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ARTICLE

Birth: A radically new meditation for philosophy

Stella Villarmea

Faculty of Philosophy (A), office 337 Complutense University of Madrid, Pl. Menéndez Pelayo, s/n Ciudad Universitaria, Madrid 28040, Spain
Email: svillarm@ucm.es

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Abstract
This paper explains why and how we should introduce birth into the canon of subjects explored by philosophy. It focuses on the epistemology of birth, namely, on the nature, origin, and limits of the knowledge produced by and/or related to giving birth. The paper provides a view on the philosophy of birth, i.e., an approach to construct a new *logos* for *genos*.

Keywords: Birth; philosophy of birth; epistemology of birth; reproductive justice; obstetric violence; values-based practice; feminist theory; capacity; autonomy

A philosophy of birth

This paper contains a philosophy of birth that aims to construct a new *logos* for *genos*. I engage in the philosophy of birth, that is, I use the tools of philosophy to analyse experiences and practices around childbirth. My paper is about why and how we should introduce birth into the canon of subjects explored by philosophy. Here I will focus on the epistemology of birth, namely, on the nature, origin, and limits of the knowledge produced by and/or related to giving birth.

Every human life begins with gestation and birth. However, in the thought and culture with which I am most familiar – commonly known as Western philosophy – delivery and birth have received considerably less attention than death and mortality. Philosophy has been concerned, for example, with how to die well. But it has been silent on how to be born well or, for the case, how to birth well. Giving birth continues to be a blind spot in contemporary prevailing philosophy.

Some of us, women philosophers, have criticised this imbalance, rescuing delivery and birth from a state of omission or abandonment. The philosophy of birth constitutes a vibrant and growing field of contemporary critical thought, which builds on the works of theorists both from decades ago (Young 1984; Held 1989; Ruddick 1989; Muraro 2018; Cavarero 1997; Battersby 1998; Jantzen 1998) and from more recent years (Schües 2016; Baraitser 2008; Heinämäa 2010; LaChance Adams 2012; Cohen Shabot 2017; Irigaray 2017; Kingma 2019; Söderbäck 2019; Stone 2020, among others), to which

I have added my own voice (Villarmea 2009, 2020, 2021a; Villarmea and Fernández Guillén 2012; Villarmea and Kelly 2020; Villarmea, Olza and Recio 2015).

I argue that it is indeed a radical shift to reorient philosophical conversation toward birth, specifically toward the origin of life in the female body.[1] In my writing, I pay special attention to the moment and experience of giving birth, rather than to the fact of being born. Or, if you like, I focus on who is giving birth rather than who is being born. The crucial reason behind my turn is that, in contrast to the history of philosophy, I insist that the birthing woman is not only the author of her own experience, but also a philosophical authority.

By doing so I look attentively at one of the beings of what is in fact a pair or, more precisely described, a dyad. A dyad (from Latin, *dyas* - a dyad; and from Greek, *duo* - two] is generally defined as an entity consisting of two elements or parts, e.g., a pair. In social science, however, a dyad is more precisely defined as a group of two people maintaining a sociologically significant relationship. For that reason, a dyad is often conveived as the smallest possible social group. In psychology, a dyad is a pair of two individuals who relate in a close and especially linked manner to each other. The interactions between the dyad's members and/or their caracteristics follow the principle of 'the whole is other than the sum of its parts'. Hence, a dyad is not only characterized by its members' attributes but also possesses unique characteristics on the basis of how they interact. The dyad members show interdependence based on mechanisms which can be sociologically, psychologically, even biologically or physiologically approached, and which in turn create a common and singular environment. From this point of view, the mother-newborn child pair is frequently seen as a paradigmatic dyad (Leclère et al. 2014).

Birth-care practices and protocols are beginning to understand what the mother-newborn dyad is and needs in its early stages. An example: there is now evidence-based research supporting the 'golden hour' and providing strategies for successfully implementing a Golden Hour protocol on a hospital-based labour and delivery unit (Neczypor and Holley 2017). The 'golden hour' encompasses a set of evidence-based practices that contribute to the physiologic stabilization of the mother-newborn dyad after birth. Important elements of the golden hour include delayed cord clamping, skin-to-skin contact for at least an hour, the performance of newborn assessments

[1]By referencing the female body here, I am strictly referring to the reproductive organs that are typically considered female in human and non-human animals – uterus, eggs, and so on. I am not asserting that gestational bodies must be 'female' in any other respect. Nevertheless, most of the issues here arise from the identification of pregnant bodies as female and what it means, culturally, to be identified as a woman or girl. These issues are obviously far more complex than I can discuss in this article, but I would still like to mention some standpoints that I hope to undertake in future work.

The vast majority of babies have been and still are born to women. The meaning of 'woman' or 'mother' is not arbitrary, but this meaning is equally neither locked nor fixed. Our use of words is a complex construct containing layers and intersections, and clashes in philosophy, history, culture, and biology. Should we speak of birthing people or parent's bodies rather than mothers so as to accommodate trans fathers or cases where the genetic, gestational, and/or social mothers are different individuals? Or should we speak of birthing women and mothers to acknowledge that the vast majority of human gestators/gestating humans have been, and still are, women?

We are far from reaching a consensus in this area. In what follows, my enquiry is limited primarily to the experiences of cisgender women, but I acknowledge that there is a much wider history and range of experiences, the discussion of which is beyond the scope of the present essay.

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on the maternal abdomen, delaying non-urgent tasks (e.g., bathing the newborn) for 60 minutes, and the early initiation of breastfeeding. The golden hour contributes to neonatal thermoregulation, decreased stress levels in a woman and her newborn, and improved mother-newborn bonding. Implementation of these actions is further associated with increased rates and duration of breastfeeding.

However, the very early stages of the dyad mother-newborn – those moments around and after childbirth – have not yet been approached by philosophy. The times have come to revert that exclusion. But I am convinced that for philosophical discourse to say anything of interest on this paradigmatic dyad, it first needs to understand better what one of the elements in the pair – namely, the birthing subject – *is, feels, does*, and *experiences*.

My research thus takes an innovative approach to explaining how we can protect women's rights during childbirth, principally by analysing how much of birth care continues to underestimate the capacity of a woman in labour to be a fully entitled subject. In what follows, I analyse the capacity and autonomy of birthing women and other birthing people to reveal gender implicit biases in birth care. My approach seeks to break down the silos that have existed historically between women's health and philosophical thinking.

A new *logos* for *genos*

I am told that my assertion is radical, but I maintain that our conception of the world and of humans is reflected in our notion of pregnancy, labour, and birth. Philosophical reflections on the question of origin have a long history of identifying 'origin' with concepts such as 'beginning', 'principle', 'cause', or 'foundation'. But in philosophy we are not used to associating 'origin' with 'birth', our birth. Thus, my intention is no less than to rethink the concept of origin itself. What I propose to achieve through a philosophy of birth is a new *genealogy* in its literal sense, a new 'logos' for 'genos' – a radical meditation on origin and birth (Villarmea 2009).

To explore the construction of this alternative genealogy, I first target obstetrics. My research identifies obstetrics as the science of origin that defines what it is to be human for today. Understanding obstetrics as a genealogy is crucial to analysing how birth care practices in health facilities across the world influence contemporary thought in significant ways.

Birth care brings to the fore fascinating philosophical questions: is a woman in labour a subject with full rights in practice as well as in theory? Can a labouring woman exercise her autonomy in a situation of maximum vulnerability but also maximum lucidity and awareness, as characterises the work of giving birth? What is the relationship between agency, capacity, and pain during and between contractions? What do we mean by informed consent and shared decision-making in childbirth? Does informed consent just equate shared decision-making? *Who*, of all involved, has the final say? Birth care proposes key questions relating to knowledge, freedom, and what it means to be a human being.

We hear it once and again: 'I've never felt so irrelevant in my life'; 'no one advocated for me, no one listened to me, on that day'.[2] It is hard to believe, isn't it? And yet we

[2]These are testimonies from the webinar, 'Women's Choices in Childbirth: *Really?*', organized by The Collaborating Centre for Values-based Practice at St Catherine's College, University of Oxford, on 30

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hear it in personal conversations, peer group exchanges, and professional meetings on birth care. Many women are shocked that their rights over their own bodies remain contested even today.

In summary, if we examine the contemporary science concerned with *genos*, we reveal serious questions about power, autonomy, and vulnerability. If maternity services are to become safer, person-centred, and values-based (Woodbridge and Fulford 2004; Fulford and Handa 2018), we need to view women's birth experiences through the lens of philosophy, feminism, and socio-legal theory. The extent to which women have agency during facility-based childbirth is a critical challenge in our access to full citizenship (Villarmea 2020).

Of course, there are many caring healthcare professionals out there who are compassionate and follow a good practice and the law. True. But I will be writing here about situations when this is not the case, about why women's rights are actually and frequently breached during childbirth, about how obstetric violence takes place.

Obstetric violence

Violence against women giving birth has become so normalised that it is still not considered as violence against women – almost as if its habitual nature renders the violence invisible. The term 'obstetric violence' has been coined to refer to the violence suffered by women in health centres during birth care. The recent 2019 *UN Special Rapporteur's Report on Violence against Women in Reproductive Health Settings* (UN Special Rapporteur's Report 2019) establishes obstetric violence as a violation of human rights. Obstetric violence, for which we now have data, statistics, and even laws, is one manifestation of gender violence which characterises patriarchy.

The UN Report focuses on abuses during facility-based childbirth to reveal that mistreatment and violence against women in childbirth happen *around* the world and affect women across *all* socioeconomic levels. That means, exactly, also *here*, in any of our own countries. Obstetric violence appeals to any facility-based childbirth that produces unneeded or harmful practices for mothers and babies. Testimonies demonstrate that mistreatment and violence during birth are both widespread in practice and deep-rooted in healthcare systems.

The report addresses, for example, the issue of informed consent as a human right and a safeguard against such violence. Women are frequently denied their right to make informed decisions about the healthcare they receive during childbirth; this lack of informed consent constitutes a human rights violation that could be attributed to states and national health systems. In a nutshell, the UN report emphasises that all such practices must be identified and treated as gender violence and violations of women's human rights. Facing obstetric violence is facing a violation of *human rights*. In that sense, my paper is about how to finally give us, birthing subjects, the 'right to have rights', to paraphrase Hannah Arendt's point (Arendt 1973).

At the heart of international documents is a call to arms for person-centred care and values-based practice in childbirth, not only in order to improve the safety of women and babies as patients, but also to improve our well-being and experience as users of

June 2021. You can listen to the full testimonies at URL: https://valuesbasedpractice.org/vbp-webinars/womens-choice-in-childbirth-really/ (accessed: 30 June 2021).

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health services. However, I argue, this process of change has reached a certain impasse because it operates under a medical model that does not pay attention to how birthing people view rationality and agency in childbirth. In so far as these notions (rationality and agency) are central to what counts as being human, this debate is of profound philosophical import.

Today I would like to present one example of this kind of import. The short phrase could be 'unveiling the stereotype: capacity and autonomy during labour'. Or should I better say it as a question? *Capacity* and *autonomy* during *labour*? Indeed, placing the emphasis on those notions might seem surprising. Let me explain why.

Capacity and autonomy during labour?

Within maternity care there is a fundamental problem, which is that, while everybody is clear that choice, women's autonomy, and agency are fundamental in theory and the law, in practice this is often, if not regularly, not enacted. Women's experience speaks to an uncomfortable truth, namely, that autonomy in decision-making about their body and health during labour is far from commonplace and that obstetric violence has to be addressed.

So, while pregnant women and people in labour are autonomous and in full capacity citizens according to the law, they are not always considered as such in clinical practice. I am interested in exploring what the tension between the law and the practice *exactly* is.

Of course, we can always mention time, money, and service pressures as reasons … and they sure play their part. But philosophy can help us acknowledge that the obstacles to enhance capacity and autonomy during labour lie also at yet another layer that is not structural but conceptual, for it has to do with our notions of what capacity and autonomy *are*. Consciously or unconsciously, professionals do not always engage in true shared decision-making with women during labour because they take them/us to be obviously not in full capacity.

And why are women in labour *obviously* not in full capacity? Because their being in an altered state of body and consciousness is taken to deeply affect their capacity to retain and recall information, and balance it in coming to a decision. Hence, what they say is taken to not necessarily convey what they mean (nor what they need nor what is good for them and their babies).

In short, women subject to the uterine influence *do not* reason well.

In my research, I examine theories of female rationality and their application to people in labour, to uncover a view from the frontline of care delivery that frequently acts as a barrier to establishing values-based practice as the norm in obstetrics and midwifery. Stereotypes can play themselves out in the unconscious bias we all share concerning women in labour as irrational. And which is the most frequent and probably most influential stereotype about women giving birth? That they are not rational, that they behave a-rationally. From this perspective, the debate on women's rationality, choices, and decision-making in childbirth is a pressing battlefield. At stake is nothing less than women's entitlement to full citizenship.

In what follows, I would like to take a particular approach to explaining how we can protect birthing people's rights during childbirth. To that aim, I focus on the role

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of implicit bias and gender stereotypes in a particular area of maternity care – the capacity or rationality of a person in labour.

Implicit bias is defined as the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. Research on implicit bias suggests that people can act on the basis of prejudice and stereotypes without intending to do so (Toribio 2018). It is thus important to pay attention to the challenges posed by the structural social injustice that implicit attitudes reflect. 'Recent empirical evidence suggests (…) that while we may typically lack conscious access to the source of implicit attitudes and their impact on our beliefs and behaviour, we do have access to their content' (Toribio 2021: S1530). Without beating around the bush – we know *what* we think even if we don't know *why* we think it.

How have we arrived to this position?

In many of the testimonies that birth rights associations and peer groups have gathered, we hear to which extent women have their rights breached during childbirth. The result is tons of emotional pain and mental suffering.

For those who are familiar with the history of ideas and the feminist analysis that help illuminate it, there are too many covertly active associations in the discourses and practices around childbirth not to be noticed. It takes awareness to ultimately challenge those assumptions. Philosophy has an invaluable role to play in uncovering such gender narratives.

A person in labour far from embodies the typical, ideal, or supposed characteristics of a 'rational agent' (one of those rational agents that traditional economic theory has fallen in love with). But rationality, which relates to reason, is more than, say, comparing stock market values to decide where to invest your money. For example, the woman in labour who decides she wants to get up and move around is indeed also *rational* since, in order to find an appropriate birthing position, she evaluates the resources and options available to her. Everyday philosophy calls this practical reasoning or, as Kant would say, practical use of reason, which involves life experience. I am reminded that nature documentaries view chimpanzees piling up boxes to reach bananas as proof of a cognitive learning process[3], while the decisions a woman takes to find a good birthing position are not recognised as a cognitive process. How is it that chimpanzees show a spark of intelligence by climbing on boxes, but a woman moving around during labour is simply 'following her animal instincts'?

Cry is a cry is a cry is a cry

The title of this section, 'Cry is a cry is a cry is a cry', is a paraphrasis of the American novelist Gertrude Stein's sentence 'Rose is a rose is a rose is a rose', part of her 1913 poem 'Sacred Emily' (Stein 1993). The sentence helps me introduce another example of stereotypical or implicit bias thinking in the case of a woman in labour: the interpretation of her cry. A labouring woman's cry is usually considered non-rational behaviour; a sign that she has lost control. However, it may be that a woman crying out at certain

[3]See Wolfgang Köhler's famous experiment using Gestalt theory, which, incidentally, he conducted in Tenerife, hence the bananas.

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stages during labour is being more rational – more *prudent*, in the Aristotelian sense – than we think. Ultimately, perhaps her cry is *premeditated*. After all, a woman in labour is not a being from another world; she is keenly aware that our culture interprets the heart-rending cry of a birthing woman as a paradigm for total loss of control. You only need watch the films. Consequently, in our context, many women think very carefully before releasing loud cries – not to mention that they may prefer not to be a nuisance, another typical learned reaction which demonstrates a certain medical socialisation. For these reasons it takes courage to emit the first cry, to try it out, see what happens and if it seems good to continue – 'good' of course, in relation to what is actually being attempted, i.e. giving birth. For it may simply be that a woman in labour *knows* her cry will help her, because she has *learned* that guttural sounds emitted from one's throat open the birth canal. There is a direct connection between the muscles of the throat and those of the pelvis – opera singers learn that controlling their pelvic floor helps them reach some of the highest or lowest notes. If this is the case, we will need to start admitting – as hard as it may be – that pregnant people may learn, in ante-natal classes or in conversations with friends, that crying out may help them. When the moment arrives, they try it out and it helps. And that is why they continue. They choose, test, evaluate, and confirm – pure method. Why are we so reluctant to acknowledge that what they do *is* rational?

Ludwig Wittgenstein explained that the meaning of a sign cannot be innately interpreted; rather, a sign needs the context of social practices to realise its meaning (Wittgenstein 2001). A quick explanation: the colour red does not mean anything without a context. It only means 'stop' when it appears in a traffic light under our driving law. A cry uttered during labour need not be any different. The cry is a sign of something. The patriarchal context interprets it as a lack of control, but the interpretative context may be different: we may interpret the sound as a way of maintaining the rhythm of breathing and working through the pain. Among humans, a cry or guttural sound can have many interpretations; it can be an order, a limit, a lament, a vindication, an impact, a mantra, or an expression of relief or pleasure, to mention a few. Why should the labouring cry not also be an *intentional* action that opens up an organ to facilitate entry to a unique existential space?[4]

Of course, there are contexts or moments in which the labouring woman's cry means something else – which is why it is so important to remember that the cry is a sign. The cry can, for example, signify that the birthing person is expressing her fear or anxiety, her complaint, or protest. Or it might be the way she asks for an epidural. There are even contexts in which the person crying out – the person learning to cry out – is the husband or partner, in a striking and emotional projection of empathy or solidarity. Reflecting on the phenomena of 'communal pushing' or empathetic sharing of cries during labour would introduce yet another rich perspective in our discourse (Quintero 2001; LaChance Adams and Burcher 2014; Cohen Shabot 2020).

There are other explanations/interpretations too. Further on during labour, a cry might cease being rational behaviour in the sense of being premeditated to connect a means to an end, or as a learnt resource. With luck, at a certain point during labour, behaviour which started for cultural reasons enters a distinct and interesting phase

[4]It is worth remembering here that labour pain does not necessarily mean that something is wrong, has to be amended, or healed.

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that I will refer to for simplicity's sake as physiological. Once a woman has tested the virtues of her cry; once she is confident of its value and has used it to transition to the next stage of labour, her scream might become something else, for example a tool for navigation or a – loud, yes – mantra for concentration. Then her cry signals that everything is going well; she feels safe to land on 'planet birth' – a notion that refers to women's descriptions of being or entering into another time zone, space, or even world during labour (Olza et al. 2020; Olza et al. 2018). In those contexts, screaming during labour is far from meaning that she is '*out* of herself', it rather means she is '*in* herself'.

Think of the sound that soldiers make on the battlefield. Initially battle cries may be chants designed to motivate, then shouts to encourage speed, later for focus, and finally, the sound of the enemy being targeted. We would not routinely consider soldiers as behaving irrationally when they let out this final cry; we would be more inclined to think of their final sound as fulfilling a function – an ppropriate means to achieve a desired end. Let us compare this with how easily in some contexts the birthing woman's sounds are taken to mean *just* one thing; that she has lost control and perhaps even her capacity.

Or consider the way in which in some cultures, the pain of grieving for lost loved ones is signified by silent behaviour when in public, while in other cultures mourning is accompanied by or even requires heart-breaking screams and loud wails. Why are we more inclined to think of (women's) birthing language as less cultural than, say, (men's) mourning language?

As humans, birthing people do the same things as, or similar things to, each other. However, the same – or similar – scream has different meanings depending on the prevailing culture, situation, lifestyle, language game, or worldview where we live, and who, where, when, and for what purpose the scream is uttered. The scream of the birthing woman is tuned into a specific culture and context and should be interpreted within both. We must challenge the univocity of birthing behaviour to allow different and better interpretations *in context*.

To reduce the multiplicity of meanings and application of labour sounds to a simplistic 'she does not have capacity' is a sign of patriarchy. We need to address the multiplicity of voices on childbirth, their autonomy, and agency, and we can advance knowledge in this area by using the feminist research frameworks of embodied philosophy to determine what works, for whom, and under which circumstances (Downe et al. 2018). In my view, the birth cry is one such *voice*.

This is what it means to say that the birthing woman's cry is a sign is a sign is a sign.

Epistemology of birth: a radically new meditation for philosophy

Some philosophers will dispute that my focus on birth can fundamentally challenge epistemology or even obstetrics. Perhaps they will grant that it may bring new knowledge, but only data that can be added to what they already know. This would be to misunderstand the origins of these disciplines. While this is not the place for a detailed account, I have thoroughly argued elsewhere that the presumption of women's irrationality is intertwined with the origin of obstetrics (Villarmea 2021a). Given this history, to take the birthing woman's guttural cry as rational and authoritative poses a radical challenge to the foundations of scientific inquiry.

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In contrast, feminist epistemologists have demonstrated how fundamentally our context impacts our claims to objectivity, rationality, capacity, and entitlement, along with the further practices that follow from them (Alcoff 2008). Sound knowledge requires an intricate analysis that is cognizant of the power dynamics that influence its conclusions. People's experiences of obstetric violence can spark such knowledge. I am reminded of a joke in the Monty Python's movie, *The Meaning of Life*. A woman is going into labor among several obstetricians who are more interested in 'the machine that goes ping' than in the woman herself. When she asks them, 'what do I do?', one doctors replies, 'nothing dear, you're not qualified'. My approach to the epistemology of birth brings about how the presumed unqualification, passivity, and irrationality of women and other people in labour leads to widespread obstetric violence – a variety of invasive, humiliating, and terrifying medical procedures. My above-mentioned question 'Is a woman in labour a subject with full rights in practice as well as in theory?' *ought* to be superfluous; but it is a very practical question indeed. The very survival of patriarchy itself is closely linked to a certain understanding of, and approach to, care during pregnancy, labour, and childbirth. Birth activists, scholars, practitioners, and policymakers provide ample evidence of the medical interventions which are undertaken against women's consent and knowledge. Although the World Health Organization and the United Nations have begun to acknowledge the existence of obstetric violence as a human rights violation, the issue remains largely invisible.

Our tradition does not quite enact the knowledge needed to understand the birthing mother-being born child dyad. That philosophy has so often taken death, instead of birth, as its existential foundation is related in no small part to the absence of women from the practice of philosophy. It is thus up to us, contemporary philosophers, to undertake a radically new meditation on birth, one that finally addresses the *logos* for *genos* displayed by the birthing subject's authority, agency, and autonomy.

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(3) '**Crossroads of the sexed body (ENCRUSEX)**' [PR27/21-020], Complutense University of Madrid; and

(4) International Platform on Obstetric Violence [**IPOV- Respectful Care**], EC HORIZON-MSCA-SE-2022.

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