (Good 1994, 58). Similarly, in her essay "The Tempering of Medical Anthropology: Troubling Natural Categories." (2001) medical anthropologist Margaret Lock writes that the ways in which individuals and communities navigate medicalization does not always render them passive victims of medical hegemony. Although clearly medical power can sometimes marginalize individuals and groups, Lock writes, people tend to exercise agency even under hegemonic social forces, and act in what they perceive are their own best interests (2001, 481). Anthropological understandings of resistance to biomedicine, therefore, encompass flat-out rejection of certain medical practices, but also include practices within biomedical practice which express individual agency

Medical anthropologist Emily Martin's book, *The Woman in the Body* (1987), is often cited as a classic example of resistance to medical power within prenatal and birth care. In this work, Martin describes how medicalized childbirth is a site of vastly uneven

power dynamics that often makes adversaries of the pregnant woman and the medical institution, and by proxy the obstetrician. In her book, Martin compares birth care choices that resist medical control of the body to various labor resistance movements (1987: 139). Martin likens hospital birth to an industrial production line in which the uterus (and not the woman), is allotted a certain amount of time to generate its "product" before medical intervention is needed, and relates how birth activist literature reads (and oftentimes describes itself) as a guide to protect oneself from harm in the hospital (1987, 140-141). Within this metaphor, Martin describes avoiding allopathic care as the equivalent of a labor strike, or perhaps more accurately, opening up your own shop (1987, 143).

Another relevant example of this line of interpretation can be found by returning to Davis-Floyd's discussion of the technocratic nature of birth care in the US (1994). Davis-Floyd describes how choices which are contrary to dominant biomedical practice, and particularly midwife-attended homebirth, can be understood as an assertion of control and personal autonomy, and a reclamation of individual power from biomedical authority (1994,1128-1131). Davis-Floyd argues that choosing homebirth functions as a means for women to reject the "technocratic body" constructed by the biomedical model of birth, and instead reinforce the "organic body," which is fostered by conceptualizations of the female body and biological processes as healthy and normal, and rejection of dualistic separation of the body and the self (1994, 1128-1133).

Choosing alternative birth care can therefore be understood as resistance against the dominant biomedical model. Here I will review some works of scholarly literature relating to medical care during childbirth which support the interpretation of alternative birth care as resistance.. Davis-Floyd's theoretical assertions are in agreement with several ethnographic case studies, including anthropologist Rayna Rapp's book, "Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America," (2000) which discusses the social presence and ramifications of accepting or refusing a prenatal test for Down Syndrome . Medical anthropologist Christa Craven (2005) conducted a study of midwives in Virginia who specialize in homebirth, even in the face of the public perception that out-of-hospital birth is not a respectable or acceptable choice (2005). Medical anthropologist Margaret Macdonald's (2006) work argues that mainstream prenatal and birth care in an obstetrically medicalized setting is constructed in a way to disempower and control women, whereas homebirth grants them subjectivity and a greater degree of autonomy.

Medical anthropologist Melissa Cheyney, in her 2008 article "Homebirth as Systems-Challenging Praxis: Knowledge, Power, and Intimacy in the Birthplace" discusses how women who select homebirth negotiate the risk-avoidance rationale that is a typical explanation for choosing to give birth in a hospital. Cheyney argues that choosing homebirth can be interpreted as both a minority social movement, and also a "system-challenging praxis" a concept which she borrows from Merrill Singer (1995).

Singer defines "system-challenging praxis," as changes which address, and attempt to permanently change, power structures within social institutions in ways that address systemic sources of suffering and inequality (Singer 1995, 90).

The study Cheney conducted connected homebirth as a practice to competing conceptualizations of safety and risk around childbirth. Cheyney found that through her ethnographic interviews, three main themes emerged regarding why mothers decided to have a homebirth: expressing personal agency and power, redefining authoritative knowledge, and creating intimacy and social connections in the birthing space (2008, 254). Women who chose homebirth created a counter-narrative to the dominant "just in case"/risk-avoidance rationale for hospital birth, that instead valued faith in the birthing body, and engagement with the experience of labor and birth (Cheyney 2008, 265). In this way, homebirth challenges the popular perception that hospital birth is superior, and the "common-sense" of the authoritative nature of biomedical interpretations of birth (Cheyney 2008, 265).

Cheyney's findings were similar to some themes that became apparent during my fieldwork in Sonoma County. In the discussion that follows, I will illustrate how my own findings both agree and disagree with Cheyney's results. The women I spoke to often chose alternative care partially as a means to avoid biomedical control over their experiences with birth—but in their case, they retained their health insurance and relationships with primary care doctors as a means to have continuity of care should they

need to go to the hospital during birth. The rationale that informants most often gave me for why they opted for, or desired, alternative forms of birth or prenatal care, was that the biomedical model made them feel dehumanized, disempowered, not in control of their bodies, or some combination of the three. Lydia, the 34-year-old mother of one whose quote opened this section, described conflicts between the way she thought about being pregnant, and how she wanted to experience pregnancy and birth, and her interactions with biomedical doctors. Much as Cheyney found in her study, Lydia's eventual decision to give birth under the care of a midwife, was rooted in wanting to express control--over her own body, the experience, and the wanting her experience to foreground intimacy and the social aspects. of labor and birth. Lydia, and other women I spoke to, chose alternative care partially because they did not buy into the ways birth was being presented to them and conceptualized by the biomedical practitioners she spoke to.

Lydia told me that her decision to seek out care from a midwife was made after her very first prenatal appointment, which she had scheduled with an obstetrician at Kaiser she had never met before. She hadn't seen an OB-GYN in years, and wanted to establish care after she had taken a home pregnancy test. "I just went in and I was like, hi, I just want to establish care… I have a complicated medical history, so I wanted to go over that with her. [She was] totally uninterested. Wouldn't see me until I proved that I was pregnant, so I had to take a urine test... And she said, well, we're not going to show

you the baby until you're eight weeks pregnant. And I was like, okay, that's not really why I'm here. 'Well then, why are you here? Why did you schedule a prenatal?'"

The complicated medical history that Lydia mentions here is that the Depo-Provera shot she had been taking as birth control thirteen years prior to her marriage had altered her body's physiology and put her into early menopause. As a result, Lydia experienced vaginal atrophy and amenorrhea, and had to be on female hormone-replacement therapy for two years to resume ovulation and her normal menstrual cycle. Her primary care provider had failed to mention this potential side effect even once over the course of thirteen years. Lydia told me that her doctor's failure to warn her about the side effects she experienced was when she started to distrust mainstream medicine. She chose to receive her hormone replacement under the care of a naturopathic endocrinologist in Marin County, whose services were not covered under her Kaiser insurance.

Lydia's primary concern with this appointment, other than establishing a care relationship with a practitioner she assumed would attend her through her pregnancy and birth, was to ask questions about how her previous hormone issues might affect her pregnancy. Instead of addressing these concerns, the OB she saw repeatedly told her that she would not give her an ultrasound, because early miscarriage was likely and she didn't want Lydia to "get her hopes up." The doctor also told her that she didn't deliver babies, and Kaiser policy meant that Lydia would get whoever was on call at the hospital when

she arrived in labor. Lydia felt deflated and unheard. "And that was the day that I was going to tell my parents that I was pregnant! I was like, on my way to dinner with my husband, and I went to this appointment." What she had anticipated being a joyous and exciting day had been derailed by her negative interaction with the OB at Kaiser, and the dismissive attitude she had expressed toward Lydia's concerns about her hormone levels, and her pregnancy itself. "So then after I told my parents, after that experience in telling my parents and they were so happy, I was like, why do I want to put myself in a system that doesn't value my experience? Like as a human being. You know what I mean?" Lydia began paying out-of-pocket to see the midwife at a local birth center for her prenatal care. While receiving care from her midwife, Lydia also continued to see her doctors at Kaiser, just in case something went wrong, and she needed to be admitted to the hospital.

Lydia's decision-making process here was a reaction to her negative encounter consulting with the obstetrician, her previous experiences with Depo-Provera and hormone therapy, and the resultant distrust she felt towards biomedical practitioners. Rejection of the biomedical model of birth can be read as resistance to its deeply entrenched social dominance, and the imbalanced power dynamics associated with it. The way that Lydia, and many of my informants, were able to express resistance, however, was highly reliant on their privileged socioeconomic status. In this example, Lydia paid out of pocket for the services of both her midwife and the naturopathic endocrinologist

who treated her hormonal issues. I didn't ask her how much she paid the naturopath, but she told me that her midwife charged $7500, which had to be paid in a lump sum before she started receiving care, and with the understanding that there would be even more charges if birth became complicated and interventions were required. Additionally, she retained her expensive insurance with Kaiser throughout. The choice to opt for alternative forms of prenatal and birth care served as a means for my informants to disallow biomedical control over their bodies during childbirth. That even women who enjoyed a high degree of social and economic privilege felt disempowered and not in control of their bodies while giving birth in the hospital speaks to how deeply entrenched the imbalanced power dynamics around the biomedical model of birth are in US culture. The decision to opt for alternative birth care as a means to reject the biomedical model can also, and perhaps most importantly, be understood as a function of socioeconomic power. To address this theme, in the next chapter of this thesis I will discuss how decisions around birth care can be not only a means to resist medical authority—but also an avenue to express something about oneself and one's community.

Medical Decision-Making as an Expression of Social Positions

Introduction

In the previous chapter, I presented a review of literature exploring the imbalanced power dynamics intrinsic to medical care, and discussed specifically how these dynamics express themselves through the technocratic rituals of prenatal and birth care in contemporary US culture. Discussing the themes of medical power and control during pregnancy and birth provides important context for my analysis of the medical care-seeking decisions among Sonoma County's alternative birth community. My informants deliberately chose non-dominant forms of care as a means to avoid the bodily and ideological control that they felt were typical of biomedical obstetrical care. A discussion of the unbalanced power dynamics between medical providers and patients that are intrinsic to birth care in the US, however, does not adequately address certain key components of the social contexts within which this populations' care-seeking processes take place. With this chapter, I will turn my attention to how medical care-seeking decisions around birth can be expressive of a community's social position. I use the concept of socially stratified reproduction to analyze this phenomenon. Medical decision-making can also be understood as a means to project one's identity and belonging to a particular group. In the second section of this chapter, I discuss my informants' medical decision-making preferences using the motif of "hierarchy of resort."

My informants' particular social positions were a central component of their ability to seek out and access the alternative care they desired. Alternative care modalities, such as midwifery, operate outside the already-fragmented US healthcare system. Non-dominant forms of care are often relatively expensive and are seldom covered by insurance, and so some degree of financial solvency becomes a prerequisite to access them (see David-Floyd's concept of "stratified holism" 2018, 38). The women I spoke with paid between $5,000 and $9,000 to access the care of midwives during their pregnancies, a cost which often had to be paid as a lump sum before care began. Those prices didn't include the "extras" which many informants availed themselves of—such as routine pregnancy bloodwork, ultrasounds, and lab tests, or the emotional support service of a doula during labor. I found that the services of a doula, for example, might cost my informants anywhere from $800 to $2,000, and even simple blood tests carried costs in the hundreds of dollars when accessed outside of insurance coverage.

Additionally, my informants sought out alternative medical care in other arenas, besides pregnancy and birth—they often mentioned, for example, their belief in the efficacy of essential oils, energy healing with crystals, and reiki. Many of my informants believed that mainstream medical institutions, doctors, and pharmaceutical corporations, were deceptive and untrustworthy. I found espousing some degree of anti-vaccine belief and rhetoric to be relatively common among these informants, including among the midwives I spoke with. As a community, my informants perceived themselves to be in

conflict with powerful social institutions, such as "Big Pharma," the government, and mainstream medicine. These deeply held beliefs colored they ways in which the women I spoke to sought out medical care, and made decisions around how and where they wanted to give birth.

Reproductive Stratifications

> *The sort of client here, because of our demographic and because of where we live and how the cost of living here, is typically, you know... Mid-thirties, white, middle-class, upper-middle-class women that have the privilege of being able to have a baby at home because they can afford it.*
> -Kate, 42, mother of three, doula, unlicensed practicing midwife

Faye Ginsburg and Rayna Rapp, in their classic edited volume "Conceiving the New World Order: The Global Politics of Reproduction" (1995) introduced the idea of socially stratified reproduction. Ginsburg and Rapp write that "experiences of reproduction are shaped by a variety of cultural ideas and practices that are hierarchically organized" (1995, 77) –or in other words, that the social categories to which one belongs—one's gender, class, or race, for example—have profound effects on what kind of experiences with conception, pregnancy, birth, and family genesis are socially deemed appropriate or acceptable. My informants, who were majority white, affluent, and heterosexual, were comfortably situated on the upper slopes of the hierarchy of reproductive experience. To address their stories from the framework of stratified reproduction means to take a closer look at how greater degrees of social power shape

reproduction. I mean to illustrate here that the medical decision-making processes of the women I spoke to can be interpreted as an expression of their particular class positions. The alternative birth community in Sonoma County, as a group, enjoys a high degree of social and economic power, and I suggest that examining the reproductive experiences of a privileged group such as this—the upper stratum—has the potential to add nuance to how we think about the social stratifications of reproduction.

In this chapter, I inquire further into what, exactly, is on offer or more available to these socially advantaged people in the context of prenatal and birth care. I argue that along with improved access to care and more control over the birthing experience within the biomedical model, my informants are able to leverage their social power to opt out altogether in favor of a more preferred form of medical care (midwifery), while still maintaining access to the rejected care model. To illustrate what the concept of stratified reproduction looks like, and how it is intrinsically related to the subject of my research and this thesis, I am going to briefly review some relevant examples from the body of anthropological research.

There are many examples of ethnographic work which addresses the ways in which reproduction among groups of socially, economically, or medically disadvantaged people becomes problematized. The literature I am presenting here demonstrates that one's social position—be it marginalized or privileged—has a profound impact on the way one experiences around reproduction. Anthropologist Ellen Lewin's essay "On the

Outside Looking In: The Politics of Lesbian Motherhood" (1995) addresses the ways in which family genesis and maternity are socially stratified for American lesbians. Lewin observes that, despite decades of social change and the advent of second and third wave feminism, motherhood remains central to popular definitions in US culture of what women are and should be (1995, 105). Lesbians, however, are often excluded from mainstream conceptualizations of "traditional" womanhood, and this outsider status also extends also into maternity—pregnancy for lesbians is not a natural byproduct of sexual activity, but rather typically linked to technological interventions such as artificial insemination (Lewin 1995, 106-107). Lewin describes a particular set of social circumstances that must be navigated by lesbian mothers—on one hand, their maternity allows them to lay claim to traditional gender markers, which in turn undermines the social construct which excludes them from womanhood because of their sexual orientation; and on the other hand, lesbian motherhood also allows for the creation of parallel constructs of gender which undermine the assumed connections between sexuality and reproduction (1995, 111-113). We see quite clearly in Lewin's example that for lesbian mothers, their experience with reproduction—from conception all the way through child-rearing—are profoundly shaped by the social presuppositions, prejudices, and assumptions that lesbian women in the US negotiate as a group.

The power of social categories to shape experiences with conception, pregnancy, birth, maternity and paternity, and family genesis, as well as access to reproductive

resources and care, is really the crux of the theoretical framework of stratified reproduction. Social context is paramount in constructing the spectrum upon which reproduction can exist for individuals or groups. Another example from Ginsburg and Rapp's edited volume is anthropologist Martha Ward's essay "Early Childbearing: What is the Problem and Who Owns It?" (1995) which addresses teenage motherhood in contemporary US culture. Ward had conducted fieldwork with family-planning establishments in Louisiana and various other parts of the United States throughout the 1980s and early 1990s (1995, 140). The rate of teen pregnancy declined steadily through the 1970s and 1980s, due in large part to an increase in safety and availability of therapeutic abortions (Ward 1995, 142). Nonetheless, at the time of Ward's writing a slew of social and political attention continued to be paid to the alleged "epidemic" of teen pregnancy (1995, 142). Ward argues that the true issue at the root of public policies designed to reduce teen pregnancy rates is not that early childbearing is inherently problematic on its own, *per se*, but rather that American understandings of family genesis and sex are firmly rooted in a national preoccupation with controlling female bodies and actions, and young, poor women are disproportionately targeted because of their otherwise marginalized social status (1995, 140).

The body of research which addresses the social stratification of reproduction has an evident tendency to focus on groups which are marginalized, have fewer available options, and have a lesser degree of control over their experiences with conception,

pregnancy, birth, and parenthood. For example, Khiara Bridge's book *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* (2011) explores the negative consequences of race on women who depend upon public healthcare for prenatal and birth care. Kelly Ray Knight's book *Addicted. Pregnant. Poor.* (2015) documents the lives of drug-addicted women living in daily-rent hotels in San Francisco's Mission District, and how their particular circumstances and the social stigma they operate beneath shape their decision-making during pregnancy, and ultimately their life possibilities. All of these examples demonstrate how the reproductive experiences of marginalized groups are often problematized.

My informants were not from a marginalized group—quite the opposite. They were privileged. Being white and affluent is not unusual for Sonoma County residents—in fact, it reflects general demographic trends in the region. Sonoma County, and the surrounding areas, make up an extremely affluent place. The median household income in Sonoma County is, as of the 2017 census, roughly $67,000, as compared to the national average of $55,000 per household (US Census Bureau, 2017). The median value of an owner-occupied home in Sonoma County is approximately $465,000, again, as compared to the national average of $185,000 (US Census Bureau, 2017). High cost of living is not isolated to Sonoma County, but is instead part of a region-wide trend in Northern California, as evidenced by neighboring Napa and Marin Counties, where the median values of owner-occupied homes are $560,500 and $908,800, respectively.

Additionally, the population of Sonoma County is predominantly white, with its population made up of 63.5% white, 27% Hispanic, 4.5% Asian, 2% African America, and 3% people of various other races (US Census Bureau, 2017). Sonoma County is also slightly more educated than the national average, with 33.8% of individuals over 25 holding a bachelor's degree or higher, where nation-wide education rates place that figure at 30.9% (US Census Bureau, 2017). The area where I conducted this research is characterized by social and economic privilege.

The women to whom I spoke were, concordant with regional trends, majority white, affluent, and highly educated. The economic advantages enjoyed by my informants became clear when I asked them about the costs they paid associated with prenatal and birth care. Midwife-attended homebirth cost between $5,000 and $9,000—a cost which needed to be paid out of pocket, and usually up front as a lump sum. Additionally, the hiring of a doula, a non-medical practitioner typically employed to provide encouragement, advocacy, and emotional and physical comfort and support during labor and birth, could cost anywhere between $800 and $2,000. If transfer to the hospital were to take place, thousands of dollars in medical copays might need to be paid as well.

Few scholarly works have effectively explored the specific ways in which reproductive experiences and access to care are altered by increased degrees of social privilege. I will next discuss two important works which contrast birthing experiences

between socially powerful and socially marginalized groups. An example which famously addresses class and race in the delivery room can be found in Emily Martin's book "The Woman in the Body: A Cultural Analysis of Reproduction."

> Whether the dominant mechanism in the differing treatment of women in labor is race or class, it is evident that both profoundly affect birthing in our society...For a white middle-class woman, the salient issue may be to stall going to the hospital so the clock cannot be started or to organize and demand that all hospitals in the region install birthing rooms; for a white working-class woman, stalling may be an issue, but behind it lurks the larger issue of finding a way to pay for prenatal, obstetrical, or infant care; for a black working-class woman, the issues of stalling and paying may be crucial, but even if she contends with them, she still may have to find a way to avoid mistreatment or to manage to have matters explained to her at all (Martin 1987, 155)

Martin's focus is comparative, describing how experiences with labor and birth are mediated along the lines of class and race. In Martin's account, the relationship between mothers and the biomedical model of care is inherently antagonistic. Middle-class white women certainly have an easier time of things in the hospital, unencumbered as they are with the social and economic issues which constrain their working-class counterparts, both black and white.

In Martin's example, more socially privileged women maintain more control over their own birth experiences. While the working-class women Martin spoke to struggled to access and pay for care, or simply to avoid maltreatment, the middle-class women were free from such concerns. These privileged women leveraged their social power not only to control their own experiences with labor and birth, but to organize, and try to initiate change in hospital procedures around birth on a larger scale.

Another relevant example which addresses how birth experiences differ along the lines of class is Ellen Lazarus' essay "What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth" (1997). In this essay, Lazarus contrasts the hospital birth experiences of middle-class and poor women (1997, 133). Lazarus writes that poor women, who are often dealing with overwhelming social and economic problems—such as unemployment, unplanned pregnancies, or lack of health insurance—are significantly more limited in the ways they could have babies and the kinds of care available to them (1997, 133). The root of this lack of control over birth experiences, according to Lazarus, is a dearth of knowledge about birth—women from upper socio-economic classes had more options within their pregnancy and birth care, and so researching and acting on their acquired knowledge gave them the impression of having more control over the process (Lazarus 1997, 145-146). Working-class women, too, wanted information about birth, but with limited options to even access care in the first place, what they wanted most was continuity of care—the idea being that a doctor who knew them could be trusted to look out for their well-being, advocate for them, and tell them what they needed to know (Lazarus 1997, 146). The issue was about quality of care rather than control for women with less social and economic power (Lazarus 1997, 146). Unencumbered by the social and economic obstacles which plagued their working-class counterparts while accessing medical care, the middle-class women in Lazarus' study were able to exercise control over the experiential aspects of birth (1997, 142-146).

Women's expectations and concerns about birth were therefore mediated along the lines of socioeconomic class.

Both Lazarus' and Martin's accounts describe within birth care a relationship between one's position within society, one's ability to access/gain knowledge, one's capacity to act on that knowledge, and the social institution of medicine. Those in positions of greater social power have more knowledge about birth and more capability to resist medical authority and control over birth. Conversely, those who are socially disadvantaged are less able to acquire knowledge about their options and more constrained in their available choices and actions.

Lazarus argues that different groups exercised different degrees of power and autonomy during birth, all of her respondents operated within the bounds of the biomedical system within which they received care (Lazarus 1997, 149). The differing degrees of patient autonomy described by Lazarus were associated with continuity of care or labor experiences, but the circumstances of birth—in this case, medicalized hospital birth—were beyond her informants' control. The medicalization of pregnancy and childbirth were so complete in Lazarus' account that even the most privileged women she spoke to wielded what little control they had within the auspices of medical authority.

Within Martin's complex metaphor of birth care as a sort of production chain, she describes avoiding allopathic care and giving birth at home as the equivalent of a labor strike, or perhaps more accurately, opening up your own shop (1987, 143). Homebirth

constituted a complete rejection of the biomedical model of birth. This wasn't necessarily the case for the mothers I spoke to—each of them retained health insurance and access to biomedical care throughout their pregnancies.

My informants were able to leverage their privileged socioeconomic statuses in order to maintain their connections to mainstream medicine while seeking care elsewhere. My informants' care-seeking decisions weren't completely circumscribed by biomedical authority, as in Lazarus' study, but neither were they completely removing themselves from the biomedical system, as Martin described. I suggest that, for the socially and economically powerful population I spoke to—this upper social stratum—the ability to resist biomedical authority can be understood as an extension of their very privileged social positions.

The ways in which the women I interviewed spoke about the costs associated with homebirth suggested that finances were not necessarily the deciding factor in their care-seeking decisions. When I asked Kirsten, a 38-year-old part-time prenatal yoga instructor who had had two homebirths, whether the financial costs caused her hardship, she responded: "It was a financial choice because at the time we were covered. I could have gone to Kaiser, have it 100% covered, but we chose to pay out of pocket to have the care from a midwife, and it was the best investment we ever made, obviously." Her response suggested it had never been beyond their reach. Kirsten became a stay-at-home mom after the birth of their first child and had a subsequent homebirth with her second. Kirsten

described her family's decision-making around the second homebirth as such: "So, second time with one income we knew that we had to do that again because the first birth was so wonderful.... So, it was just a decision that we made, and we knew that it was going to be worth the investment. So, instead of taking like a big vacation or something, we paid for a home birth." The issue that Kirsten and her family faced in paying for her homebirths was not accessing it at all, but rather, that they would have to forgo another big-ticket expense that year.

Similarly, Brianna, a 36-year-old mother of two whom I visited at her home, described the financial trade-offs involved in choosing birth care. Brianna had wanted homebirths, but had forgone them because of the cost: "I think it would have been, at least for my four year old, like $7,000 to $9,000 for a homebirth, which would have made it so I couldn't stay home with her for a year...so that's ultimately what we decided to do and I'm happy with how it all went." In lieu of paying for a homebirth, Brianna chose to give birth in the hospital and take a year off work to stay home with her baby. She made the same decision with her second child, only in that case, she took a year and a half off.

Brianna was able to give birth at a local Kaiser hospital which is known to have midwives working shifts in the delivery room, in addition to OB-GYNs. She had come up with a very specific birth plan to use in the hospital, which outlined her wishes in several ways, including what music she wanted to play while she labored, and that she wanted to give birth with as little assistance as possible. In this way, Brianna was able to leverage

some control over her experience with birth, even in the hospital environment where she felt she had little control:

> It was basically like I had a home birth in the hospital… [The midwife] had read my birth plan. She knew I wanted like a really natural birth and she was just like, 'no, you got this, you're good.' She poked her head in once while I was the shower and was like, 'Do I need to get my raincoat, are you going to have the baby in the shower?' Like, [laughing] I was just like, 'Who is this person? You are so *not hospital*.' She just stood and listened. And when she figured it was almost time, she got dressed and then she came and sat in a chair next to my mom and talked to her and like she just waited. And then she started fixing the table and you know, she did her thing and it was, it was so lovely. Like I almost cried when I think about her because I was like, 'no, that's exactly what I wanted'… It was basically like a home birth in the hospital and it was lovely. (Brianna, interview with author, August 1st 2018)

Brianna seemed to be at pains to tell me that, even though she had hospital births, they were not *like* hospital births. She had had the wherewithal to research a hospital which staffed midwives and was amenable to her wishes. Brianna's actions had created for her a sort of simulacrum of the homebirth she desired within her financial constraints. Brianna was eager to reassure me that her hospital birth had been as un-hospital-like as possible—repeating that her experiences were like a "homebirth in the hospital," describing her midwife as "not hospital," for example. The community Brianna belonged to—the Hippie Moms—had such a deep distrust of the medical establishment that any engagement with it must be as minimal, and as tightly controlled, as possible. By downplaying the "hospital-ness" of her hospital births, Brianna expressed that she had still given birth on her terms and in accordance with her beliefs. Doing so had both reinforced Brianna's own bodily and ideological autonomy during birth, as well as her sense of belonging to a

special community that valued nonconformism and countercultural philosophies. I discuss how medical decision-making around birth care can be expressive of group identity in the next section of this chapter.

Both Brianna's and Kirsten's stories involve making trade-offs in some other sector of life to offset the cost of homebirth—in Kirsten's case, her family forwent taking a "big vacation" that year in order to pay for her homebirth; in Brianna's she forfeited having a homebirth in favor of a homebirth-like hospital birth and taking a year off work. These decisions were described to me in terms of sacrifice, but their terms were indicative of their particular class positions. Big vacations, and taking years off work, are luxuries that might not be available to a woman from a lower socioeconomic class. These options were made available to the women I spoke to because of their financial solvency. In these examples, we can see how the decision to opt for alternative birth care can be understood as an expression of this population's particular privileged class position.

Hierarchies of Resort

> *In my community of friends and such ... I feel like there was more pressure, in a way, to do it as a home birth. Maybe even just in my own mindset of, I'm holistic, like, super mama. I'm just going to be one of us. Like, if I* don't *get this home birth, I'm not one of us that gets to say, "I had a home birth."*
> -Rachel, 37, licensed marriage and family counselor, mother of one

The previous section of this chapter discusses the ways in which the decision to opt for alternative prenatal and birth care can be understood as an expression of

socioeconomic status. What, then, are we to make of the fact that the women I spoke to chose the non-dominant form of birth care, when their privileged social positions could have potentially made available for them myriad other options? That, indeed, this population preferred alternative forms of medical care as a general rule, whether pertaining to childbirth or otherwise? I suggest that my informants' medical decision-making can also be understood as an expression of the particular identity, value-systems, and beliefs about themselves and their position in society that they cleaved to as a group. By choosing alternative forms of medical care, the women who I spoke to were able to express their belonging to a special community, with certain expectations for alternative philosophies and lifestyle choices.

Here I analyze the medical decision-making engaged in by my research participants using anthropologist Lola Romanucci-Ross' motif "hierarchy of resort." The term hierarchy of resort originates from Romanucci-Ross' article "The Hierarchy of Resort in Curative Practices: The Admiralty Islands, Melanesia" (1969). In this work, Romanucci-Ross discusses medical decision-making in the Manus culture in Melanesia. Romanucci-Ross writes that post-World War II, the Manus people had, as a group, been enthusiastic adopters of European-American lifestyles and culture (1969, 201). This eagerness to acculturate themselves into Western culture, however, did not extend into the realm of medical treatments—to a certain degree, the Manus accepted and made use

of Western medicine, but preferred their own systems of medical theory and treatment (Romanucci-Ross 1969, 203).

Romanucci-Ross writes that the Manus people chose between three alternative forms of medical care: 1. The traditional medicine; 2. Western medicine; or 3. Healing which came from the Manus version of Christianity, used primarily to treat "moral illness" (1969, 206). Both traditional medicine, and Christianity-based healing allowed for a moral dimension to illness, as well as an explanation of why ill-health might befall a specific individual—as punishment for a moral infraction, for example (Romanucci-Ross 1969, 206). Western medicine offered no such explanation for illness—it was often viewed as only descriptive where it ought to have been explanatory (Romanucci-Ross 1969, 206). Romanucci-Ross describes that Manus understandings of illness, as well as the relationships between bodily health, moral value-systems, sorcery, and spirits, were expressed in their tendency to exhaust all other types of care before turning to Western medicine (1969, 208).

Taking the framework provided by Romanucci-Ross, wherein medical care-seeking decisions can be understood as an expression of broader social dynamics, I will turn back to the example of the Sonoma County alternative birth community. The first resort for care among the informants I spoke to was usually whatever forms were perceived as non-allopathic, non-institutional and alternative. As an example of this, one of my informants, Brenda, a 35-year-old mother of one, described a previous pregnancy

in which the fetus had died at eight weeks gestation. Her physicians at Kaiser urged her to undergo a D&C (dilation and curettage) procedure to empty her uterus and prevent infection, but she opted instead to use clary sage and frankincense essential oils applied under her tongue, over her abdomen, and on her ankles, to induce contractions and encourage the expulsion of the fetus. The essential oils worked, and Brenda interpreted being able to remain at home while she miscarried as a positive aspect of an otherwise negative experience, telling me: "Even though it was only eight weeks… I got to have a natural birth at home in my living room. So, you know, that's like a really sweet… I mean, it's bittersweet, but it's a good memory." My conversation with Brenda suggested that she overall viewed biomedical care in a negative light, which was a sentiment I found to be commonplace among my informants.

Biomedical intervention became unavoidable for Brenda while she was pregnant with her son. When Brenda was first trying to get pregnant, she was unable, and suffered recurrent early miscarriages which she initially thought were very heavy and painful menstrual periods. After trying various remedies using herbs and essential oils, Brenda finally saw an OB-GYN at Kaiser, who discovered that she had a uterine fibroid she described as "the size of a cantaloupe" which was preventing pregnancies from growing beyond a certain size. To remove the fibroid, Brenda underwent a laparoscopic myomectomy. Because of the fibroid's position at the very top of her uterus, and the size of the incision required to extract it from her body, Brenda's doctor told her that the risk

of uterine rupture during labor was now unacceptably high. Should she get pregnant, she would require a cesarean section to deliver her child. "And I even asked doctors, I asked my surgeon, 'Are you sure I have to have a c-section?' And then the feedback I got from them was, 'If you want to have a different birth, then you're going to have to sign an against medical advice waiver and insurance won't cover it. And it could be risking your life.' I mean, they tried to scare me big time."

Brenda believed her doctors' admonitions, and so, faced with a birth that she felt was undesirable, Brenda did what was in her power to control the experience: "Because I knew I was gonna have a c-section, I filled the form out knowing that, with all my wishes, things like delayed cord clamping. No bath, I wanted to nurse right away. I didn't want them to like put anything on my breasts, like wash them or do anything like pre-surgery. Not that they needed to. I didn't want him circumcised." Brenda had brought crystals with her into the surgical theater—Baltic amber, to reduce pain and inflammation. At her insistence, her surgeon waited to remove her placenta and suture the incision until the umbilical cord stopped pulsating. "It was like the most natural, like everything that you would do in a regular birth or like a home birth that I could possibly do in the delivery room." Similarly to the example I discussed above—in which Brianna had hospital births that were as un-hospital-like as possible—Brenda had used what power she had to retain some alternative elements in what otherwise would have been a completely medicalized birth.

The hierarchy of resort employed by my informants meant that, to them, hospital birth, and the care of an obstetrician, were less-preferred options than midwife-attended homebirth, and surgical birth was the least desirable route. In instances where Western biomedicine might need to be used, it was important for my informants to engage with the biomedical system in a way that still maintained their autonomy and expressed their values. Many of the same sentiments of nonconformism and deep-seated distrust of medical authority were evident in my informants' medical decision-making for issues besides birth. Research participants' attitudes about vaccines, and other childhood medical interventions, revealed how they perceived Western biomedicine as an untrustworthy social institution, and biomedical knowledge as unreliable and potentially deceptive. Later in my conversation with Brenda, she told me that she often blatantly disregards her doctors' recommendations, and even her husband's wishes, for her son's medical care. "I didn't want him vaccinated, my husband did, so we compromised with a super delayed schedule. I would, like, make an appointment, and if he even coughed that morning I would just not go… And it's kind of been like that with everything. They prescribed us fluoride and my husband picked it up from the pharmacy and I just threw it away last week. He never got any of it. And he won't."

Willow, a 35-year-old homebirth mother of three, described a similar way of engaging with vaccine requirements—on her terms, and exercising as much autonomy within the constraints of institutional policy as possible. She didn't vaccinate her children

at all until they started school, where immunization records were required to attend. "We actually just got our five-year-old, or almost five-year-old, her first dose of TDaP last week… We knew we wanted to skip the early ones." Willow describes their family as partial-vaxxers. Her compromise with her childrens' school's vaccination requirements was to begin immunizations, but on an extremely delayed schedule of her choosing. She rationalized this decision as being a result of her own pragmatic thinking, rather than medical advice: "We've decided now she's going into kindergarten… My husband's a teacher so he's potentially a carrier for some of these illnesses. And so, we decided to start her on a schedule." By describing her decision to vaccinate, even partially, in this way, Willow reframed it from a response to an institutional mandate, and made it instead into active, voluntary choice on her part. This emphasis on personal autonomy and nonconformist decision-making is an essential component of how the population I worked with viewed themselves. The hierarchy of resort in this community, wherein alternative medical care is much preferred, and biomedicine is only resorted to when absolutely necessary, reflects this community's shared identity as individualistic and unconventional resisters of social power. The women I interviewed saw themselves as being at odds with powerful social institutions, such as mainstream medicine, the government, and "Big Pharma," and this belief strengthened their bonds as a group.

The medical decisions these women made served to reinforce their identity as nonconformists resisting powerful institutions and societal norms. The disparity between

how my informants perceived themselves, and their privileged social positions—majority white and affluent—became apparent when I asked direct questions relating to race or financial matters. During my fieldwork, I concluded each interview by asking my informant for some demographic data. I would ask for their age, how long they had lived in Sonoma County, and how they identified racially. The question about race was often met with awkward responses—informants would often look at the floor, and sometimes they would dodge the question, or change the subject without actually responding. During my interview with Brigit, a 40-year-old doula and "integrative wellness counselor" my question about race seemed to visibly annoy her. The tenor of the conversation noticeably shifted—for the better part of an hour, Brigit had been describing her thoughts and experiences about pregnancy and birth. Her tone had been one of friendly lecturing. Brigit was highly educated—she had two bachelor's degrees, a graduate certificate in mediation, a master's degree in psychology, was trained and certified as a wellness coach and counselor, and was also trained as a doula. She viewed herself as an expert about pregnancy and birth, and I got the strong sense that she wanted me to see her that way too. Brigit was light-skinned, with sandy-colored hair and light brown eyes. She was clearly identifiable as white, but when I asked her about her race, she stammered, and her voice changed. "I identify as a blend of a lot of ethnicities, and also Jewish."

I noticed the same kind of disconnect with how Brigit perceived her own financial situation. I found Brigit's office to be lavish—it was situated in a center for alternative

practice. She shared the space with doulas, reiki energy workers, therapists of several different varieties, and yoga instructors. The space itself was decorated with a variety of beautiful items—Tibetan prayer flags hung on the walls, a glass display case held healing crystals, and a small fountain burbled in the waiting room. The carpet was thick and sound-absorbing, and the air smelled pleasantly of incense and herbs. On my way to the interview, I got lost trying to find Brigit's office and accidentally interrupted a private yoga session. I mistakenly opened the door to a spacious yoga studio—sunlight pooled onto the hardwood floor from an open skylight, and was reflected from the mirrored walls. A slim white woman was engaged in a standing pose, while another white woman adjusted her posture. They stopped what they were doing, and directed me towards my destination in a patient, albeit somewhat quizzical manner.

In Brigit's office, we sipped fragrant tea made from rose hips and cardamom while she told me about her practice, and her own homebirths. She described to me that she kept her health insurance, while simultaneously receiving care from a midwife, so that she wouldn't have to pay for ultrasounds or lab tests. When I asked Brigit how much she charged for her services as an integrative wellness coach, instead of responding, she began describing that she does pro-bono cases from time to time. When I asked her again, she told me that her going rate was $120 an hour. According to the US Department of Labor, Bureau of Labor Statistics, the median hourly wage for Santa Rosa, the largest city in Sonoma County, in 2018 was $26.58 (2018). The median wage for community

and social service occupations, of which Brigit's practice would be considered a part, was $26.38 (US Department of Labor, 2018). By either measure, Brigit was quite affluent, and yet she was reluctant to see or describe herself that way.

The observation that the women in this community largely came from a place of social privilege was also reflected in my interviews with birth practitioners, when I asked them if they could tell me what their typical clients were like. Lucy, a 33-year-old practicing midwife and former doula, described a similar demographic: "... I usually find they're like, white families, highly educated… and I don't think that's to say that minorities aren't interested, but there's this financial burden. You know?" Linda, a 48-year-old doula and yoga instructor, told me that she noticed a pattern in who hired her: "I think it's definitely by a certain socioeconomic class. People who can afford to pay out of pocket." She laughed awkwardly and looked at the floor, and I asked, as gently as I could, if this meant that the majority of her clients were also white, and she said "Yes. Yeah… It's the truth, man. I am not proud. It's the truth." She continued: "I want it to be accessible. I... wish I had more access, availability for people of lower income brackets."

Linda seemed embarrassed and reluctant to admit that her doula practice mainly provided services for wealthy white women, just as the mothers I spoke to were hesitant to describe themselves that way. The reticence I encountered when talking about race, or economic privilege, with the homebirth mothers I interviewed might have been due to a conflict with how they perceived themselves as a group. The image of a special

community of nonconformists who actively resisted social power was so integral to the group identity of my informants, that pointing out that they were in fact members of a powerful segment of society—white and affluent—caused them discomfort. The women I spoke to did not perceive themselves as powerful, or privileged, but rather as being in conflict with powerful social institutions, such as medicine. They, somewhat paradoxically, leveraged their powerful social positions to reinforce this perception—by seeking out alternative forms of medical care, these informants were able to evade the biomedical care they perceived as coercive and disempowering.

Examining the care-seeking choices of the Sonoma County alternative birth community in this way suggests another dimension of what becomes available to privileged reproduction—wherein decisions can be made not only to control the experience of labor and birth, but to express something about one's beliefs, and one's belonging to a group. For this population, resistance against medical authority can be partially understood as a form of privileged expression—an exclusive means to broadcast belonging to a group that valorizes alternative philosophies, countercultural lifestyle choices, and distrust of institutions. This finding suggests that for the privileged sector of society represented by my research population, their powerful social positions granted them not just increased situational control, access, and care options during birth, but the capacity for their medical choices to function as a means to both express their particular group identity, and strengthen their bonds as a community. For the women I interviewed,

choosing alternative forms of birth care had value beyond the control it allowed them to leverage over their medical care—the choices themselves had meaning in relation to their particular identities and positions within society. Thinking about medical decision-making that rejects biomedicine in terms of how it can create meaning opens future research avenues for better understanding the motivations which may compel groups to purposely avoid the dominant model of medical care.

Findings—Interview Content in Context

In the previous chapters, I have raised several themes which are relevant to my informants' decisions to seek out alternative forms of birth care. I have written about the hegemonic nature of the biomedical model of birth care—and the extreme medicalization

of the processes of birth it entails. As I have argued, seeking out alternative forms of care can be partially understood as a means to deny, or disallow, biomedical control over the body. Also relevant are the considerable financial costs often incurred by consuming alternative forms of care—as we know from Davis-Floyd's discussion of "stratified holism(2018, 38) non-biomedical forms of healthcare are often outside of the scope of insurance, and their costs often render them inaccessible to the poor (2018, 38). In practice, the financial component of alternative medicine serves to limit the use of most non-dominant forms of care to more privileged sectors of society—and therefore, choosing them can be understood as an expression of one's class position. Additionally, seeking out alternative forms of birth care can be understood as way to express group identity—for the "hippie moms" of the Sonoma County alternative birth community, seeking out non-allopathic forms of care provided a means to reinforce and project their belonging to a special community which valued nonconformism, distrusted institutions, and had certain expectations of alternative philosophies and lifestyle choices. Chapters One, Two, and Three of this thesis have provided textual and theoretical context for understanding my informants care-seeking processes. In this chapter, I will present the results of the analysis I conducted on the interview content I obtained during my fieldwork. [Briefly summarize the points of this paragraph and transition to the core argument of the chapter: In this chapter, I will… etc.]

In the course of speaking with women from this community, and later analyzing interview content, I discerned twelve main themes that ran through many discussions of pregnancy, birth, and associated care, which I will describe briefly Many interview participants expressed the parallel views that birth, and the female body, were inherently safe whereas the hospital, and the care of biomedical physicians, were not as safe as they might be popularly assumed to be. I found certain patterns in what informants perceived as the particular benefits of midwifery care—that it was individualized, holistic, and attended to the social and emotional components of birth in a desirable way.

Several informants also made the case that midwives gave more information and were less controlling of patients' medical decisions than their biomedical counterparts, and so midwifery was thought to offer improved or "true" informed consent. The biomedical model of birth, conversely, was described as infringing on personal choice and control during birth. Biomedical standards for birth care were often seen to diminish the importance of the emotional and social components of birth. I also noticed an interesting theme in which many of my research participants suggested that biomedical practitioners didn't want them to understand their own bodies or the processes of birth—that their doctors positioned themselves as the gatekeepers of medical knowledge, which in turn caused friction when their patients attempted to learn or leverage medical information on their own. Many of the women I spoke to were motivated to choose alternative forms of care because of a negative experience with biomedicine.

Nevertheless, I often encountered the sentiment that retaining access to biomedical care was necessary, despite its perceived problems, in case it might be needed.

Additionally, choosing alternative medicine was often described to me as the result of gaining more knowledge, and was therefore the "educated" choice. The term "natural" was often used to describe alternative forms of care, and there was a strong thematic pattern that suggested to me that things which were "natural" were understood as superior. I will further present these thematic findings in turn, under the three subheadings of *Competing Definitions of Safety and Risk; Biomedical Birth as Dehumanizing and Disempowering/Alternative Birth as Humanizing and Empowering;* and *Meanings Within Care-Seeking Decisions*. Discussing these twelve main themes in this detailed way sheds light on some of the specific social perceptions, values, and belief systems at work within the Sonoma County alternative birth community relating to medical decision-making.

Competing Definitions of Safety and Risk

Birth and the Female Body Are Safe

During my fieldwork, I often encountered the perspective that birth (and the female body) are intrinsically trustworthy. Linda, a 48-year-old doula and prenatal yoga instructor emphasized that she had immense faith in the inherent safety of the birth process. This sentiment surprised me, because Linda knew first-hand just how harmful

birth could potentially be—she had just moments earlier described her three births, all of which had been traumatic in different ways. Her first labor had been a medically complicated induction that lasted multiple days and ended in an emergency a c-section. During her second birth, Linda had had a successful VBAC (vaginal birth after cesarean) at home, but discovered tragically upon delivery that her daughter had died sometime during labor. Linda's third and final birth was a planned c-section due to a transverse lay (a condition in which the fetus is positioned horizontally in the pelvis, making vaginal delivery next to impossible). Linda describes the surgery itself as a "beautiful cesarean birth," but ten days postpartum she suffered a massive hemorrhage which frightened her family and nearly ended her life. Despite all these events, Linda still believes birth to be inherently safe: "Even though I've had those experiences I really trust birth. I really trust birth, and hopefully those experiences make me a better doula."

Similarly, Dianna, a practicing midwife whom I spoke to in June, described her homebirth clients to me in this way: "They have an innate trust in their body and the process that, you know, despite a few things here and there like, this really will work. Birth will work. The baby will be born, and you don't have to mess with it a whole lot." The mothers voiced parallel thoughts about the intrinsic safety of the birth process, and the female body. Lydia, a 34-year-old mother of one, told me that she thought of pregnancy as a normal part of life, rather than a medical event: "I'm not sick. I am pregnant. Those are two totally different things. I don't need death and dying care. I am

just going to have a baby. That's how this entire earth has been populated over and over again, not just by human women, but by every species on this planet that is mammalian. And how many of them die in the wild? Not as many as you think." Kirsten, a 38-year-old mother of two, expressed an identical sentiment: "Pregnancy and birth is not sickness, it's not necessarily like... Women have been having babies for millions of years before there were hospitals and they survived. Enough to overpopulate!" Willow, a 35-year-old mother of three, said that her trust in her body's ability to give birth safely was a key factor in her decision to have homebirths. "I don't want drugs. I don't want to think about when it's time to go to the hospital. I don't want to have to think about anything. I want to just relax and let my body... I trust my body to do what I need it to do. I have a healthy functioning body, and [homebirth] sounds like the way to do it."

I encountered some version of the sentiment that birth, and the birthing body, are inherently safe in thirteen out of the fourteen interviews I conducted. The belief in the intrinsic trustworthiness of the birth process is contrary to the dominant biomedical narrative, which frames birth as dangerous and requiring medical surveillance and intervention at nearly every turn. Included in the beliefs held by most of my informants is the idea that midwives as practitioners are more trustworthy because they share these views and are experienced with attending to birth from the perspective that it is natural, variable, and usually safe. Trust in the safety of birth poses a challenge to the deeply

entrenched medical authority over knowledge around pregnancy and birth in US culture, which I discussed in detail in Chapter Two.

The Biomedical Model Is Not as Safe as it Seems

In addition to a belief in the inherent safety of birth, respondents also expressed a tendency towards the inverse belief—that the hospital, and the biomedical model of care, are not as safe as they are purported to be. I encountered both a refutation of the popular belief that hospital birth is inherently safe, as well as an assertion that birth can go wrong, no matter where it takes place. I encountered this theme in discussions with both birth practitioners, and mothers. Diana, a practicing midwife, noted that the popular idea that hospital births are the safest choice is in fact a misconception: "There's so many people that think that if you're going to have your baby in the hospital nothing can happen to you… unfortunately we're seeing that now the maternal and infant death rates for our country… We are far down on the line, and it just goes to show you that you're not safe just because you're in the hospital." Multiple informants expressed to me that the idea that biomedical care offers safety was a popular misconception. As regards childbirth, this perception has been well established in the scholarly literature. Claire Wendland (2005), for example writes about the harms potentially caused by cesarean sections, and how their gravity is often downplayed within biomedical literature and by biomedical practitioners themselves. Similarly, Elizabeth Newnham, Lois McKellar, and Jan

Pincombe's (2016) article about epidural anesthesia reveals that what is popularly conceived of as an inherently safe technology in fact carries significant risks—risks which are often not framed as legitimate or serious within the biomedical community. Multiple other studies have likewise addressed the potential for iatrogenic damage during hospital birth.

Most of the women I spoke to believe the opposite—not only is biomedicine not as safe as it seems, but in fact is often a source of danger itself. Kirsten, a homebirth mother I interviewed in August, questioned what she saw as the overuse of epidural analgesia in the hospital: "Like, if they're offering you an epidural in the hospital, they don't go down the list of what the risks are when they're offering it. So, unless you know, beforehand, then, you probably… You may not know. My mother's first birth, she had an epidural and it gave her like this… She had basically like little stroke and like half of her face was paralyzed for two weeks." Kirsten felt that biomedical care posed danger both because of its inherent riskiness, and because its practitioners are not up front about the potential harm it may cause.

Vaccinations were also viewed as suspicious and potentially damaging. Brianna, a 36-year-old mother of two, told me that her child's physicians' seemingly cavalier attitude about administering immunizations was troubling to her. "I found out that the Hep B [immunization] that they give at birth is like a throwaway… I went to her pediatrician and they were like: 'We're starting the first of her three Hep Bs', and I was

like: 'Well she had one when she was born.' They were like: 'No, no, no, that's just an extra.' I was like: 'wait, you're shooting my kid up with extra stuff on the day they're born for no reason?'" To Brianna's thinking, the extra shot had exposed her tiny, fragile infant to dangerous chemicals for no reason at all. Brianna's children are now partially vaccinated, on a delayed schedule.

Brenda, a 35-year-old mother of one who was pregnant with her second child at the time I spoke to her described the pressure to be vaccinated while she was pregnant. "I felt a lot of pressure a lot of the time, like to get the TDaP [tetanus, diptheria, and pertussis] shot… I didn't realize I could just say no. So, I got it. And then I just recently heard about a mama whose baby died inside of her the next day after getting it. So, this time around it's going to be an absolute no."

The overarching theme in these beliefs suggests that, for this community, biomedical knowledge and practice are viewed with heavy distrust. At issue here is the construction of how much risk is acceptable during pregnancy and childbirth, and how that risk must be mitigated. The biomedical model seems to its patients to insist that every possible risk-reduction measure must be taken, even when those measures potentially carry iatrogenic effects. Conversely, the women I spoke to often understood their avoidance of biomedical care to be a risk-reduction measure. Biomedical care was understood as potentially harmful, and so seeking out alternative types of care was an action taken to protect oneself.

Keeping Concurrent Biomedical Care is Necessary—"Just in Case"

Despite their strong misgivings about biomedical care, the mothers I spoke to all retained their health insurance, and relationships to biomedical physicians, throughout their pregnancies. The choice to retain this contact was explained in terms of both wanting to have their insurance pay for as much as possible, and also wanting to have access to a doctor they knew, should they need to transfer to the hospital during birth or postpartum. Lydia, a 34-year-old mother of one, explained: "I had dual care. I was going to my midwives because that's where I wanted to birth, but I also wanted to have records in Kaiser in case anything were to happen, or if they needed any information after the fact. I also wanted to get all my testing done through Kaiser since I paid for it anyways, so it wasn't an out of pocket cost in that regard.". The homebirth midwives I spoke with also noted that the majority of their patients received care concurrently with biomedical doctors. Diana, a 37-year-old practicing midwife, described her clients: "They'll continue to see a doctor… And sometimes it's for different reasons. Some women it's because if…there's any signs that aren't going the way that we would like them, that [then] she has an established relationship with a doctor so that when we go to the hospital she's not this completely new patient that they've never met before. Sometimes women stay with their doctors while they're also seeing me for insurance reasons. Ultrasounds, bloodwork, even though I can do all their bloodwork, and I can source them out for their ultrasound, all of that's out of pocket."

Keeping appointments with an allopathic physician at the same time one is also seeing a midwife is often framed in terms of wanting continuity of care, should the need to transfer to the hospital arise. The hospital is often described as a last resort, after an attempted homebirth "fails." This demonstrates medical pluralism, in which both the biomedical and midwifery models of birth care operate side by side. Patients' access to each form of care is dependent upon certain social factors, such as having the financial capacity to afford paying for care that is not covered by insurance. This also speaks to a hierarchy of resort among this population (see Romanucci-Ross 1969) in which a midwife and homebirth are the first resort, the second resort is a biomedical physician and a hospital delivery room, and the last resort (in the case of a cesarean section) is an obstetrical surgeon in a hospital operating room. The women I worked with enjoyed a high degree of social privilege which allowed them to seek the forms of care that they preferred, while retaining access to the less-preferred form of care, should they need it.

Biomedical Birth as Dehumanizing and Disempowering/Alternative Birth as Humanizing and Empowering

Midwifery Attends to the Social Aspects of Birth, is Holistic, and Individualized

Much of the rationale that informants described in their decisions to seek out alternative forms of birth care centered around the perception that midwives offered superior care. The mothers I spoke to also engaged with midwives in a more personal

way than they might with an OB-GYN. Midwifery-care was often described as highly individualized—midwives paid attention to the emotional aspects of experiencing labor and birth, and welcoming a newborn into one's family in a way that biomedical practitioners might not. Additionally, homebirth midwives are less bound by institutional guidelines (for specifics see Davis-Floyd 2018), and operate on a more dyadic basis. Diana, a practicing midwife who holds a master's degree in Psychology in addition to her credentials as a nurse and midwife, described how she saw her interactions and level of engagement with her clients: "I wear so many hats when I'm their midwife. I am talking to them about their birth, I'm also helping them talk out why they had a fight with their partner… Counseling them on how to talk to their mom about the fact that they're having a homebirth and she doesn't believe in it, and she's nervous. You become... A lot of my psychology kicks in. If you're doing it right, they really see you as part of the family, part of... It's a much closer bond. It's so intimate."

The mothers also described their relationships with alternative birth practitioners as special—midwives and doulas focused on them as a whole person, rather than just a series of pregnancy-related symptoms. Kirsten, a homebirth mother of three, described that the conversations she had with her midwife were valuable to her. "I will say that just having the time and space to sit with someone and talk with them for an hour once a month… It's just so helpful, because a huge amount of our experience in pregnancy and birth is that emotional component, which isn't really addressed if you do the medical

[model]. You're in and out in ten minutes. A midwife, she takes the blood pressure, you get weighed, she looks at your pee… All the normal stuff that you would get in a medical office. But then you have all this time to just talk, too." Midwives were described as being concerned with things that fall outside the scope of biomedical obstetrical practice, such as diet, lifestyle, and emotional health, and the women I interviewed said this led to a higher quality of care.

"I basically gave her like a meal plan of what had been eating that whole week. I would go in and I would spend probably an hour and a half there, just talking about, 'Then I had a cup of quinoa, and then I had this with some chicken and rice and then I had some broccoli…'" Lydia, a mother of one, explained that her midwife's attention to her eating pattern and mood during her appointments helped her wellbeing during pregnancy: "She noticed that I would be… that my moods were going down in the morning time and she attributed that to not having enough to eat. And so, she would encourage me in the middle of the night to wake up and have some peanut butter toast. And so as soon as I started doing that, I was off and running again." Lydia didn't think that a regular doctor would have paid enough attention to her to have been able to make the small—but apparently extremely beneficial—suggestion that she eat a small meal in the middle of the night to keep her blood sugars stabilized.

The descriptions I recorded during these interviews rendered midwifery as a practice as more holistic, and centered on the individual, than the biomedical model of

care. This more personalized care was often framed as positive, in contrasts with the perception that the dominant model of obstetrical care and hospitalized birth are impersonal and concerned with birth as a purely biomedical event. The women I spoke to felt that the midwifery model desirably foregrounds the social, emotional, and experiential aspects of birth more so than the biomedical model might.

Midwifery Offers "True" Informed Consent

Informed consent was an important component of what was so desirable about midwifery care. Informants often expressed the connected ideas that the informed consent offered by biomedical physicians was inadequate—doctors did not provide enough information for patients to make knowing, informed, intentional decisions about their own care—and that the informed consent offered by midwives was substantially better. My informants described that midwives do a better job explaining options to their clients, and allow mothers to more autonomously choose which practices and interventions to accept, and which to refuse. Biomedical physicians, on the other hand, were understood to describe or offer information only about the care options they supported. Biomedical doctors expect the patient to cede decision-making power to them, on the basis of their superior knowledge, and the social perception that doctors know what is "best," whereas midwives would discuss care choices in a more informative, less biased way.

"I try not to give my opinion… But just, 'These are what all the options are,' and if I have a recommendation, I make it, but like 'whatever you guys choose, it's totally up to you. As a midwife I have skills that you can utilize, tell me what you want.'" Lucy, a practicing midwife and homebirth mother of two, described that she paid close attention to making sure she furnished her clients with all available information, so that they could make medical decisions in an informed and supported way. "[I tell them] 'This is the reason we would take your blood pressure today. Do you want that, or do you not want that?' True informed consent. Versus like, just showing up and having things done to you, and you're like: 'I don't even know why I'm peeing in this cup, or why I'm going to the lab to have my blood drawn.' Making sure that [my clients are] saying that, 'Yes, I do want that. I don't want that,' and taking control, because at the end of the day they have to live with the decision."

It was particularly important to this community that midwives present refusal as a legitimate, viable option. Lucy described that she did not vaccinate her children, and that when she spoke to her clients about vaccinations, and various other medical interventions, that she presented opting out of each as a possible solution which she would support. One of the key issues at stake in discussions of informed consent is whether a lay person without medical expertise and training can, when presented with information, make good choices about their medical care. Is it better to cede control over the body to an expert, or retain personal autonomy even when the patient perhaps cannot

completely understand the issues at stake? How strongly should a doctor recommend the course of action they believe to be correct, or disallow that which they think mistaken? Informed consent creates a fulcrum, where a balance must be found between the authority of specialized medical knowledge on one side, and patient autonomy on the other. For the women I spoke to, "true" informed consent meant medical practitioners supplying only neutral information and leaving the patient in control.

As I have discussed at length elsewhere in this manuscript, an important component of the way that these informants conceptualize themselves is that they are a special community which is at odds with various powerful social institutions. For this cohort of patients, avoiding biomedical care was a way to resist medical authority and control over their bodies. It follows that the most valuable kind of informed consent for this community would offer information, but leave authority over medical decision-making squarely in the hands of the patient—rather than yielding a degree of control to a medical practitioner on the basis of their expertise.

The Biomedical Institution and its Physicians (Wrongly) Control Medical Knowledge

Directly related to the question of supplying medical information and informed consent in decision-making is the issue of medical knowledge, and who should have access to it. A common theme that came up in conversations with homebirth mothers was the feeling that biomedical physicians do not want to be questioned and are resistant to patients challenging them or doing their own research. Lydia, a mother of one, described

her doctor's negative reaction when she told her that she was also seeing a midwife, and planned on giving birth under her care. "I actually really hated my Kaiser doctor. I think that she was, if I'm going to be honest, unhappy with the amount that I knew about my own body… I mean I had questions that she was kind of annoyed that I even understood or knew about, and she would answer them. I would question her answer and she would become defensive and say things like, well just go ahead and take that to your midwife if you don't like what I have to say." Lydia felt that her doctor at Kaiser disapproved of her trying to learn more about her body and the processes of pregnancy—that she was guarding this knowledge for herself. Lydia described to me that she strongly disliked being discouraged to seek information and bodily self-knowledge—her doctor's attempts to dissuade her from learning and questioning served to make Lydia more and more untrusting of taking her doctor's advice at face value.

"I went to Kaiser and they were worried that I had preeclampsia because of the…The edema. Yeah. All of that, so I peed in a bucket for 24 hours and gave it to them and they were concerned with the amount of proteins in my urine." Edema and protein in the urine are hallmark symptoms of preeclampsia, a potentially life-threatening pregnancy complication. Lydia described that, because of the adversarial relationship that had developed between herself and her biomedical doctor, she resisted when her doctor wanted to induce labor immediately. Lydia didn't return the voicemails asking her to come back to her doctor's office, and instead went to her midwife for advice. "I talked to

my midwife and she's like, 'You know what? Everything that I've seen and everything that I've tested on you, I don't think that you actually do have preeclampsia. I think that they're being very cautious, which is good for them to be cautious. That's great, but I think you'll be okay.' And I trusted her." Lydia gave birth to her daughter the following day, under the care of her midwife, and this episode reinforced her perception that biomedical knowledge is not infallible, and moreover that it should often be questioned.

Informants often questioned the authority of their doctors, believing that biomedical knowledge was inconsistent or incomplete, despite popular beliefs to the contrary. For example, Lily, a 42-year-old mother of three, described trying to find a physician who performed vaginal breech birth (a condition in which the fetus is poised to descend the vaginal canal feetfirst instead of headfirst—a circumstance which can make vaginal birth more painful, complicated and risky). "All the hospitals were like, 'What are you talking about? We don't do this.' I'm like, 'Well we used to do these… Doctors used to know how to do this.' And I finally found someone who was like, 'Well, so and so at Warrack [Hospital]. And he is a very old man and was about ready to retire. He would come. He knew vaginal breech birth very well, even footling breech (where the fetus' buttocks are positioned to descend the birth canal first), and he would consult if anyone was open to it. But people really weren't open to gaining that knowledge and that is actually something we've lost." To the community I worked with, the tight control that

biomedicine and its practitioners retain over medical knowledge was perceived as flawed and wrong.

The Biomedical Model Mitigates Choice and Personal Control

The biomedical model of care was perceived to often take away individual power and bodily autonomy. Authority is instead ceded to the physician. Control over medical decision-making, and by corollary the body, belong to the institution, and not the individual. Diana, a practicing midwife, described that hospital birth was often quite disempowering. "I think that in general the medical system tends to take away that power… You know, women check in and [are] told what we're going to do. You know, 'We're going to start an IV now, we're going to take your blood, then we're going to have you do this and we're going to have...' And there's never a moment of, 'These are the things that we would like to do, how are you doing? Are you ready for that? Do you want us to start with the IV? Do you even want an IV?'" Diana told me that the care she provided, as a midwife, allowed her patients more personal autonomy over medical decision-making.

The patient perception that biomedical care during pregnancy and childbirth infringes on personal autonomy and control is perhaps not surprising. As I presented in Chapter Two, a significant body of scholarly literature is devoted to the unbalanced power dynamics within medical care, and birth care more specifically. The biomedical

model of birth care is often described as disempowering and dehumanizing (see, for example, Davis-Floyd 1994). The community I spoke to sought out alternative forms of care partially as a means to maintain personal control over medical decision-making.

The Standards Used by The Biomedical Model Erase the Individual, the Emotional, and the Social

Part of the desirability of alternative models of care was that midwifery foregrounded the social and emotional components of birth in more so than biomedical care was perceived to. A thematic element which I noticed in many interviews was the perception that allopathic care problematically defines birth as a biophysical event. This was unacceptable for some of my informants, because from their perspectives, birth was a profoundly meaningful social and emotional event with experiential value beyond medical health outcomes. Brenda, who had a medically necessary cesarean section for the birth of her first child described that she didn't feel her surgeons respected what she saw as the gravity, significance, and sacredness of the birth of a new child. "The doctors were having like lunch table conversation, like, 'Oh, what are you doing this weekend?' While they're stitching me back up. Here I've just experienced one of life's most incredible things and they're just shooting the shit, for lack of a better term." Brenda described to me that the cavalier attitudes of her surgeons left her feeling like the birth of her child was just unremarkable business as usual—a perception which clashed with the emotional

experience of meeting her longed-for son after a difficult pregnancy. The care that Brenda received in the hospital diminished the nature of birth as a significant life event—replete with individual social and emotional meaning—and instead framed it as a routine medical procedure.

Brigit, an informant who worked as a pregnancy and postpartum life coach, as well as a doula, stressed to me that being emotionally neglected during childbirth can have potentially life-altering ramifications for mothers. "But actually, there's an unprocessed pain and grief and they didn't actually get to move through that. A lot of the time what happens is people say when that [pain and grief] is there it doesn't matter—if there's a healthy baby. And everything else gets shoved under the rug. But the fact is, it's still under the rug for that person." Brigit tells me that she spends a good deal of time with her clients working through birth-related psychological and emotional trauma, and that she sees a strong connection to the seeming frequency of these issues and the medicalized model of birth.

Beyond the potential to cause emotional and psychological suffering, many informants described to me how the biomedical model's neglect of the experiential aspects of childbirth could cause physical harm, as well. Kirsten, a homebirth mother and prenatal yoga instructor, told me that when emotional needs aren't met during labor there can be negative physical ramifications "A lot of times if women go into the hospital when they're in early labor and then they're not quite feeling comfortable, then that can actually

stall labor and then they go into the cycle of having the pressure of needing to be active or we're going to have to induce [labor medically]. And then the pain is worse with Pitocin [a synthetic form of the hormone oxytocin which stimulates the force of contractions]… So then once the pain's worse, then they're looking for help with the pain. It becomes like this sort of domino effect." Kirsten told me that this cascade of potentially harmful medical interventions could be avoided by focusing on a laboring woman's emotional wellbeing—but that hospital doctors simply do not address emotional needs as part of the care they provide. Many of the women I spoke to felt that the care they received during pregnancy and birth should treat birth as both socially and emotionally meaningful—as well as medically significant—a belief which was a major motivation behind their choices to avoid biomedical birth care as much as possible.

Choosing Alternative Care Because of a Negative Experience with Biomedicine

Many of the major themes I took note of during my fieldwork had to do with negative perceptions of the biomedical model of birth care—that giving birth in the hospital took away one's autonomy and control over their body, that biomedical care discouraged women from gaining knowledge about their own bodies or alternative forms of care, that medicalized birth erased the emotional and social aspects of birth that these informants found so vitally important. It is perhaps not surprising, then, that previous

negative experiences with biomedical care were often cited as a major factor in decisions to opt for alternative care during pregnancy and birth.

Kate, a 42-year-old practicing midwife and doula, gave birth to her second baby in the hospital, because of issues with previous preterm labor that had been stalled with medication. When it came time to push, she felt instantly off. The pushing phase during her first birth had felt like a physical relief, but this time, it hurt. "The doctor was going to be leaving at 6:30, and it was 6:00. So, it was like 'You need to push this kid out!' And I kept saying something's not right…I'm like, something is not right this time. I don't, I don't want to push. It's painful. And I wanted to switch positions… I didn't have an epidural, so it's not like I couldn't move. He just didn't want me to move." Upon performing a cervical exam, Kate's obstetrician discovered that she had an anterior cervical lip—an extremely painful condition in which part of the cervix has not dilated as rapidly as the rest, and subsequently becomes swollen and obstructive to the passage of the fetus' head (Simkin, Hanson and Ancheta 2017, 153). Kate's doctor offered to "just push it out of the way" on her next push, reassuring her that doing this would just cause mild discomfort—and make it easier for her baby to be born. "So, the next contraction came and I started to push, and he started to push that lip back and it was more painful than anything I've ever experienced. It hurt bad and I did not want to push. And I kept telling him to take his hand out and he wouldn't. And I kept saying, 'Take your hand out, please take your hand out, take your hand out. You're hurting me. Please stop. Please

stop.' And he just wouldn't. I stopped pushing entirely and he still didn't take his hand out after the contraction ended." While retelling this, Kate's voice has become higher and reedy. She is breathing heavily and looks like she is about to cry. Her hands are shaking a little as she winds her scarf through them—back and forth, back and forth. Clinical educators Penny Simkin, Lisa Hanson and Ruth Ancheta, in *The Labor Progress Handbook,* write that changing position or immersion in water can serve to reduce pressure on the cervix and help a cervical lip to correct itself, given time (2017, 153-154). Manual reduction of a cervical lip is usually only indicated if other measures have been ineffective, or in the case of emergent circumstances such as falling fetal heartrate (Simkin, Hanson and Ancheta 2017, 238).

Kate's son was born with the next contraction in respiratory distress. The doctor and nurse rushed her infant from the room as he gasped for breath, and Kate told her husband to follow. "He left, and I was just waiting naked in stirrups, with the cord hanging out. With the door open, with people walking by, and I was left there. Then I thought *this is not okay*. And the OB eventually came back and he was like, 'The pediatricians are working on him and I'll let you know what I know.' And then he started to pull on the cord. He kept yanking on the cord, and my placenta had not detached and it was a sharp, searing pain. And I jumped and screamed, and then the placenta came out and the doctor left." A short while later, Kate passed a blood clot "the size of a watermelon" and began to hemorrhage. She required an emergency dilation and curettage

to remove pieces of retained placenta from her uterus, and a blood transfusion—both of which were performed by a different doctor, since the OB who had attended her delivery and removed her placenta had already gone home. Kate told me that she believed that her hemorrhage was caused by the forceful way her placenta had been removed, and that this experience was the deciding factor in her choice to have midwife-attended homebirths for her subsequent pregnancies.

Kate's story is intense, but many of the women I spoke to told me about negative experiences they had had with biomedical care. Experiences of being hurt, of not being believed, of not feeling respected, or valued, or in control. That experiences with medical trauma—of whatever severity—came up so often, even in the small group of women I spoke to, reinforces some of the themes I have previously described. These interviews suggest that a number of problems with the biomedical model of birth care revolve around its defining of birth solely as a medical event, and therefore valorizing medical authority over the processes of birth—at the expense of individual patient bodily autonomy, and sometimes contrary to conceptualizations of birth as a holistic and meaningful life event with social and emotional dimensions.

Meanings Within Care-Seeking Decisions

Alternative Medical Decision-Making as an Expression of Alternative Identities

In addition to the previous sections which address conceptualizations around birth care within my study population, I also noticed three themes which centered around different meanings that these women invested in their medical care-seeking choices. My informants belonged to a very specific subculture—I gained access to my study participants primarily through a private social media group for self-described "hippie moms." The hippie identity comes from the countercultural movements of the 1960s and 1970s—which was strongly associated with Sonoma County and the surrounding areas, due to their proximity to San Francisco and Berkeley. The hippie subculture, in its modern iteration, embraces values such as individualism and questioning of powerful social institutions, and valorizes alternative philosophies and lifestyle choices.

My informants' medical care-seeking decisions can be understood as expressive of the alternative identities associated with the hippie counterculture they viewed themselves as part of. They commonly engaged in other forms of alternative medical care, such as energy healing with crystals, vaccine refusal and delay, and essential oils. Posts on the social media group often centered around medical themes—members would post, for example, recommendations on which pediatricians would agree to sign vaccination requirement exemption forms for their children's schools. A recurrent tag I

noticed within the group's postings was "#namethatrash," with which mothers would post with pictures of their children's skin rashes seeking diagnoses from the group as a means to avoid visiting their biomedical doctor. Often, posts asking for recommendations or medical advice would be prefaced by the poster requesting that they not be told to seek biomedical help—"don't suggest antibiotics" a post might say, or "trying to avoid going to the ER." Parallel to the hierarchy of resort within my specific research participants that I discussed in detail in Chapter Three of this thesis, the original posters would often seek help from a physician if their situation did not improve, but their first resort for care were generally non-biomedical treatments. The prevalent preference for non-dominant forms of care within this group is related to shared perceptions among this community that they are at odds with various powerful social institutions, including medicine. This perception colored informants' care seeking choices, both for their children and for themselves. As Rachel, a 37-year-old mother of one put it: "In my community of friends and such … I feel like there was more pressure, in a way, to do it as a home birth." The hippie mom community in Sonoma County was partially defined as a group by expectations that its members make alternative lifestyle choices—such that choosing non-dominant forms of birth care became a way to signal belonging to the group.

"Natural" as Superior

The term "natural" came up quite frequently in conversation with informants, and was almost always used to denote something positive—the better choice. In a sense, the frequent use of the word natural is perhaps not surprising, since many—if not most—homebirth midwives and non-medical practitioners, such as doulas and prenatal yoga instructors, align themselves with the natural birth movement. "Natural" birth can mean several things, but I found it most commonly referred to forgoing pharmacological analgesic measures and biomedical intervention as much as possible. Ivy, a 32-year-old mother of two, told me that she had struggled to find a doctor who would cooperate with her wish to avoid a c-section with her first birth, even though the baby was breech. "At CSF in the city, they'll do it, but they prep you and have you already ready for a cesarean. You're not having a *natura*l childbirth because you're already in an OR, you're already prepped, [with an] epidural and so… I would've gotten to sort of do it but not. I ended up deciding that it made more sense to stay with our midwife."

To have a natural birth meant to have a birth that was as little medicalized as possible. Kirsten, a prenatal yoga instructor and homebirth mother of three, explained to me: "It's just so much more personalized and that's I believe how we're meant to give birth. If you want to have a natural birth, then you need to be in a natural environment, with people who support that and understand it and have the wisdom around it. So that's midwives…they're good at that." Kirsten continued to describe to me how watching her friend give birth surrounded by medical equipment and monitors (to read more about the

story of Kirsten's friend, see Chapter Two) had been a key component in what convinced her she wanted to have homebirths with her pregnancies: "Being with her for both of those [births] helped me see that if I wanted to have a natural birth, a nonmedicalized birth—because it's all really natural—the best place for me to do that was at home." This comment is interesting because Kirsten walks back the assertion that homebirth was the best way to have a natural birth by saying that "it's *all* really natural." I took this to mean that, although Kirsten recognizes that childbirth is itself a natural process, homebirth with minimal medical intervention is somehow *natural* in a slightly different, more desirable way.

Additionally, the women I spoke to frequently connected the idea of naturalness during birth with the use of complementary care measures, such as yoga, massage, hypnosis, or immersion in water. However, if we take "natural" as a baseline of how we imagine birth might occur in nature—sans any outside involvement at all—then it follows that any intervention would indeed make birth less natural. Strictly speaking, the use of essential oil of lavender, for example, to reduce anxiety and relieve pain during labor, is no more natural than the administering of pharmacological chemicals through an IV to accomplish the same. I believe that the key idea, for my study population, was that natural implied *nonmedicalized,* and therefore desirable given the adversarial relationship these women perceived themselves to have with mainstream medicine.

Alternative as the "Educated" Choice

The choice to seek out alternative forms of care was often understood to be a result of my informants educating themselves about their options. Since these women profoundly distrusted the biomedical institution, finding their own information about medical care was quit important to them—and a mark of their nonconformism, as a community. Ivy, a 32-year-old stay at home mom of two, told me about her experiences with the test for gestational diabetes during her second pregnancy. This is a medical test performed routinely in the second trimester, in which a pregnant woman ingests a syrupy liquid, and then undergoes several blood tests to determine her body's ability to process sugar normally. "[My midwife] allowed me to not do the drink and allowed me to do an alternate way. I just took a pancake breakfast at my house and then pricked my finger, which was awesome. Everyone should do that because I did the drink with my first because… I didn't know enough. I wasn't educated enough about alternative ways to do it and it made me so sick…I'm really sad that more people don't know that there's other ways of doing it." Ivy told me that having pancakes instead of the high-sugar drink protected her from the harm to her body she felt had been associated with the test during her first pregnancy. By telling me that she was sad that more people weren't aware of this as an option, Ivy implied that this knowledge was hard to come by—that the alternative care which she saw as superior came about as a result of educating oneself.

To this community, there were more desirable options available that were either left out or deliberately obscured by the biomedical narrative around birth.,. I got the sense that my informants believed that if other women simply knew about all the options, birth would be better for everyone—and that because they had put in the work to do the extra research, this made them special in their improved understandings of their medical options. My informant Kirsten described these sentiments to me when I spoke to her in August:

> The more women can learn about how their body works and like educate themselves on how physiological birth works, and then sort of put that up against like, 'Well, would I be able to have a physiological birth in the hospital?' Because some women can. But for every woman, it's worth asking yourself the question. I think a lot of times women just assume, okay, I'm pregnant, I'm going to go to my OB-GYN and this is how we do it... But there is another way. There are other options. It would be awesome if more women started asking themselves the question of, 'Well, how do I want to do this? How do I want to be cared for? What environment do I want to be in?' Because oftentimes, when we're a patient it's more about being a good patient than being this empowered mother.

Here, Kirsten expresses the idea that, if only other women *knew* about the alternative choices, they too would have the opportunity to become "this empowered mother." Kirsten's assertion that it might be better for pregnant women to have more control over their situations as they give birth resonates with some of the literature I reviewed in Chapter Two of this thesis—that it has been well established that the biomedical model of birth can be disempowering and coercive. Likewise, biomedicine as a dominant social institution has the tendency to delegitimize alternative forms, and suppress different ways

of knowing about birth—as I have discussed in relation to Brigitte Jordan's concept of the production of authoritative knowledge.

The sentiment that alternative birth is the educated choice also comes from a place of social privilege. There are in fact further barriers in place, in many cases, between women and alternative forms of care, beyond simply being aware that these forms of care exist and might be beneficial. The point of view which underlies this thinking—that alternative forms of healthcare are superior, and more women would make use of them if only they would educate themselves—completely ignores the social factors which might deny someone access to healthcare options outside of what their insurance might cover. Most of the women I spoke to enjoyed the advantages of being white, highly educated, and upper-middle-class—as I discussed in Chapter Three, their medical decisions can be partially understood as an expression of their powerful social positions. Likewise, these informants' opinions about their care-seeking choices—and their seeming lack of self-awareness around their own privileges—can be partially understood as a function of social privilege.

Conclusion

This thesis has addressed medical decision-making among the an alternative birth community in Sonoma County, California. In relation to this population, I have posed the question of what it means for a socially powerful group of patients to actively seek out medically marginalized forms of care. I have addressed this problem on three fronts. In Chapter One, I discussed the history of medicalization which has taken birth in the US from home, to the hospital, and home again. Chapter Two included a review of literature around the imbalanced power dynamics intrinsic to the biomedical model of birth which can make hospital birth disempowering, and how avoiding biomedical care during birth can be understood as an act of resistance to medical authority. In Chapter Three, I argued that medical decision making can be understood as both an expression of class position and group identity.

The majority of women I spoke to chose to seek out the midwifery model of care as a means to evade biomedical control over their bodies and experiences of childbirth which they described as coercive and dehumanizing. Choosing alternative forms of prenatal and birth care can also be understood as a demonstration, and reinforcement, of class position, group and individual identity, and shared value systems. The women I spoke to were self-described hippie moms, and as a community they valorized alternative philosophies, countercultural lifestyle choices, and resistance to powerful social institutions, such as "Big Pharma," the government, and mainstream medicine. These

women leveraged their powerful social positions to reinforce their identity as nonconformists resisting social power, and to strengthen their bonds as a group by rejecting the dominant form of medical care.

This thesis argues that my informants' choices to avoid biomedical control over their bodies during birth, while simultaneously expressing their identities as "hippie moms," is made available to them by their powerful social positions. The group of women with whom I spoke chose to avoid biomedical care as much as possible because of their distrust of medical and pharmacological institutions—while still retaining access to the rejected form of care, should they need it. My informants' decisions to opt for alternative forms of medical care can therefore be partially understood as a form of privileged expression—a means to broadcast something about one's beliefs, and one's belonging to a group. Interrogating the social motivations behind avoidance of biomedical care is a necessary undertaking in US culture at this point in history. As a society, the US has seen recent outbreaks of preventable diseases—such as measles or pertussis—due to vaccine refusal in groups demographically similar to my own study population (see for example Phadke, Bednarczyk, Salmon, and Omer, 2016). This thesis argues that for the Hippie Moms of Sonoma County, opting for alternative forms of medical care can be partially understood as resistance to medical authority over birth and their bodies, but also—and perhaps more importantly—can be interpreted as a means to reinforce their identities, values, and beliefs about themselves as a community.

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