

Witnessing as an Embodied Practice in German Midwifery Care

Annekatriin Skeide

Introduction: Witnessing in Midwifery Care

The first birth I saw was a homebirth. At the time I was interested in becoming a midwife and I accompanied two midwives in order to get an idea of their work. They were living in my neighbouring village in the south of France and had been attending homebirths for over twenty years. It was a dark and silent night. When I arrived, the mother-to-be—I will call her Lisa—lay on her bed in white sheets. The midwife H el ene sat cross-legged at the front-side of the bed. She appeared to be relaxed and highly concentrated at the same time. H el ene smiled slightly when I arrived, but barely took her eyes off Lisa. Lisa did not seem to notice me at all. She was lying on her side breathing heavily. I remember her wearing a white t-shirt. Her body seemed to dissolve in the white sheets, while her naked arms and legs seemed to function apart from her. Every time she had a contraction, she clutched the metallic bedframe with her strong, muscular hands and the whole bed was shaken by the

A. Skeide (✉)

Human and Health Sciences, University of Bremen, Bremen, Germany

  The Author(s) 2018

F. Krause, J. Boldt (eds.), *Care in Healthcare*,

https://doi.org/10.1007/978-3-319-61291-1_10

enormous tension of her muscles. She seemed to be in great pain: at the height of a contraction she screamed deeply and desperately. Meanwhile, H el ene remained silent and immovable. Her calm comforted and irritated me at the same time. How could she leave Lisa suffering without doing anything beneath murmuring now and then that Lisa was doing very well? It seemed to be endless and circular: 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 bluish body followed easily. Lisa took her child and lay down—she seemed exhausted but suddenly very present and relieved. I was overwhelmed: still shocked by the force of Lisa's contractions which had seemed to be torturous but amazed by this unbelievable miracle I just had been part of.

H el ene was witnessing Lisa's birth: Highly attentive, she was sitting an arm's length away from Lisa who was absorbed by the enormous effort and pain of giving birth to her child. H el ene knew that everything went fine. Lisa found her own strategies of handling the birthing pain and by doing so she enacted H el ene as a witness.

In the situation described, witnessing compromises embodied¹ inter-relatedness in a particular environment. The witnesses presence has to be characterized as an intervention: an activity which shapes and constitutes what happens but which is shaped and constituted by what is happening as well.

In order to elucidate why and how I use witnessing as a concept I am going to introduce juridical, religious and philosophical reflections on witnessing and connect them to midwifery practices.

In a second step, I will elaborate on witnessing in midwifery care with the help of my empirical findings. Firstly, I am going to introduce and confound two widespread stereotypes in midwifery care: the knitting midwife and the head-led woman in labour. In doing so I would like to demonstrate that witnessing signifies 'being-with' and relates to mutual obligations; I also point out the limits of witnessing. Secondly, I develop the interpretative aspect of witnessing and displaying possible

consequences. Thirdly, eye-witnessing will be revealed as a practice and a state. Fourthly, I am going to introduce touch as another sensual mode of witnessing in midwifery care. Fifthly, I define and illustrate trustful witnessing. Finally, I explain how CTGs perform technological testifying. I shall reveal the limits of witnessing throughout the text. I am going to present these aspects separately for analytical purposes. Nevertheless, it hopefully becomes evident that these witnessing states and techniques are intertwined.

Juridical, Religious, Philosophical and Sociological Facets of Witnessing Applied to Midwifery Care

At first view, witnessing seems to be inseparable from the legal sphere: The witness is the third person (Lat. *terstis* = the third) who assisted (Derrida 2005, p. 23). A witness is called to court in order to testify. In the legal context, the witness seems to be indispensable, because he or she is supposed to be the one who actually participated in the situation he or she is expected to bear witness about without being involved. He or she is the one who knows (old Engl. *witnes* = knowledge, understanding) without being the one who did it. In the quest to find just judgement, clear evidence furnished by a neutral and objective observer is required. But it is also obvious that the witness cannot tell the truth because he or she is not independent, but influenced (and even transformed) by what happened, by his or her feelings and also by those assigning him or her the role of being a witness and testifying (Krämer 2011, pp. 122–125; Schmidt 2011, pp. 48 f.). Witnesses can but re-interpret situations they are involved in and so they have to be trusted. Witnessing constitutes sense and orientation (Krämer 2011, p. 128; Schmidt 2011, pp. 47–66). For being trusted the witness has to be self-conscious and responsible. Eye-witnessing is meant to furnish strong evidence not only in juridical but also in historic or religious contexts. The sense of sight is also of particular importance in certain philosophical traditions (Onfray 1992, pp. 34 f.). In rationalism, language is a fundamental medium of reason. However, Jewish and

Christian martyrs (Grk. *martyrs* = witness) testify divine truth not only through words but also through action which has to be seen (Drews and Schlie 2011, pp. 7–21).

The multidisciplinary approach to witnessing shows its epistemological ambiguity: a witness is supposed to be the third, the neutral, the observing. But being the third does not mean not being involved and related. Being neutral does not mean not feeling or not experiencing or not reflecting and not acting. Being the observer does not mean only being made up of an eyed brain.² Because it is situated and embodied witnessing involves trust.

The integrative active part of participating cannot be separated from the seeing and observing presence in midwifery care. Even if the midwife seems to do nothing else than observing, she actually is intervening and interpreting. As witnessing is inter-relational, the midwife is enacted as a witness too. Eye-witnessing in midwifery care has a distant and alienating potential, because it might stem from or lead to women's bodily exposure. Women feel a separation with regard to their body then. Midwives witness and testify³ birth which can be perceived and influenced by midwives but 'happens to' childbearing women and regarding which midwives have a certain professional knowledge and experience which the childbearing woman generally does not have. The childbearing woman for her part disposes of (medical, social, corporeal etc.) knowledge and experience, too. The witnessing role is socially and politically assigned to the midwife.⁴ This assignment is constantly renewed in interaction with women and families but also with colleagues, surroundings, and things. It is performative: Witnessing is established and maintained in and by acting. Legally speaking, midwives testify by doing paper work and documenting what they saw and did.

Trust is conditional in the relationship between midwives and women. The midwife is usually met as a trustworthy person in regard to her competences, her confidentiality and her good intentions. Trust is not only anticipated by mothers-to-be but also established or reinforced in reaction to the required intimate exposure of themselves, especially during birth.

Midwives are using technical aids such as the cardiotocograph (CTG) in order to produce testimonials. Technological testimonies function as

providers of the objective and neutral evidence, the higher truth that the witness fails to provide. The CTG is enacted as the ideal witness, as a producer of a category of knowledge which is not partial and subjective, embedded in embodied presence, but which is total, neutral and objective. The ambiguity of witnessing becomes quite obvious when midwives use the CTG as a competitor, a colleague or a superior.

Empirical Findings

I conducted one year of ethnographical fieldwork in two midwife-led birthplaces, one obstetrical ward in a mid-sized hospital and in numerous families' homes in Northern and Eastern Germany.⁵ As I introduced myself as a midwife I was quite frequently asked for my opinion about how to proceed in certain situations by the midwives⁶ and often included in conversations between midwives and women.⁷ Sometimes I could lend a hand, too. Usually, I made quick notes during the rare pauses, which I elaborated after having left the field site. Furthermore, I conducted about twenty guided interviews with women and midwives. I conducted fieldwork and data analysis parallel using theoretical sampling and conceptualized the data by coding and memo writing as proposed by grounded theorists (Glaser and Strauss 1971; Strauss 1987).

Witnessing as a Contractual Being-With

The role the midwife played during Lisa's birth actually illustrates the topos of the knitting midwife⁸ which seems to do nothing apart from sitting and knitting. Actually, this is not the case. The knitting midwife is the sage-femme.⁹ She does little *because* she knows a lot. She knits to occupy her skilful hands. Nevertheless, she sees, hears, feels and speaks. She could interrupt the knitting at any time in order to intervene actively if it would become necessary. Deciding if and when this necessity appears is crucial. The knitting midwife is "active-passive". H el ene attended Lisa's birth at Lisa's home. The domestic setting relieves midwives from pressures initiated by institutional settings

such as attending several women at once, working in shifts, following clinical guidelines, being subordinated to doctors and therefore being obligated to report and follow instructions. Being a guest, H el ene depends on Lisa’s permission and guidance when moving around or using anything. Lisa is all by herself, not tasking the midwife to intervene, to validate or interpret her bodily functions. H el ene’s knitting midwife’s role is situated in a specific configuration, which yields the knitting midwife.

Midwife Anna describes a stereotype which I have been socialized with when becoming a midwife and which I met again frequently during my fieldwork: the head-led woman in labour. The head-led woman is not able to “let her body guide her” as midwives advise. In consequence, her birth has to be medically assisted. I would like to show that these situations rather lie on relational aspects: The configuration of midwife and woman in labour has contractual implications.

Anna, a young self-employed midwife, told me about Katharina, who, as Anna told me, had been quite exhausting to attend to during her homebirth. Katharina had the impression that Anna called her “every five minutes” during the night, even though she had only had light contractions. When Anna finally got there she had been quite annoyed because Katharina “had only been at two centimetres”.¹⁰ Katharina stared at Anna continuously and expectantly. Anna said that Katharina “had not been in possession of herself [nicht bei sich war]”. Instead Katharina had figuratively tried to “crawl into [hineinkriechen]” Anna. Anna felt like Katharina “wanted to get it done” by her, the midwife. Katharina for her part needed even more than the midwife’s interpretative support. She appealed to her midwife to manage the pain at her place and share it with her corporeally, what Anna described as “crawl into me”. In this situation, witnessing had not been possible anymore.

Apparently expectations and appeals towards the midwife’s participation differ in dependence on the woman’s experience of her body-in-labour (Akrich and Pasveer 2004, p. 65).¹¹ Katharina had been overwhelmed by her labours. She desperately appealed to the midwife to define what was happening to her in order to make it understandable and even to handle her body-in-labour in her place. The alienation

Katharina feels towards her body-in-labour cannot be mitigated by midwife Anna, because Anna is neither able to remove it nor to handle it in her place.

Midwife and childbearing woman are situated in a kind of contract: The woman in labour cannot escape from her body. She has to fulfil her role and assume the birthing process in order to allow the midwife to fulfil her professional role for her part.

In what follows, I would like to show that corporeal insecurity women perceive during pregnancy and birth can also be reassured by midwives. If midwives concede a scope of action to women and if women are actually able to make use of it, they might handle what they perceive as their *dys-appearing* body (Leder 1990).

Witnessing as a Reassuring Being-With

Most women undergo a feeling of uncertainty during pregnancy, birth and the postpartum stage, even if it is not the first time they are experiencing it. One main aim of the attendance by a midwife is to reassure the woman by “normalizing” her experiences. The feminine body is subject to significant changes. The usually absent body can become a *dys-appearing* body: it manifests itself as a difficult or disharmonious body. A problematic interpretation could be that life phases in which this usually happens are identified as being dysfunctional or alienating themselves (Leder 1990).

Eli had an appointment with the midwife in the early morning. She arrived crimson red and snorting, obviously suffering from her enormously big womb. The expected delivery date had been three days ago. “I’m in such a bad mood”. Eli sat down straddle-legged, face-to-face to the midwife who looked at her attentively. Eli had given several false alarms because she had thought the baby would come. “I can’t sleep, I have cramps and my back hurts. I have been ill for nine months. It has to come now”. The midwife says that she understands her and then asks when Eli 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.

The midwife acknowledges Eli's pain and legitimizes her anger by not refuting it or trying to calm her. Instead she establishes a scope of action or at least a scope of decision: Eli who had suffered from her dys-appearing body throughout the whole pregnancy is now taking the decision to give birth to her child.

Similarly, Melanie asks her midwife if it would be normal that she was having headaches very frequently since she became pregnant. Instead of answering her question the midwife 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". Actually, Melanie had already adopted a strategy to get along with her headaches. Nevertheless, she felt insecure and needed support. The midwife normalized Melanie's discomfort by evaluating her strategy.

Frequently, midwives attribute a scope of action to women during birth by encouraging them: "You're doing well!"; "Yes, keep pushing. Your feeling is completely right". Or by helping them to understand and interpret their body-in-labour and their emotional state: "You're feeling tired, huh? You would like to go home, huh? That's normal at this point. Your cervix is surely fully dilated now". External interpretation does not necessarily create alienation, but joins or integrates corporeal dys-appearances. In order to make this work women have to cooperate with their dys-appearing body and to use their scope of action.

Eye-Witnessing as an Alienating Being-With

I have described witnessing as an inter-relational practice which is situated in specific midwife-woman-body-setting-thing-time configurations. Witnessing is being-with, an active passiveness, an intervention which is associated with acknowledging a scope of action to women during pregnancy and birth. Witnessing is associated with fulfilling certain role obligations. In what follows, I would like to show a different configuration in a clinical setting in which witnessing was experienced as alienating.

Samia, who had had a lengthy birth in hospital, had been attended by several midwives and she went through all the shifts she explained. Samia told me, she felt "unsheathed [blankgezogen]" during birth and that she

“really had to do circus there”. In the end, this would have been “the only way to make it work”. Samia had handed over responsibility: She said her head had been turned off. She simply did what she had been told knowing she was in good hands. “And at the end comes the child”. Samia had neither decided who had taken care of her during her birth nor what should have been done. She describes her birth experience through a distanced perspective, qualifying herself as being at the mercy of the event. Birth is the unforeseeable spectacle¹² she had been involved in. In order to succeed in “giving birth to a healthy child” Samia had to cooperate and to expose herself. Samia had witnessed herself having been “handed off [weitergereicht]” and having done what she was told.

I would like to describe Samia’s perception of having been unsheathed as a state of *existential nakedness* (Janz 2011, p. 465)¹³: Samia felt ashamed because she was corporeally and existentially naked and was neither able to cover herself nor escape from herself.¹⁴ Being existentially naked means being aware of oneself while being in a kind of oblivion of oneself (Janz 2011, p. 465).¹⁵ This alienating experience could be described in terms of eye-witnessing. Eye-witnessing as an analytic term stresses the existential nakedness interpreted in the sense of hierarchy and power differences. Being eye-witnessed signifies being exposed to someone else’s and to one’s own observation at the same time. So eye-witnessing describes a double witnessing.

Samia obviously doubted her “scope of action”, her own involvement in giving birth. She told the midwife that she, the midwife, would have been the one who had given birth to her child. “No, it has been only you”, the midwife reassured her and Samia seemed to be very happy about it. The midwife seemed to really mean it, Samia told me: “I could see it in her eyes”. Interestingly, the “cold” eyes she had been exposed to transmitted trustworthiness as well. This multiple and paradoxical potential of witnessing is one of its characteristic features: Samia had seen herself being exposed to the clinical management of her *body-in-labour*. She had been alienated to a degree that made her doubt her proper participation in giving birth to her child. The midwife is responding to Samia’s need with the same eyes—not cold anymore, but warm and friendly—which unsheathed Samia during birth. In order to reconnect with her exposure Samia charges the midwife to re-establish her scope of action for her.

Apart from seeing and speaking, touching is a significant technique in witnessing in midwifery practice. Of course, touching is not *only* witnessing, but also doing something practical. As I mentioned before: putting hands on is an active intervention. Anyhow, in certain situations touching can be understood as an active production of testimonials. These testimonials differ depending on how, where and why they are performed.

Touching as a Witnessing Strategy

The core element of what is called the midwifery craftwork or the midwifery art is body work. Body work is leading from bodies and directed at bodies (Twigg 2006; Twigg et al. 2011). Body work includes professional competences such as observation, developing and using tacit knowledge and performed knowledge (Hirschauer 2008) and applying certain—for instance, labour- and birth-facilitating—postures, gestures or procedures. Several important examinations for surveying the growth and the condition of the child or the condition of the mother are performed with the help of intimate touches. These touches can be realized in more or less caring manners and are not purely instrumental per se. Touch can be imposed: “I have to examine you”, or it can be proposed: “Do you want me to examine you?”; “Should we have a look at how it went?”. Touch can be a medium of creating a contact between mother, midwife and the unborn child: Midwife while touching the mother’s womb: “Hello child, how are you? Oh, you are awake?” and to the mother: “For how long has he been awake this morning?” or it can happen silently, routinely, en passant. In any case, these touches intentionally lead to a diagnostic or therapeutic result. They are testifying the position of the foetus, its existence even. In doing so, they are creating medically and legally relevant testimonials. But they create social and cultural testimonial as well. The midwife testifies certain traits (liveliness, laziness), gender (shy girl, strong boy) or the mother-child-relationship (“Where do you feel the baby kick?”) as well. Touching is always a strong intervention and it depends on its qualities and aims if it creates or intensifies alienation directed to the touched body or if it intensifies or re-establishes the association of body and self (Akrich and Pasveer 2004, p. 64). If

touch supports association processes, it is to be performed within the woman's scope of action: the woman is explicitly and honestly agreeing to be touched or she is asking for the touch herself, but also the midwife's scope of action: time and a trustful, continual relationship permit a participative and perceptive presence.

When I arrived at the birthplace late in the evening, Jasmin was taking a bath. The midwife and a friend were sitting next to her. It was very warm and sticky in the small and sparsely lit bathroom. Jasmin laughed and talked a lot until contractions became heavier. The midwife praised Jasmin after each contraction: "Great! You are doing great!" She proposed that Jasmin change position when she said she felt a "pressing pain". Jasmin was kneeling and saying that the contraction she was having would not end. Via the Doppler foetal monitor the midwife used, we could hear the heartbeat of the child beating slower and slower. Impressively calm, the midwife administered Jasmin with medication, ceasing the contraction. The child's heart regained its rhythm. Jasmin was unrecognizable: distracted and carried away. She turned to her midwife: "I was afraid just now. Could you caress me? Could you breathe with me?" The midwife sat next to her and Jasmin fell into her arms.

As well as Samia and Katharina, Jasmin felt alienated and even threatened by her body-in-labour. She asked the midwife to caress with her and breathe with her so that she could "re-corporate". Witnessing as a perceptive and participatory presence can also be carried out by touch. This presence transmitted by touch can be a source of (re-)association of body and self. Touch as an intimate intervention is associated with trust. When being touched by midwives, women have to trust that midwives know what they are doing and that their touches are skilful and respectful.

Trust as a Strategy of Being Witnessed

"Trust" or even "basic trust" seems to be a leitmotif, a grounding feature of the relationship between pregnant and childbearing women and midwives. Firstly, midwives seem to have a kind of credit of trust. During my participant observation I always experienced that at the very moment I told women and families that I am a midwife, they open their doors for

me even though I am a stranger. When we had seen each other several times, they sometimes asked me what my research will be about, even though I had told them when we met first. What I was actually doing seemed less important than the fact that I am a midwife. A midwife's presence nearby a pregnant or childbearing woman seems to be self-evident. Secondly, trust is intensified in bodily interaction and in relation to the degree of intimacy. Thirdly, trust is a strategy to handle potentially shaming and even molesting situations.¹⁶

Helma had been attended by the same midwife during both of her pregnancies, births and postpartum stages. She told me about the "basic trust" she would have for her midwife and the midwife would have for her. So I asked her what the midwife did that lets her, Helma, be this confident. Apparently it is more important what Helma herself does in order to establish and maintain a trustful relationship: "I open up completely. But I didn't have any problems with it from the beginning on. You lay down and you are examined [vaginally]. Somehow this is the most normal thing in the world. And that, I think, is so nice".

Helma describes trust and her capacity to abandonment relating to the midwife in the context of intimate physical interventions. Being examined vaginally out of an explicitly sexual context in agreement with all interactors is just not "the most normal thing in the world". It seems to be the intimate intervention which "opens up Helma completely". Helma legitimizes the vaginal examination by trusting and by perceiving it as being "the most normal thing in the world". 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 that one was in good hands and at the end comes the child". Being trustful is also a legitimizing consequence of handing over responsibility to the midwife. Samia is following advice in order to achieve a purpose, which is giving birth to her child. Being trustful seems to be without any alternative.

Finally, women expect to have an intensive and trustful relationship with the midwife as Dörte explained:

And that I know somehow for this period I can build up a very intensive relationship. Not only in prenatal and postnatal care but also that in the middle so to speak. That self-indulgence and intimacy somehow. And

nevertheless dealing professionally with each other. This extreme opening-up-to-each-other and just letting yourself go. I still find quite impressive. It starts with somehow being able to say all you want without feeling embarrassed. And during birth this self-indulgence and intimacy. Somehow just letting yourself go. This is definitely special.

As well as Samia and Helma, Dörte describes a trustful relationship as one in which she does not feel embarrassed or in which she is anticipating shame by trusting. Trust is intimately linked to the inevitability of bodily exposure during childbirth, pregnancy and antenatal care. In order get along with “this extreme opening-up-to-each-other”, “letting yourself go”, are required strategies within a professional relationship. Dörte defines professionalism as being able to say and do things in interaction with her midwife without fearing consequences. Dörte calls it the “objective gaze [den objektiven Blick]”¹⁷: She can speak to her midwife about difficulties in the relationship to her husband without worrying her midwife “developing an opinion” about her husband as friends or family members would. Objectivity as a feature of the witnessing role does not exclude intimacy per se and does not necessarily lead to alienation. Witnessing objectively means to be an intimate part of a situation without being durably involved. Temporal and local limitations seem to be important variables of witnessing in midwifery care.

Technological Testifying

Finally, I would like to show that technical devices produce powerful testimonials in midwifery care. One of them is the CTG,¹⁸ which has advanced to be one of the obstetrics’ and midwife’s assistants.

In hospitals, CTGs are usually permanently located next to the head side of a bed replacing the bedside table. Often women have to stay next to it, because cables join the sonic heads to the device. During birth in clinical settings it is used regularly, even continuously. In birthplaces or at women’s homes they are replaced by much smaller Doppler foetal monitors or a wooden ear trumpet called the Pinard horn. In hospitals as well as in birthplaces, CTGs often seem to replace the absent midwife, even though it is “only” registering the foetal heartbeat.

I accompanied Agnes on a visit to Ruth. Ruth attended her fourth child and the birthing date had already passed. Ruth had had two of her three children at home with Agnes. Agnes visited her regularly now in order to register the foetal heartbeat, verifying if the baby is still going well. Agnes announced she would register for ten minutes only, because it would be no more than a “snapshot” anyway. While Ruth lay down on her sofa, Agnes installed the device in front of which she was kneeling on the floor. The CTG’s tone was set off, but both of them stopped talking and fixed the paper with the two jagged lines gliding out. A midwife’s witnessing expertise is established with the help of the CTG. It produces a public and durable artefact which serves as a testimonial. This artefact testifies the foetus’s vitality without penetrating the mother’s body. Like ultrasound, it creates something visible out of something invisible. It seems to extend the witnessing-room of the midwife, but actually it creates its own witnessing presence. The testimony it bears or produces is material and supposedly objective, which the midwife is not able to do. Agnes emphasizes the fugitive character of the CTG to try to diminish its competitive significance, even though both Agnes and Ruth are subjected to its presence. In hospital, midwives do not seem to compete with the CTG, but co-operate and even subordinate. In this setting, the CTG is a potent producer of testimonials because of its objectivity, materiality, continuity and its impetus-giving character.¹⁹ Therefore, it fulfils the legal criteria of witnessing. The presence of CTGs is helpful when midwives attend several women at once in clinical settings, which usually happens. In this case, the midwives as well as women in labour usually seem to feel more secure as a result of the CTG’s continual presence and surveillance of the child. But the CTG certainly also affords frequent absences of midwives and doctors by surveilling mother and child.

Conclusion: Witnessing Configurations in Midwifery Care

I introduced witnessing as a mode of being-with of midwives and women during pregnancy, birth and the postpartum stage. I pointed out that witnessing as it is idealized in the legal context, but also in certain philosophical traditions does not work out. As the witness is embodied, she is not neutral but involved in situations and related to people, surroundings, and things. I

used witnessing characteristics as being more passive and receptive than active, being knowledgeable, being trustable and being a witness because of having been assigned to be a witness to describe midwifery care. Witnessing is not the only mode of action and interaction concerning midwives and women, of course. It has its limits: Witnessing ends if hands-on action leaves no room for passivity, for passive activeness as I called it. Witnessing cannot happen if women do not assume their body: their body-in-labour, their disappearing body, and want to escape and leave it to the midwife. Witnessing always involves a distance. Even if one and the same person is witnessing herself, which results from and leads to alienating experiences, there is distance involved. Women handle the shaming potential of being witnessed bodily exposed—I called it eye-witnessing—by trusting the midwife not only in advance but also in reaction. Witnessing seems to be easier when there are fewer temporal and structural restraints. In clinical settings, witnessing is a lot more difficult and eye-witnessing is more likely. How to witness if it is impossible to stay nearby the woman because several women at once have to be attended to? How to witness if guidelines and standards impose certain medical interventions? Apparently, midwives' scope of action and women's scope of action are entangled with each other. It would be helpful to create environments in which midwives-women relationships happen which give opportunity to midwives to have time and space to attend one woman continually, even at the hospital, and which give opportunity to women to be involved in decision-making and action-taking and to be carefully protected against exposure (see also Hodnett et al. 2013; Sandall et al. 2013).

Acknowledgements I would like to thank Annelieke Driessen, Tim Opgenhaffen, Kristine Krause, Jeannette Pols, Theresa Kerbusk, Tanja Müller and Franziska Krause for their helpful comments on previous drafts of this paper.

Notes

1. I understand embodiment as a corporeal bounded, interacting and interactive being-in-the-world. The phenomenological description of the body (the German *Leib*) as the condition of experience and concernment as well as the sociological view on how bodies are constructed or shaped (*doing bodies*) are part of this embodiment.

2. How uncomfortable this disembodied state might be is marvellously illustrated by Roald Dahl in his short story *William and Mary* (Dahl 2004).
3. In legal contexts, witnessing and testifying are spatially and temporally separated. In contrast, I would suggest there is simultaneity of witnessing and testifying in space and time in midwifery care (apart from the paper work which serves as testimonial and can be defined as a legal act).
4. According to the *Hebammengesetz* (1985/2014), midwives are supposed to *survey* [überwachen] birth, provide intrapartum assistance and *survey* postpartum stage. Surveillance entails control and distance within a hierarchical structure. Witnessing could be described as a “soft” surveillance which is interrelated, which involves mutual responsibility and trust and within which hierarchies as well as distance and proximity are constantly shifting.
5. In this article, I draw on observations I made during an internship in southern France and during my midwifery training in Germany as well.
6. Actually this did not seem to happen out of uncertainty, but in order to get to know my point of view. There might have been a certain apprehension about me judging about professional competences or the quality of the provided care. I am even more thankful for having been admitted to observe!
7. I am aware of the fact that midwives are women, too. In midwifery it is totally unusual to talk about women as patients or customers, because midwives usually tend to characterize pregnancy, birth and the postpartum stage as a non-pathological process during which they do not provide service (only) but also care.
8. It would be interesting to spend more thoughts on knitting as a cultural phenomenon. Knitting is a traditional feminine occupation and craftwork belonging to the private sphere. A renaissance of knitting as a social and ecological and therefore even political activity can be stated in western cultures. The act of knitting itself seems to be more important than its products, which is the case for the knitting midwife, too. The knitting midwife belongs to the private sphere and would not be situated in a clinical setting.
9. The French term *sage-femme* for midwife can be translated literally as “wise woman”. The English term *midwife* signifies literally “woman who is with”. Both terms contain the passive and knowing presence which is also described by the image of the knitting midwife. The German term *Hebamme* has a more practical-active meaning: The “ancestor/grand-

mother who lifts the child (during birth)”. Wisdom (usually attributed to the elder) leads to a practical knowing-how.

10. Uterine contractions lead to a progressive opening of the cervix from ca. 1 cm until 10 cm during birth. The first 3 cm of opening take quite a long time—especially if the woman is giving birth for the first time—and this phase is not yet considered as the active phase of labour, but the so-called latent phase.
11. Madeleine Akrich and Bernike Pasveer analysed women’s childbirth narratives and concluded that women would differentiate between an embodied self and a *body-in-labour*. I would like to borrow the term *body-in-labour* from Akrich; Pasveer to the extent to which it illustrates externally and internally induced objectification processes during birth which might create a sensation of this *body-in-labour* being separated from the embodied self of the woman in labour (Akrich and Pasveer 2004).
12. I understand “doing circus” as being involved in a spectacle (Lat. spectare: to watch) which means having been watched.
13. In his article, “Shame and silence” the American professor of philosophy Bruno B. Janz develops further a former publication of Samantha Vice (2010). He refers to Emmanuel Levinas and Giorgio Agamben in order to show what “kind of self [...] whiteness in South Africa makes possible today” (Janz 2011, p. 462). Non-white people might evoke an existential shame in white people because of the “immiseration and oppression of blacks during apartheid” (Janz 2011, p. 467). It might seem as if I was using an inadequate template—the midwife-mother relationship is certainly not necessarily comparable to the situation of non-white and white people living together in South Africa—but actually I am borrowing a philosophical anthropological approach to the self in the same way in which Janz is using Agamben’s concept of witnessing of Auschwitz survivors (Janz 2011, p. 469).
14. Agamben explains that shame derives from discovering oneself (or one’s Being) and not being able to avoid it. Being ashamed also means being aware of oneself (see Agamben 2002).
15. Jean-Paul Sartre has also worked on “le regard d’autrui” (the look of the other), which objectifies and alienates (see for instance: Sartre 1982).
16. Luhmann describes trust as the anticipation of disappointment (cf. Luhmann 2014, p. 104). I would like to argue here that trust is established in practices and has to be constantly renewed. Trust can be a reaction to a disappointing (shaming, frightening, painful etc.) situation as well.

17. Dörte does not use the term “objective gaze” in the Foucauldian sense of the “medical gaze” (Foucault 2011). For her the objective gaze is a relating, but respectfully distant gaze.
18. The CTG records the foetal heart sounds and the uterine contractions during pregnancy and birth. While recording it reproduces the foetal heartbeat laudably and prints out a paper with two curves on scales representing the foetal heartbeat and the maternal contractions.
19. Intrapartum care is usually based on information given by the CTG.

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