Politics & Gender, 11 (2015), 522–549.

Humility, Autonomy, and Birth as a Site of Politics

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Western political thought, from the classical Greek era to our own time, is notorious for its relegation of bodily and family matters to the private sphere. Contemporary feminist and critical political theorists have taken measures to counter this impulse. Yet even as these discourses acknowledge the centrality of the body, vulnerability, and relationality for social and political theory, they continue to functionally disavow giving birth as an important cultural institution in which to engage political and ethical questions.

Within feminist theory, there are discourses on motherhood, mothering, new maternalisms, pregnancy, surrogacy and reproductive rights, technologies, and freedom (Bordo 2003; Chodorow 1978; Luker 1984; McRobbie 2013; Okin 1991; Ruddick 1989; Shanley 2001; Young 1990). Within political theory, Arendt (1958) importantly revitalized the concept of natality in relation to citizenship and collective world-making, and some recent scholarship in philosophy and political science addresses the politics (or antipolitics) of parenthood (Archard and Benatar 2010; Duff 2011; Greenlee 2014; Richards 2010). Within philosophy, biomedical ethics has raised the question of "respect for persons" in various contexts of knowledge, dependency, and authority, including, very occasionally, the delivery room. But to really theorize about birth one must piece together a literature across multiple

This article benefited from the very helpful feedback of many readers, particularly Libby Anker, Wendy Brown, Mark Button, Mary Dietz, Kathy Ferguson, Heath Fogg-Davis, Bridget Kevane, Matt Moore, Tracy Osborn, and Leah Schmalzbauer, as well as the anonymous reviewers for this journal.

Published by Cambridge University Press 1743-923X/15 $30.00 for The Women and Politics Research Section of the American Political Science Association.

doi:10.1017/S1743923X15000276

disciplines, including sociology, medical anthropology, gender studies, law and social policy, public health, psychology, history, nursing, midwifery, and obstetrics. Having done so, what does one glean about how and why birth matters, ethically, culturally, and politically?

In this article I raise the question of birth as a site of politics: a space of potential contestation within which new subjectivities or dimensions of agency and freedom might be experienced, or, alternately, denied and desired. How do dominant American birth practices and policies produce conditions within which women can exercise and value freedom, self-trust, and self-determination versus conditions within which such impulses and desires are trivialized, disciplined, or foreclosed? I frame my critical political analysis of American birth culture here through the lens of humility and autonomy — two concepts that I believe are, or should be, central to contemporary democratic theory and conceptions of citizenship in complex, diverse, and pluralist polities. With regard to contemporary childbirth in the United States, then, I am interested in what conceptions of humility and autonomy shape up and do work under the prevailing medico-insurance conditions and managerial logic. But my analysis here is also reciprocal: I critically analyze trends in childbirth through the lens of humility and autonomy, and I critically analyze traditional conceptions of humility and autonomy through the lens of contemporary childbirth. Through this analysis, I develop an inquiry into birth as a site of potential political awakening — an event of exposure within which particular manifestations of humility and autonomy might inform distinctly desubjugating experiences, but alternate understandings might enable distinctly empowering experiences.

At work here is a commitment to the spirit of participatory and agonistic democracy, whereby citizens assert control over their own lives by actively associating with and engaging in contestation with others largely through "those channels that fall below the formal apparatus of the state: cultural, social, educational, and civic groups of various kinds" (Button 2015, 325). Birth, though a narrow channel with crucial if temporary associations, should be recognized for the ways it can either facilitate or impede what I will posit as democratically productive experiences of autonomy and humility. As numerous studies now make clear, women can come through the process of birth feeling more like a subject or more like an object, but rarely do they emerge from the experience neutral about its impact on their intimate relations, experiences of

embodiment, trust in authority, and perceptions of self-efficacy (Ayers, Eagle, and Waring 2006; Beck 2004; Emerson 1998).

This article works from the premise that the way a society treats birth — like the way it treats sickness, aging, death, grief, poverty, and other gender and life-plan inclusive experiences of dependency and vulnerability — exposes significant historical developments, cultural anxieties, and value structures. The contemporary U.S. context can be understood in terms of dominant practices and discourses that have developed under neoliberal capitalism, with its emphasis on market values of efficiency, risk management, privatization, and freedom as consumer agency and self-care, and not public goods of participation, meaning, and equality. The hypermedicalization and administration of birth must be situated within this context, particularly if we seek to retain for birth meaningful concepts of choice, control, freedom, and empowerment. I use these concepts here as a way to reflect on humility and autonomy, which I define and address in detail later in this article. But in order to use these concepts I also engage in a fair amount of conceptual ground laying precisely because what "choice" and "control" increasingly connote, as they are deployed in contemporary neoliberal discourse, is quite at odds with a participatory-democratic normative impulse.

Building on Foucault's late work on biopolitics and governmentality, scholars like Brown (2006), Dean (2009), McRobbie (2007), and Mouffe (2009) have illustrated the extent to which terms like "freedom" and "empowerment" under neoliberalism have come to be figured through idioms such as "responsibilization," man-as-entrepreneur-of-himself, capacity-building (for nations and subjects), efficient administration (of subjects and populations), and stakeholders rather than citizens (Brown 2006; Dean 2009; Foucault 1991, 2009, 2010; McRobbie 2013; Mouffe 2009). Within this rationality, choice is legitimate (indeed, intelligible) only when "aligned" with the needs of the organization. When that organization is a hospital, what Brown has called the "de-democratizing force" of neoliberal rationality overlaps in a complex way with lingering values of benevolent paternalism (2006, 693). Add to that the logic of insurance — both medical malpractice and for individuals — and minimizing risk and resistance comes to define responsibility.[1] As I discuss in greater detail below, 98.8% of women in

1. There is a vast literature on risk management, discipline, and self-care under neoliberalism, particularly with regard to financial markets, social services, and health care. Beck's 1992 classic, *Risk Society: Towards a New Modernity*, captures early thinking on this topic as does Foucault's work on governmentality (1991, 2009) and biopolitics (2010). For useful conceptualizations of risk, see

the United States give birth in a hospital. In recent years, however, the rates of planned homebirth with a trained midwife have been steadily increasing (MacDorman et al. 2014). Debates about that trend, which are often quite heated, have centered on whether homebirth is safe and responsible, as well as a valid form of "systems-challenging praxis" for some (Cheyney 2008), or whether it represents women willingly subjecting their baby to undue risk in order to aestheticize their birth experience or "to put themselves first" (Krauthammer 1996). On multiple levels, this debate and others about birth raise questions central to the study of politics and gender.

In what follows, I first address what I mean by the phrase "birth as a site of politics" and as an event of exposure through which dispositions relevant to democratic citizenship might emerge or be practiced. Next, I lay the groundwork for thinking about how humility and autonomy are relevant for my consideration of birth as a site of politics. Because these concepts are pivotal for my analysis, I offer a brief overview of recent debates about how to understand each. Having provided working definitions of humility and autonomy, I then map the terrain of what Mitford called "the American way of birth," (1993) examining how social values, relations of power and identity, and questions of choice and control circulate in childbirth. Building on these foundational sections, I turn directly to humility and autonomy in childbirth, primarily as embodied by birthing women but also by the practitioners who attend to them. In conclusion, I return to the question of birth as a site of political awakening and a context for cultivating dispositions important for public life and engaged citizenship.

BIRTH AS A SITE OF POLITICS AND CITIZENSHIP

Birth matters. It is one of those unique events of existence — mundane in its prevalence, profound when it directly implicates you or your loved ones — through which we cannot help but be produced literally and figuratively as humans and, I suggest, as citizens. I construe "citizenship" broadly here as a subjectivity oriented toward social and political agency, which embodies a desire for, or even a sense of entitlement to, individual and collective self-determination. My analysis is best understood as animated

Castel (1991), Giddens (1999), Lupton (2013), as well as Simon (1987). With regard particularly to pregnancy and childbirth, see Weir (2006), and with regard to conceptualizations of life more broadly, see Rose (2006).

by Brown's concerns regarding, "the hollowing out of democratic political culture and the production of the undemocratic citizen. This is the citizen who loves and wants neither freedom nor equality, even of a liberal sort; the citizen who expects neither truth nor accountability in governance and state actions . . ." (2006, 692). To an extent, my inquiry is situated in liberal theory. Yet I also aim to illuminate the limits of liberal philosophies of freedom and seek to uncouple the idiom of citizenship from questions of the state and of rights, as well as from market metaphors of freely choosing consumer-citizens.

This itself is not a novel project — feminist political theorists have long sought to reclaim citizenship as a practice of radical democracy (not a status), and moreover a practice manifest in informal as well as formal politics (Dietz 1987; Lister 1997). My distinct contribution here is to situate this project in the context of childbirth and to figure birth as a site of informal politics that exposes paradigmatic dimensions of human interdependence and vulnerability, not something that offers a uniquely feminine or maternalist lesson. Like other formative and nondelegable experiences of extreme corporeal or psychic vulnerability, such as dying, grieving, and facing mental or physical illness, birth brings into focus the limits of the will to agency. I argue for the study of birth as a site of politics here because I characterize such limits as constitutive dimensions of cohabitating in political society, not as traumatic or exceptional "outliers" in an otherwise tidy sovereign human existence. Put simply, we don't all birth, but birth has something to teach us all, as people who live in bodies that will confound us and as citizens that live with others and in worlds we do not necessarily choose or embrace and yet cannot simply will to control.

I am interested in two qualities of "citizenship" here: (1) empowerment and freedom enabled by relationally supported self-knowledge and self-definition and a spirit of critique and resistance (the "autonomy" dimension of my analysis), and (2) our interdependence with and vulnerability to others, to history, and to our own human limitations (the "humility" dimension of my analysis). Though each birth is experienced differently, this article suggests that birth should nonetheless be conceived politically and studied by political scientists who care about the relationship between gender and political agency, just as they have studied the politically mobilizing or desubjugating effects of rape, abortion, motherhood, and breast cancer.

Contemporary childbirth practices implicate a range of more traditionally recognizable "political" questions — for example, public

policy issues regarding resource distribution, the effect of structural inequality on how one is "treated," legal liability, and risk analysis. And recent films like *The Business of Being Born* (Epstein et al. 2008), as well as many popular press books on the politics and economics of birth, point toward a growing reform movement targeting the rising cesarean section rate as an appropriate subject of politicization and public address and not merely market solutions (Block 2008; Cassidy 2007; Epstein 2010; Margulis 2013; Morris 2013; Rosewood 2013). However, I am focused here more on birth as a site of contestation affecting how the birthing subject is figured and treated, how that subject is solicited to participate in her own care (or not), and how values and preferences forged prior to but also in the event of birth matter for one's subjectivity and sense of identity and efficacy after the fact. To raise this question is to take embodiment seriously and to recognize that extreme corporeal vulnerability can mark us in ways we may fail to fully appreciate at the time. As affect theorists have argued, "action is not an all or nothing business, but involves a process of capacitation and a preparedness in the body…" (Hynes 2013, 567). Bodies matter. Of course, to a certain extent the questions raised here have empirical dimensions: Exactly how do experiences in birth translate into active citizenship? Or, put differently, under what conditions do birth experiences enhance or diminish one's sense of herself as an agent? Definitive answers to these questions are beyond the scope of this article. Thus here I primarily aim to make the case that dominant birth culture in the United States raises ethical and political questions — questions about power and knowledge within institutions defined by rationalities, norms, and objectives. These questions are worth studying through the lens of democratic theory and should not be understood as irrelevant or off limits to political scientists, or outside of and even corrupted by political analysis.

CONCEPTUALIZING HUMILITY AND AUTONOMY

Birth implicates a number of political concepts, such as freedom, accountability, power, and agency. In this section I focus on two political and ethical concepts foundational for my analysis: humility and autonomy. Humility, not unlike birth, has long been marginalized within Western political thought. Its origins within Christianity as a largely feminized virtue of submission, deference, and self-denial likely helps explain why scholars interested in dispositions relevant for modern

democratic citizens have found humility to be problematic. When traditionally conceptualized as a disposition of lowliness, obedience to a higher authority, or even the explicit disavowal of our capacity as agents, humility seems in tension with secular liberal democratic requirements of individuality, self-determination, and rational agency. And indeed, a look at the treatment of humility in Western thought suggests that the dominant Christian conception became linked by political theorists such as Machiavelli, Spinoza, Hume, Mill, and Nietzsche to myopia, inaction, and even, with distinct gender undertones, to irrationality.

Recently, however, a number of scholars have argued for revitalizing humility as self-expansive, generous, and foundational for democratic life (Button 2005; Keys 2008; Konkola 2005; Kupfer 2003; Rushing 2013; Snow 1995). This emergent account seeks to posit a "new humility" (Hare 1996) that is a quality of moral strength, which can emotionally equip us to better engage with our fellow citizens and to face the complexities and uncertainties of contemporary political and social life with a capacious and resilient spirit. As I have written about at greater length elsewhere, a revitalized concept of humility can be defined as a disposition toward learning and reflection, realistic self-assessment, and recognition of one's constitutive human and historical limitations (Rushing 2013). Such a disposition conduces to political sociability and even resistance to domination because it underlies presumptive generosity toward self and the others with whom we are interdependent and functions to clarify what we cannot, but also what we *can*, control. As this characterization suggests, and as I argue here, efforts to revivify humility and its political value remain incomplete absent a compelling consideration of the relationship between — indeed, interdependence of — humility and autonomy. The context of giving birth brings this interdependence into stark relief.

In contrast to humility, autonomy — understood traditionally in terms of the self-governing individual who serves as the moral and political ground of and limit to legitimate authority — has long been a pillar of liberal and democratic theory. Benhabib (1992, 155) has described this version of autonomy, particularly as perpetuated by Rawls and modern social contract theory, as maintaining an essentially Hobbesian conception of men as "mushrooms" that spring from the ground independent and fully formed. It is not a stretch to say that this autonomy lacks humility, not to mention a realistic account of birth.

Despite its historically central role, due largely to the rise of value pluralism in liberal theory (Galston 2002) and feminist critiques of

liberal theory (Benhabib 1992; Friedman 2003; Kittay 1999; Meyers 1989; Nedelsky 1989; Okin 1991; Young 1990), some scholars recently have abandoned autonomy (Button 2015; Christman and Anderson 2009). If liberal theorists have failed to sustain a vital discourse on autonomy, however, American society is arguably as obsessed as ever with the popular correlates of personal responsibility, freedom from government interference, and individuality as expressed through consumer choice. These correlates are often articulated in theoretically impoverished, masculinist, and deeply antidemocratic ways. Like humility, then, autonomy is in need of a rebirth.

Feminist theorists articulate a revived concept of "relational autonomy." The positions scholars have carved out within this discourse resemble those in parallel discussions about "choice feminism" (Hirschman 2005). Both debates grapple with whether a more procedural or more substantive account of autonomy and feminist choice is preferable.[2] Stoljar, for example, argues that there are certain choices that, while procedurally autonomous, evoke a "feminist intuition." Stoljar describes that gut feeling that certain choices do not register as genuinely autonomous because they can only be grasped as the effect of having internalized warped and oppressive social norms of femininity (2000). Like other substantive relational autonomy theorists, she thus insists on criteria like self-worth, self-respect, or self-trust and emphasizes how the cultivation of such traits requires more than merely a lack of external constraint on an individual's freedom. Rather, fostering meaningful self-definition and direction requires a recognition of structural inequalities of gender, race, class, sexuality, (il)legality, and religion, among others, as well as a conception of the just society as affirmatively valuing and promoting effective agency, for example, through "processes involving educational, social, and personal resources" (Christman 2005, 87).

Between the extremes of procedural and substantive autonomy, Meyers offers an account emphasizing "autonomy competency" — the "repertory of coordinated skills that makes self-discovery, self-definition, and self-direction possible" (1989, 76). Importantly, autonomy competency is not a version of what McRobbie identifies as neoliberalism's individualistic and economized "new female subject of capacity" (2007). Rather,

2. Procedural accounts aim to "reduce judgmentalness" through value neutrality and thus focus purely on the process of decision making as the criterion according to which an action can be called autonomous or feminist (Snyder-Hall 2010, 259). Substantive accounts aim to retain a sociologically richer vision of the good for women and argue that normative criteria must be part of the analysis of social conditions and of the mental dispositions of the situated "self" acting within them.

Meyers' point is a structural and systemic, or relational, one: our desires and preferences themselves must be acquired and developed autonomously within social conditions that foster autonomy competency for all. Only under such conditions can we limit our focus merely to the procedural dimensions of any individual choice. As I turn my attention below to dominant trends in American birth practices, I raise the questions of where, when, and how the conditions for relational autonomy are nurtured or neglected and explore how a certain conception of humility then comes into play both for birthing subjects and the health-care providers that attend to them.

THE AMERICAN WAY OF BIRTH

If popular media depictions are any indicator of how we regard childbirth culturally, it is a terrifying, hysterical, rushed, gross, and humiliating event that typically involves a frantic car ride, a lot of bright lights and metal apparatuses, threats of a lifelong sexual strike by the beleaguered mother, and a benevolent medical authority who enters late in the game to take charge of the situation, usually by administering a variety of high-tech interventions to "help move things along." At the same time, a markedly different set of cultural depictions offers a competing narrative about the radical power of the human body, of being stripped down to one's elements and yet pushing through that exposure and surrender with strength and dignity and a sense of ability, respect, and efficacy. Is it not a fascination with experiences of mastering physicality and tolerating pain that at least partly explains the widespread cultural consumption of extreme sports, shows like *Survivor*, *Man vs. Wild*, *Extreme Makeover*, and *The Biggest Loser*, or of best-selling books like Ralston's *Between a Rock and a Hard Place*, detailing his self-amputation and survival after 127 hours in a remote canyon in Utah? As cultural tropes of self-sufficiency and the triumph of the human body and spirit persist in captivating our imaginations and capturing our entertainment dollars, depictions of birth and actual trends in American birthing are moving further and further away from these ideals. In contrast to the dispositions of critical strength I outlined above, and as I discuss more below, humility in birth is figured as submission to corporeal dependence on medical authorities that will manage the risk and minimize the humiliation of the event; autonomy in birth is figured as submitting willingly to such management.

Granted, even mainstream American birth culture is not monolithic. Birth experiences frequently reflect race, class, sexuality, and age distinctions, as well as forms of oppressive socialization and the expectations and practices that develop within those constraints (Zadoroznyj 1999, 267. See also Benson 1991; Lazarus 1994; Martin 2003; McAra-Couper, Jones, and Smythe 2011; Oliver 2010). For example, addressing the role of class, Lazarus (1994) argues that the desire for knowledge and control over birth is, in certain regards, a luxury. She writes,

> [C]hoices and control are more limited for poor women, who are overwhelmed with social and economic problems. They are usually unemployed; they have less education and more unplanned births; they start childbearing at earlier ages and are frequently unmarried. In addition, many poor women have no health insurance, leading to fewer choices for perinatal care (26).

Lazarus's interviews suggest that while poor patients have a strong desire for quality health care, they do not cite "control" or triumphing over physical challenge as something they are focused on. The "Listening to Mothers III" survey (Childbirth Connections 2013), done in 2011–2012, brings to light a range of other important differences. For example, black and Hispanic mothers in the United States are far more likely than white mothers to report poor treatment by hospital staff and less choice in a prenatal care provider. A 2013 study conducted in the UK found that, among other differences, black African, Asian, and women of other ethnicities were significantly more likely than white women to report being left by themselves in labor or shortly after birth in a way that worried them and were significantly less likely than white women to rate care in labor as good (Henderson, Gao, and Redshaw 2013).

While these differences in experience are important, there are nonetheless clear national trends that largely hold across racial, ethnic, and class lines. Birth is increasingly medicalized, technocratic, and consumerized, particularly as pregnant bodies have become increasingly commodified and sexualized (Malacrida and Boulton 2012; Oliver 2010). And these changes have accelerated more recently.

For example, artificial induction of labor increased from 10% in 1990 to 23% in 2008 (Fisch et al. 2009; U.S. Census Bureau 2012). The use of epidural anesthesia today is believed to range from around 60–90% by region and hospital, with an average rate of more than 61% of births (Osterman and Martin 2011). If a woman does not actively decline or

https://doi.org/10.1017/S1743923X15000276 Published online by Cambridge University Press

resist, she can expect an IV drip inserted upon arrival at the hospital, continual fetal monitoring throughout labor, and the use of a urinary catheter to allow her to empty her bladder without getting out of bed. Most women will encounter policies or practices that discourage or disallow eating during labor, will be guided or directed to labor in bed and to push and deliver on their back, and will be put on a normative "labor clock," which often results in the use of augmentation via the drug Pitocin to manage the progression of labor according to expected rates of dilation. If labor "stalls out" or deviates too much from normative time, it is categorized in terms of "failure to progress," which is the main justification provided for conducting a cesarean section. If a woman delivers by C-section, she is frequently refused a trial of labor for vaginal delivery of subsequent children, thus necessitating repeat C-sections. If she delivers vaginally, there is still a good chance that she will undergo an episiotomy to bring pushing to an end: rates of routine episiotomy were as high as 60% in the U.S. in the 1980s, and remain at around 30–35% today.

Birth by cesarean section in the United States increased from 5% in 1970 to 33% in 2008, and the fastest rate of increase was a 53% rise from 1996 to 2007 (CDC 2010). Though C-section rates in U.S. hospitals vary considerably, from around 15% to 65%, the World Health Organization has suggested that 10–15% is an "optimal" rate and that anything above that is concerning (Childbirth Connections 2011). Obstetricians in the United States and England, among other countries, have pushed back against this standard, arguing that arbitrary percentages should matter less than seeing that every woman who needs a C-section should be able to have one. While linking practices and policies to need and healthy outcomes seems intuitively obvious, what it means to "need" to deliver by cesarean then becomes an important question.

A number of factors might explain why the C-section rate has skyrocketed in the Unite States.[3] Yet while there are reasons one can point to for this increase, between 1996 and 2008 rates rose for mothers regardless of age, race, and ethnicity, and for infants of all gestational ages and in all states. The C-section is now the most frequently performed major surgery in American hospitals (Morris 2013). Consequently, it has been normalized,

3. For example, advanced maternal age; increasing rates of obesity and diabetes; the rise of infertility, increase of in vitro fertilization, and thus growing rates of higher-risk multiple births; the distinct U.S. medical malpractice landscape, high obstetrician malpractice insurance costs, and lawsuit avoidance via restrictive preemptive policies; increasingly surgical emphasis of obstetrics training and decrease in familiarity with nonmedical labor facilitation and pain management techniques; the trend toward general acceptance of surgery as safe and necessary when suggested by a medical authority.

and in the process sanitized of connotations of pain, cutting, and risk. Increasingly, popular attention has focused on the rise of "elective" C-sections. While women who choose this procedure in the Unite States are still relatively rare (particularly compared to the media coverage the issue receives thanks to the celebrity "too posh to push" phenomenon), at doctors' urgings the American Congress of Obstetricians and Gynecologists (ACOG) recently "deemed it ethical for doctors to deliver a baby by C-section upon the request of the mother even if she faces no apparent risks from labor and vaginal delivery" (ACOG 2008). Thus "patient choice" is increasingly cited by doctors as one reason for the rate increase.

While the debate over the ethics of elective C-sections brings issues of choice and control in birth into unique focus, these are not new aspirations for birth. The "first wave" of birth reform activism in the early twentieth century focused on access to pain medication (or the "twilight sleep" that doctors often denied women in doubt of its safety); the "second wave" in the 1960s and 1970s focused on opposing hypermedicalized and anesthetized birth (Beckett 2005; Caton 1999). Whether it was the demand for drugs or for support not to use drugs, however, choice and control were the operative aims of these health citizenship movements. Within hospital settings, the last decades have seen the rise of the "birth plan," a concise statement of preferences a woman provides to her doctor and the nursing staff in an effort to have her choices known and respected in the (likely) event she loses the wherewithal to express and defend them during labor. The inclusion of doulas (trained labor support specialists) in hospital birth is another increasingly used measure to control one's birth environment and experience. As noted in the introduction, recent studies show a marked increase in women opting for planned homebirths under the care of a trained midwife, with the number rising 20% between 2004 and 2008 (Carroll 2014; Goodman 2011). While hard to quantify because of being generally unreported, rates of planned unassisted homebirths are believed to have increased steadily in the last decade as well. Both of these trends are also explained in terms of choice and control in birth.

DIMENSIONS OF CHOICE AND CONTROL

So what is the precise relationship between choice and control, and do debates over choice and control get to the heart of the question of

https://doi.org/10.1017/S1743923X15000276 Published online by Cambridge University Press

autonomy? In this section I explore this question by distinguishing between the types of control one might assert in birth and considering how perceptions of control impact the experiences of birthing subjects. As a number of feminist theorists have suggested, the rhetoric of choice articulated in the context of abortion rights suggests an essential connection between choice and control: if legal choice is protected, then women will have control over their bodies. Yet this rhetoric also betrays what Oliver has called "an existential anxiety about the very notion of choice" (2010, 768), within which "the language of choice becomes the fantasy of planning, controlling, and eliminating chance from reproduction" (770).

Discourses attached to certain birth practices noted above tend similarly to cast choice as a reliable path to control. Moreover, satisfaction with one's birth experience is directly related to feeling in control (Green and Baston 2003, 246). But control is not a straightforward, monolithic, or static concept. A number of recent studies have examined how women's experiences of control in birth fluctuate during labor and delivery, and others have sought to distinguish internal control from external control and to understand the relationship between the two for an overall perception of control (McCrea and Wright 1999; O'Hare and Fallon 2011). External control involves a woman's feelings of control over what her midwife or the nursing or obstetric staff does to her. This form of control hinges on factors like the quality of communication between her and her caregivers: Is communication thorough, open, and respectful, and does it convey to her that she is an active and equal subject who is involved in as much decision making as possible? Or is communication limited, cryptic, and unidirectional and convey that she is a passive object being managed and treated by experts who know what is best for her? Internal control involves a woman's perception of control over what she does and feels and hinges on factors like control of one's breathing, the ability to manage one's own pain, and the ability to control how one interacts with others. Internal control has been characterized broadly in terms of "keeping it together," or at least directing how one "loses it" (O'Hare and Fallon 2011, 167).

Identifying these distinct facets of control is an important step. But critically analyzing their operation is important as well. For example, the feminist and sociological literature on birth has traditionally ignored internal control by focusing on how "women and their bodies are controlled and disempowered by social institutions during childbirth" (Martin 2003, 54). In line with the relational autonomy literature's

concern with oppressive socialization, Martin dissects the extent to which internal control itself may be problematically gendered, involving disciplinary power over the self that reflects deeply internalized norms about how women ought to behave. She writes that many women "worry about being and often are nice, polite, kind, and selfless in their interactions during labor and childbirth" (54). For example, one mother recalled for me how, during childbirth, she felt sorry for "the poor medical student who had to hold one of my legs while I was pushing" and attempted to put him at ease by asking between contractions what he was doing that weekend and where he was from. In Martin's account, internalized technologies of gender complicate the ideal of internal control because they lead many women not to ask for what they want and to feel like failures when they cannot behave like proper ladies, so to say.[4] The women in Martin's study (who, it bears mentioning, were almost entirely white, heterosexual, and middle class) described themselves in retrospect as crabby, inflexible, whiny, short-tempered, and out of control. Rather than characterizing their behavior as understandable or importantly expressive of needs and desires in the midst of childbirth, they felt apologetic and frustrated with their lapses. So-called feminine lapses in birth and beyond (remember when Pat Schroeder cried?) have long been deployed in debates about rational capacity, gendered citizenship, and participatory self-determination.

How external control operates is subject to critical scrutiny as well. External control is an ideal that hospitals have worked to enable through "informed consent." Dodds (2000) examines how practices of informed consent represent an improvement over traditional "beneficent paternalism." In that model of treatment, which calls to mind the trustee model of representation in democratic theory, the doctor does what he or she thinks is best for the patient, and the patient obligingly receives the care doled out. Under what Dodds characterizes as more of a modern consumer model, the physician is figured as an expert-advisor providing information to a consumer-patient who makes decisions without paternalistic intrusion (213). Respect for autonomy in this latter model is somewhat thinly reduced to noninterference.

There are numerous problems with this on Dodds' account: the consumer-patient model assumes a fully autonomous and rational agent, it adopts a simplistic understanding of "knowledge" and "choice," it

4. Such insights are particularly interesting in light of recent studies showing that swearing triggers an emotional and physical response that can increase pain tolerance (Keele University Press Release 2011).

makes the primary ethical consideration for physicians simply obtaining consent, and it fails to consider the crucial importance of autonomy-influencing practices and policies within medical institutions, which condition what a "rational" choice looks like.[5] While protecting the right to informed consent is an improvement over practices of beneficent paternalism, it is not hard to imagine how the context of birthing — and numerous other medical contexts within which men and women experience acute vulnerability, the weight of intense decision making, and understandable information overload and confusion — frustrates this attempt to institutionalize external control.

For example, with regard specifically to birthing, one question that arises is what it means to be informed. There is evidence that the majority of women who opt for epidural anesthesia or plan for a C-section (either electively or after a previous one) are inadequately apprised of the risks attendant to those procedures. To offer another example, while continuous fetal monitoring during labor provides ongoing information about the baby's heart rate, it is not clear that this information is always accurate or useful for the woman hooked up to the monitor. (In fact, often the constant feedback becomes a distraction or a source of worry.) Thus even when a patient is provided with more or even full information, grasping its meaning and implications can be extremely difficult. And often doctors committed to a principle of noninterference are unwilling to provide decision-making assistance that truly helps one grasp how the choice will impact her. Answering the question "What should I do?" requires personalized understanding that goes beyond technical knowledge.

The other question that arises is what it means to consent. Does a woman whose birth plan expresses a preference against episiotomy choose one if a doctor offers it when she is compromised after hours of pushing? Does having her sign an informed consent form between contractions accomplish anything other than protecting the doctor from a malpractice suit? Does a woman who is told that her placenta has a chance of failing if she goes past her due date and that she should schedule an induction of labor even if the fetus shows no signs of distress, consent from a position of informedness, or simply fear? Does a woman who is told by her doctor, "Just say the word, and I'll get this baby out of you"

5. Brown captures dimensions of the problem of informed consent I touch on here when she discusses the compatibility long recognized in political theory between individual choice and political domination, especially when subjects are "absorbed in a province of choice and need-satisfaction that they mistake for freedom" (2006, 705).

genuinely consent to a C-section? While Hobbes may have believed that consent was legitimate even if motivated primarily by fear, for contemporary liberal democratic citizens this is usually not a compelling account of autonomous choice (1968, 262). As I address below, recent studies of what differentiates a satisfactory or empowering birth experience from an unsatisfactory or even psychologically traumatizing one suggest that a more complex notion of autonomy is at work in the "labor union" that defines childbirth.

"GET ME OUT OF HERE!": TOWARD AUTONOMY AND HUMILITY IN CHILDBIRTH

Increasingly, the dominant values surrounding birth are efficiency, convenience, and extreme risk avoidance — outcomes over process. Consider a 2008 American College of Obstetricians and Gynecologist (ACOG) report criticizing home birth, which stated, "The main goal should be a healthy and safe outcome for both mother and baby. Choosing to deliver a baby at home, however, is to place the process of giving birth over the goal of having a healthy baby" (Freeze 2010, 283). As one anesthesiologist and recent mother interviewed for another study put it,

> I don't really care about the birth experience like a lot of patients do — into soft lights, soft music garbage. For me it was about getting a good baby. I've seen too many times where patients are so concerned about it being a lovely experience for them that this has overridden the desires for having a good baby and they put themselves and their birth experience in front of having a "good" baby come out and having the best care for that baby (Lazarus 1994, 35).

A good birth and a good baby are figured here as in tension. And this statement is not anomalous, but rather representative of a prevailing rationality. A woman's desire to self-determine her own priorities for a good birth, for example, by resisting medical interventions or opting out of the hospital altogether, are framed as self-centered and irresponsible, not as a form of health citizenship and educated agency. While ACOG may formally express support for patient autonomy, a woman who wants to make choices about her care that exceed the narrow set of options sanctioned as normal and reasonable is figured as lacking humility and is marginalized, disciplined, and even stigmatized as a bad mother. Here, the context for autonomous choice is clearly burdened. Burdened

autonomy involves constraints that can be quite subtle, where no external factors force one to agree to certain choices, and yet one seemingly consents to be so governed.[6] For example, dominant obstetric practices today result in 33% of women having a birth attendant they barely know (Childbirth Connections 2013, 14). And participation in childbirth education classes has dropped decade by decade since the 1970s. Given this, more and more women now go into labor unprepared and anxious, as reflected in birth narratives that describe shock, terror, isolation, and importantly, as a simple Google search will show, the words "I would have agreed to anything at that point … ." Under such conditions autonomy is clearly burdened, and birthing subjects are primed to defer to authorities with whom they have little to no preexisting relationship.

Deference to authority is not, per se, a problem. Building on the analysis of choice and control above, one recent study showed that a significant form of control cited by many women after giving birth involved "relinquishing control" to their obstetrician or midwife (Jones 2011). As the title to this section — "get me out of here" — suggests, giving birth often involves a profound desire to get *out* of the moment. The baby, of course, wants to get out; and caricatures of obstetricians at birth tell us that they want to get out, in order to make tee time, teatime, or whatever. But birthing women also frequently recount hitting a limit in labor when they decide they have had enough and resolve to call it a day and get out of there. This desire to get out — to have one's "Enough!" or "No more!" or "Because I said so!" be determinative, is deeply characteristic of the quest for self-determination under conditions of embodiment and interdependence defined largely by unfreedom (again, an apt way to characterize political cohabitation in complex, pluralist democratic life more broadly!). If autonomy is figured as sovereign agency secured through noninterference — the traditional liberal, negative freedom model — then both the inability to will a situation under control and the desire to cede control to another person comes to look like failure. But autonomy need not be conceived that way. At least in childbirth, relinquishing control itself can be experienced as a kind of humility-informed-*relational*-autonomy — as something one reflectively

6. For example, though a majority of women surveyed for one study said they understood that they could decline most interventions during birth, and a majority said in advance that they desired to avoid most interventions, in fact only 10% of the women interviewed for the study actually refused any intervention suggested to them (Declercq et al. 2007, 13). Of course, autonomy can also be explicitly bounded. If, as per ACOG recommendations, one's insurance company does not cover homebirth or one's hospital does not allow a vaginal birth after cesarean, then those choices are effectively foreclosed.

and willingly delegates to a trusted partner, and not something grudgingly surrendered to an expert with asymmetric power and knowledge. When experienced as a genuine choice, relinquishing control has been shown to have a positive relation to overall satisfaction with one's birth experience.

In contrast to the "labor union" model gestured toward here, within the dominant cognitive and value framework underlying contemporary U.S. hospital birth, a woman's demand for a more expansive autonomy often gets cast as being "difficult," and the humility solicited from her takes the form of deference to experts and cooperation with the system's logic. As one jaded obstetrician lamented, "Autonomy stops at the door of the labor room. Women are implicitly allowed, or encouraged, to make only those choices that increase the power of the physician . . . . Is it not the opposite of autonomy to support only those choices that increase the woman's reliance upon the physician?" (Plante 2009, 1). In this version of the conceptual nexus, humility as acquiescence reduces autonomy to picking from a predetermined and limited set of menu items. But again, these are not particularly appealing concepts, as they require birthing subjects to bracket off values of democratic citizenship, empowerment, and supported self-determination.

To have a chance of functioning as a source of strength and grounding substantive, relational autonomy, the humility of the corporeally vulnerable birthing woman must be met by the humility of the practitioners attending to her. For the practitioner, humility requires that "individuals constantly engage in self-reflection and self-critique," that they "bring into check the power imbalances that exist in the dynamics of physician-patient communication by using patient-focused interviewing and care," and that they "develop and maintain mutually respectful and dynamic partnerships" with the communities and individuals they serve (Tervalon and Murray-Garcia 1998, 118). Where "achieving" cultural competence can lead practitioners to a false sense of security in their knowledge of what is best for a patient, cultural humility involves a process of "realistic and ongoing self-appraisal" that cultivates flexibility and openness with regard to the experiences, needs, and desires of each individual patient (119). This dispositional flexibility points to an important shift in attitude, namely respecting the process of giving birth as well as the outcome and taking seriously the centrality of the birthing woman as a person undergoing a significant life event, not simply a patient, a case number, a set of data points on a monitor, or even a "mother to be."

As explored above, while "respect for persons" and their autonomy is the ethical foundation of informed consent, cultivating the kind of humility

that Tervalon and Murray-Garcia advocate, which exemplifies the "new humility" I discussed earlier, is essential for giving formal, institutionalized respect a necessary substantive and relational quality. And this matters, for while measures to ensure informed consent have increased in recent decades, levels of trust in the medical establishment have decreased (O'Neill 2002, 3). Often, informed consent is experienced as a rote formality and not a genuine attempt at ensuring equality and partnership. Many patients report feeling they have been told that they are informed, told that it is time to consent by signing, and told that they have now freely chosen whatever is to come. This trend is likely to be exacerbated as neoliberal rationality more deeply permeates health-care contexts (Gordon 2004), for the performance of informed consent effectively conveys the message of responsibility mentioned at the outset — you consented, and now you are responsible for the consequences (see also Lupton 2013, 121).

Absent a cultivated humility on the part of the practitioner, O'Neill suggests informed consent "illustrates a simulacrum of autonomy" that erodes trust and belies the connection between choice and control (27). This experience of faux autonomy and lack of trust in authority may incite anger that spurs a will to change through subsequent citizen activism like that of the birth reform movements noted above. But absent supportive relations grounded in mutual humility and bolstering instead of burdening autonomy, the distinct conditions of exposure and vulnerability in birth may result not in a sense of empowerment or entitlement to self-determination, but rather in objectification and impotence. Psychologists have studied these possible trajectories from the perspective of self-efficacy broadly construed. But here I urge consideration of how birth experiences impact the particular kind of collective self-determination associated with citizen-subjectivity, and the will to make the personal political and then transform it.

In the context of birthing, the midwifery model of care more consistently practices patient-centered partnership through the cultivation of highly personalized relationships. This is due partly to the values and training at the center of midwifery, which eschews the managerial and market logic of efficiency. Midwives also typically practice outside the assumptions, constraints, and resources (including inductions, epidurals, and surgery) of the mainstream medical establishment. Free from billing practices developed under insurance agency and profit imperatives, for example, midwives generally schedule 40 minutes per patient visit because preventative care and trusting relationships are regarded as the most

reliable route to uncomplicated birth. In contrast, despite figuring birth as inherently risky, obstetricians spend on average just ten minutes per patient at most prenatal visits (O'Connell et al. 2009). This informs the stereotype mentioned above, namely that obstetricians are always impatient to take off from routine appointments or from labors that threaten to drag on. One recent study, however, found that the high rate of obstetrician burnout was directly attributed to the gap between how much time they believe they need to competently tend to a patient, and the amount of time they are allotted based on scheduling pressures, billable hours, and caseloads. Significantly, doctors expressed their frustration in terms of lacking autonomy to decide how to care for patients (O'Connell et al. 2009).

When I began this project, I speculated that the "C-section epidemic" at least partly reflected a well intentioned, if misguided, benevolent expediency on the part of doctors, executed within a context where pharmaceutical and surgical interventions are a sign of skill and high-quality care. I speculated, further, that subtly or not so subtly at work here might be a desire to save women from the unnecessary indignity of suffering through childbirth, and the messy lack of control it entails. This paternalistic benevolence, particularly when mixed with neoliberal efficiency, risk management, and lawsuit avoidance, ultimately struck me as lacking humility. Birth is a typically low-risk physiological process that does not generally require extensive management and manipulation by a medical authority, not to mention a valuable human process with its own logic and clock. Tervalon and Murray-Garcia's (1998) insights, however, are illuminating here: it may not be doctor-as-god hubris that has driven the birth trends we are witnessing today so much as an unquestioned security in a body of knowledge about what is normal, possible, and desirable for birth, namely the avoidance of risk and pain and the guarantee of a good outcome in the form of a "good baby."

The picture that emerges here is thus a complex one: the dynamics of humility and autonomy mix and morph across the multiple relations of power and knowledge that converge during birth, an event that practitioners attend to daily but that most women go through, if they do at all, but few times in their lives. To the extent that a pregnant woman can neither delegate giving birth to another, nor intentionally command the process entirely on her own, birth exposes and disposes us to others, to uncertainty, and to the precariousness of the body and the will. What we can learn from examining extreme events of exposure like birth is how the quest for control as an important animating spirit must be partnered with the disposition of humility outlined above. This is not

default self-denial and submission to authority or regimes of expertise, but realistic self-assessment, a commitment to learning and reflecting, and an appreciation of the whims of fate that inevitably affect human agency and put us at the disposal of others — others with whom we must engage in contestation over values and goals, and also with whom we must attend to our inevitable relationality. This "new humility" is important, I argue here, because it allows us to aim at self-determination while also locating the limits of our autonomy. Further, this "new humility" encourages us not to berate ourselves for those limits but instead to enlist the generosity and supportive relations needed to survive, and to thrive.

CONCLUSION: BIRTHING CITIZENS?

As noted above, 98.8% of women in the United States give birth in a hospital, almost all with a physician. For some, this is because of insurance exclusions justified in terms of ACOG recommendations. For others, the choice of a birth center or their home is undesirable for practical reasons. For others with high-risk pregnancies, the hospital generally is the best place to birth. But for most women, tacit though this choice may be (meaning they do not think of it as a choice), birthing in a hospital with a physician may reflect their sharing, at least to an extent, mainstream medicine's belief that birth is an inherently dangerous medical event and that taking all precautions to minimize risk and get a "good baby" is what good women and good doctors do. There is nothing natural or inevitable, however, about how this grid of intelligibility of women's birth choices came about. Furthermore, there is a passive subjectivity implicitly assumed, and in turn compelled here.

Birth ultimately resists the desire for self-mastery. Yet structured passivity or tightly delimited participation neglect the fact that there are nonetheless clear dimensions of choice and control possible in birth experiences. When a woman opts for a homebirth, for example, she establishes a certain amount of control over her environment and the protocols she is subject to. Of course, in choosing homebirth one also forfeits the choice of interventions and anesthesia — forms of control — unless she transfers to a hospital setting. As numerous books detail, a large part of preparing for homebirth is the psychological work of coming to terms with the complex nature of choice and control; with the idea that ultimately your body is in charge and your mind best get out of the way, be patient, and surrender to the process (Dick-Read 2013; England and Horowitz 1998;

Gaskin 2003). This sentiment represents a complete contradiction of liberal subjectivity and an affront to modern political theory's crusade against fate since Machiavelli described *fortuna* as a woman who must be beaten and bullied into submission (1992, 69). But supported and informed yielding (something like the "relinquishing autonomy" discussed above) is not the same as subordinated passivity. Conceptually distinguishing the two in birth might help clarify dispositions of engaged citizenship that aim to balance between the will to glorious self-mastery and radical political transformation, on the one hand, and simply opting out of public endeavors, on the other. To the extent that lack of control is conceived in the liberal tradition as a failure to master one's self, and thus as humiliating, birth poses an inevitable problem: it belies the fantasy that if humans only manage themselves well they can transcend chance, vulnerability, and exposure and achieve autonomy from social and corporeal inconvenience and unpredictability.

We can't. This is particularly evident in birth, but it is the case in political coexistence more broadly, too. So the disposition of humility that I defend here, far from mere submission to our limitations as embodied beings, is aimed at helping put us in a fruitful partnership with our fate, bodies, sociality, and relational dependencies. Humility as openness to our humanness, with all that entails in terms of failure of intentions and abilities and aspirations, emotionally equips us for generosity to self and others in the face of our limitations. Humility thus has the potential to move us beyond being humiliated, frustrated, or demoralized by such limitations — defensive of our lapses — and empower us to persevere despite the fact that we simply cannot control every outcome. Humility helps clarify what control we *can* have, in our joint venture with fate and our body, with other people and with the conditions for self-definition, self-trust, and self-determination. To say this is to highlight an ethical disposition that has profound political implications in terms of how citizens aspire, struggle, relate to, and persevere with each other.

So humility needs autonomy, a realm of freedom we can identify and pursue despite never being truly independent. Without such autonomy in the form of the supported self-direction that feminist philosophers have characterized as relational autonomy, humility would be merely a consolation for relative impotence. And autonomy needs humility because autonomy is not a one-time achievement but an ongoing process, a project of claiming over and again our lives as our own. Autonomy is a practice that we may have the opportunity to engage in where we are perhaps least likely to look for it, if only we are attuned to

seeing those opportunities and we *value* that undertaking. Unfortunately, as has been pointed out, and as so many dimensions of our contemporary political condition affirm, "the value of autonomy is often discerned … only by suffering its denial, absence, or delay" (Button 2015, 318). For too many women, this is a palpable dimension of their birth experience. Thus birth can be a site of political awakening within which spaces of resistance to particular ways of knowing and being governed can be staked out. Put differently, we ought to figure it and study it as such.

I began this article with the contention that birth matters and not just for the individual or family or community it directly impacts, but as a social and political phenomenon that is saturated with questions of power, ethics, gender, discipline, and resistance. Birth is thus the proper territory for feminist and political theory. The process of preparing for and giving birth may provide an experience through which to undergo a certain change in political subjectivity or to cultivate dispositions that are important not only for birthing. These are dispositions that are important for engaged democratic citizenship: self-knowledge, self-determination, intellectual courage, spirit of critique, presumptive generosity toward the vulnerability and limitations of self and others, openness to uncertainty, and the will to persevere in our aspirations despite the inability to control everything on one's own. I have broadly explored these traits in terms of autonomy and humility from the perspective that a sense of choice and control over our lives probably matters deeply to us, and yet our quest for control is never guaranteed and is frequently frustrated.

Assumptions about the birthing subject have been forged in the context of imperatives within which the participatory desires, agency, or supported self-determination of the woman giving birth are not central concerns. Birth as a practice that implicates democratic values and citizenship impulses largely fails to register. Concepts of humility and autonomy circulate in birth, but as I have discussed here, they are often impoverished concepts that ground and justify largely managerial dynamics and metrics of success. In a time saturated by logics of risk and efficiency and outcomes over process, being attuned to an alternative way of thinking about humility and autonomy may present us with a way of behaving according to a different, subversive, and potentially vitalizing political subjectivity.

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