Unnaturalizing bodies

An ethnographic inquiry into midwifery care in Germany

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CHAPTER 6 – CONCLUSION
UNNATURALIZING (BODIES IN) MIDWIFERY CARE IN GERMANY

Strengthening midwifery care has been a concern for and mission of midwifery associations and birth activists, anthropologists and other researchers, birth givers and obstetricians. Depending on the respective motives and objectives, the strategies for supporting midwifery have differed. Midwifery was safeguarded as UNESCO Intangible Cultural Heritage in Germany in 2016. A midwifery science has been developed, equipping the profession with objective evidence for its truth and authority. The leitmotif shared by these initiatives is been that midwifery has been threatened by obstetrics and its 'unnatural' technologies. Medicalizing pregnancy and birth is said to disrupt natural events and to alienate the social processes that midwives work with. Midwives' raisons d'être—what or whom midwives care for and how they do so—have thus been put under the aegis of 'nature' and 'naturalness'.

In this thesis I have questioned these discourses on nature, which claim that nature and natural bodies speak by themselves and of midwifery's essential identity and qualities, and whether they really support midwifery care. The idealization of midwifery as a practice of letting nature do its work assumes that nature is just 'out there', an objective material reality waiting to be dealt with by midwives and to be discovered and understood by scientists. But at closer look, nature does not speak in one way: In homebirth midwifery care, nature doing its work requires thorough preparation and training. In labor wards, nature is in need of obstetric optimization. In evidence-based midwifery, nature is structured by correlations, probabilities and causalities. In research on midwifery that analyzes subjective experiences, nature is endlessly interpreted as a social construct. Midwifery, as an art of social care that lets nature take its course, can mean very different things.

As I showed in the preceding chapters, analyzing how, under which conditions, and which versions of bodies are enacted in midwifery care practices leads to a broader and clearer understanding of midwifery care.

Rather than idealizing midwifery care practices through romantic notions of benevolent nature, I have pointed to the various bodies, techniques, and 'goods' that take shape in midwifery practices. These findings have come about from studying bodies as products of midwifery practices and relationships investigated as "'semiotic technologies'" (Haraway 1991b, 187; see also Haraway 1991a, 1991c). As such, midwifery practices make bodies 'speak' and act in specific ways, also, but not only, as individual and biologically structured bodies.

My research suggests that midwifery care practices may be strengthened by showing how, in midwives' activities of the midwives, different relationships among obstetrical technologies, bodies, and midwives are brought into being. These relationships entail different rationales and values of what is 'good' midwifery care. While midwifery care practices are oriented towards improving fetal-, pregnant-, and birthing lives, how exactly this is shaped and which values or 'goods' hence emerge need to be empirically determined. Not only do 'goods' differ from one midwifery care arrangement to the other but also one specific arrangement may attend to various, sometimes contradictory, 'goods'. The ways of shaping and addressing (care-) problems and values are informed by how obstetrical technologies are put into practice as well as by the surroundings in which midwifery care takes place: in ob-gyn practices and hospitals, ideals, standards, and goals partly overlap and partly differ from those in midwife-led birthing places and people's homes.

The approach to midwifery care developed throughout this thesis is aimed at supporting midwifery by studying how, and with which effects, midwifery care is enacted in everyday care practices. Midwifery care relationships give rise to medical, technical, and social repertoires that run through classic binaries: nature-culture, medical-social, and bodies-technologies. Because bodies in midwifery care practices are neither pre-existent realities nor essential goods, they become more-than-physical and more-than-human 'entities' themselves, incorporating and giving rise to various values, techniques, and knowledges. This thesis therefore *unnaturalizes* bodies in midwifery practices by studying bodies as collective, distributed, and heterogeneously composed actors and effects. Doing so, juxtapositions of nature and culture are left behind, just as is the assumption that bodies in midwifery care practices are natural and as such essentially different from what is subsumed under culture. Through the strategy of unnaturalizing bodies,

I have articulated the diversity and creativity of professional midwifery care practices in which pregnant-, fetal- and birthing bodies and lives are brought about, and which get hidden in natural childbirth discourses according to which midwives just let natural bodies do their work.

Shifting Midwifery Research

This thesis began by posing these **research questions**:

- ☞ 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?

To answer these questions, I draw out three interconnected shifts that may support the fostering of midwifery care practices and avoid unhelpful oppositions. These shifts, as detailed in this thesis, form a proposal for how to study midwifery care. The aim is to show the particular professional repertoires midwifery care practices may provide.

The **first shift** moves away from claiming that midwifery is un-medical and un-technical, or inherently good, to showing how 'medical' and 'social' repertoires are intertwined. Through studying which kind of sociotechnical relations and identities are shaped, and how, this thesis shows that in midwifery care techniques 'the medical' and 'the social' come in different shapes and mix together.

The **second shift** is from presupposing bodies as natural to articulating the *kinds* of pregnant, fetal, and birthing bodies that are enacted in midwifery care practices. As these bodies are lived realities, their enactments are interventions in and shapings of lives. This is an ongoing, collective, and unavoidably political endeavor, as it suggests what good (or bad) bodies and lives are.

The **third shift** is from assuming midwifery necessarily is 'good' to comparing values-in-practice in order to learn about good practice. While acknowledging that midwifery care is oriented towards 'doing good' or 'improving' the situation, I have argued that it is fruitful to study the values embedded in practices. This makes it possible to identify the diversity of values, to articulate dominant and marginal values, and to show the effects of different values that shape 'good' midwifery practices. What good midwifery

practices and good pregnant-, fetal-, and birthing lives are, cannot be set once and for all. But we can study which kinds of 'goods' are brought about.

All three shifts form the approach I propose: to do away with understanding midwifery care as a given set of natural activities and social support, towards studying midwifery care as it is shaped in practice. This allows me to articulate these practices on their own terms, to attend to the conditions, concerns, aims, and strategies that matter to the people in my field without unconditionally praising or harshly criticizing but by thoroughly attending to their specificities.

Shift 1: Studying the Sociotechnical Relations of Midwifery Care Practices

To demonstrate the intertwining of medical and social repertoires, I have analyzed the case of fetal heartbeat listening technologies which shows clearly how the medical and the social are intimately related in midwifery techniques. Obstetric technologies are used by both midwives and obstetricians, in all of the different surroundings in which prenatal and birthing care happens. Devices that are usually designated as *medical* and used predominantly in ob-gyn practices and hospitals, such as the cardiotocograph (CTG), are never merely medical: they co-create social relationships, as I have shown. Technologies such as listening to fetal heart sounds with the help of the Pinard horn, mostly employed in midwife-led environments and commonly understood as social, may show medicalizing effects in practice, as I have demonstrated.

Both these technologies generate obstetric surveillance information *and* shape social relations between the participants. But they do more: obstetric and midwifery technologies inform each other, which becomes clear when fetal heart beat sounds are produced in midwifery practices. For instance, obstetric techniques, such as monitoring fetal heart rates to prove a child's well-being via the Doptone, incorporate midwifery skills such as educating parents-to-be through listening to 'good' fetal heart sounds. And midwifery-specific knowledge repertoires, for example, about the 'good' or regular course of birth, include the obstetric technique of interpreting fetal heart rate and uterine contraction curves produced by the CTG.

The Pinard horn illustrates the intertwined medical and social relations coproduced by a specific fetal heart beat monitoring device. Midwives, and especially those providing so called extra-clinical prenatal care

and birth assistance, consider the fetal stethoscope, or Pinard horn, to be the midwifery tool par excellence. Symbolically and practically the Pinard horn is a supposedly non-obstetric but social and natural instrument. A small, simple, and seemingly ordinary device, it is made of wood and hence 'warm' to the touch. The tool is claimed to be modest and flexible; instead of electricity and abstract curves to interpret, it only needs a skillful midwifery ear to listen. The Pinard horn is an instrument for creating an intimate physical proximity between midwife, fetus, and woman. Preceded by abdominal palpations, the device helps to bring the midwife's hands onto and head close to the woman's belly. Compared to other, more sophisticated medical technologies such as, for example, the CTG that monitors also in absence of medical staff, the physical closeness created by the Pinard horn may imply a social closeness as well.

There is, however, another 'cold' and 'asocial' side to this charmingly 'warm' midwifery technology. With the Pinard horn, the listening person cannot be the pregnant woman herself, so that the only person who hears the fetal sounds is usually the midwife. In these listening arrangements, the Pinard horn appears as a classic medical device, with the professional as the authorized listener, and the pregnant woman making her body available for the listener to hear a fetus hidden inside of her belly. She must lie still on her back and is not allowed to talk as to not disturb the expert listening. This analysis shows that the physical proximity orchestrated by the Pinard horn is a social arrangement that is at once intimate *and* openly surveillance-oriented. It creates a social and epistemological disparity between the midwife, enacted and acting as an authoritative expert who knows; the woman, a body that is helping to make knowing possible; and the fetus, an object of surveillance that is known.

However, within the range of the possibilities offered and suggestions made by the device (Akrich 1992), one and the same instrument may also produce different information in different ways. The Pinard horn's sound could, for example, be made audible to everyone by translating the beats into vocal sounds, by humming a fetal heartbeat melody. The Doptone's and the CTG's sounds may be turned off, so that the numbers on the displays and curves of the script are the only artifacts to relate to. That can be done in silence, through reading the numbers aloud, or by saying that "everything is okay," but also by characterizing and qualifying the results as signs of a child's character, mood or gender. Switching the loudspeaker of a CTG on

can also be useful for coordinating the midwives' activities in ob-gyn practices or labor wards, as they may listen to the fetal heartbeat while doing other things nearby.

Nevertheless, the three instruments available for monitoring the fetal heart rate—the Doptone, the Pinard horn, and the CTG—produce specific information, most importantly the fetal heart rate, in different ways. While the Pinard horn creates an exclusive access to the heart sounds, the Doptone renders them hearable to everyone in the vicinity. The CTG produces scripts, translating the sounds into visible curves.

I argued that, despite these differences, all three devices shape fetal heart rates into something more-than-information, namely into various types of *fetal heartbeat music* that can be listened to and can move the listeners in different ways. Fetal heartbeat music is a material-semiotic effect of particular fetal heartbeat listening techniques and orchestrations, constituted of interrelated devices, words, bodies, sounds, fetuses and appreciations in specific surroundings. It is a mixture of physical and technical, medical and social, and factional and fictional genres of producing fetal heart sounds. Depending on how, what for, and where it is put to use, each of the obstetric monitoring devices helps to enact particular types of fetal heartbeat music together with particular relationships.

Shift 2: Unnaturalizing Pregnant-, Fetal- and Birthing Bodies in Midwifery Care Practices

Midwives, together with their devices and techniques, do not leave 'their objects' untouched. Instead of assuming pre-existing and stable relations between knowing subjects and known objects, I have shown how midwifery practices *enact* their participants in specific ways and how these entities may act. To articulate the various versions of pregnant-, fetal-, and birthing bodies that emerge in practice, I analyzed how bodies-in-labor-pains are addressed, and brought about, in midwifery care practices.

In all surroundings, the overarching goal of midwifery birth attendance is to handle labor pains in ways that allow birth to progress and that help to avoid obstetrical complications, such as slow or obstructed labor. In obstetrical terms, 'good' labor pains are uterine contractions that are effective in opening the cervix and pushing the fetus through the pelvis and vagina within a certain timespan. However, midwives' attendance during birth is not only guided

by the effectiveness of labor pains in making birth happen but also by how and to which extent these pains are bearable for the woman giving birth, the fetus, the partner, the midwife, and whomever else may be present during the birth and concerned with it. These two goals are in tension with each other when bearable pains are not effective and effective pains are not bearable.

Midwifery techniques for handling labor pains are extensive, each suggesting different versions of and relations between effective and bearable labor pains. Bathing in warm water, for example, aligns bearable with effective labor pains, staging them as interdependent: bearable pains have the potential to become effective. In this arrangement, the body-in-labor-pain is not bounded by its skin but incorporates pleasurable environmental qualities such as warmth, calm, or intimacy. The body-in-labor-pain is inhabited as an activity: laboring in a relaxing situation.

Vaginal examinations, in contrast, enact labor pains as objectively measurable effects of biological processes. Labor pains are located within a body as a biological system, and more specifically in its reproductive organs, the uterus and its cervix. How the pains feel and how they act upon the body-in-labor other than dilating the cervix is not at stake when this technique is used. Here the pains' effectiveness in terms of obstetric standards is foregrounded.

Labor pains can also be measured and felt by the subject-in-labor herself. Together with other devices such as clocks, the body-in-labor-pain becomes a diagnostic tool. Labor pains' effectivity remains uncertain (and may be hoped for) when feeling and measuring the frequency and intensity of contractions is foregrounded. As the pains are worked with in ways that align 'subjective' feelings, the hurting, with 'objective', measured data—the pains need to be felt in order to become measurable—they become bearable.

When labor pains are staged as products of bodily tensions, they are both ineffective and unbearable. In these cases, labor pains are also situated in individual biological bodies, as in the case of vaginally exams, but an operating psyche or mind is added to the tableau. Pathological labor pains are interpreted as symptoms of a fearful mind provoking an overall muscular tension that prevents the cervix from opening. These pains hurt excessively and are not effective because they are not adequately 'coped with' by the embodied psyche-in-labor.

An epidural anesthesia, often combined with an infusion of oxytocin, is administered, with the goal of rendering labor pains bearable through diminishing the hurting as much as possible while also increasing their

effectiveness as much as possible. Here, labor pains are distributed over complex medical and technical infrastructures. As labor pains are not felt as pains but as uterine contractions in this arrangement—Tina described it as a working of her uterus that did not hurt—diagnostic examinations and the 'objective' data they provide are needed for managing labor. The body-in-labor is shaped into an obstetric object that may be comprehensively directed and controlled quasi-independently from the subject-in-labor.

As my empirical examples showed, bodies-in-labor-pains are not naturally given. Instead they actively engage in and are acted on by midwifery techniques, themselves constituted of mixed obstetric and social repertoires. Depending on which techniques are used to handle labor pains and on the goals they foreground—such as rendering labor pains effective, bearable, or both—bodies take various shapes in labor pain arrangements. They may become pleasurable activities, biological systems, helpful tools, or obstetric objects. How bodies act and what they become also depends on what the surroundings they are situated in have to offer or what they necessitate, ideally and sociomaterially.

Unlike what is often suggested, each technique for handling labor pains, including analgesic or anesthetic ones, requires the active co-participation—not to be confounded with control—of the woman giving birth. Labor pain arrangements co-shape subject positions in birth that, while inviting to be lived in active and creative ways, also impose themselves on an embodied subject-in-labor-pain. In the bathing arrangement, the embodied subject is enacted as an unbounded component of a relaxing situation; in the epidural arrangement, a disembodied subject is enacted, put in the position to merely observe its obstetrically manipulated body.

In midwifery care practices, the ongoing transformations and uncertainties that shape bodies and lives, such as those demonstrated by the multiple actorships of labor pains, for example, need to be acknowledged and dealt with. When labor pains are handled in one way or another, bodies become lived realities or "conditions of possibilities we live with" (Mol 1999, 75, see also 2002, 6–7). Given that ways of life are at stake in midwifery attendance, it is necessary to think about – and to weigh – their promises and limitations. Which kinds of bodies-in-labor-pain to cultivate, and which to keep at bay, is a matter of carefully attending to the problems and challenges that may be encountered during pregnancy and in the course of giving birth.

Shift 3: Comparing Midwifery Care Values and their Effects

Midwifery care practices are normative practices. They are directed at 'doing good,' meaning at stabilizing or improving life situations. What exactly is 'good' for whom or what, and in which terms, is not decided beforehand but enacted in practice. Midwifery care practices are also structured by more 'overarching' values, by ideals, standards, and goals that do not (only) emerge from the concrete handling of a care situation. They may belong to specific surroundings, such as hospitals or homes, which afford certain options but not others, or they may come from other places and practices, for example scientific ones. These institutionalized values need to be dealt with – integrated, adapted, or counteracted, for example – in concrete midwifery care situations. Studying how midwives do this can provide insights into the effects of such values.

To demonstrate the analytic strategy of comparing values-in-practice in order to evaluate their effects, I take up an influential ideal that shapes midwifery care, one that only implicitly appears in the precedent chapters: *woman-centered care*. Woman-centered care is a synonym for a woman's right and duty to make choices and to be in control of the care situation. I approach this ideal in two steps. Firstly, I ask what this ideal does: what are its effects and limitations? Secondly, I contrast it with a more marginal goal-in-practice.

Women-centered care resonates with the famous medical ethical principle of autonomy. This principle assumes competent individuals who, after having been informed about their possibilities, make the most reasonable choice according to what is offered to them and in line with their preferences. But midwives do not only attend to pregnant and birthing women but also to fetuses. And women and fetuses are physically, and vitally, interdependent. Interventions such as continuous electronic fetal heartbeat monitoring during birth have been shown to bring risks and benefits for both, mother- and child-to-be. What would a reasonable choice look like, when a woman has to decide whether to be monitored? The ideal of woman-centeredness hides these complex and challenging physical, obstetrical, and moral relationalities between pregnant and birthing women and fetuses. While overburdening women with competency and responsibility, and eclipsing fetuses and the affectivities they and their (future) lives are equipped with (also through fetal heartbeat monitoring), woman-centeredness also turns midwives

into service providers whose appreciations and doubts do not matter and are not allowed to form part of their working relationships. A consequent problem is that woman-centeredness does not capture the relational, collective, and contingent endeavors that attending to pregnancies and birth in midwifery care practices become.

An alternative to woman-centeredness is enacted in homebirth environments and their long-term care relationships. Interestingly, the ideal of woman-centeredness is often invoked in these surroundings: women have made the brave choice not to take the usual path of pregnancy and birth attendance but have opted for the alternative, so the credo goes. In homebirth practices, however, notions of choice and autonomy are not enacted as individual competencies but as situational and relational events. Women and midwives are in this together. What matters in these homebirth care relationships is ongoing communication and contact through words, touches, devices, and physical proximities in homely and intimate surroundings in which obstetric surveillance examinations are *routinized* and *multiplied*, as I have shown. Data and entities such as healthy fetuses and pregnant bodies produced through obstetric technologies are embedded in daily lives and allowed to have various 'meanings' in relation to the specific situation in which physical, emotional, and social becomings are intertwined. The challenges (or limits) of these *co-responsive relationships* in homebirth surroundings are that they require quite some physical, emotional, and social investments, long-term training, and discipline.

Both the ideal of woman-centeredness and the relationship-based goals of homebirth come at a cost. Articulating what they foreground and their limits, especially in comparison to each other, will help midwifery care practices to improve. Through such an analysis, I have provided tools and insights for evaluating midwifery practices in terms of their effects; to adopt techniques, ideals, and goals reflexively; and to develop techniques, ideals, and goals that best fit specific pregnancy and birth situations.

Strengthening Midwifery: Lessons for Research and Teaching Practices

In this thesis, I suggest methodological and analytic strategies for strengthening midwifery care practices in and through research. What are the advantages of this practice-based approach? It can show both the heterogeneity

and the diversity of midwifery care repertoires: devices, goals, and bodies emerge in relation to each other and give shape to many different midwifery care techniques that bring about different moralities, skills, and sets of (tacit and explicit) knowledges. Attending to these complexities-in-practice is a way to work with the challenges, hopes, and negotiations that form part of midwifery's everyday routines. It thus provides a form of (scientific) support for what midwives, women and their companions (have to) do.

Studying practices teaches that 'goods' are not defined once and for all but continuously negotiated, in this case in the provision of care. Midwifery thus cannot be preserved, such as intended by the UNESCO Intangible Cultural Heritage Program, if those concerned—the participants of midwifery care practices—do not creatively take care of it themselves. I suggest facilitating this by establishing conditions that allow midwives to engage reflexively with their care and research practices. Providing analytical tools for gaining theoretically informed and practically useable insights into the specificities of midwifery practices and their dynamics, not by juxtaposing the medical and the social but by unnaturalizing bodies with a sensitivity to values-in-practice, is a start.

Clinical trial based evidence may answer some questions but leaves many others unanswered. Similarly, pointing to women's points of view also covers some ground, but not all. This thesis encourages midwifery to study in practice what matters to pregnant and birthing women, fetuses, and midwives. This research can be extended upon, for instance through studying pregnancy diets or self-tracking apps for pregnancy surveillance. Another promising avenue of further research could be in studying how gender, class or culture are enacted in midwifery care practices.

The praxiographical turn I developed in this thesis allows midwifery to enter into dialogue with other disciplines and strands of research such as anthropology or STS. Anthropologists of birthing may research midwifery practices in ways that overcome nature-culture and medical-social binaries; instead investigating their situated intertwinements. STS interest can be broadened beyond studies of reproductive technologies and sciences, to include midwifery care practices in their research repertoire.

Such a practice based approach may also help in the teaching of midwifery. Instead of adapting ready-made theoretical concepts to explain midwifery and to prescribe what good midwifery practice is, midwifery techniques and arrangements may be taught in complex ways,

while simultaneously rooting these complexities in practice. Using concrete cases helps to articulate and to discuss ideals and techniques, to explicate values, and to bring dilemmas to the table.

My praxiographic approach to midwifery care dissolves a separation between the practical aspects of caring and of theorizing. In ways of supporting midwifery care practices, both caring and theorizing are tightly enmeshed.