Introduction

An Overview of This Volume and of Significant Concepts Used

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This book is Volume II of the three-volume series *The Anthropology of Obstetrics and Obstetricians: The Practice, Maintenance, and Reproduction of a Biomedical Profession*, co-edited by medical/reproductive anthropologist Robbie Davis-Floyd and perinatologist and medical anthropologist Ashish Premkumar. Volume I is entitled *Obstetricians Speak: On Training, Practice, Fear, and Transformation* (Davis-Floyd and Premkumar 2023a); Volume III is *Obstetric Violence and Systemic Disparities: Can Obstetrics Be Humanized and Decolonized?* (Davis-Floyd and Premkumar 2023b). In all of these volumes, we have left the decision about what words to apply to people who are pregnant or are in the process of giving birth to the individual chapter authors. These terms include "women," "childbearers," "pregnant people," and others; sometimes they are culture-specific.

In this Introduction to Volume II—the book you are now holding in your hands—we provide a brief overview of its chapters. We also note here the relevance to the entire series of Chapter 1 of this volume, as some of our chapter authors make use of its schema of the "4 Stages of Cognition" and "Substage." And since some of these chapters utilize Robbie Davis-Floyd's (2001, 2018, 2022) delineations of the technocratic, humanistic, and holistic paradigms of birth and health care (described more fully in our Series Overview at the beginning of Volume I), we first present a brief overview of these paradigms, just as we also have done in the Introduction to Volume III.

Cognition, Risk, and Responsibility in Obstetrics
Anthropological Analyses and Critiques of Obstetricians' Practices
Edited by Robbie Davis-Floyd and Ashish Premkumar
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The Technocratic, Humanistic, and Holistic Paradigms of Birth and Health Care: A Brief Overview

The hegemonic technocratic paradigm, or model, is based on the *principle of separation*—of mind and body, practitioner and patient, body parts from the bodily whole. Its practitioners metaphorize the human body as a machine, view the female body as a defective machine, teach other practitioners to objectify their patients and their disorders ("the gall bladder in room 212"; "the cesarean in 314"), and rely on multiple technologies to manage, surveil, control, and intervene in the normal physiology of birth. This over-management and over-intervention exemplify the *obstetric paradox*: intervene in birth to keep it safe, thereby causing harm (Cheyney and Davis-Floyd 2019:8). These authors (Cheyney and Davis-Floyd 2020a, 2020b, 2021) have argued for the humanistic replacement of TMTS (too much too soon) and TLTL (too little too late) forms of care (see Miller et al. 2016) with RARTRW care—the right amount at the right time *in the right way*—for *how* care is provided matters as much or more than what care is provided and when.

The humanistic model, toward which many maternity care providers strive, is based on the *principle of connection*—the connections of mind to body, person to person, body part to body whole. This paradigm heavily emphasizes this "right way," because its practitioners define the body as what it is: an organism that responds well to kind and compassionate treatment and poorly and defensively to what the organism perceives as unkind and hurtful treatment. Davis-Floyd (2018, 2022) has been careful to distinguish between *superficial humanism*—in which compassionate treatment, including allowing the presence of a partner and/or doula, is often just an overlay on multiple and usually unnecessary technological interventions in labor and birth—and *deep humanism*, in which the "deep physiology" (2018, 2022) of birth is understood, honored, and facilitated. Deeply humanistic maternity care practitioners recognize, for example, that the uterus is responsive to the environment and can function well, or poorly, depending on how the body/organism it inhabits is treated. Thus Davis-Floyd (2022) has re-defined her "technocratic–humanistic–holistic" spectrum as "technocratic–superficially humanistic–deeply humanistic–holistic."

The holistic paradigm that lies on the far end of this spectrum defines the body as more than an organism; its practitioners view the body as an energy system in constant interaction with all other energy systems around it. And this holistic model is based on the *principles of connection and integration*—of mind, body, and spirit, of practitioner and "client" (a much more egalitarian word than "patient," often used by holistic prac-

titioners of all types). Within this model, unlike in the other two, spirit and energy are brought into play, for example, by having the parent(s) "call the spirit" of an unresponsive baby (before and/or while a practitioner performs neonatal resuscitation) to ask that spirit to choose come into its body, as many midwives and some neonatologists do, and/or by following the holistic maxim C*hange the energy, change the outcome*. This can mean keeping what Brazilian obstetrician Ricardo Jones (2009) calls the "psychosphere" of birth clear and clean, perhaps by asking people with fear- or tension-filled "negative energy" to leave the birthing room.

We stress that these paradigms lie across a *spectrum*, as they can elide into one another in practice: for example, highly technocratic obstetricians (obs) trained to keep emotional distance from their patients can choose to take the emotional risk of developing personal relationships with those patients when they become aware of the value such relationships have for the perinatal process. Or humanistic obs might bring some elements of holism into their practices, perhaps by having the parents "call the baby" as described above, while they call a neonatologist. In fact, a neonatologist once approached Robbie at a medical conference and earnestly asked her what homebirth midwives do when a baby is not breathing when it is born. To his great relief, Robbie responded that all US homebirth midwives are trained in neonatal resuscitation—but, wanting to give him more, Robbie also explained that homebirth midwives have the parents call the baby. She told him that first, it can do no harm; second, it gives the parents a sense of agency; and third, it just might work! Thrilled with this information, around four months later, this neonatologist sent Robbie a letter saying that ever since he had started asking parents to call their non-breathing babies, those babies began breathing right away, making resuscitation unnecessary. In holism, the interpretation is that babies' spirits or souls are often hovering, trying to make the decision to be or not to be (!) born, and that the assurance of truly being wanted that they feel when their parents call them will help the spirit to decide to come into its newborn body, or if that soul feels unwanted, perhaps it will decide to pass back through the gateway to "the other side." (Most holists are deeply spiritual, and many believe in reincarnation.)

Having briefly described these paradigms, we now turn to a presentation of the chapters in this volume.

An Overview of the Chapters in This Volume

In Chapter 1, which series lead editor Robbie Davis-Floyd has constructed as a "think-piece," she offers a conceptual framework within

which various ways of cognizing and believing can be fruitfully understood, including those utilized by obstetricians of all types. She describes the differences between "open" and "closed" ways of thinking, and delineates "4 Stages of Cognition," correlating each with an anthropological concept. She correlates Stage 1—rigid or concrete thinking—with *naïve realism* ("Our way is the only way, or the only way that matters"), *fundamentalism* ("Our way is the only right way"), and *fanaticism* ("Our way is so right that everyone who disagrees with it should be assimilated or eliminated"). She correlates Stage 2 thinking with *ethnocentrism* ("There are other ways out there, but our way is best") and demonstrates that technocratic obstetrics is a relatively rigid Stage 1 or Stage 2 system, depending on how it is practiced.

The next two Stages represent more fluid types of thinking—Robbie correlates Stage 3 thinking with *cultural relativism* ("All ways have value, and individual behaviors must be understood within their sociocultural contexts") and suggests that obstetricians should seek to understand the cultures within which they practice and should demonstrate cultural competence and provide Cultural Safety[1] in their care via what Robbie terms "informed relativism" (see Davis-Floyd et al. 2018). She relates Stage 4 thinking to *global humanism* ("We must search for better ways that honor the human rights of all individuals") and insists that obstetricians should always honor women's rights in their care, even in cultures that devalue women and do not honor their human rights in daily life.

Robbie then categorizes various types of birth practitioners, especially obstetricians, within these 4 Stages and shows how each Stage affects and influences practice. She goes on to show how ongoing stress can cause even the most fluid of thinkers to shut down cognitively and operate at a Stage 1 level or to degenerate into "Substage"—a condition of cognitive breakdown, or "losing it," which can include treating birthing people and other practitioners with disrespect, violence, and abuse. She describes how the performance of rituals can help such practitioners to ground themselves at least at a Stage 1 level and offers ways in which they may move beyond rigidity and rejuvenate and inspire themselves to think and practice more openly and fluidly. She also describes the ongoing battles between fundamentalists and global humanists, and the persecutions that Stage 4 globally humanistic birth practitioners, including obstetricians, often experience from fundamentalist or fanatical Stage 1 obstetricians and officials—often referred to as the "global witch hunt" from which humanistic and holistic practitioners frequently suffer, as some of them describe in their chapters in Volume I (Davis-Floyd and Premkumar 2023a).

In Chapter 2, authors Margaret Dunlea, Martina Hynan, Jo Murphy-Lawless, Magdalena Ohaja, Malgorzata Stach, and Jeannine Webster describe the culture of Irish obstetrics and obstetricians. They begin with the characterization of Irish society not only as a "man's world" but also as one where the "patriarchal dividend" continues to underpin widespread cultural acceptance of male authority as entirely appropriate. The Irish government unquestioningly accepts the mainstreaming of this obstetric authority, funding maternity services on this basis. These authors describe the international hegemony of the Irish text *Active Management of Labour: The Dublin Experience*, now in its 4th edition (O'Driscoll, Meagher, and Robson 2004) and the *National Maternity Strategy* of 2016, wherein a woman's "care pathway" is determined by obstetric risk criteria. They conclude with arguments about the need to take women's activism in more fruitful directions to reach obstetricians directly and to effect positive changes in their practices.

In Chapter 3, "Becoming an Obstetrician in Greece: Medical Training, Informal Scripts, and the Routinization of Cesarean Births," medical anthropologist Eugenia (Nia) Georges begins by showing that in Greece, the vast majority of women give birth in private or public hospitals under the exclusive care of obstetricians, with highly trained professional midwives mostly relegated to obstetrician-subservient roles. Greece currently has the highest cesarean birth (CB) rate in the European Union and in the world. Despite a growing public awareness that many, if not most, cesareans are unnecessary, Greece's CB rate remains at its long-standing 65%.

Over the course of her long-term ethnographic research on pregnancy and birth in Greece, Nia has often heard obstetricians themselves bemoan the high cesarean rate. To date, however, there have been no qualitative studies that explore their points of view—a gap that Georges' study fills. In her chapter, she complements her prior research on the experiences of pregnant women with interviews with obstetricians to explore their understandings of their profession and their perspectives on cesarean births. To examine the "hidden curriculum" (Dixon, Smith-Oka, and El Kotni 2019) that implicitly informs their understandings, Georges also draws on the perspectives and experiences of adjacent medical doctor (MD) care providers, such as neonatologists, who are increasingly called upon to attend to the unintended consequences of the large number of Greek babies born by cesarean. These consequences include many preterm births, as Greek obs often schedule CBs at or before 37 weeks of pregnancy, as Georges describes.

Chapter 4, by Michelle Sadler, a medical anthropologist, and Gonzalo Leiva, a practicing midwife in Chile with a Master's in Health Ad-

ministration, explores obstetricians' explanations for the high rates of cesareans in Chile, especially considering the extreme differences among health insurance systems. In the Chilean public health insurance system in 2017, cesarean births were at 28%; in the private system, 62%; and in the PAD (Pago Asociado a Diagnóstico) Birth system—public insurance until the 37th week of gestation followed by transfer to the private system—72%. In this latter subsystem, only women with full-term healthy pregnancies can be attended, and therefore this sector should have the lowest rates of cesarean births. Instead, it has the highest.

When trying to explain these extreme differences, Sadler and Leiva's ob/gyn interlocutors acknowledged that economic incentives are primary. In private care, fees are paid per birth, and therefore, a greater number of births—a number that can be optimized by performing cesareans—translates into higher income. In the PAD Birth system, the institutional and practitioners' fees are much lower than in the private system; thus, the volume of procedures is privileged, leading to the 72% CB rate. Obstetricians take different positions on this problem, ranging from a defense of these options in a free market framework to a profound criticism that highlights the violations of women's human rights and of biomedicine's ethical core values. In addition to financial incentives, the interlocutors mentioned other factors that weighed differently, depending on their approaches to childbirth. Those more closely aligned with a technocratic view of birth identified causes that they considered "external" to their own practices, such as maternal request and fear of lawsuit, and were less critical of their own influences on the high cesarean rates. Those ascribing to a humanistic approach placed greater weight on economic incentives and on obs' general ignorance of how to attend vaginal births. Since cesareans are decided on mainly by obstetricians, Sadler and Leiva argue that understanding the factors and incentives that drive these surgical interventions is vitally important for the effective design of humanistic birth models.

In Chapter 5, social anthropologists Caroline Chautems and Irene Maffi begin by noting that Switzerland ranks among the European countries with the highest cesarean rates (32.3% in 2017)—around the same as that in the United States. Those obstetricians who recognize the adverse consequences of unnecessary CBs face difficulties in inversing the current trend. Although some public hospitals are trying to modify standard practices that contribute to increasing CB rates, such as frequent induction and systematic active management of labor, in situ decisions frequently lead to cesarean instead of vaginal deliveries. However, most obstetricians conceive of "normal birth" as vaginal, and the majority of parents want to limit medical interventions during childbirth. In this

context, the recent introduction into some Swiss hospitals of "gentle cesareans"—a technique mimicking vaginal delivery—appears to be an attempt to reconcile the natural childbirth model with surgical birth. "Gentle cesareans" are intended to favor parents' participation in childbirth within the constraints of the hospital environment—for example, by allowing them to see the baby's extraction and for the mother to have her baby on her chest immediately after birth. (Our readers can see a photo of a gentle cesarean on the cover of this volume. Just after this photo was taken, the baby was passed directly to the mother.)

This chapter is primarily based on an in-depth, lengthy interview with one of the two obstetricians, Alexandre Farin, who introduced the "gentle cesarean" technique in French-speaking Switzerland, which has become the default protocol in the maternity ward where he practices. The interview focused on his professional trajectory, his conceptions of normal childbirth and surgical birth, and the reasons for his commitment to "gentle" cesareans. More broadly, this interview investigated Farin's opinions on obstetrics in Switzerland, including medical training, protocols, obstetric cultures in public hospitals and private clinics, and couples' attitudes toward childbirth.

In Chapter 6, obstetrician/gynecologist Nicholas Rubashkin provides a historically and ethnographically grounded overview of the emergence and rise to dominance of the Maternal Fetal Medicine Network (MFMU) VBAC (vaginal birth after cesarean) Success Calculator in the United States. The "VBAC calculator" was designed to assist providers and women to make more informed mode-of-birth decisions. Drawing from interviews with clinician users and non-users of the VBAC calculator as well as with pregnant and postpartum women, all of whom had a prior cesarean, Rubashkin demonstrates how certain uses of the VBAC calculator circumscribed VBAC-interested women's decision-making capacities, because the calculator put forth cesarean surgery as the best and only treatment for a predicted low probability of success. Importantly, the MFMU VBAC calculator used race/ethnicity to predict a score and, as a result, assessed Black and Hispanic women to be, on average, 5 to 15 points less likely to achieve a VBAC compared to white women with similar risk factors. Because the VBAC calculator explicitly factored in race/ethnicity, as opposed to racism, as an intrinsic risk factor for poor individual health, the calculator put VBAC-interested Black and Hispanic women at risk for cesareans they didn't desire or need. Rubashkin also examines how some maternity care providers—more often midwives but also some obstetricians—challenged the calculator's approach and supported women wishing to have VBACs in a range of birth options. In his concluding remarks, Rubashkin discusses how,

through the selective sharing of information, the calculator drew from and perpetuated the authoritative status of obstetrics as the modern science supposedly best equipped to deal with risks in childbirth through invasive procedures, and describes the development of a new VBAC calculator that does not include race/ethnicity as a variable but has its own set of problems, in that this new calculator is not "preference-sensitive"—it does not include women's preferences and commitments to achieving a VBAC, *yet it should*.

In Chapter 7, medical anthropologists Vania Smith-Oka and Lydia Z. Dixon also address risk and responsibility in obstetrics, this time among Mexican obstetricians. They begin by noting that there has been a growing body of literature on women's experiences with obstetric care, yet less attention has been paid to the ways in which obstetricians themselves have come to behave, believe, and practice as they do. This chapter draws on the authors' combined years of research on childbirth in Mexico to specifically examine the perspectives of Mexican obstetricians. Using rich ethnographic data from obstetricians, obstetric residents, and midwives, Smith-Oka and Dixon focus on how changing narratives about risk, maternal mortality, and obstetric violence in Mexico are interpreted by obstetricians and ultimately impact patients. These narratives at times motivate changes in patient care, while at other times such changes are framed as unrealistic, unnecessary, or even undesirable.

Smith-Oka and Dixon's analysis highlights the roles that medical hierarchies, defensive medicine, social inequalities, and structural inadequacies play in the decisions obstetricians make. The extent to which obs embrace changes in their field (such as humanizing their practices and working with midwives) depends on more than individual willingness; it also depends on the socio-structural contexts within which Mexican obstetricians work. Building on the well-known trope of the need to "listen to women" during maternity care, these authors insist that ultimately, "If we hope to see change in obstetric practice, we have to *listen to obstetricians*." They show that ethnography is a powerful and effective tool for achieving this goal.

Chapter 8 by Vania Smith-Oka, the medical anthropologist who co-authored the preceding chapter, and Megan K. Marshalla, an obstetrics and gynecology resident, keeps us in Mexico to investigate how class, ethnic, and gender differences are reproduced in biomedical training in that country. These authors begin with the premise that bodies are useful instruments for understanding the reproduction of inequalities. They go on to investigate why and how bodily, social, intimate, and physical boundaries are crossed in biomedical practice in general, and specifically

in obstetric practice, and what this can tell us about individual and social bodies. Smith-Oka and Marshalla unpack how seeing and being seen, touching and being touched, and feeling and being felt are conditioned in very particular ways by obstetric training and by the broader political economy. Ob participants in the authors' ethnographic research in Mexico used the term *manitas* to describe how they trained their sensory organs (hands, ears, eyes) during medical practice; how they learned through practice on the bodies of less-agentive populations (female, raced, impoverished); and how they crossed intimate, structural, and physical boundaries through what these authors term "somatic translation": seeing others' bodies through their own. *Manitas* were developed unconsciously by obstetricians, were never explicitly taught or learned in practice (but rather were part of obstetrics' "hidden curriculum"), and (re)produce social differences. As Smith-Oka and Marshalla demonstrate, these forms of learning highlight the friction between the "violence of knowing" and the importance of touch as a legitimate mode of care. This tactile and sensorial learning not only entails a form of boundary crossing that is medically useful but also highlights social inequalities by taking advantage of them.

In Chapter 9, "The Limitations of Understanding Structural Inequality: Obstetricians' Accounts of Caring for Substance-Using Patients in the United States," Katharine McCabe, who works in law, gender, and health care, shares findings from a study examining obstetricians' attitudes and responses to substance-using patients to demonstrate that these providers already engage in a process of "social diagnosis," by which signs of social precarity and disadvantage are identified and incorporated into clinical decision-making. However, as McCabe shows, the ability of obstetricians to identify disadvantages does not necessarily improve patient care or outcomes; rather it creates a new set of iatrogenic effects. Patients identified as "problematic" due to their substance use and positionality (i.e., poverty, lack of access to opportunities) are less likely to be treated in a clinically normative manner and are often referred to coercive and punitive social systems to address structural and social risks deemed outside of the scope of obstetricians' expertise. McCabe concludes with a discussion of the limitations of approaches that seek to resolve health inequalities through consciousness or awareness raising. Instead, she encourages a more complete understanding of "biomedicine as a structure of inequality in and of itself" and argues that actors working within this structure—especially obstetricians—must be morally and politically committed to transforming biomedicine from the inside out to generate effective humanistic changes.

In Chapter 10, Melissa Goldin Evans, a community health researcher, addresses "Contraceptive Provision by Obstetricians/Gynecologists in the United States: Biases, Misperceptions, and Barriers to an Essential Reproductive Health Service." Evans begins by noting that unintended pregnancies occur in nearly one out of every two (45%) pregnancies in the United States and that unintended pregnancies and short interpregnancy intervals are associated with adverse health and social outcomes for the infant and the mother. She continues by affirming that the risks of unintended pregnancies and short interpregnancy intervals are significantly reduced when women use long-acting reversible contraceptives (LARCs)—intrauterine devices and implants. Evans emphasizes that ob/gyns play important roles in patient uptake of LARCs—whether or not they provide routine unbiased contraceptive counseling that preserves patient autonomy in choice, have the training to insert LARCs**,** and can provide LARCs by removing on-site barriers such as multiple-day protocols for insertions. Additionally, although the American College of Obstetricians and Gynecologists (ACOG) and the CDC (Centers for Disease Control and Prevention) state that LARCs are safe and effective for the majority of women, many reproductive healthcare providers consider certain populations to be inappropriate LARC candidates. Since LARC insertion is a procedure that requires a trained healthcare provider, any bias against LARCs for women with certain demographics and gynecologic histories can prevent equitable access and uptake of LARCs.

The objective of Evans's chapter is to describe contraceptive provision practices, particularly LARCs, among ob/gyns to both the general population at risk of unintended pregnancies and to postpartum women. She delineates ob/gyns' fundamental duty to help women achieve their reproductive goals through unbiased, woman-centric contraceptive counseling and, for contextualization, includes descriptions of historical and present-day efforts to control the reproductive autonomy of low-income women and Women of Color. She follows up with a discussion on system-level barriers that restrict LARC provision with suggestions for overcoming these barriers.

In Chapter 11, "Cognition, Risk, and Responsibility: Home Birth and Why Obstetricians Fear It," obstetrician Amali U. Lokugamage—who herself gave birth at home—and midwife and researcher Claire Feeley describe home births as "physiologic births that take place under the social, deeply humanistic, and holistic models of birth" and note that these tend to be rare in hospitals—meaning that obstetricians have little experience in attending them. Therefore, obstetricians traditionally have

been very fearful of home births, cognizing them as "extremely risky." Lokugamage and Feeley demonstrate that normal physiologic births contribute to improving public health and that obstetricians are often not aware of the extent of these benefits, which include adaptive physiologic functions in the baby, better mother and baby bonding, and higher breastfeeding rates, which in turn lead to better lifelong emotional and physical health for infants. Normal birth affirms health, promotes empowerment in mothers, and is linked to promoting positive emotional qualities in society via the hormone oxytocin—often referred to as "the hormone of love." Training within the technocratic model constrains obstetricians' ability to value normal birth, especially when it occurs outside of hospitals. Experiences of complications and a lack of awareness of the evidence surrounding home birth—compounded by their lack of training in normal physiologic birth—perpetuate fear of home birth among obstetricians, as this chapter illustrates.

In the Conclusions to this volume, we describe the theoretical concepts and frameworks used by the chapter authors and the key points made in their chapters.

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Note

1. According to the authors of Chapter 6 in Volume III of this series (Lokugamage, Ahillan, and Pathberiya 2023), Māori nurse and educator Irihapiti Ramsden of New Zealand recognized that midwifery and nursing education needed to incorporate the concept of *Cultural Safety*—which, as she and the Māori insist, should always be capitalized; not to do so is considered a subtle insult. In their chapter, these authors state that "It is vital to distinguish *Cultural Safety* from *cultural competence*. 'Cultural Safety' acknowledges the inherent power imbalances between clinician and patient, requiring practitioners to use critical self-reflection on their own beliefs, values, biases and assumptions, but 'cultural competence' does not include this important reflexivity on power." Amali Lokugamage (personal correspondence with Robbie, February 2022) adds to this that: "Cultural competence is deficient due to the perpetuation of racial stereotypes as it depends on Western interpretations of other cultures; it doesn't include co-creation of health policies through patient/public engagement; and, again, doesn't include reflexivity or power imbalances" (see Lokugamage et al. 2021).

References

Cheyney M, Davis-Floyd R. 2019. "Birth as Culturally Marked and Shaped." In *Birth in Eight Cultures*, eds. Davis-Floyd R, Cheyney M, 1–16. Long Grove IL: Waveland Press.

———. 2020a. "Birth and the Big Bad Wolf: A Biocultural, Co-Evolutionary Perspective, Part 1." *International Journal of Childbirth* 9(4): 177–192.

———. 2020b "Birth and the Big Bad Wolf: A Biocultural, Co-Evolutionary Perspective, Part 2." *International Journal of Childbirth* 10(2): 66–78.

———. 2021. "Birth and the Big Bad Wolf: Biocultural Evolution and Human Childbirth." In *Birthing Techno-Sapiens: Human-Technology Co-Evolution and the Future of Reproduction*, ed. Davis-Floyd R, 15–46. Abingdon, Oxon: Routledge.

Davis-Floyd R. 2001. "The Technocratic, Humanistic, and Holistic Paradigms of Childbirth." *International Journal of Gynecology & Obstetrics* 75, Supplement 1: S5–S23.

———. 2018. "The Technocratic, Humanistic, and Holistic Paradigms of Birth and Health Care." In *Ways of Knowing about Birth: Mothers, Midwives, Medicine, and Birth Activism*, Davis-Floyd R and Colleagues, 3-44. Long Grove IL: Waveland Press.

———. 2022. *Birth as an American Rite of Passage*, 3rd edn. Abingdon, Oxon: Routledge.

Davis-Floyd R, with Matsuoka E, Horan H, Ruder B, Everson CL. 2018. "Daughter of Time: The Postmodern Midwife." In *Ways of Knowing about Birth: Mothers, Midwives, Medicine, and Birth Activism*, Davis-Floyd R and Colleagues, 221–264. Long Grove IL: Waveland Press.

Davis-Floyd R, Premkumar A. 2023a. *Obstetricians Speak: On Training, Practice, Fear, and Transformation.* New York: Berghahn Books.

———. 2023b. *Obstetric Violence and Systemic Disparities: Can Obstetrics Be Humanized and Decolonized?* New York: Berghahn Books.

Dixon LZ, Smith-Oka V, El Kotni M. 2019. "Teaching about Childbirth in Mexico: Working across Birth Models." In *Birth in Eight Cultures*, eds. Davis-Floyd R, Cheyney M, 17–48. Long Grove IL: Waveland Press.

Jones R. 2009. "Teamwork: An Obstetrician, a Midwife, and a Doula in Brazil." In *Birth Models That Work*, eds. Davis-Floyd R, Barclay L, Daviss BA, Tritten J, 271–304. Berkeley: University of California Press.

Lokugamage AU, Rix EL, Fleming T, et al. 2021. "Translating Cultural Safety to the UK." *Journal of Medical Ethics* Jul 19: medethics-2020-107017. Epub ahead of print. PMID: 34282043.

Lokugamage A, Ahillan T, Pathberiya SDC. 2023. "Decolonizing Ideas of Healing in Medical Education." In *Obstetric Violence and Systemic Disparities: Can Obstetrics Be Humanized and Decolonized?* eds. Davis-Floyd R, Premkumar A. Chapter 6. New York: Berghahn Books.

Miller S, Abalos E, Chamillard M, et al. 2016. "Beyond Too Little, Too Late and Too Much, Too Soon: A Pathway Towards Evidence-Based, Respectful Maternity Care Worldwide." *Lancet* 388(10056): 2,176–2,192.

O'Driscoll K, Meagher D, Robson M. 2003. *Active Management of Labour: The Dublin Experience*. London: Mosby.