Unnaturalizing bodies

An ethnographic inquiry into midwifery care in Germany

Skeide, A.

Publication date
2020

Document Version
Other version

License
Other

CHAPTER 1 — INTRODUCTION
UNNATURALIZING BODIES IN MIDWIFERY CARE

In Germany, the vast majority of pregnancies and births are attended to in obstetrician-gynecologist (ob-gyn) practices and in hospital-based obstetric units. Midwife-led prenatal and birth care in non-clinical environments is comparably marginal. In long-standing campaigns, midwives and their advocates promoted midwifery care practices and the 'normal physiological' pregnancies and births they foster. These efforts gave rise to two initiatives that were implemented in 2016 and in 2019: midwifery's denomination as Intangible Cultural Heritage and the legal consolidation of an academic education for midwives.

To the pride of many midwives I encountered during the fieldwork that lies at the basis of this dissertation, in 2016 midwifery joined the ranks of Germany's Nationwide Inventory of Intangible Cultural Heritage [*Immaterielles Weltkulturerbe*], after being promoted by several German midwifery associations and researchers as well as the German Commission for UNESCO (Deutscher Hebammenverband 2019).[1] Midwives' "fundamental medical, anatomical and obstetrical knowledge, which has been mediated for generations from midwife to midwife", has been assigned to two cultural heritage domains: Traditional Craftsmanship, and Knowledge and Practice Concerning Nature and the Universe (Deutsche UNESCO-Kommission 2019b).[2] As such, midwifery is conceptualized as a set of long-time, traditional cultural techniques engaging with 'nature' and, thereby, imbued with significance and qualified as worthy of protection.

As part of the UNESCO Cultural Heritage Inventory, midwifery joins a varied ensemble of human customs, expressions, representations, knowledge, and skills, together with their instruments, objects, artifacts, and cultural spaces

1 Intangible Cultural Heritage is meant to complement the material, tangible, and walkable UNESCO World Heritage Sites including, for example, the Bauhaus buildings in Dessau and Tel Aviv.

2 Other domains are Oral Traditions and Expressions; Performing Arts; and Social Practices, Rituals and Festive Events (Deutsche UNESCO-Kommission 2003).

(Deutsche UNESCO-Kommission 2003). Like other practices that have made it into the Nationwide Cultural Heritage Inventory of Germany, from playing the card game Skat to falconry, midwifery is "carried by human knowledge and skills. It is an expression of creativity, conveys continuity and identity, and shapes societies" (Deutsche UNESCO-Kommission 2019a). The German Commission for UNESCO's Cultural Heritage program thus presents midwifery as a nationally owned cultural good in need of measures to safeguard it against globalization and social change (Deutsche UNESCO-Kommission 2003).

Three years later, in November 2019, the academization of midwifery was legally consolidated, following the European Guideline 2005 / 36 / EG, which prescribes an academic education for midwives within the European Union (see Hebammenreformgesetz [HebRefG] 2019). Midwifery associations supported this reform and their representatives were involved in drafting the law. Midwifery's academization started officially in 2009 when the first professorship for midwifery science [*Hebammenwissenschaft*] was established, though the academic training of midwives will not be fully implemented until 2027. In this process, midwifery is becoming a science also in Germany, the last European country to take that step.

Midwifery associations and researchers hope that by producing scientific facts and establishing their own domain of credentialed knowledge midwives will be better able to assert themselves in relation to obstetricians and obstetrics, and to gain recognition, including through better remuneration. They recommend that midwifery-specific scientific evidence should promote physiological processes and attend to the psychosocial dimensions of caring for pregnant and childbearing women (Geppert-Orthofer et al. 2019; Bauer et al. 2018; zu Sayn-Wittgenstein 2007).

In its scientific version, midwifery allows pregnant and birthing bodies to just 'be,' that is, to unfold their innate biological potential while receiving heartfelt social care. Backed up by scientific evidence, midwifery releases 'naturally' pregnant and birthing bodies from the cold grip of technocratic obstetrics, which focuses on identifying and treating (potentially) pathological bodies and is responsible for unnecessary and risky interventions, such as routine electronic fetal monitoring and cesarean sections (Schäfers and Kolip 2015, 12–13; Zinsser, Stoll, and Gross 2016, 98).

These initiatives mobilize notions of nature in order to imbue midwifery care in Germany with cultural and scientific significance, premised on the notion that midwifery care practices are inherently 'good'. I share the interest

in preventing midwifery from eroding, but develop another strategy in this thesis (Mol, Moser, and Pols 2010a, 7). Instead of assuming we know what midwifery in Germany *is*, I conducted praxiographic fieldwork in hospitals, midwife-led birthing places, and people's homes to understand what midwives *do* (for praxiographic fieldwork, see Mol 2002; Mol and Law 2002; Mol, Moser, and Pols 2010b; Ceci, Pols, and Purkis 2017). I suggest that attending carefully to the specificities of midwifery care practices is necessary in order to strengthen midwifery.

Building on material semiotics (Haraway 1991a, 1991b, 1991c, 1997) and its use in feminist science and technology studies scholarship on care practices (Mol, Moser, and Pols 2010b; Moser 2011; Pols 2012), I analyze specific midwifery care arrangements as particular sets of relationships and techniques that are realized, and valued, by women, midwives, technologies, and fetuses. In this thesis, I *unnaturalize* bodies in midwifery care practices. Doing so, I not only evade repertoires that would naturalize these bodies, but I also suggest that they 'have never been natural' (see Latour 1993): Bodies in midwifery practices have not always been there, but are enacted in concrete midwifery care situations. When bodies acquire, adapt and innovate midwifery care techniques, they are enacted as open, flexible and yet assertive participants. Bodies become part of various, changing, and contradictory sets of values that come to matter in midwifery care arrangements.

These questions guide the following chapters:

- ☞ **What are midwifery care techniques?**
- ☞ **What do bodies become in midwifery care arrangements?**
- ☞ **How can 'good' midwifery care practices get strengthened in and through research?**

The answers to these questions are meant to foster midwifery through highlighting the "creativity" of midwifery care practices, as recognized by the Deutsche UNESCO-Kommission (2019a), that are directed at opening up and diversifying possibilities for how to live pregnancy and birth, in practical, political, and ethical terms. As each of the following chapters presents a specific facet of the main argument, in the format of a journal article, this introduction is the occasion to further situate my investigations into midwifery practices and the challenges, hopes, and concerns that are moving through

and shaping midwifery in Germany today. To contextualize this discussion, I provide an overview here of natural childbirth discourses that feed into wider public, political, and scientific debates around good pregnancy and birthing care, including the Cultural Heritage program and the scientification of midwifery in Germany. I then present my methodical approach to studying midwifery care practices and outline the following chapters.

Situating Midwifery Care Practices

"Contexting," or situating my research, is part of my endeavor to articulate midwifery care arrangements (Asdal and Moser 2012, 300; Law and Moser 2011, 333). The term "articulation" is drawn from Donna Haraway's material semiotics (1991a, 1991b, 1991c, 1997), and denotes the research strategy I pursue in this thesis: I identify influential discourses in order to reveal less visible or marginal realities. These realities are necessarily partial; they privilege certain actors, relationships, and effects while not examining others.

In situating my research, my aim is to build a trail through the thicket of discursive, social, and material conditions that together shape the midwifery care relationships I analyze. As is true with any field site, mine is situated in a specific environment. However, I do not treat particular geographical, historical, legal, social, and political 'structures' as determining or causal factors that explain what happens in a given care situation. Instead, I approach these contextual elements as realities-in-becoming, enacted in relation to the other elements that form part of midwifery care arrangements.

Countering 'Medicalization'

Pregnancy, birth, and postpartum care are fragmented in Germany, taking place in different surroundings, involving several obstetricians and midwives. The common path through the contemporary landscape of German pregnancy and birth healthcare starts with monthly, later biweekly, prenatal care provided by obstetrician-gynecologists (ob-gyns) in their practices.[3] It continues with childbirth and prenatal classes taught by midwives in facilities leased for that purpose. Birth takes place in a clinical labor ward,[4] accompanied by both midwives[5] and medical doctors. During the following days, nurses, midwives,

3 Some ob-gyns carry out the three ultrasound examinations only, delegating the usual prenatal care visits to midwives with whom they cooperate.

4 In 2017, approximately 98.7% of all newborns were born on a labor ward (Gesellschaft für Qualität in der außerklinischen Geburtshilfe [QUAG] 2019; Statistisches Bundesamt [Destatis] 2019).

and medical doctors take care of women and newborns on the maternity ward. From the third day on, a midwife does home visits to check on the woman's health and the child's development until twelve weeks after birth.[6] Six weeks after birth, woman and child return to the obstetrician, who does a follow-up examination.

This fragmented provision of perinatal care, assumed by a number of different care providers in various surroundings, is commonly understood as a consequence of what has become known as the medicalization of pregnancy and birth: the supposedly all-encompassing redefinition and treatment of pregnancy and birth in medical terms. The founding myth of this medicalization process follows a specific, historically based and gendered narrative, according to which pregnancy and birth had been integral elements of female life worlds and were appropriated, and redefined, by obstetricians. Pregnancies and births took place in homely environments, and were accompanied by other women, mid-wives, before, from the late eighteenth century on, they were taken over by male scientists working in institutions dedicated to that purpose: accouchement hospitals (Schlumbohm et al. 1998, 12; Schlumbohm 2012, 245). In and through these accouchement hospitals,[7] not only bodies but also mentalities have been subjected to medically defined normalities and risks, according to body historian Barbara Duden's (1998, 1991) wide-ranging exegeses of these transformations.[8]

However, not least because of the National Socialist regime's fervent endorsement of midwife-assisted homebirth for both economic and propagandistic reasons, homebirth continued to be rather the rule than the exception

5 Midwives are present during the vast majority of births in hospitals, including those done via cesarean sections. This is legally secured. Obstetricians are not allowed to accompany ('uncomplicated') births on their own, but are legally required to call in a midwife for birth (Hebammenreformgesetz (HebRefG) 2019, §4, 3). Midwives' right, and duty, to accompany every birth in Germany was introduced strategically as part of the so-called *Reichshebammengesetz* under the National Socialist regime in 1938. These policies expanded midwives' responsibilities and entitlements. They also made of midwives handmaids to the Nazis' racial hygiene program in particular and to their health and population policies in general, legally at least. According to the same law, only non-Jewish midwives were given this 'privilege' and Jewish midwives were forbidden to practice in Germany (see David, Dudenhausen, and Ebert 2019).

6 In the first twelve weeks after birth, up to sixteen home visits – daily visits in the first ten days after birth – by the midwife are covered by health insurance. The number of visits may be increased if ongoing breastfeeding support is needed and if complications occur.

7 According to Duden (1998, 151–53), accouchement hospitals were research and training institutions for obstetricians but also midwives in the eighteenth century, became aseptic and thus supposedly safe birthing environments in the nineteenth century, and turned into institutions of risk control in the twentieth century.

8 Many midwives in Germany are familiar with (and sympathetic to) Duden's understanding of these developments, as she has been one of the preferred guest speakers at midwifery symposiums, has published in German midwifery journals (such as the *Deutsche Hebammenzeitschrift*) for many years, and has been explicit about her sympathy for and support of midwives' cause.

until the 1950s, especially in rural parts of Germany. Changing family structures, an economic upswing, and euphoric faith in medical progress were the driving forces for births moving into the clinics in the 1960s (Schumann 2009, 33). By 1975, 99 percent of all births took place in hospitals, where perinatal medicine was more and more refined, eventually extending to prenatal diagnostics and institutionalized medical prenatal care. Midwives, who moved to the hospitals together with their 'clientele,' have been left with only responsibility for the postpartum care and breastfeeding support in domestic settings. Only some midwives still offer so-called extra-clinical prenatal care and birth assistance, often understood as an oppositional, non-medical niche within a medicalized pregnancy and birth care domain (see zu Sayn-Wittgenstein 2007, 19–21).

The prominence of medical surroundings for the provision of pregnancy and birth care in Germany has not changed much in the last fifty years: in 2017, half of the midwives were employed, part- or full-time, in hospitals, where they mostly worked in prenatal and maternity care units and on labor wards.[9] Of the midwives working independently, exclusively, or in combination with an institution, most provided postpartum care and some also give childbirth and antenatal classes. Very few of the independently working midwives also assisted births at home or in a midwife-led birthing center (Statista 2019). In these so called extra-clinical [*außerklinisch*] modes of care, women see obstetricians only a few times during pregnancy and after birth, and are mostly attended to by midwives; midwives accompany them throughout what is called a "care trajectory [*Betreuungsbogen*] of a life phase [*Lebensphase*]," compromising pregnancy, birth, postpartum, and breastfeeding phases (zu Sayn-Wittgenstein 2007, 24). Constantly rising costs of liability insurance—covering large compensation payments in case of negligent misconduct as cause of perinatal morbidity and mortality—comparably low wages, as well as the need to work nights, weekends, and holidays make non-clinical birth care an increasingly unattractive field of occupation (Albrecht et al. 2012, xviii–xxi).

Midwives working in hospitals also face challenging working conditions: Because of staff shortages, many of them are overloaded with work and must frequently work overtime. It is not unusual for one midwife to be in charge of

9 Compared to other medical professions, midwives have been and still are a rather small professional group in Germany. Approximatively 24,000 midwives were counted in 2017 (Statista 2019).

two or three births in parallel. This situation leads to proactive medical interventions, such as continuous fetal heart rate monitoring, and leaves midwives, for whom a one-to-one attendance has become a rare luxury, dissatisfied and exhausted (Schirmer and Steppat 2016; see also Albrecht et al. 2019, 245–48). Under these circumstances, midwife-led homebirth care is either idealized as a holistic and relation-oriented substitute to obstetric care, or it is dismissed as a risky, irresponsible and romanticized act.

Midwifery associations and midwifery researchers deem the denomination of midwifery as Cultural Heritage and the birth of a midwifery science as appropriate recognition that allows midwifery to step out of obstetrics' shadow and to reconquer their terrain of "physiological" pregnancy and birth care "without invasive [obstetric] interventions" (Stone 2012, 574). However, the claim of a culturally specific, historically stable, and 'pure' set of midwifery-specific knowledge and skills falls short of the practical realities as I argue in this thesis. In their research and care practices, midwives also 'do obstetrics': They use obstetric technologies to surveil pregnancies and birth, and they stick to obstetric standards, norms, and goals.[10] But midwives also expand and redefine obstetric repertoires and the norms established therein, thereby enacting obstetrical alternatives. Accordingly, assigning pregnant and birthing bodies to the physiological care of midwifery as opposed to their pathological counterparts in obstetrics is not helpful. Nor is assuming bodies to be pre-existing substrata for psychological and social (see Mol 2012, 5), or cultural influences. A midwifery science may help to strengthen midwifery if it attends to the alternative sets of normativities that come to matter in midwifery practices. Rather than taking pregnant and birthing bodies as objects whose physiologies—that is, their life and health—are given and indisputable facts (see Mol 2002, 172–73), represented neutrally by scientific evidence, the physical realities of pregnant and birthing bodies need to be opened up for self-reflexive[11] empirical analyses.

Before outlining the methodological underpinnings of such an approach, I present an overview of natural childbirth discourses that, intimately entangled with critiques of medicalization, have contributed to understanding

10 In Germany, midwives' and obstetricians' practices have been co-constitutive for more than 250 years: When providing prenatal and birth care, midwives use Leopold's maneuvers and fetal stethoscopes for diagnostics. Their eponyms, Christian Gerhard Leopold and Adolphe Pinard, were famous obstetricians in early twentieth-century Germany and France. Like many of their colleagues, they also taught their techniques to midwives (Hailer and Loytved 2015).

11 This 'self' is not a stable entity. Reflexivity is directed both towards the specific self that is reflecting and its particular position.

pregnant and birthing bodies as natural givens. These discourses and their repercussions have not only imbued and been coproduced by the UNESCO and midwifery scientification agendas, but are also part of wider, public, political, and scientific research and childbirth practices. Despite their historically and politically specific goals and ideals, natural childbirth programs have shared an idealist, atavist view that positions "natural childbirth" as a morally superior, seemingly lost past that can and must be revived.

Idealizing Natural Childbirth

In 1933, Grantly Dick-Read, the conceptual father of natural childbirth, British general practitioner, and obstetrician suggested that labor pain was the result of excessive obstetric interventions. What became widely known as the Dick-Read method in Europe and the United States was published under the title *Childbirth without Fear: Principles and Practice of Natural Childbirth* in 1942.[12] Dick-Read's philosophy of childbirth was pervaded by a Rousseauist understanding of nature as uncivilized and 'primitive,' and therefore pure and healthy, living environment and state of (human) being. His evangelical faith in nature as God's purposeful and essentially good creation also fed into his theory. Nature, Dick-Read (1961) announced, does not *intend* for birth to hurt, but the devastating maelstrom of civilization or "culture" (18), and especially "the science of obstetrics" (1–4), have overrun nature's good intentions and introduced fear, tension, and pain to childbirth. Most importantly, he argued, psychological childbirth education[13] may help to overcome fear, and eliminate (cervical) tension through physical and mental relaxation (Dick-Read 1961, 18). Continuous attendance while refraining from obstetric interventions such as anesthesia and forceps delivery[14] would help the cause of promoting "good midwifery," which is "the birth of a baby in a manner nearest to the natural law and design" (Dick-Read 1961, ix). "The natural reward of the physical achievement of pregnancy and parturition is not only a beloved possession," he declared, "but an endowment of spiritual force enhancing the receptivity of Divine guidance in motherhood" (Dick-Read 1961, 19). At the heart of

12 The British National Childbirth Trust, founded in 1956 and still the premier British institution for birth preparation and support during the first weeks and months after birth, is mainly inspired by Dick-Read's ideas, who also was its first president.

13 "Pregnancy and its physical and mental changes, the baby and its nourishment and growth, the preparation of mind and body to the natural experience of childbirth are all a sensible part of her education" (Dick-Read 1961, 12).

14 Forceps delivery is a method of so-called assisted birth. Obstetric forceps are large metal tongs, curved at the ends to fit the child's head so that the child can be pulled by an obstetrician.

this promise of salvation lay conservative, if not reactionary, pro-natalist and anti-feminist convictions. Those were widely propagated (not only) in Britain at the beginning of the twentieth century, which was marked by eugenic concerns tied to social criteria and declining birth rates, especially among educated, middle-income women, genetically and socially deemed as the best mothers (Moscucci 2003, 168–69).[15]

Similar motivations drove obstetrician Ferdinand Lamaze to introduce a birth preparation method he had witnessed[16] in the USSR to his home country of France in the 1950s. Apparently, Lamaze's missionary zeal did not lag behind Dick-Read's, and the Lamaze method, called "psychoprophylaxis" or "painless childbirth" [*l'accouchement sans douleur*], rapidly spread into other European countries—concurrent with and superseding Read's teachings—but also to North Africa, the Middle East and Latin America (Michaels 2014, 45).[17] Psychoprophylaxis was influenced by Ivan Pavlov's Nobel Prize-awarded insights into first animal and then human physiology, especially by what has become known as "classical conditioning," consisting of animal and human behavior modification via environmental stimuli. Also the psychoanalytic approach to women's psyches of Helen Deutsch, Sigmund Freud's disciple, fed into the Lamaze technique. According to Deutsch, painful births proved women's childhood traumata and indicated their personality disorders (Michaels 2014, 4–5).[18]

Initially, the Lamaze method was comprised of two pillars: "conscious relaxation and controlled breathing to manage the pain of contractions, avoiding the need for drugs" (Lothian 2011, 118).[19] Lamaze was convinced that these techniques were a matter of dedicated training and saw the causes of poor birth performances—screaming and restless behavior—as a lack of training and an overly intellectual tendency in some women (Kitzinger 2003, 203).

15 Dick-Read's teachings, especially the Fear-Tension-Pain Syndrome (or vicious circle), has been part of the teaching of many generations of midwives in Germany and inspires both their birth preparation courses as well as their attendance of births.

16 Interestingly, both, Dick-Read and Lamaze describe a moment of awakening during which they witnessed a woman giving birth in what they defend as the most natural way: without (legibly expressing) pain (Dick-Read 1961, 13). I read their 're-discovery of true nature' as a claim to the higher, irrefutable truth and goodness of their theories.

17 The Lamaze method is still internationally popular today and represented by the international childbirth education organization Lamaze International.

18 Both, the "Pavlovian neuropsychological and the Freudian psychosomatic" theories electrified not only Lamaze but generations of medical doctors in the beginning of the twentieth century (Michaels 2014, 4).

19 Today, breathing techniques are combined with other "comfort strategies" such as changing positions or moving. Other factors such as privacy; continuous support, especially by familiar people; or the waiving of routine interventions, including restrictions on moving or eating and drinking, have been integrated into the Lamaze program (Lothian 2011, 119–120).

Under the label of natural childbirth, Dick-Read and Lamaze, with the help of enthusiastic female supporters, developed detailed training programs built on the conviction that individual women's psyches were unruly, yet educable, actors in giving birth. A trained and thus focused—yet 'unthinking'—mind had the power to direct and discipline the natural body productively, namely in a way to render medical interventions, and especially pain medication, superfluous. Natural were bodies in childbearing that were, literally, self-disciplined and undemanding, so went their conviction. Birth attendants were meant to prepare for and to surveil women's disciplined birthing behavior, thereby preventing any potential derailment and need for medical intervention.[20] Dick-Read's and Lamaze's conceptions of natural bodies as given working objects sculpted by human ingenuity resonate with the UNESCO's understanding of nature, even though the UNESCO program conceives culture affirmatively while natural childbirth harbors inhabited cultural pessimist positions.

In the 1970s, natural childbirth was revived in the US civil liberties movements, backed up by second-wave feminism and its uptake in anthropological research (Ginsburg and Rapp 1991, 312). At that time, calls for natural childbirth were accompanied by a vehement promotion of homebirth and midwifery assistance as a means for making birth "humane" and "woman-centered" (DeVries et al. 2001, 245). Natural childbirth was more attached to feminism and consumerism[21] than to pronatalism and eugenics, medical historian Ornella Moscucci suggests (2003, 173). However, even though the natural childbirth movement and its "critique of industrialized labor" emerged under different historical, political, and social conditions, they built on the teachings of Dick-Read and Lamaze (Jones 2012, 100).[22] Women's psychological control over birth as a biologically inherent process, posited by Dick-Read's and Lamaze's methods, grew into a more comprehensive, namely definitional, control. While Dick-Read and Lamaze had overemphasized the importance of preparing for natural birth to happen, this notion was backgrounded in the 1970s version of natural childbirth. The concerns of this 'consumer protest' were taken up by anthropologists. Inspired by Michel Foucault's ([1975] 1979) work on disciplinary power,

20 This discipline was of 'higher,' namely national and civic, interest as it was needed to make many 'good' women give birth to many 'good' babies.

21 Freedom of choice and informed decision-making were important ideals when 'patients' became 'consumers'.

22 The circumstance that the natural childbirth movement attracted, along with feminists, also "members of the religious right," "back to nature types" and "pro-family crusaders" (DeVries et al. 2001, 245) is rather unsurprising considering its inspirational sources.

Melissa Cheyney (2008, 261) and Ann Oakley (1986, 276) denounced the overpowering social control exerted by, predominantly male, obstetrics. One of the US protagonists of these cultural criticisms, anthropologist Robbie Davis-Floyd (2003), exposed a technoscientific ritualization of pregnancy and birth deeply rooted in American cultural values. Female bodies were turned into "abnormal, unpredictable, and inherently defective" machines (Davis-Floyd 2003, 53; see also Martin 1987, 54) and obstetricians became considered "the unequivocal or sole experts in the birthplace" (Cheyney 2008, 265). Like many of her colleagues, Davis-Floyd (2003) praised the "holistic model of birth," which values "natural bodies" over "science and technology" and respects "the sanctity and safety" of people's own homes. In homebirth, "the whole of birth—its rhythms, its juiciness, its intense sexuality, fluidity, ecstasy, and pain" can be experienced (Davis-Floyd and Davis 1996, 239), an incantation that resonates with Dick-Read's (1961, 19) promise of a "natural reward of the physical achievement of pregnancy and parturition."

Since the 1970s, as birth practices became understood as socially and culturally constructed in much anthropological research (Mcclain 1975; Rothman 1982; Oakley 1986; Martin 1987; Wertz and Wertz 1989; Jordan 1993; Simonds, Rothman, and Norman 2007), the experience of birth was opened up for empirical investigation.[23] The idea was to liberate 'natural,' inherently 'good,' and 'female' birthing experiences from 'cultural,' inherently alienating and disruptive, and 'male' obstetric technologies (see Brubaker and Dillaway 2009, 35–38). Obviously, the arguments provided by the midwifery scientification initiative in Germany draw comprehensively on these strands of scholarly work.

Juxtaposing midwifery to obstetrics, these natural childbirth discourses conflate midwifery with nature, femininity and passiveness and obstetrics with technologies, masculinity and activeness. But accounting for specificities complicates the generalized condemnations of obstetric technologies and surroundings, and questions the unconditional praise of midwife-led homebirths. Not only have obstetricians themselves pioneered the 'de-medicalization' of childbirth, even if in favor of psychologizing childbirth, but also some birth givers have gratefully accepted pain medication while others refused to. Such specificities also undermine the thesis, endorsed by

23 In these works, the meanings of birth were not understood as products of singular, individual, and essentially female minds *only*, such as Dick-Read and Lamaze suggested, but as governed by culturally specific surroundings, professionals, technologies, convictions, and so forth.

the anthropological proponents of natural childbirth, that women—'patients' and midwives alike—are inextricably caught in the webs of a single overpowering obstetric discourse. Even though these criticisms have certainly, at least in part, been legitimate, they overlook that obstetrics and midwifery are not unities structured by coherent sets of norms. And they essentialize, and thereby patronize, pregnant and birth-giving subjects, reproducing what they criticize and set out to abolish. What if women have not learned to, could not, or did not wish to become 'natural' experts of pregnancy and birth? What if their idea of "holistic" birth includes supportive obstetric technologies?

Methodological Sensitivities and Methodical Realizations

Instead of praising 'good' midwifery practices and opposing them to 'bad' obstetric practices, I asked how and with which the effects midwives attended to pregnancies and births. When doing so, I was interested in specifying what midwifery practices' normative orientation was, towards which kinds of 'good' midwifery practices and their participants lived up. While doing so, I refrained from imposing ready-made definitions and solutions to problems that were evident to me, as an uninvolved and objective outsider, to my field of study. Such presumptions and positions are neither helpful for care nor for research practices, as chances are high that they miss the point: being involved in messy practical realities that are "finite and dirty, not transcendent and clean" (Haraway 2004, 236). Throughout this thesis, I analyze midwifery practices that are specific and local in order "to improve [midwifery] care in its own terms" (Mol 2008, 2; see also Pols 2003).

My analysis is inspired by a set of sensitivities and analytical tools coined "material semiotics" by feminist philosopher of science Donna Haraway (1991a, 1991b, 1991c), and elaborated by those who use it within feminist science and technology studies to study care practices in healthcare and other environments (see Mol, Moser, and Pols 2010b). Material semiotics takes the idea that words obtain meaning in relation to other words from the linguistic study of signs and extends it to material entities, such as bodies or (other) technologies. Haraway argues that matter and meaning are not separate. Bodies and flesh that have often been counted as 'nature,' and words and meanings that have been subsumed under 'culture' coproduce each other: bodily matter is constituted discursively-linguistically and meanings are

generated through bodies (Haraway 1991a, 163). Haraway (1991b, 200) suggests that scientifically known bodies are "material-semiotic generative nodes" whose boundaries are the effects of practices in which bodies themselves play "structuring and active" parts. As material-semiotic 'entities,' bodies are combinations of organisms and machines, thus exceeding not only natural but also 'human' realms (1991a, 151–52). Drawing bodies' boundaries are necessarily "risky" endeavors, because they produce lived realities (1991b, 201).

Under the umbrella of material semiotics, scholars have developed actor-network theory (ANT), which pays analytical attention to relations among materially heterogeneous participants, such as technologies, words, humans and their effects, and to how they bring about actors or objects. They have also developed ANT's approach to studying practices as situated events (Mol 2010, 260; Law and Mol 1995, 275–77). Empirical philosopher Annemarie Mol (2002, 31–33) calls for studying ethnographically, or rather "praxiographically," what "entities" might become, how this might happen, and the kinds of relations in which they are "enacted" *in practice*. As a result of this approach, realities, together with the materialities and normativities they are made of, multiply and become complex. Complex realities consist of various different, multiple, orders – rationales, repertoires, discourses, practices – that co-exist and interfere with each other (Mol and Law 2002, 7–10; see also Haraway 1991a, 1991b, 1991c).

Mol (2002) shows this in her praxiography of diagnosing and treating—as part of living with—atherosclerosis in a Dutch hospital. Atherosclerosis as a disease is enacted differently in different medical practices, for example surgical or laboratory, she argues. These multiple versions of atherosclerosis do not add up to a whole, but may co-exist side by side. They may also mutually include or interfere with enactments of other objects (Mol 2002, 151). Mol (1999, 75) urges considering the "ontological politics," that is, how realities—"the conditions of possibility we live with"—are shaped in medical and scientific practices, understood as reality-generating practices (Mol 2002, 153). What to do in medical practices can only be answered unsatisfactorily by clinical trials that naturalize the goals and norms (saving life, restoring health) guiding the answers to that pivotal question. Mol (2002, 174) declares that "what the good life might entail is … an essentially contested and thus a political issue."

Mol and other feminist science and technology studies researchers such as Jeannette Pols and Ingunn Moser, have studied (health)care practices together with their political and ethical normativities (Pols 2003, 2005;

Moser 2008, 2011; Mol 2008; Mol, Moser, and Pols 2010b). They argue that, in care practices, lives (and deaths) are shaped through attentively experimenting with what might work best in a specific situation. This involves needing to compromise between different, possibly conflicting 'goods' that are enacted as "intra-normativities" within care practices (Pols 2014, 177; 2015, 82). In her empirical ethics of care practices, Pols has also emphasized the important role of healthcare technologies—often staged as 'cold,' namely as instrumental and alienating 'others,' in opposition to social and thus 'warm' care relations—in shaping meaningful affective and aesthetic care relations (Pols and Moser 2009; Pols 2012, 25–44, 2017). Following Haraway, Pols (2017a, 2) has developed a situated philosophy of care technologies, arguing that technologies, together with other care participants, people, things, and words, "get their meaning, and ultimate function, in the way they are put to use." Her empirical ethical approach is 're-scriptive': the "material objects, methods, and techniques" used for shaping "goodness in daily life and care" (Pols 2015, 82) are analyzed by using specific methods and techniques that help to bring about or to articulate specific objects of research (Pols 2014, 179).

With these theoretical premises, I studied how particular midwifery techniques, involving different and related 'entities' such as technologies, words, people, or surroundings (that bring each other into being in specific ways), help to craft specific values or goods in midwifery care. I analyze what bodies-in-practice become in situated midwifery care arrangements, and develop a re-scriptive approach to articulate what good midwifery practices are, not in general, but in particular situations. I do so by using praxiographic material gathered through participant observation and semi-structured interviews in various sites where midwives in Germany work.

After having 'observingly participated' in specific prenatal, birth, and postpartum care situations, I conducted semi-structured interviews with midwives and women. Initiating the interviews with a question such as: "What happened when you [attended to someone who] gave birth?" allowed me to explore my interlocutors' understanding, and evaluation, of the situation. Answering this question, my interlocutors addressed the practicalities of the midwifery care events I had witnessed earlier: what was done, how, why / what for, and with which effects, thereby becoming their own praxiographers (see Mol 2002, 15). I brought my observations of midwifery practices and the accounts of my interviewees together when coding my material in the style suggested by grounded theorists (Strauss and Corbin 1991).

With the help of my codes, I compared and contrasted different midwifery care arrangements, what their participants do and become, and the values realized therein in order to analytically map out relevant and interesting aspects. These co-emerged from my research questions and my engagement in academic debates within the disciplines I situate this thesis in: midwifery, (medical) anthropology, and science and technology studies.

In the following chapters, I do not mention my interlocutors' socio-economic or ethnic affiliations, identifications, and realities, but only specify their gender[24] and / or profession. Refraining from analyzing how these categories, together with the differences and commonalities they create, were enacted in midwifery care is not meant to suggest their irrelevance but was a choice to limit the complexity of the argument. I focus instead on the particularity of midwifery care situations; the heterogeneous, embodied, technological, and discursive participants they configure; and the values they incorporate. Instead of generalizing them in order to say what midwifery is, I insist on attending to the details of midwifery practices, hoping to render them mobile, to make them usable to think with about similar or different midwifery practices in other places.

Research Position and Field

My study was situated in Germany, the country I have lived in for most of my life. Midwifery has actually accompanied me for a long time, as my grandmother was the head midwife of a private labor ward in the German Democratic Republic in the 1950s. This was one of the few labor wards in the newly founded socialist country that offered the Lamaze technique to a privileged clientele, and I grew up with a bunch of curious stories about that time of my grandmother's life, that, to my pleasure, she never tired of telling. In the beginning of 2000, I accompanied two independently working midwives in the south of France, where I lived at the time, mainly out of ethnographic curiosity.

24 As I articulate midwifery practices in which bodies are unnaturalized in this thesis, it might be surprising that I use the terms *woman* or *women* for denominating pregnant or childbearing people. Am I contradicting my own argument? The safest way to get rid of the biological essentialism (sex) and/or core experience (gender) along with their political implications (which may be roughly subsumed under exclusionary reductions of far more complex realities) is to do away with *woman* in favor of, hopefully, more open and more neutral terms such as *person*. However, taking midwives' emphasis on *women* as an alternative to *patients* into account, I have chosen to use these field terms. Even though this was not the focus of my analysis, I hope to show that in midwifery care *women* are enacted in various versions. However, this choice risks excluding people who cannot identify with *woman*, even in its queer—widely expanded, different, new and uncompromisingly situated—notions.

Then, following a voluntary internship in a small hospital in the south of Germany, I decided to become a midwife as well.

The empirical basis of my dissertation is mainly—but not exclusively, given my earlier interest and professional training in midwifery—the result of praxiographic fieldwork I did between February 2015 and March 2016 in various sites where midwives work, sites such as hospitals and homes, birthing places and ob-gyn practices. Instead of comparing midwifery practices in different countries, I contrasted practices in these different working sites and in different regions: northern and eastern Germany. Through participant observation, twenty semi-structured interviews with midwives and women, and many informal conversations, I 'gathered' empirical data not from an uninvolved outside, but as part of the sociomaterial worlds I was allowed to enter and with which I was already familiar to a certain extent. I followed midwives in their daily work and attended approximately fifty prenatal care visits, thirty births, and fifty home visits to women in the postpartum stage. In the hospital, I accompanied midwives during their morning and evening shifts on obstetric wards, during which they examined openings of cervixes (again and again), massaged sacra,[25] held umbilical cords for the partners to cut through, weighed babies, instructed women in breastfeeding, and documented for hours what they had done the hours before. I also accompanied the women giving birth and their partners (mothers, friends, siblings) during their stay on the labor ward, during which they moved among pre-labor and labor rooms, and sometimes operating rooms. In these spaces, they were engaged in being monitored, receiving medication, and undergoing cesarean sections, and were accompanied by several midwives and doctors. Independently working midwives took me to their prenatal care appointments and to births that took place in their midwife-led birthing places. They also took me to their prenatal and postpartum home visits as well as to their homebirth attendances. I was called in the middle of the night and told: "Hurry! The baby is on its way!" On one occasion, we left a home at five in the morning and were called to another three hours later. This allowed me to visit over one hundred homes in every part of the respective cities. I was also invited to visit people's homes in order to introduce myself and my research, and to talk about midwifery care attendance both informally and in interviews.

25 The sacrum is the large bone at the base of the spine. It often hurts badly when the head of the child descends into the pelvis.

Retrospectively, my research into midwifery practices and into vulnerable and intimate events, pregnancy, and birth benefitted from my position as a trained midwife and from what it afforded. It was not always easy when midwives expressed surprise or skepticism in response to my questions when I accompanied them in their work. When I asked why they did something, or how they would have handled this or that situation, they sometimes were very clear about how stupid or, worse, doubtful my questions sounded to them, retorting: "Well, isn't this what *we* do? How would *you* do it?" In these situations, I emphasized that I was interested in getting to know how *they* did things, because what *we* as midwives were familiar with—and what contrasting different midwifery care situations as crucial analytical strategy of my praxiographic research had quickly rendered obvious—was that there was usually more than one way of handling situations. This reply was mostly helpful. Many midwives would then respond: "Yes, and every situation is different as well," before then going into the details.

Introducing myself as a researcher studying midwifery practices who is also trained as a midwife, the common reaction from the side of the women and their partners, parents, siblings, and friends was reliably positive: "Another midwife? What a luxury!" When we met first, I explained that I wanted to find out what midwives actually did in their care practices, to discern what was specific about midwifery care through observing and interviewing. I explained that I would treat the data confidentially and anonymize the names of people and places, so that no conclusions could be drawn about their actual identities. I also pointed to the possibility that all participants, whether women, midwives, or partners, could withdraw their consent any time and without any need for justification, which never happened.

Being trained as a midwife, I was also obliged to take out insurance that covered the delicate situation, I was spared of luckily, in which I would have had to intervene because 'life and physical integrity of woman and child' would have been in danger. My position as a midwife researching midwifery practices thus rendered the "radical relationality" between me and what happened in my field strikingly present (Pols 2014).

On Situated Midwifery Care Practices: The Chapters

The **second chapter,** following this introduction, asks how homebirth midwifery practices may be conceived without juxtaposing them to obstetric practices. Homebirth arrangements are syncretic, more or less coherent combinations of various knowledge and skill repertoires, I argue. By means of routinizing and multiplying obstetric interventions, pregnancies and births are configured as physical, emotional, and social becomings. In the process of attending, homebirth bodies learn to co-respond to each other, to the midwifery techniques, and to the homebirth environment. This is necessary to make birth in this environment work. In addition, I suggest that a better, detailed understanding of how and why midwives and women invest in long-term engagements specific to homebirth surroundings could also inform clinical practices.

In **Chapter 3**, I introduce the concept of witnessing, so far mostly understood as legal, religious, or scientific practices, to describe modes of participation in midwifery care. Witnessing, I argue, helps to complicate common notions of intervention and non-intervention in midwifery practices by foregrounding the relationalities and interdependencies of the various participants. I explore how agency is distributed in midwifery care relations and describe witnessing as active-passive and distributed modes of co-participation in midwifery care arrangements. Describing the witnessing techniques of touching, trusting, and fetal heartbeat monitoring, I show that witnessing in midwifery care is necessarily ambiguous: it may help to make handling challenging pregnant and birthing bodies easier while also contributing to coproduce them.

In **Chapter 4**, I show how labor pains, which are thought not to reside easily with subjectivity and thus often evaded in childbirth discourses focusing on choice and control, take shape in women's and midwives' childbirth practices. Conceptualizing labor pain as both experiences and (enacted) actors, this chapter develops a practice-based notion of labor pains. Revealing an extensive repertoire of techniques used to deal with continuously shifting "actorships" of labor pains, I argue that these pains are creative sociomaterial experiences and (enacted) actors that are shared and worked with in childbirth practices. Experiences such as labor pains are not only passively known, felt, and done but also take an active part in shaping practice. I suggest that studying experiences in this way may help

STS-inspired practice approaches to understand better how care practices are constituted.

Chapter 5 investigates techniques of fetal heart rate monitoring as part of midwifery prenatal care practices. Comparing three different techniques, each of which involves a different tool for listening to what fetal heart sounds become, I show how relations are shaped that belong to a sensuous and material genre of affective appreciation I name "aesthetic." Particular orchestrations of prenatal care situations, kinds of "heartbeat music," versions of fetuses, as well as fetal well-beings emerge when fetal heart rates are surveilled. I argue that what counts as obstetrical fact cannot be separated from what the participants were moved by, what they held dear and found important. It seems important to consider which kinds of fetal heartbeat listening tools should be used in midwifery care arrangements, as they do not merely measure fetal heartbeats but co-shape fetal well-beings and how they may be related to.

In **Chapter 6**, I conclude by discussing the three interdependent shifts in studying midwifery care practices I have developed in this thesis. Starting from the understanding of medical and social genres as parts of one another, I show how I studied the values that come to matter in midwifery care. I emphasize that midwives and women do not act upon pre-existing and self-acting pregnant, fetal, or birthing bodies. Rather, they intervene in pregnant, fetal, and birthing lives. These conceptual shifts, this thesis concludes, may guide research on midwifery as well as teaching, learning, and evaluating midwifery care practices.