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### Unnaturalizing bodies

*An ethnographic inquiry into midwifery care in Germany*

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## CHAPTER 3 – WITNESSING IN PREGNANCY AND BIRTH ON CO-PARTICIPATION IN MIDWIFERY CARE<sup>43</sup>

### Abstract

In this chapter, I introduce the concept of witnessing, so far mostly understood in terms of 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 participants. This allows an exploration of how agency is distributed in midwifery care relations. I show how witnessing is active-passive and involves distributed modes of co-participation in midwifery care arrangements. Describing the witnessing techniques of touching, trusting and fetal heartbeat monitoring, I demonstrate that witnessing in midwifery care is necessarily ambiguous: it may help in handling dys-appearing pregnant and birthing bodies, while at the same time, contributes to their co-production.

<sup>43</sup> Originally published as: Skeide, A. (2017) Witnessing as an embodied strategy in midwifery care. In Krause, F.; Boldt, J. (eds.): Care in Healthcare. Reflections on Theory and Practice. Basingstoke: Palgrave Macmillan, 191-209. While I understood embodiment in phenomenological terms, namely “as a corporeal bounded,

interacting and interactive being-in-the-world” (Skeide 2017, 205) and described witnessing as different modes of human “being-with” in midwifery care in the original version of the paper, embodiments have become practical achievements of various participants in its revised version.

## Introduction

It was a dark night, heavy with silence. When I arrived at Lisa's home, Lisa lay on her bed and the midwife, Helene, sat cross-legged at its head. Helene appeared to be relaxed and highly concentrated at the same time. She smiled slightly when I arrived, but barely took her eyes off Lisa who did not seem to notice me at all. Lisa was lying on her side, breathing heavily. Every time Lisa had a contraction, she clutched the metallic bed-frame with her strong, muscular hands and the whole bed was shaken by the incredible tension of her muscles. She seemed to be in great pain: at the height of her labor pain she screamed deeply and desperately. Helene, meanwhile, remained silent and immovable. Her calm comforted and irritated me at the same time. How could she leave Lisa suffering without doing anything besides murmuring now and then that Lisa was doing very well? It seemed to be endless: silence, a throaty groaning swelling to a scream accompanied by metallic rattling and silence again. Then all of a sudden the midwife moved forward to take a look between Lisa's legs. She stayed next to Lisa, telling her to breathe shortly. Holding my breath, I noticed the baby's head appearing slowly. His slick and blueish body followed easily. Lisa took her child and lay down – she seemed exhausted but suddenly very present and relieved.

Lisa giving birth to her first child at her home was the first birth I witnessed. It was in a remote, rural and mountainous area in the South of France, where I lived at the time. I did an internship with midwife Helene and her colleague over several months, curious about their work as midwives providing home-birthing in a country where only one percent of all births take place outside hospitals. The two things that struck me most were Lisa's enormous effort and pain in giving birth to her child, and Helene's way of attending to it: she seemed to do nothing at all. She just sat there. On our way home, Helene explained to me, that, yes, Lisa had had especially strong contractions, but everything went fine on its own. She, Helene, did not have to do anything besides just being there.

I later recognized this ideal of non-intervention in midwifery practices during my training as a midwife in Germany, and again during my ethnographic fieldwork in hospitals, midwife-led birth places and people's homes, on which this paper draws. Regardless of the particular environment in

which midwives in Germany work, midwives emphasized the importance of intervening as little as possible, with no intervention whatsoever representing the best case scenario. However, what was understood as intervention or non-intervention differed greatly between different environments and care situations. In this paper, I argue that the opposition of intervention and non-intervention is not helpful to understanding how participation works in midwifery care are practices. In these practices, active / passive distinctions are blurred and action is distributed over several different participants, not only people, but also devices and surroundings. I instead suggest *witnessing* to describe active-passive and distributed modes of co-participation that characterize midwifery care. In contrast to common understandings of witnessing as a legal term that insists on an uninvolved observer accounting objectively and neutrally for what happened, I show how witnessing, in midwifery practices, is participative and creative. Witnesses co-shape or enact the events they testify, while also being co-shaped by them. My analysis is guided by two questions: How do witnessing practices shape midwifery care? What do pregnant and birthing bodies become in midwifery witnessing techniques?

At first view, witnessing seems to be inseparable from the legal sphere: A witness is called to court in order to testify. In the legal context the witness seems to be indispensable, because the witness who testifies is the *third person* (Lat. *terstis* = the third) who participated in the situation they are expected to bear witness about without being involved. Witnesses are the ones who *know* (old Engl. *witnes* = knowledge, understanding). In the quest to find just judgement, clear evidence furnished by a neutral and objective observer is required. An eye-witness is meant to furnish strong verbal evidence not only in juridical, but also in historic and religious contexts. But can a witness see and tell ‘the truth’? When being assigned the role of a witness and called to testify, a witness is not independent, neutral and objective (see Krämer 2011, 122–125; Schmidt 2011, 48–49). Witnesses can but account for situations they were involved in. Jewish and Christian martyrs (Grk. *martys* = witness) testify divine truth action as well as words (Drews and Schlie 2011, 7–21). Witnessing and testifying are practices aimed at constituting sense and orientation. They are based on trust (see Krämer 2011, 128; Schmidt 2011, 47–66): testifying includes trusting a witness who has to be self-conscious and responsible (Derrida 2005, 30, 40). Witnessing is thus epistemologically ambiguous: a witness is supposed to be the third, uninvolved and unrelated, and hence neutral, observer. But witnesses are expected to testify for events

they *form part of*, which they are co-shaped by and which they co-shape. Donna Haraway (2004, 223) also questions this understanding of the witness by examining scientific practices that strive for objectivity through making the reliable, “modest” witness invisible and disembodied. She calls for a “more adequate, self-critical technoscience committed to situated knowledges” (233) which are “finite and dirty, not transcendent and clean” (236).

Yet witnessing is not only done in courts, scientific experiments and research papers. It is also done in midwifery care practices. I introduce the concept of witnessing to midwifery care practices in order to better understand how midwives and women co-participate in these practices and to hint at the complexities of witnessing in care practices.

### Methodical Approach

The midwifery witnessing practices I present here are mainly based on material I ‘gathered’ during ethnographic fieldwork in midwife-led birthplaces, hospitals and families’ homes in Germany between February 2015 and March 2016. Next to participant observation or, as I am neither a neutral nor an objective observer either, co-participation I conducted twenty guided interviews with women and midwives, alongside many valuable informal conversations. I did fieldwork and data analysis in parallel, and conceptualized the data by coding and memo writing according to the theoretical sampling, processes proposed by grounded theorists (Charmaz 2006; Strauss 1987). My analysis is underpinned by material semiotic and actor-network theory tools. Particularly influential to my approach to midwifery witnessing practices, are Madeleine Akrich and Bernike Pasveer’s (2004) study of how selves and bodies are performed in women’s childbirth narratives, as well as Charis Thompson’s (2005) analysis of how women interact with assisted reproductive technologies. Following Akrich and Pasveer (2004, 64), I do not understand bodies as pre-existent and coherent entities underlying subjective experiences, but am interested in what pregnant and birthing bodies become in relation to (equally unstable) selves, midwives, technologies and surroundings. This follows onto my interest in how action is distributed over various participants in a situation of midwifery care. In line with Thompson (2005, 180), I depart from the notion that objectifications of pregnant or birthing bodies—whether through medical technologies, through midwives’ observation, or through labor

pains—are not necessarily incompatible with agency. Engaging with (occasional and partial) objectifications may also serve as pragmatic strategies in order to achieve ‘higher’ goals.

## Witnessing as Co-participative Midwifery Practices

The supposedly non-interventionist position of the midwife during Lisa’s birth, illustrates the ideal of the knitting midwife. This is an ideal shared with many midwives in Germany, especially with those who work in extra-clinical environments. Knitting, a craftwork that has been understood as a female occupation located in private spheres, helps to mark the birthing environment as female and private instead of male and clinical. During homebirth, the knitting midwife seems to just be there, having all the time in the world and doing nothing apart from sitting and knitting, thereby occupying her skillful hands. These skillful hands are all the midwife needs to attend to birth. Both the English term *midwife*, which literally signifies *woman who is with*, and the French term *sage-femme*, meaning *wise woman*, suggest the female, passive, and knowing, presence evoked by the image of the knitting midwife. The German term *Hebamme* resonates with these meanings even though it has a more practical-active connotation: the *ancestor / grandmother who lifts the child* (during birth). Wisdom, commonly attributed to the elder wealthy in experience, consists of practical know-how. The practical engagement is, however, limited to the very last phase of birth. The midwife / *sage-femme* / *Hebamme* does little because she knows a lot, or so the idea goes.

The knitting midwife, however, is not as passive and naturally knowledgeable as it may seem. Sitting and knitting are activities that create space for observing, listening, smelling, speaking, and feeling, and can be interrupted at any time in order to lend a hand. Deciding if and when this is necessary, is crucial, and can only be realized through active assessment. The knitting midwife is thus not just there, doing nothing, but is active-passive. The knitting midwife is also not alone or independent from that which happens around her. The homebirth environment and the woman giving birth co-enact a knitting midwife, tasking her to behave in certain ways. During Lisa’s homebirth, for example, Helene was there to attend to Lisa’s birth in her, Lisa’s home. That also meant that Helene did not have to attend to several women at once, which is common in clinical surroundings. She did not have to follow clinical standards

such as, for example doing regular vaginal examinations in order to determine and document the progress. Lisa was all by herself, not tasking the midwife to intervene, to validate or interpret her bodily functions. Helene's position of a knitting midwife is thus situated in a specific arrangement, which helps to bring about this seemingly non-interventionist and knitting position.

In other arrangements, this ideal of just being passively present may not work out at all. The midwife might not have the occasion to sit and knit, if what midwives in my field called "an overly rational [*kopfgesteuert*]" woman-in-labor was not able to "let her body guide her," to handle her body in a way that allows the midwife to stay seemingly passive. In consequence, active participation of the midwife and obstetrical technologies may become necessary. I argue that situations, in which the stereotype of an overly rational woman-in-labor are used to explain what happens or has happened, can be better understood if analyzed in relational and situational terms.

How midwives and women participate in a homebirth care situation and which kinds of activities become necessary in order to make birth happen, is part of a contractual co-participation. (Passive) Actions need to be coordinated and are subjected to specific rules, as Katharina's homebirth shows:

Anna, a young self-employed midwife, tells me about Katharina, who, as Anna says, had been quite exhausting to attend to during her first birth. To start with, Katharina called her "every five minutes" when she thought that labor set in. It was in the middle of the night. Anna could tell, hearing Katharina's voice that she had only light contractions, "nothing serious", but nonetheless decided to check on Katharina. When Anna got there, she examined Katharina vaginally and found that she "was only at two centimeters."<sup>44</sup> During the then following hours, Anna had the impression that Katharina "was not in possession of herself [*nicht bei sich war*]" but tried to "crawl into [*hineinkriechen*]" Anna, as Anna put it. Anna felt like Katharina "wanted to get it done" by her, the midwife. "But that," Anna explains, "is impossible. I cannot give birth in a woman's place."

Surprised by the intensity of her labor pains, Katharina needed more than a knitting midwife's presence, however active she might have been. Katharina

44 Uterine contractions lead to a progressive opening of the cervix from one to ten centimeters during birth. The first three centimeters of opening take quite a long time – especially

if the woman is giving birth for the first time – and this phase is significantly called the latent phase and not considered as the active phase of labor.

appealed to Anna to manage the labor pains, which Anna described as Katharina not having been “in possession” of herself but instead trying to “crawl into,” or give her body over to her, Anna. This situation hints at the limits of the homebirth ideal of the active-passive witnessing of a knitting midwife. Yet the stereotype of excessive rationality also doesn’t help in understanding what was happening. According to Katharina, Anna was not overly mastering her “body-in-labour” (Akrich and Pasveer 2004, 66), but was overwhelmed by it. That, however, is no option in homebirth settings, where women are expected to deal with labor pains that can be pharmacologically eased to only a limited extent. Both Katharina and midwife Anna seem to be taken by surprise as Katharina’s body-in-labor-pain emerges. Who may deal with this body-in-labor-pain and how exactly, is negotiable only to certain limits, as Anna emphasizes. Where Anna is neither able to remove the pain (completely) nor handle Katharina’s body in her place, Katharina cannot escape from her body but must assume it. Katharina has to take her part by handling the labor pains, using the tools and techniques at hand in the homebirth surrounding, so that Anna can fulfil her professional part, by accompanying and supporting her. If this contractual co-participation does not work out, Katharina needs to leave for the hospital. This is exactly what happened, several hours after Anna had arrived at Katharina’s home. In the hospital, Katharina was given an epidural anesthesia which allowed her to take some distance to her then less hurtful body-in-labor-pain.

As Lisa and Katharina’s homebirths show, the ideal of the knitting midwife is related to a fixed set of conditions. In contrast to what is suggested by the ideal of the knitting midwife, there are many (professional) activities undertaken in attending homebirths. Furthermore, the knitting midwife is not just there, but is brought about in and by the homely environment, and enacted through contractual cooperation between woman and midwife. Next to the midwife, the woman also needs to actively engage in dealing with the homebirth situation and her body-in-labor-pain, in order to realize homebirth. The stereotype of the overly rational woman-in-labor does not help to understand the relational character of midwifery attendance and its participants. Neither the stereotype of the overly rational woman-in-labor, nor the idea of bodies as natural guides in labor, are helpful in understanding the relational character of midwifery attendance and its participants. Dichotomizing the overthinking mind and the intuitively doing body misses the diversity of relations possible within midwifery care. During Katharina’s birth, the midwife may have helped



as a guide, but this is possible only if Katharina fulfils her obligation to assume her body-in-labor-pain in ways that fit the homebirth surrounding.

Instead of understanding midwifery practices as non-intervening, I introduce the concept of *witnessing* in order to describe different modes of participation in midwifery care. Witnessing describes sets of sociomaterial and co-participatory midwifery practices in which action is distributed and active and passive participation are blurred.

### Witnessing Dys-appearing Bodies

In less urgent and less surprising events than that of Anna's homebirth, witnessing in midwifery practices consists of cooperative strategies for dealing actively with uncertainties and difficulties around handling pregnant and birthing bodies. Challenging pregnant and birthing bodies may thus become manageable. This is suggested in the strategy of Eli and her midwife Nina:

Three days after her expected delivery date, Eli has an appointment with midwife Nina in the early morning. She arrives crimson red and snorting, obviously suffering from her big belly. "I'm in such a bad mood." Eli sits down straddle-legged, face-to-face with Nina who looks at her attentively. Eli gave several false alarms the days before because she thought labor had started. "I can't sleep, I have cramps and my back hurts. I have been ill for nine months. This child has to come now!" Nina asks Eli when she wants her child to come. "Tomorrow." she answers. "What time?" "In the morning." This would be doable with her schedule, too, the midwife says and Eli leaves apparently relieved.

Phenomenologist Drew Leder (1990) explains that a usually "absent body," a body of daily life that usually disappears, may manifest itself in a difficult or disharmonious way; in dysfunction, an absent body can dys-appear. When this happens, both a body and a situation may seem dysfunctional or even alienating. While I would not suggest that bodies are usually absent, the stories of Anna's homebirth and Eli's prenatal care visit demonstrate that pregnant and birthing bodies may indeed dys-appear. In these situations it is not Anna's and Eli's minds and rationalities that take over and prevent their bodies from acting intuitively. Rather, their dys-appearing bodies dominate events and turn out to be difficult, if not impossible, to tame. Nonetheless,

Eli's prenatal care visit involves a strategy to counteract the challenges that midwives and women might face when dealing with pregnant and birthing bodies that are difficult to handle because they hurt or render sleep and rest impossible. Midwife Nina acknowledges Eli's pain and anger. She takes up Eli's wish to give birth and concretizes it. Nina invites Eli to participate in making plans for the child to be born the next morning, thus ending Eli's straining pregnancy. Taking this decision together already seems to help in handling an overly imposing body, through reassurance that it will soon be over and the midwife's co-operation with Eli to make that reassurance reality. The idea is not to master or to discipline the dys-appearing body but to attribute agency to Eli so that she may actively handle her body in ways that render her discomfort livable. This is a co-operative endeavor in which both, Nina and Eli (must) engage.

During Melanie's prenatal care visit this witnessing strategy also takes effect:

At the end of their prenatal care visit, Melanie asks her midwife, Agnes, if it was "normal" that she was having frequent headaches since becoming pregnant. Instead of answering her question Agnes asks her what helped her when she had these headaches. "Lemon oil." she answers. "Well, it's great that you found something which helps you."

Asking midwife Agnes if her headaches would be a "normal" side-effect of pregnancy, Melanie expresses her need for support. Instead of classifying Melanie's dys-appearing pregnant body as normal or not, Agnes foregrounds the importance of finding and adapting strategies to deal with it. Melanie has indeed found something that eases her headaches and is compatible with her pregnancy. Agnes encourages her to do so, to find her own strategies and tools to counteract her dys-appearing body. Midwife Agnes and Melanie co-participate in foregrounding self-help strategies.

As Anna's homebirth story has already shown, witnessing in midwifery care practices can also be an ambiguous endeavor as it may contribute to objectifying a body-in-labor. Witnessing may also produce a dys-appearing body. The following story about Samia giving birth to her second child in the hospital, makes this clear:

I had witnessed Samia giving birth and was able to follow up with an interview about what happened. It was a lengthy process that, after labor

had been induced pharmacologically, took several days and nights. In our interview Samia tells me that she felt “completely unmasked [*blankgezo-gen*]” during birth because she “really had to do acrobatics [*Zirkus*] there.” In the end, the practices her and the birthing team engaged would, in her words, have been “the only way to make it work,” to give birth “to a healthy child”, “in the best and normal way [vaginally].” She said that her head had been turned off and she “simply did” what she “had been told,” knowing she was in the midwives’ “good hands.” She smiles: “And in the end comes the child.”

Samia describes her birth as an event she was distanced from. She qualifies herself and her body as having been at the mercy of the event, giving birth, and of how it was enacted in the labor ward. In order to give birth “to a healthy child,” Samia needed “to do acrobatics”. Giving birth, she became part of a spectacle of which she was main protagonist. Not a self-determined protagonist, but one that did as told, as she puts it. With parallels to Anna giving birth at her home, Samia’s birth story shows that in clinical labor wards, women also have to cooperate to make giving birth work. In the hospital where epidural anesthesia and cesarean sections are at one’s disposal and often thought of as interventions that relieve women from active participation, Samia needs to actively engage in what is offered to make birth happen. During Samia’s birth these ‘offers’ were frequent vaginal examinations but also instructions to take various positions “in order to help the child descend,” as Samia explained. She needed to change between standing, taking a crawling position, kneeling, taking one leg up and then the other and, finally, lying on her back with her legs in two leg holders.

Samia describes the ambiguity of her body being guided by ‘others,’ authoritative experts with whom, however, she shares the goal of giving birth “to a healthy child” vaginally. Having felt “unmasked,” as she puts it, Samia expresses shame about being exposed. She felt naked and was powerless to escape the situation but needed to go along with it. What she describes as her experience of birth seems to be similar to Jean Paul Sartre’s *regard d’autrui*, the look of the other, which has objectifying and alienating effects (see Sartre 1982).<sup>45</sup> Following Sartre’s concept, this objectifying mode of co-participation

45 However, Sartre’s experience as a public intellectual in Second World War and post-war Paris were certainly very different from

Samia’s experience as a birth-giver in a hospital in Germany in the beginning of the 21st century.

could be described in terms of eye-witnessing. Samia's body dys-appears through being objectified as a tool that needs to be used in specific ways in order to give birth "to a healthy child." However, Samia also emphasizes that this was "the only way to make giving birth to a healthy child work," and that even though she found it demanding and shaming to engage in the procedure, she felt to be "in good hands." Samia thus makes clear that she shares the final goal of these objectifying procedures. Even though these procedures are not easy to go along with, they are means to a 'higher good': "And in the end comes the child." The objectification of her body-in-labor-pain that Samia actively coproduces thus does not lead to an existential strangeness. Instead it may be understood as a certainly unpleasant, but also successful, part of her active involvement in making birth work (Akrich and Pasveer 2004, 72-73).

### Sociomaterial Witnessing Techniques

Bodies-in-labor take shape through a plethora of professional midwifery activities such as observing and listening, touching and treating. Examinations for surveilling the course of birth or the well-being of a fetus are also performed with the help of intimate touches: vaginal examinations. They serve to determine if birth progresses regularly through measuring the opening of the cervix and the position of the child's head (or buttocks) in the pelvis. In pregnancy, abdominal palpations, called Leopold maneuvers, are performed to determine the position and growth of the child, and the amount of amniotic fluid.

These touches can be realized in different ways and serve several purposes. Palpations of a pregnant belly may be done silently and routinely, concluded with the comment: "Everything is okay." Or they may be accompanied by many significant words. Abdominal palpations not only help to surveille but are also a means to create a contact between woman, midwife and fetus. For example, midwife Anna while touching a woman's belly addresses the fetus: "Hello child, how are you today? Oh, you are awake? This is usually not your time, is it?" and to the woman: "For how long has she been awake already?" However explicit or tacit, these abdominal palpations also always lead to a diagnostic result. They are testifying that there is a fetus in this belly that this fetus is alive and, in later weeks of pregnancy, they also testify the position of a fetus-in-a-belly. However, the testimonials created by palpations are not only of medical and legal relevance. They also create sociomaterial identities and

relations. Next to getting in contact, midwives also testify to a certain character of “a child.” If a fetus kicks, it may be characterized as “lively.” Fetuses that sleep may become “calm children.” Fetuses are also gendered through touches and words and emerge as “shy girl” or “strong boy.”

Palpating a fetus-in-a-belly is a technique of witnessing in midwifery practices which is active-passive and co-participative. Depending on how it is done and what for (explicitly and implicitly), it grants fetuses and pregnant or birthing selves more or less agency. If midwives stick to describing how they touch or where they feel instead of characterizing or gendering “a child,” what a fetus is or becomes for whom, is left more open. A fetus thus has more possibilities to act and to participate. The same applies to pregnant women who are allowed to describe what and how they feel through sensing the fetus’ movements in their belly before or during the midwife’s abdominal palpations, and who are guided to touch and to feel their belly with their own hands.

Touching may also help to handle a dys-appearing birthing body, as the following story shows. When Jasmin gives birth to her first child in a midwife-led birthplace, she experiences a frightening complication and asks midwife Barbara to caress her and to breathe with her in order to help her to reconnect to her dys-appearing body-in-labor-pain:

As I arrive, Jasmin walks through the room, while a friend of her’s and midwife Barbara sit on chairs and watch Jasmin making her rounds, stopping at every contraction to take deep breaths. Barbara encourages Jasmin after each contraction: “Great! You are doing great!” Then Jasmin screams: “I feel a pressing pain [*drückenden Schmerz*]! It does not stop.” Barbara grabs the Doptone to listen to fetal heart beats. As the heart sounds are slow and become slower and slower, she administers Jasmin a so called tocolytic drug to ease the contractions and to help the child’s heart to regain its rhythm. This is a matter of two minutes, after which Jasmin sits down on the bed, trembling and pale as a sheet. She turns to Barbara: “That was frightening! Could you hold me? Could you breathe with me?” Barbara sits next to her and Jasmin falls into her arms, crying.

Similar to Katharina, Jasmin felt alienated and even threatened by her body-in-labor-pain to the point that she felt dissociated from her body. Both, Katharina and Jasmin turn to their midwives to mediate between their bodies-in-labor-pain and themselves. After ‘objectively’ confirming

Jasmin's feeling of an endless "pressing pain" by measuring slow fetal heartbeats that prove what Jasmin feels, midwife Barbara uses a tocolysis in order to 'tame' Jasmin's body. However, even though the contractions are eased and the child's heartbeats have gone back to normal, Jasmin cannot reconnect to her body. She asks Barbara to help her to *re-corporate* by caressing her and breathing with her. In this witnessing situation, besides the fetal heartbeat monitoring and administration of tocolysis, the midwife's touching is another technique that helps to reassure Samia and trust her body-in-labor-pain.

Intimacy and trust are effects of sociomaterial witnessing relationships in midwifery care. But intimacy and trust are not only brought about in midwifery techniques that afford physical closeness such as touching. Trusting may become a witnessing technique in itself, on that can interfere with other techniques, such as touching. Trusting makes touching easier, more pleasurable and also more efficient (in diagnosing and contacting). Trusting interferes with (potentially) objectifying examinations. It may render them less 'objectifying,' less shameful and alienating. This is what I learned, for example, from Helma:

Helma gave birth to her first child at the birthing place where midwife Jana works and Jana again accompanied the birth of her second child at home. When I ask Helma about how her and Jana's cooperation would look like, she says that she trusts 'her' midwife "fundamentally." "And what does your midwife do exactly?" I ask. It is rather about what Helma herself does in order to establish and maintain a trustful relationship, as she explains: "I open up completely. I didn't have any problems with that from when Jana started to accompany me during my first pregnancy onwards. You lay down and are examined [vaginally]. Somehow, this is the most normal thing in the world. And that, I think, is so nice."

Helma describes how trustful relationships help her to "open up completely" relating to the midwife in the context of intimate physical examinations. Being examined vaginally thus becomes "the most normal thing in the world". The trustful relationship is "nice" because it allows intimate and (potentially) shameful examinations to become routines, "the most normal thing in the world." Helma's own active participation is pivotal to making this happen. Helma stresses that it is she who opens up completely in her relationship with midwife Jana. Samia described it very similarly: "I would say the head was turned off, one simply did what was said, because then one

had confidence, too, and one knew to be in good hands, and at the end comes the child.” Trust is thus established in co-participative practices. It helps to hand over responsibility and authority to the midwife without, however, ‘losing one’s face’ but still actively participating and recognizably co-shaping the event. Like Samia, Helma shares the same goals with ‘her midwife’: giving birth to her child in this particular environment. Trusting helps the cause. Dörte, who was also accompanied by midwife Jana when she gave birth at home, emphasizes the importance of building trustful relationships with Jana, her attendance techniques and the homebirth environment:

“For this period I can build up a very intensive relationship, not only in prenatal and postnatal care but also during birth. You can let yourself go and be intimate, and, nevertheless, work professionally with each other. This extreme opening-up-to-each-other [*sich aufeinander einlassen zu können*] and just letting yourself go [*sich fallen zu lassen*], I still find quite impressive. It starts with being able to say everything that comes into your head without feeling embarrassed. [...] This is definitely special.”

As well as Samia and Helma, Dörte describes “extreme opening-up-to-each-other” and “letting yourself go” as the required strategies of working “professionally” with midwife Jana. Exposing one’s body and one’s life seems inevitable in the homebirth care relationship. A trustful relationship for Dörte is one that allows her to not feel embarrassed or exposed because she can rely on being taken seriously in what she is concerned with, no matter how ordinary or ‘strange’ it might be. Dörte explains that she can speak to her midwife about difficulties in the relationship with her husband, without worrying that midwife Jana would “develop an opinion” about her husband in the same way in which her friends or family members probably would. Dörte calls it getting Jana’s “objective gaze [*den objektiven Blick*]”: Jana is involved and concerned without making judgments and taking sides. Differently from the Foucauldian “medical gaze” situating a disease inside a body (Foucault [1963] 2003, 9-10), Jana’s “objective gaze” is both, intimate and concerned while also respectfully distant, situating Dörte’s body into an everyday life. Intimacy and distance, which may result from objectification, can co-exist in the witnessing relation Dörte describes. Dörte also makes clear that witnessing means to take part in an intimate situation without being durably involved. As it is a professional relationship, it is temporally limited and tied to specific situations.

Finally, I would like to show more explicitly, how technical devices produce powerful testimonials in midwifery care. These are, for example, devices used for fetal heartbeat monitoring in pregnancy and birth. One such device is the cardiotocograph (CTG). The CTG records fetal heart sounds and uterine contractions. While recording, it produces the fetal heartbeat sonically through two curves on a paper script that are read and interpreted as fetal heartbeats and maternal contractions.

In hospitals, CTGs are usually placed on trolleys next to the head side of a bed. As the transducers which are attached to a woman's belly are linked to the device via cables, women have to stay close and cannot move freely. Cardiotocography indeed works best if women move as little as possible. For births in clinical settings, CTGs are used regularly towards the end of birth, and often already in earlier stages, or continuously throughout birth. In midwife-led birthplaces or women's homes, CTGs are rarely used. They are replaced by much smaller, handheld Doppler fetal monitors, called Doptones, or by wooden ear trumpets called Pinard horns. The rare occasion in which CTGs are also used in birthplaces or people's homes occur when the expected due date has been transgressed. In these cases, CTGs need to be done every second day for at least twenty minutes in order to check the 'wellbeing' of the fetus. One of these homebirth cardiotocographies took place during midwife Agnes' prenatal care visit at Ruth's home:

Ruth has given birth to two of her three children at home, together with midwife Agnes. All three children were born earlier than expected but this fourth one seems to take its time. As the birth date passed a week ago, Agnes visits Ruth regularly to "write a CTG", registering the fetal heartbeats in order to verify whether the baby is still going well. While Ruth is lying down on her sofa, Agnes installs the device and kneels on the floor in front of the sofa. She looks at Ruth and then at me: "I will register for ten minutes only. It is no more than a snapshot anyway." Agnes fixes the transducer on Ruth's belly with the help of two rubber straps and turns the device on.

The CTG produces durable testimonials. These CTG scripts, fabricated to prove the fetus' well-being, serve as both medical and legal testimonials for an adequate attendance (consisting of assuring fetal health in a situation that is obstetrically classified as risky). As the CTG curves need to be produced,



read and interpreted, it may seem that they are an addition to other witnessing techniques. However, the CTG witnesses and testifies in a way that Agnes cannot. The testimonial the CTG produces is durably material and undoubtedly objective. The CTG script seems thus to compete with midwife Agnes' witnessing position but also with Ruth's. Agnes and Ruth actively co-participate in producing the script, and adapt the "CTG writing" as Agnes calls it, to their needs. This means that they do not monitor during the recommended twenty minutes but limit it to ten minutes only: "It is no more than a snapshot anyway." Agnes makes clear that she does not believe in the significance that is attributed to CTG scripts in obstetric surroundings. The curves on a script that supposedly testify the fetus' well-being may be durable and objective, but what they show is no more than a situation in a certain moment in time, according to Agnes. The "snapshot" cannot see into the future; the situation may change any time and without notice. She "writes the CTG" because she has to, not because she thinks it is worthwhile.

CTGs have a very different position and function in the hospital. Here, the CTG testimonials do not function just to monitor, but also serve to organize and structure the care work. On the one hand, the CTG can continually witness and testify, thereby allowing midwives to be present only intermittently and to attend to several births at the same time. On the other hand, the CTG curves make it possible for several different midwives (and doctors) to attend to one birth, which is the case in hospitals where staff works in shifts.

## Conclusion: Witnessing Arrangements in Midwifery Care

In midwifery care attendance, midwives and women co-participate in and co-shape the events by which they themselves are also co-shaped. I introduced the concept of witnessing as an alternative to common oppositions between the notion of intervention and non-intervention. Contrary to the ideal of the non-intervening knitting midwife, midwives are as much embedded in the care relations that they co-shape, as the other human and technological participants. Accordingly, I argued, the stereotype of the overly rational, head-led woman in labor who is not able to let her body guide her, misses the point. Such a characterization is unhelpful in understanding what happens in situations in which pregnant or birthing bodies dys-appear, are challenging, and difficult to handle. Such situations are also relational or co-participative.

They show that midwives and women work together in specific birth surroundings, such as the home, and engage in a particular repertoire of supportive techniques.

I demonstrated that witnessing techniques may bolster agency when dealing with a dys-appearing pregnant or birthing body. Yet witnessing techniques may also contribute to enacting a body that dys-appears. That, however, does not mean that women are necessarily stripped of their active participation and are alienated by their bodies and the events they are involved in, as Samia's story showed. Samia co-participated in shaping her dys-appearing body-in-labor-pain in ways that made giving birth in the clinical environment work. I specified three midwifery witnessing techniques: touching, trusting and fetal heartbeat monitoring. Touching in midwifery care may be done in different ways and aim at different goals, for example of surveilling, or of building a trust relationship. Trusting is both a result of midwifery care relationships and professional practice, as well as a technique used to make these relationships and what they aim at work. Depending on the surrounding in which it is done, fetal cardiotocography's 'objective' and durable proofs, that seem to be reliable and true, may concur with other testimonials produced in midwifery care arrangements that are based on long term relationships where trust is both needed and built.

As my analysis has shown, witnessing in midwifery care practices shapes how agency is distributed. It enacts pregnant and birthing bodies, along with fetal and midwives' bodies, in more or less helpful ways. In legal and scientific spheres, witnessing is understood as an objective, disembodied and neutral position of an uninvolved outsider. In midwifery practices however, witnessing is quite different. Here, witnessing is a set of involved and embodied practices in which midwife, fetal, and woman's bodies co-participate. In doing so they are never (merely) passive, even though they may seem 'to do nothing at all'. Witnessing hits its limits if the participants do not stick to the 'rules': A woman giving birth cannot leave her body and hand it over to the midwife. A midwife cannot be pregnant or give birth in the woman's place. What can be done, however, is to co-participate in ways that enable active co-shaping of a body, especially when a body is painful and challenging to handle. Witnessing techniques such as touching, trusting, and monitoring, may help to craft the conditions for such active co-shaping. They are effective not in producing objective truth, but in trying to collectively find alternative solutions to challenging life situations.