The midwife’s present

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Dedication:

To midwives everywhere and especially those I have known and loved:

[...] May the nourishment of the earth be yours,
may the clarity of light be yours,
may the fluency of the ocean be yours,
may the protection of the ancestors be yours.

And so may a slow
wind work these words
of love around you,
an invisible cloak
to mind your life.

(John O'Donohue 1997:12)
Thank you to:

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to do and for holding the space for me to do it
browyn for her gift to me: special skills, understandings and unending
generosity as she midwifed the midwife through a (long) gestation and labour.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other university.

Jennifer Anne Browne
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Abstract

This thesis develops an approach to midwifery that is more open to the (un)known, to the (un)thought, to the (im)possible. It argues for practitioners who have an ethical responsibility to embrace difference and to welcome the other. In this thesis I write of ways midwives and others ‘word the world’ and act in it, in order to understand how midwives can and do embrace opening themselves to possibilities and difference, in order that childbearing women will not have their possibilities for personhood closed.

As a midwife and a midwife-academic, I ask how current discursive practices in midwifery and childbearing function as they do. Using the techniques of ‘writing as inquiry’ and genealogy I bring to the foreground ways in which midwives think and act with and against the grain in the maternity health care system. Interrogating overlapping and competing discourses in midwifery, I work to understand how discourses produce at the same time numerous identities and accompanying ambivalence. In seeking understandings of the work that women do to constitute themselves as midwives, I write of midwives’ political and ethical moves towards and away from difference and towards and away from sameness, rules and order.

While midwifery does not generally recognise itself in poststructuralism, midwifery is (sometimes often) a poststructural practice. As I spotlight moments in which midwives already move in poststructural ways, I argue that a serious reflexive turn for midwives towards poststructural theory and practice is easily imaginable, and desirable.

The thesis argues that theories and practices which help midwifery move closer to the (un)known, the (un)thought, the (im)possible are ethically and politically responsible. In embracing difference and welcoming the other, childbearing women and midwives together may create their best chances yet for viable mothering and midwifery lives. This is the ‘possibilities work’ midwives and midwife-academics can do.
Writing the midwife

What else might writing do except mean?
(St Pierre 2005:969)

Making introductions…

Midwifery’s raison d’être is to be ‘with woman’ during pregnancy, in labour, while giving birth, and in the early time of parenting. Childbearing holds within it amazing complexity and, at the same time, beautiful simplicity. Because midwives share this remarkable and often challenging time in women's lives, midwifery and childbearing hold the promise of (extra)ordinary work. Despite (or because of) the challenges of working in a society and a health system which increasingly doubts bodies, what midwives do and say can have lasting, significant and helpful and/or harmful effects on women and their embodied processes.

While human beings often seem to like their worlds ordered and understandable, a desire for order can, unfortunately, act to curtail humans’ potential. In the maternity health care system a tendency towards order often translates into attempts to make childbearing definable, logical and organisable. Yet, paradoxically, the desire for order can also make pregnancy, labour and early parenting more complex, less
knowable and less doable. As well, a desire for (easy) understanding of women in pregnancy, childbirth and early mothering oversimplifies childbearing women's processes and underestimates their needs. Midwifery, working often against the grain of the dominant discourses which work towards order, tends towards understanding women’s embodied work in childbearing as complex, precious and not always ordered or orderable.

Yet midwives and midwife-academics have not yet (fully) theorised midwifery as a practice which is open to the (un)known, to the (un)thought, to (im)possibilities, nor have we (fully) theorised midwifery practitioners who embrace difference. Thus my aim in this thesis is to write of the ways midwives and others ‘word the world’ and act in it, in order to understand how we can (and do) embrace opening our midwife-selves to possibilities and difference, in order that childbearing women will not have their possibilities for personhood closed.

This is a thesis of optimism, a work of the future set firmly in the present and embracing the past. In the spirit of poststructural work it is about locatedness and everyday discursive and embodied practices as it focuses on the generation of multiple possibilities, subjectification and subjectivity and the recognition of difference. In the particular circumstances of Canberra, Australia’s national capital, in the early 21st century, midwifery opens and closes itself to possibilities, as it is opened and closed by others, while it tangles intimately with childbearing women doing their business of pregnancy, labour, birth and parenting. This thesis traces lines of flight (Deleuze cited in St Pierre 2005:967) as they move towards and away from the subjectification of midwives. Its trace is optimistic while at the same time I work to understand failings and messy bits, knowing that midwives (and childbearing women) cannot be, cannot be becoming, without them. It is a work, à la Derrida, of saying ‘yes’ to everything, yes to life ‘in spite of everything’ (Butler 2005:33). We do not know what the midwifery and childbearing future hold. Potentially, though, if we close ourselves off to (im)possibilities, to the (un)thought in the present, our futures will be not what they might have been.

How then do we proceed forwards, backwards and sideways, to a less comfortable midwifery, to a midwifery that tries to be accountable to complexity (Lather 2001)?
How can we be with woman and trouble being with woman? How can we upset the very category of midwife and yet remain useful and connected to women in our work?

To achieve my aim of writing ways midwives can and do (and do not) embrace opening our midwife-selves to possibilities and difference, the thesis is structured in the following way. Writing the midwife introduces the thesis and some of the midwives who people it. In order to set the scene for the thesis as a whole, writing as a ‘method of inquiry’, genealogy and the story of the early processes of the work, are woven in with the story of midwifery’s move from the private to the public domain. Midwifery across time and space is a play written to bring my data into life. Writing the play was a fascinating and useful way for me to begin what felt at first like a very daunting writing process, in part because of midwifery’s complexity. I used Kristeva and Butler and Derrida and Richardson and Lather and St Pierre and other wonderful authors, authors who helped me be brave enough to (love to) use writing as a method of inquiry (Richardson and St Pierre 2005), authors who made me bold enough to write into being my midwife-writing self and others’ midwife-selves. In Puncturing the known: speaking in times/spaces in birth I introduce the discourses I have called profound/profane and ideas of the (un)known, the (im)possible in childbearing and its sister work, midwifery. Often a pregnant/birthing woman is pushed, or goes willingly, beyond the limits of her and our collective imaginations, into a time/space zone of (im)possibilities, into a time/space of the (un)known, into the birthing unthought. In so doing she embodies a (poststructural) practice of ‘freedom’ and a critique of the signifiers that limit us as women and midwives. At the moment of the (un)known, the old discourses/embodied practices become irrelevant to her (and us). These moments open up spaces/times for new discourses, for new possibilities; possibilities of being (other) rather than only othered. These moments open up pregnancy, birth and early mothering, and therefore, midwifery, as works-in-progress. Building on this in ‘With woman’, worth doing, I investigate how the ‘being with/being useful’ discourse in midwifery leads to (and from) a complicated intersection of other discourses. I begin to ‘unpack’ the ways in which midwifery is spoken in (to existence) in the present by understanding the ways midwifery has been thought of and practised in different historical moments. In doing so, I seek to understand how
midwives and students of midwifery come to be constituted as legitimate and recognisable members of the midwifery discipline/profession and how midwifery discourses create and are created by childbearing women’s and midwives’ work in spaces and times which are unexpected and astounding. In The (re) politicisation of midwifery: history, circumstance, accommodation, resistance I look at our immersion in two of the available and arguably most persistent feminist discourses in midwifery, access and celebration and the midwifery journey towards and away from them. This chapter looks at the effects of midwives’ immersion in the discourses of access and celebration: the demands to increase childbearing women’s and midwives’ space/time in the public domain and the desire to raise the profile of both childbearing women and women-midwives because of their specialness and their special contributions. I ask are midwives snagged on these discourses that have served us (relatively) well at the same time as they have confined us? Finally, in An ethics of responsibility: working in/from the (im)possible, the (un)known, I consider poststructural theory and practices which might be (more) enlightening for midwifery and childbearing women and their families than the earlier discourses of access and celebration. This chapter foregrounds the ways in which midwives think and act against the grain of dominant discourses, in order to consider an ethics of responsibility towards difference for midwifery. While midwifery would not generally recognise itself as poststructural, I believe that midwifery (on a good day) is a poststructural practice. By spotlighting moments in which midwives (already) move in poststructural ways, I argue that if midwifery is a poststructural practice as I believe it (sometimes) is, then a serious reflexive turn for midwives towards poststructural theory/practice is easily imaginable and desirable. It is also responsible. After summarising the thesis in Possibilities-work: being with, becoming, I look briefly at the ways that midwifery might (further) make/open possibilities for more viable/livable lives. Midwives have a responsibility to watch the way we ‘word the world’: to make new possibilities by writing, talking, naming what we know and saying it, by asking hard questions, refusing binary opposites, by keeping open/opening the embodied times/spaces for women to do their work (with our help). Such openness has implications for both teaching midwifery and for further research.
Who we are as midwives, our subjectivity, is complex and often difficult in Australia’s current maternity health system and is the subject of inquiry in this thesis. I believe we have a responsibility to try to understand ourselves and our work so that we can be useful to childbearing women and their babies in ways which do not rely on following rules and being consistent but which assess in each moment what appears to be the best decisions (made together) in terms of human wellbeing. Vicki Bell (1999:50) says (of feminist genealogy, and the same is true, I believe, for midwifery) that it needs to ‘[…] resist the tendency to see always the same patterns, has always instead to begin again, in order to make the present strange, in order to consider being otherwise’. The work that midwives do in becoming a midwife not only includes taking up a ‘with woman’ position, which is at the same time joyous and difficult and gratefully received and thankless, in our current health system, but actually taking up seemingly incongruent positions: positions of power, of selflessness, of surveillance, of judgement, of guardianship, of responsibility, of boundary-rider, of subservience/obsequiousness/deference, often simultaneously. It is in the taking up of those multiple and contradictory positions, positions which are ‘capable of disrupting old meanings of gender, even potentially overwriting or eclipsing them’ (Davies and Gannon 2005:319) that we become midwives in the present.

Midwifery is slowly picking up and using poststructural concepts for analysing, understanding and doing midwifery work with childbearing women. Quite a lot of work is written about how poststructuralism works in some practice fields, perhaps especially education (Cherryholmes 1988; Lather 1991; Spivak 1993; Davies 1994; Scheurich 1997; St Pierre and Pillow 2000b; St Pierre 2000; Davies et al. 2001). Some authors, although many fewer in number, are interpreting poststructural theory for midwifery (Reiger 1999; Davis-Floyd, Pigg and Cosminsky 2002; Browne 2003; Hunt 2004; Thompson 2004; Lane 2006), for childbearing, obstetrics and midwifery (Papps and Olssen 1997; Murphy-Lawless 1998) and there have been calls for poststructuralism’s use in midwifery work (Browne 1999; Walsh 2002; Kirkham 2005). This thesis speaks to these calls.

Feminist poststructural practices promise the possibility of a more viable [midwifery] life (Butler 2004b:8). They promise us (momentary, uncomfortable) release from
humanism’s ways of fixing identity and meaning, from its knowing rationality (Weedon 1997). Poststructural practices can bring relief from humanism’s production and enforcement of order and its defining of the essence of things in ways that advantage some people and silence others, including women ‘[s]ince women are usually on the wrong side of the binaries and at the bottom of the hierarchies […]’ (St Pierre 2000:481). Poststructural theorising moves midwifery towards openness. It moves midwifery towards difference, in the multiple senses of Derrida’s play with/on to differ (in space) and to defer (to put off, to postpone in time), where difference functions as a moment of doubt; difference in ‘[…] neither time nor space and makes both possible’ (Bass 1978:xviii). I believe that childbearing women and their families, and midwives, can benefit if midwifery makes this reflexive, theoretical turn.

In disrupting our ‘safe’ midwifery world, I also seek to interrogate Butler’s (cited in St Pierre 2000:478) awkward poststructural question of why we ‘[…] come to occupy and defend the territory we do, what it promises us, from what it promises to protect us’. Midwives’ immersion in midwifery discourses and the ‘love of, immersion in and indebtedness’ (Davies and Gannon 2005:319) to those discourses also make midwives who they are. I have spent years as a midwife and midwife-academic thinking and saying that this or that is strange, odd, queer, not understandable, bizarre. So much of my teaching and academic work involves trying to recognise the beauty and strangeness of birthing work, without forcing these discourses and practices into binary opposites, and trying to recognise the complex and often odd mix of knowledges and total lack of understanding that midwifery sometimes requires. When I began my initial midwifery learning I did not dream I would spend the next twenty years seeking ways to both understand my own and others’ work with women and their babies and families, and ways to recognise and talk about the strangeness of what I saw around me so that I could instigate change for women and midwives.

In my study I seek understandings of the work that women do to constitute themselves as midwives. I ask how current midwifery practices function as they do, using a mixture of ‘writing as inquiry’ (Richardson and St Pierre 2005) and Foucauldian genealogy as a ‘history of the present’ (Meadmore, Hatcher and
McWilliam 2000:463). I ‘unpack’ multiple discourses which produce numerous identities, and the (frequent) ambivalences that accompany these multiple positions. Even though they are precious to midwives and often to childbearing women, midwifery discourses cannot be thought of as producing a ‘truth’ any more than any other discourse. My intention is, by bringing to the foreground midwifery’s instability, to put midwifery sous rature ‘under erasure’ (Spivak 1974:xiv-xvi; Derrida 1976) to help us think differently by questioning received meanings (Spivak 1974; St Pierre 2000). My intention is to create a liberating if possibly uncomfortable work because I believe, with Elizabeth Grosz, that:

_We have forgotten where we come from. This is a double forgetting: of the elements through which all living things are born and live, a cosmological element; and of the specific body, indeed a chain of bodies, from which we come, a genealogical or maternal element. Life is this double debt, and its forgetting is perhaps the condition under which the living come to know the world though not understand themselves. The exploration of life - traditionally the purview of the biological sciences - is a fundamental feminist political concern [...]_.

(Grosz 2004:2)

So what is the work that women do to constitute themselves as ‘midwife’? What competing and overlapping discourses about women are at play in midwifery learning environments (as the students and midwives find themselves subjected to them)? What competing and overlapping discourses about midwives are at play in midwifery learning environments (as the students and midwives find themselves subjected to them)? How is desire relevant for women in constituting themselves as 'midwife'? What part does practice play in constituting themselves as midwife?

These are the questions which guided my research.

Undertaking research to answer these questions means ‘outing’ the system which, for several reasons, is a complicated and sometimes uncomfortable undertaking. First, many fine people work in the maternity health care system with the best intentions to ‘do good’ and many of those people carry out daily acts of human kindness, undertaken often in the midst of complex circumstances and under unimaginably busy and difficult conditions. Second, the hospital system is old, and sometimes slow to change, even though many people have worked for many years to
successfully make in-roads into a more humane childbearing world. Third, and this point relates to me personally as it does to many people who work for change, I do not work every day inside that complexity any more, as my work is teaching and research, intimately entwined with midwifery practice though they may be. So while I research to understand the overlapping and competing discourses about women, midwives and others in the practice arena, and even though I abhor some of the discourses and practices inside this long lasting, complicated societal institution, I do not wish in any way to be disrespectful of the people working in the maternity health system. (More than enough violence is perpetrated on those people already by the system). However, I did practise first as a nurse for ten years and then as a midwife and midwife-educator-lecturer for seventeen years before I worked solely for the university sector as a (midwifery) academic. So I come to this work as a researcher with a good working knowledge and an admiration for (and a love of) many of those who do work every day in our complex maternity system. I am especially respectful of those who work tirelessly both for women and for women-centred change. From an odd research position of being midwife and being not-midwife I often, but not always, use the pronoun ‘we’ when writing about (us) midwives as a recognition of my midwifery life and my love of/immersion in midwifery discourses and to mark my respect for midwives’ work.

**Introducing the midwife’s present…**

When midwifery works, midwifery is a gift for childbearing women. They receive that gift at a time of great importance, and in turn, midwives receive multiple gifts from women. Gifts are shared and exchanged as we vulnerably approach the other (Butler 2004a; St Pierre 2005) in body work, women’s work and midwifery work. As midwives, we witness the joy of birth, the love between people, the strength of human bodies, the power of determination and the delight of good luck. We become involved in people’s loves and hates, in their families and in their lives. On a one-to-one basis we are often loved, appreciated and acknowledged for our understanding of the body, for keeping women and babies safe, for supporting people and helping them manage, for making things less frightening and often for making the unbearable doable. Midwives know women can often do what women think they cannot, and
midwives share the utter joy that achievement brings to women, their partners and loved ones. We watch women feel instantly clever after giving birth. We see women grow up and grow wise and then marvel at their growth and wisdom. We know many women in pregnancy, during labour or while giving birth, or when they feed their babies for the first time, start to believe in their bodies for the first time. Some women even fall in love with themselves, for the very first time. We witness (and help) women change as they become baby-growing, birthing and lactating body and woman/mother. These gifts are midwifery gifts.

There are other ‘gifts’ in childbearing and midwifery which sometimes push women, men and midwives to, and (well) beyond, the boundaries of experience, comfort and understanding. The reproducing human body’s simplicity can be inspiring and its complexity overwhelming. The complexities midwives see, hear and come to (mis)understand in this process challenges us (as does its simplicity sometimes) and then we often compare/contrast what we see with our own lives. Sometimes that makes us grateful for what we have. Sometimes our lives seem lacking in comparison. Midwives see distance and sadness between people, even in the midst of birthing new life. We see violence and family chaos and destructive behaviours. We know people’s worlds out of control and systems which increase the chaos. We smell fear and know dread. We work with pain and despair. Midwives see and engage in manipulation, denial, arrogance, meanness and power seemingly out of control. Midwives are also kind, considerate, strong, believing, encouraging, skilled and careful. We are often surprised and yet sometimes we are not, even perhaps when we could be. We hear quiet women yelling and see noisy women in a trance. We hear primal grunting and uncontrolled screaming and ‘I can’t do this any more’ even at the point of it being almost done. We see a smile on a woman’s face after her work is done that is second to none. We see (big burly) men sobbing, with joy, in fear, and just because. We see babies come out who should not fit and we see others needing help to be born or breathe or feed when it looked like it was going to be ‘easy’. Midwives watch as women and babies receive help they do not need and the help hurts them. We do things to women they do not need and our ‘help’ hurts them, and us. We (sometimes, often) do not do what women want. We (sometimes, often) do what women do not want. We do not give them what they need. We miss cues because we are too busy, too tired, too bored or too scared to
notice/acknowledge/act on what we know and see. We see ill babies get well and seemingly well babies die. Sometimes we are at death and feel relief and peace. Sometimes we are at death and feel a searing anger and the pain of debilitating guilt that goes on and on.

Complicated as it is, the presents from women to midwives and from midwives to women, of both joy and adversity, can be gifts of knowledge and growth. Midwives learn about ourselves while we learn about others and the universe. We see body, mind and spirit things that we will never fully comprehend. We see and hear things we cannot fix or sort or change or even influence. We want seemingly opposite things at the same time. We want women to be strong and at the same time we want to save them from themselves and others, even as we know saving them will make them more fragile. We want very ill or extremely small babies to die and we want them to live. We want men to be very involved and we want to be engaged in women's business. We want to hold families close and we want to manage our work space (alone). Midwives and women and their loved ones often have multiple and competing realities, beliefs, desires, personalities and identities, all at the same time and in the present. These complex presents/presences often mean our discourses and our desires overlap and compete.

Apart from the idea of a gift, the word present in the title of this work, ‘The midwife's present’, is also a play on the word presence and brings to mind the present tense-ness of midwifery. Midwifery, as a presence, a connection, exists for women and only because of women (Guilliland and Pairman 1995). Just as a curriculum can be considered to be the relationship between learners and teachers (Bevis and Watson 1989), so too can midwifery be conceptualised as the relationship between women and midwives (Guilliland and Pairman 1995). The word midwife comes from the old English ‘midwyt’ meaning ‘with woman’ and is precious to midwives as both describing and creating our midwifery meanings. ‘Being with woman’ or ‘with woman’ is used in practice, in theory and in teaching as a foundational concept (see for example, the work of Guilliland and Pairman (1995), Page (2000b) and Fraser and Cooper (2003b)). Midwifery is work. It is a practice based discipline. Midwifery is not a theory even though it is theoretical and it is not sociology, even though it is sociological and it is not a philosophy, even though it is philosophical.
Midwifery works, and is, between people in the here and now. Midwifery can be said to be a verb, signalling the immediacy and doing-ness of midwifery. Midwifery also has a past and future, again like a verb; past imperfect, future infinitive, the metaphor can be extended and extended. Midwifery as a present tense verb signals the immediacy and doing-ness of midwifery and also its relationship to people and to the past and future, its becoming, in the sense that Deleuze understands:

“What is real,” Deleuze writes, “is the becoming itself, the block of becoming, not the supposedly fixed terms through which that which becomes passes... Becoming produces nothing other than itself... [A] becoming lacks a subject distinct from itself... Becoming is a verb with a consistency all its own; it does not reduce to, or lead back to, ‘appearing,’ ‘being,’ ‘equalling,’ or ‘producing.’” What Deleuze finds missing in all of these apparent synonyms for “becoming” is the focus on process itself. Whereas evolutionary language focuses our attention on the beginning and endpoint of a process in a way that obscures the passage between them, the language of compound becoming draws our attention to what happens between these ever-receding endpoints. Becomings take place between poles; they are the in-betweens that pass only and always along a middle without origin or destination.

(Schrift 2000:152)

The terms woman/women and midwife/midwives, while they are of course nouns, are also used here in the sense of a verb, of the present tense. I am cognisant of the potential for arrogance, inappropriateness and impossibility of putting all women [and/or all midwives] into a generic group and talking about them as if there are no differences among them (Butler 1990; Weedon 1999). So I employ the two categories here, woman and midwife, for two main political (and ethical) purposes guided by Elspeth Probyn (2003:298) who writes of attempting to speak for the ‘other’ ‘[b]y now, hopefully, it is common sense that I cannot speak for an amorphous group, be it other, or women or whomsoever’, and Wanda Pillow (2002:23) who writes, ‘[a]s long as we are gendered and engage in gendering each other, this work, the work of feminist research, is necessary’. Therefore, I first use the terms as a resistance to the ‘pervasive cultural condition in which women’s lives were either misrepresented or not represented at all’ (Butler 1990:1). Second, and perhaps more importantly, I use the terms also in the sense of the present and the future, in the sense of fluid subjectivities, of being in progress, of becoming:
If there is something right in Beauvoir’s claim that one is not born, but rather becomes a woman, it follows that woman itself is a term in process, a becoming, a constructing that cannot rightfully be said to originate or to end. As an ongoing discursive practice, it is open to intervention and resignification.

(Butler 1990:33)

Introducing the ambivalence of childbearing...

My thesis starts with the following story as a way of recognising the complexity of the historical inscriptions on the body (Foucault 1984a) for (me, and) childbearing women and midwifery, complexity which puts ambivalence at the forefront of pregnancy, birthing and midwifery:

She had felt really odd all that Sunday: sore, tetchy and kind of anticipatory. Her sister Mary rang. When she described how she felt, Mary laughed and said 'Last time you felt like that, you were having David!' She suddenly remembered. She knew she was pregnant. Crying, she hung up the phone. She asked her partner to go and buy a pregnancy test. It was the kind that you wee on and the two dots stay white if you’re not pregnant and go purple if you are.

The dots went so purple, they were iridescent. She had wanted to have another baby but as those dots went glow-in-the-dark purple, she thought, 'What are we going to do about child care?' and 'Oh! We will have to put another child in and out of a car seat!' In a complete panic, she couldn’t stop crying.

Her partner said ‘It’s OK. It will be all right. She will be beautiful. We’ll call her Dotty.’

She stopped crying and laughed.

(JB’s Journal, 1992)

In this memory story the woman (me) is at the same time and at different time/s glad and sorry, nervous and excited, angry, panicked and totally filled with joy. My embodied knowledge of the complexities of being ‘with child’ fuels my ambivalence. I both knew I was pregnant and at the same time didn’t know until my sister reminded me how my body was last time ten years earlier. I understand the body-work which has already begun, almost without my permission. I see my future changing again. I know how it is to be pregnant and to feel many things at once. Even as the pregnancy test turns positively purple, I have (re)assumed the position of pregnant body. I knew I was
pregnant before the dots glowed purple and I know that for this baby and for me, all of me, this is just the beginning.

This story of a new pregnancy and the accompanying ambivalence can be read as one in which the male partner takes up the position of leader. We do not know from this story how he felt, but in trying to be kind to his now crying partner, he decides it will all be OK and says so, and she feels better. The story can also be read as an example of how excited and accepting a man can be about a new baby ‘on the way’. It can also be read as a man understanding a woman’s feelings about body work and how he, in his empathy, tries to speak a different way of feeling/thinking/managing into being. This story may also be read, outside the boundaries of the patriarchy, as a space/time in which two humans, together, manage a new exciting scary possibility in a way which was useful to them. Adrian’s voicing of a new word in their world opens up a different space. Naming the ‘dots’ changes the woman’s world. It makes the (un)thought thinkable, the (un)known recognisable. It makes her new work doable…

‘Dotty’ became Louisa after birth, when we knew who she was differently, when we knew her better, when we saw her and felt her in a different way (from outside me, not from within) when she looked at us and changed minute by minute, when she frowned at my sister trying to dress her for the first time and when she smiled at us all, knowingly, as if she had been here before. But she was Dotty as well, interchangeably, for many months and we still have a carry bag called the Dotty Bag and we tell her Dotty stories, even though she is now in high school and her parents are embarrassing.

Louisa grows and the need for Dotty has gone but the complexities of baby-growing, of mothering, of parenting, of knowing how to raise a strong girl, who will belong securely to her generation, into capable connected womanhood, remain. As the world inscribes itself on the body of the now adolescent girl, our no longer newly born Dotty, I am sometimes indecisive, unsure, lost, scared even, trying to do the right thing to her and for her and by her. I am a Dotty mother. However, I can’t even write that I am always unsure in parenting, in mothering. Sometimes, I am sure. I feel strong and capable and embodiedly sure of myself as a mother and a co-
woman for my girl-woman child. Often these feelings occur all at the same time. Sometimes my mothering works. Sometimes it doesn’t. Often I can’t tell. I have come to see this as good enough. I am a good enough mother. I am a Dotty mother.

Writing in this work (that is, writing it and writing into existence myself and others and ideas in the writing), this work of complexities and ambivalences, I also see myself as a Dotty researcher. By writing in the known and the unknown, the possible and the impossible, the certainties and the uncertainties, the confidence and the complete unknowable-ness of midwifery (and in the process, of birthing and learning) and having none of them be simply opposites (Derrida 2001:63), I signal the methodological grounding of my study in women’s bodies in general and in particular, and in my body too. As Michel Foucault suggested:

_The body is the inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated self (adopting the illusion of a substantial unity), and a volume in perpetual disintegration. Genealogy, as an analysis of descent, is thus situated within the articulation of the body and history. Its task is to expose a body totally imprinted by history and the process of history’s destruction of the body._

(Foucault 1984a:83)

Foucault does not mean that if we keep digging we will come to the ‘real’ body. On the contrary, he suggests that there is no body not imprinted by history. His understanding of ‘history’ is different from many other historians’, considering heritage not as an acquisition or a something to be owned but as ‘an unstable assemblage of faults, fissures and heterogenous layers that threaten the fragile inheritor from within or from underneath’ (Foucault 1984a:82). The researcher’s task, therefore, is to expose the imprint of history in order to come to new understandings of bodies as they are (re)created by history. Pregnancy and birthing and also midwifery and its teachings are embodied and complex works. From most viewpoints in our society, growing another human being is not simple. It is a biological, social, spiritual and cultural process with long term (often unforeseen!) consequences. These processes are tied up not only in women’s embodied work but also in the discursive constructions which dictate what they (can) become. As Wanda Pillow says of embodiment in her research about young pregnant women and education policy:
[...] I am not only discussing the actual embodied fluctuations and needs of the pregnant teen body but importantly how society interprets, names, judges and prescribes for these needs. Embodiment does not ignore the complex relationships between women, mothering and the state. Nor is embodiment neutral – it includes the constituted politics of gender, race and class.

(Pillow 2003:153)

As in the Dotty story above, interwoven with the ‘constituted politics of gender, race and class’ (Pillow 2003:153), childbearing and midwifery become part of the complex tangle of the dailyness of women’s lives at the same time as being part of an often woman-unfriendly health system, in a society which has a complicated relationship with its reproducers and carers. Midwifery’s possibilities, like pregnant and labouring women’s, grow out of our simultaneous involvement in so many intricate processes. Midwives’ complex positions come from ‘making it up as we go along’, from trying to be useful and connected to the women with whom we work, from following and using and making history, philosophy, technologies and relationships. While all humans have much in common, we are of course all different. In midwifery it is often difficult to know what to do or say or how to be. It is difficult (and fun) being with a woman who wants/needs many often opposing things at once while at the same time we have our own competing and overlapping wants and needs. Alison, an experienced and very influential local midwife-leader who was an important person in my study, describes the responsive and often individualistic and yet collective character of midwifery:

I see myself being very clear about what we should be doing for women. I suppose [...] you have to change what you have to do according to the woman and the situation and the staff you’ve got around you.

Alison, interview

As my study grew it shifted, moved, folded and re-folded, developed, hid from view and came (briefly, sometimes) into the light, and in so doing, became more known to me and became more nameable. After several years its final title, ‘The midwife's present’, sits well. The midwife’s present calls in the (extra)ordinary and brings to mind and body, women and midwives together working in spaces/times of the (un)known, the unthought, in Derrida’s (2001:63) ‘possibilities of the impossible’. The title means that throughout this doctoral work, as in midwifery, childbearing
women and midwives give and receive and talk and work not just themselves into existence but each other (Davies 2000:85). Midwifery involves being in the presence of the self and the other, and in so being, creating (new) others and (new) selves through embodied work. ‘The midwife’s present’ hints that working with/in the self and working with/in the other is an active form of construction, a weaving, a utilising of colours and textures and senses and un-nameables; calling to mind patterns-in-progress, unknown patterns in unknown progress.

Poststructuralist theory is a gift to such complex work as it helps us look at the ‘folding and unfolding of history, in the movement from one configuration to another, in the lines of flight that make new realities’ (Davies 2004:7). This analysis of midwifery centres, therefore, not only on discourse but also on discursive and regulatory practices, looking for ways we actively speak ourselves, and are spoken, into existence in our social world (Davies and Gannon 2005). Women’s [and midwives’] ‘[…] subjectivity is embodied, and discursive practices shape our bodies, our minds and emotions, in socially gendered ways’ (Weendon 1999:104).

Just as women can do their work (probably, usually) without midwives, so too can women’s lives be enhanced by what midwives bring to their presence. Proudly purple, the dots foreshadowed an important and lasting gift in my life and our lives, being simultaneously strange and beautiful, scary and wonderful, unreal and frighteningly concrete, (in)significant and (un)important. Similarly, what we do and say as midwives both makes no difference and is hugely important, at the same time.

**Introducing (my) genealogical writing…**

_You look at yourself in the mirror. And already you see your own mother there. And soon your daughter, a mother. Between the two, what are you? What space is yours alone? In what frame must you contain yourself? And how to let your face show through, beyond all the masks? It’s evening. As you’re alone, as you’ve no more image to maintain or impose, you strip off your disguises. You take off your face of a mother’s daughter, of a daughter’s mother. You lose your mirror reflection. You thaw. You melt. You flow out of your self._

(Irigaray 1981:63)
When I look at myself in the mirror, I do see my mother there and I see many others. In my own family of origin, our Celtic inheritance was played out in significant and multiple storylines in everyday life. While my father’s family can be traced back to the Catholicism of the Irish bogs or to the Hill of Tara and Queen Maeve, depending on who was telling the tale, my mother’s family is a messy mix of Irish Catholic and Scottish Presbyterian and ‘high’ Anglican. In our family folklore, our Irish and Scottish farming and working class backgrounds gave us our strength, our humour, our religion and anti-establishment attitudes. Our Anglican heritage diluted our Catholicism so we were not so enmeshed in the Lives of the Saints as were some other (Irish) Catholic families of the 1950s and 1960s. We also grew up surrounded by left wing politics with stories of Ben Chifley, Australia’s prominent post-war Labor Prime Minister, my grandfather’s exploits in the Australian shearsers’ strikes of the early 20th century and a fledgling union movement seeking ‘justice for the workers’. The (2nd World) War, and the post war need and responsibility to be grateful for, and cherish, our hard won freedom, and nurture a free and peaceful world so we would never have another war, were also strongly valued storylines in my family, and are now part of our own children’s heritage.

In my childhood, shape, height, temperament, colouring, wit and multiple other personality and bodily characteristics and, especially, aberrant behaviours, were frequently traced back to long dead or still living individuals. On the days I annoyed our mother by being too definite, forthright and argumentative I took after her (much loved) mother. When I was viewed as being outrageously generous or a loyal friend, I was read again as being like her mother. We could never be sure, though, how we would be positioned on any given day. Genealogy, in my family, belongs firmly in the present. Inherited genetic endowments bear real and significant influence on both the dailyness of our lives and our future potential. The naming and understanding of traits by some classifications, for example, Catholic/Anglican and Irish/Scottish have now (almost) dissolved as a means of categorisation for family members. However, as we age and in the context of the next generations, who we are considered to be ‘like’ in the family still sets the scene for describing, and I am sure, producing, who we can (in part) become. Our historical inheritance, our genealogy, still remains in the present and in the future. In the midst of these family
story lines, ‘taking after’ individual family members is considered to be an integral part of our potential as human beings (human ‘becomings’). It is also a moveable feast, with ‘I don’t know who she is really like…’ often said when there is a problem! Not being like anyone is not an option. It must be someone, we just have to work it out...

One of the storylines in my family is that I am difficult. Being difficult (or eccentric, as I am sometimes labelled outside the family) suits poststructural theory too, as poststructuralism demands we look askance, that we ask hard questions. Gavin Kendal and Gary Wickham, in describing ways to understand and use poststructural theory, in particular Foucault’s methods, wrote that genealogy is:

[…] a methodological device with the same effect as a precocious child at a dinner party: genealogy makes the older guests at the table of intellectual analysis feel decidedly uncomfortable by pointing out things about their origins and functions that they would rather remain hidden.

(Kendall and Wickham 1999:29)

So while uncomfortable or difficult is ‘normal’ for me, I did not exactly go looking for ways of working which would radically change my world the way poststructural theory and practices have. However, in a way I was poised and already opening to new ways of understanding midwifery (and life), yet waiting to go (further) out into the midwifery (un)thought. I feel fortunate to be working, studying and writing in what Laurel Richardson (2005:961) calls the ‘postmodernist context of doubt’. I have been a regular ‘doubter’ as a midwife. Not only the sort of ‘standard doubting’ many midwives engage in, that of doubting the authoritative knowledges of science, obstetrics and nursing, but more and less than that. I have been both a lover and a (sometimes closet) doubter of midwifery. In my twenty years of mothering, midwifing and teaching I have become increasingly uncomfortable with (midwifery) certainty. Because poststructural theorising/writing not only reads uncertainty as healthy but demands it and creates it, I found this method of inquiry very freeing. In poststructuralism, as in being with birthing women, one cannot know everything. In fact, not knowing is the beginning of another time/space, a Derridean time/space of difference (Bass 1978), that is the joy and the work of both midwifery and (feminist) poststructuralism.
I remember when I began to hear, see and touch, to understand enough to use poststructural ideas. The notions of multiple subject positions, dominant discourses, reality construction, binaries and theories of micro and macro power took hold in my feminist, midwifery imagination and worked their magic. The poststructural suggestion that there is no one universal ‘truth’ made perfect sense to me, coming from a feminist midwifery world where we often do not know what is happening or why, and where dominant discourses are often ineffective and, at times, destructive. Kristeva’s (1987) call for women to hold our truths up for analysis in order to be ethical, held a wondrous promise I thought, given the (sometimes, often) narrow view of ethical thought and behaviour in the health sciences. Kristeva’s ideas gave me the nerve to invest time and energy, and risk a many-year journey into a theoretical perspective which some claim to be nihilistic, anarchic. From the time of my early understandings I was able to position myself as a ‘poststructural optimist’, one open to difference. I believe in the world and in people and my understanding of poststructural theory and practices helps me live life to the full, in the sense that Hélène Cixous (1991:347) writes ‘[…] living means wanting everything that is, everything that lives, and wanting it alive’. I believe that theories can enhance our lives and that there is ‘nothing as practical as a good theory’ (Lewin cited in Jordens 2006), and I agree with Julia Kristeva when she writes that we have a responsibility to enhance the lives of others, given the opportunities:

*In order to bring out – along with the singularity of each person and, even more, along with the multiplicity of every person’s possible identifications (with atoms, e.g., stretching from the family to the stars) – the relativity of his/her symbolic as well as biological existence, according to the variation in his/her specific symbolic capacities. And in order to emphasise the responsibility which all will immediately face of putting this fluidity into play against the threats of death which are unavoidable whenever an inside and an outside, a self and another, one group and another, are constituted. […] this is how we might understand an ethics which, conscious of the fact that its order is sacrificial, reserves part of the burden for each of its adherents, therefore declaring them guilty while immediately affording them the possibility of jouissance, for various productions, for a life made up of both challenges and differences.*

(Kristeva 1981:35)

Now, as a midwife-researcher, I am inspired by the congruence of using a combination of genealogy and ‘writing as inquiry’. In my life and in my work
before the notion of genealogy-as-research came to my notice, genealogy-as-a line of descent/development was part of my every/day understanding and practice. Working with pregnant and birthing women, thoughts and words often turn to inherited characteristics. Exclamations such as “Oh, she looks like mum”, “Look at his eyes – they are just like mine” or “She takes after you…” are an everyday occurrence in birthing rooms across the globe. Midwifery is intimately involved with the seemingly random and multiple manifestations of the human species. Looking at research and research methods in the same detailed, discerning way seems fitting in my work. Foucault said of Nietzsche’s genealogical work that:

*Genealogy does not resemble the evolution of a species and does not map the destiny of a people. On the contrary, to follow the complex course of descent is to maintain passing events in their proper dispersion; it is to identify the accidents, the minute deviations – or conversely, the complete reversals – the errors, the false appraisals, and the faulty calculations that gave birth to those things that continue to exist and have value for us; it is to discover that truth or being does not lie at the root of what we know and what we are, but the exteriority of accidents. [...] The search for descent is not the erecting of foundations: on the contrary, it disturbs what was previously considered immobile; it fragments what was thought unified; it shows the heterogeneity of what was imagined consistent with itself.*

(Foucault 1984a:81,82)

So new (poststructural) words and ideas and practices opened up possibilities for new knowledges and this began understandings of a more comprehensible, multiple me and multiple them. Poststructural theory also helped me see that my desire and work for change in the maternity health care system (and society) could be grounded in a rich, relatively new and still developing theory. That understanding felt liberating, useful and responsible. I grew to love deconstruction (Derrida 1976) by beginning to understand how to use it, because as Butler (1992:15) suggests, ‘To deconstruct is not to negate or to dismiss, but to call into question and, perhaps more importantly, to open up a term, like the subject, to a reusage or redeployment that previously has not been authorised’. I also became fascinated with the ways deconstructing meaning-claims creates a way to look for the power that meanings carry, and opens up a space for other/different/new meanings (Ferguson 1991). I liked how it saw discourse and structure as entities which could be acted upon and changed. These possibilities for change have made many feminist writers see
poststructuralism’s revolutionary potential (Davies 1993). I could see revolutionary potential for midwifery and for me.

So in my work here, I occupy a writing/research space/time which grew to feel (un)comfortable to a feminist-white-woman-mother-midwife-academic, a space/time where I write of women, midwifery, mothering and teaching because of, and in spite of, being woman, midwife, mother and teacher. I have come to often painfully slow and intermittent but clearer understandings of midwifery by using a poststructural lens. Those understanding opened up, and closed, spaces I did not know nor could believe existed in my work as a midwifery academic. (Feminist) poststructuralism gave me a new way to bring together bodies, theory and practice in my work and in my life, a complex process in (midwifery) academia as seen in the following story:

Nicole
She took the student for coffee - they talked about heaps of stuff - the student’s new and lovely boyfriend, their mothers, the teacher’s partner and daughter, the other students and then eventually, work, which was really the topic for the coffee session, but every time the student tried to talk about work at first, she started to cry and couldn’t say anything. The teacher waited. She had been here so many times in 13 years. As the teacher sat there, she realised she had a pain in her stomach, the same pain she always gets when her students, her beautiful, wonderful, giving, strong students, are reduced to tears which run down their faces. They tell the same stories: mean midwives, not enough support, not knowing what to do or say, not enough help, not enough staff and a feeling of alienation from themselves and others. Her pain is anger. She cried too.

Memory story JB’s journal

Midwifery is an embodied practice and therefore midwifery can never ‘just’ be the content I teach. In this story I feel physical pain as I hear of Nicole’s awful time as a learning midwife. As I take up a position of midwifing body for this beautiful student, I hurt, as she does. I remember my own painful midwifery learning as Nicole transports me back to 1986. I remember, too, how hard it is as a midwife to find time and energy every single day for midwifery learners when you don’t have enough time to do your own ‘with women’ work properly. I easily remember the collective sting of learning new knowledges and skills to be ‘with woman’ in a misogynist health system. These are all sources of my pain, and Nicole’s, but the pain in this story is more than all of that. It is a pain that comes particularly from the

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kind of learning required in midwifery because of the necessary emotional and
embodied work. I felt Nicole’s pain in a way which called on my reserves and the
reserves of others. Midwifery is tough even though its rewards are spectacular. At
that moment, with the beautiful Nicole, and at the time of writing about her distress,
I am the text and it is me:

The practice of writing poststructuralist texts is not simple reporting, since
the writing itself is understood as a constitutive act, as is the collection and
analysis of data. The text may not follow predicted patterns of report writing
but may set out to deconstruct or disrupt report writing itself (Neilsen, 1998;
Richardson, 1997). The subject of the author will not be removed from the
writing but will be evidently at work in the text that is produced.

(Davies and Gannon 2005:321)

As it was for Nicole and me, midwifery (and research) often requires much of the
learner, the teacher and the researcher. Midwifery (dis)comfort comes in surprising
times/spaces. (Dis)comfort brings (un)knowing by recognising and peeling back
those layers of text on the body. In order to be open to this recognition, I believe that
a researcher needs to be not only investigative, but invested. As Laurel Richardson
(2000b:962) writes ‘knowing the self and knowing “about” the subject are
intertwined, partial, historical, local knowledges’. So I am a connected researcher in
an embodied way, I value bodies as bodies and text and I open myself and the
midwives and our shared midwifery world to scrutiny to disturb the ‘nature of
subjectivity’ (Scheurich 1997:162) in midwifery; to problematise midwifery, to cast
doubt (Richardson 2000b). By employing feminist poststructuralist writing and
genealogy as a ‘multiplicative possibility’, which is how Scheurich (1997:160)
describes archaeology, I open times/spaces for multiples, for potentialities, for
strangeness. In the spirit of Nicole’s and my embodied work, and that of
childbearing women, I hope for wild, new possibilities in midwifery and midwifery
teaching and research in order that we might be different ‘in order that we might
begin again, in order that we might consider being otherwise’ (Bell 1999:50). In my
thesis and in my work I am using my genealogy and writing thus:

Seeking a place for the body in a world ruthlessly cognitive, and a place for
spontaneity in a world overly organised, genealogy calls not for the end of
the subject but for the constitution of a new form of subjectivity, one less
colonised by and more resistant to the disciplinary strategies of modernity.

(Ferguson 1991:336)
Genealogy is the way Foucault (1984a) suggested research could be done. As a research method it sets out a way to both trace and explore the interweaving of historical and cultural practices which constitute our realities. It has a particular orientation to the present (Meadmore et al. 2000). At the same time as it provides a theoretical tool for doing research, it also assists our reflection on the nature and development of modern power (Tamboukou 2003). Genealogy is concerned with the production of truth and knowledge and so looks at the processes, procedures and apparatuses by which truth and understanding is produced. ‘Genealogy is grey, meticulous, and patiently documentary. It operates on a field of entangled and confused parchments, on documents that have been scratched over and recopied many times’ (Foucault 1984a:76).

Truth cannot be separated from the procedures of its production and so genealogy asks questions of practices and conditions which produce knowledge and in which we ourselves figure (Tamboukou 2003). Foucault’s approach to history is to select a problem for investigation, rather than an historical period (Kendall and Wickham 1999). Therefore, a genealogist ‘problematises’ the subject (as does poststructuralism in general) (Alloway and Gilbert 2004:110), and takes the ‘modern subject as data to be accounted for rather than as a source of privileged accounts of the world’ (Ferguson 1991:328). The genealogist ‘cautiously reminds us that things could be other than they are’ (Ferguson 1991:333). As Wanda Pillow writes of her feminist genealogy work concerning educational policy as it relates to pregnant teenagers:

*Feminist genealogy builds from Foucault’s work by focusing analysis upon historically and culturally situated decision-making [...]. Feminist genealogy pays explicit attention to ‘messy realities’ and questions that which seems the most natural, the most hegemonic, thus providing an ongoing critique and questioning of discourses (re)inscribing power, body, knowledge relationships. Influenced by Foucault’s use and description of genealogy, this work turns repeatedly to the body and theories of the body to interrupt normative practices, unmask liberatory discourses, displace binaries and resist hierarchical arguments.*

(Pillow 2003:150)
This is a thesis of messy realities, a space/time/text where writing is integral in its creation and birth. Here, my intention is to be both ethical and political by undertaking an exploration of (midwifery) life which is not descriptive, but disruptive. For me, writing has allowed a move into my ‘[…] own impossibility where anything might happen – and will’ (St Pierre 2005:973). It helped me realise Hélène Cixous’s demand:

*By writing her self, woman will return to the body which has been more than confiscated from her, which has been turned into the uncanny stranger on display […]. Write yourself. Your body must be heard.*

(Cixous in Weedon 1997:65)

Laurel Richardson (2005:959) suggests that researchers across several disciplines are finding ‘[…] writing as a method of inquiry to be a viable way in which to learn about themselves and their research topic’. By writing in different ways, we discover new aspects of our topic and relationship to it. Form and content are inseparable’. Poststructural writing is not just reporting ‘since the writing itself is understood as a constitutive act, as is the collection and analysis of data’ (Davies and Gannon 2005:321). In this work, I have put writing to use as a strategy to ‘disrupt the known and the real’ (St Pierre 2005:967), to help disrupt citational practices which lock us into patterns of language and behaviour (Butler 1997). By writing in ways which do not ignore bodily knowledges, ambiguity and ambivalence, I worked to come to a lucidity, a clarity otherwise difficult (or impossible) to find (Davies 2004).

**Introducing the midwife…**

For a family filled on both sides with strong, independent women, there is a dearth of nurses in my family. Only the second person of three in my extended family ever to ‘go nursing’, I was the first to qualify as a registered nurse. This always seemed odd to me, given that nursing was one of the few viable career choices for women for more than one hundred years. It is even more unusual when I think how many of my female relatives, sisters, older cousins and aunts entered the convent (a both conventional and ‘feminist’ choice) in the last one hundred years. Each of them
chose teaching or welfare work. None became nurses. After 10 years of happily being a nurse (and two years after the birth of my first child), I decided to ‘do midwifery’ mostly because I was sick of working night duty. Becoming a midwife opened up a line of inheritance in my family which nursing did not. I am the first and only midwife since my great-grandmother, my mother’s father’s mother, but I can trace midwifery back from her, through many generations of midwives: from rural midwifery practice at home in New South Wales in the 1910s and 1920s, back to an immigrant ship of the 1860s and further back into Fife, Scotland, in the early 1800s (and presumably, the line of inheritance would keep going back, if we could trace it). My sense of my inherited midwifery self is strong. A sepia photo of Granny Byrne, my great grandmother, who was midwife for my grandmother when my mother was born 85 years ago, hangs in my 21st century study above the computer screen, which shows the words of my thesis as I write each of them in blood. Granny Byrne is my genealogical connection (both in the sense of my ‘line of descent’ and also in the sense of a midwifery ‘trace’) to midwifery before hospitalisation and medicalisation. This is Granny’s story, adapted from a presentation I gave about her life and her midwifery several years ago:

Alice Braid was born in 1867 in country Victoria of Scots immigrant parents. She married Michael Byrne at 15 and had 14 children raising 7 to adulthood. She ran a boarding house in Narrandera, a small country town on the Murrumbidgee River, in south-west New South Wales. The boarding house was mostly for railway workers but many other people lived with her over the years, including her mother, two of her brothers and their children, her sisters, one of her daughters in law, her nieces, some of her grandchildren and one of her best women friends whose husband had died. At times she looked after up to twenty boarders as well.

My mother remembers Granny as a strong, somewhat outrageous woman, with a keen love of music and parties and a fairly sharp tongue. She loved pretty things and liked to dress up in beautiful clothes and wear a lot of jewellery. Her husband Michael became ill in his forties and spent the rest of his life in psychiatric hospitals in Sydney and Goulburn. Granny owned her boarding house in her own name in 1923.

Granny was born in Echuca, Victoria, the youngest of eleven children. Her mother, Janet, was attended at Granny’s birth by Granny’s second sister Ann. Three of Granny’s sisters, who were up to twenty years older than Granny, were midwives. It is said that Granny learned her midwifery from her oldest sister Margaret. Margaret learned her midwifery skills from their mother
Janet who was born and lived in a small village in Scotland before immigrating to Australia.

Granny also was a midwife who assisted women to give birth in the front bedroom of her boarding house in Narrandera. Granny attended the births of almost all of her 24 grandchildren and the children of many other women in the district, especially those who were poor, unmarried or from outlying country areas. Granny’s boarding house seems to have been a safe place to go if having a baby was not exactly the acceptable thing to do. About one third of the women whose babies were born at Granny’s were not married, a number which was high in proportion to the number of unmarried mothers in the birth register. It seems that as women came close to their due date for birthing, they would go and live at Granny’s house and stay until after their baby was born. They often brought their other children to stay as well.

If Granny ever kept a written record of her deliveries it has been lost but she is named as the midwife in the birth register of many children over a period of many years and she is remembered in the district as a midwife. She was certainly talked about in my own family as my mother’s and my uncles’ midwife. My mother, who is 85, was named Janet Alice after her mother’s mother and Granny, her father’s mother. On my mother’s birth certificate Alice Byrne is named as the midwife (the ‘nurse attending’ as it was written then) along with a doctor and the place of birth is recorded as ‘the Wagga Road’, meaning Granny’s house.

It seems that birthing in Granny’s house was very private and very much women’s business. There are members of my family who either lived or stayed with Granny and remembered pregnant women sharing meals with the boarders and the family and then remember the baby at the dining table with their mother but knew nothing of the happenings in between, in a house that was less than twenty squares. Family folk lore has it that Granny gave up midwifery when New South Wales introduced the registration law for midwives. This is confirmed by the birth records. The last registered birth attended by Granny that I could find was in July, 1924.

Alice Byrne died in 1953, and is buried in Narrandera where she had lived for over fifty years. This was her obituary in the local paper:

[...] the death occurred in hospital in Sydney on the 22nd January of Mrs Alice Byrne, wife of the late Mr Michael Byrne, of Narrandera. She was 85 years of age. [...] Mr and Mrs Byrne came to Narrandera 55 years ago and shortly afterwards Mrs Byrne opened a guest house at "Violet Dale" in Victoria Avenue or the Wagga Road as that street was then known. Some years later Mrs Byrne purchased "Kilmarnock"...She conducted "Kilmarnock" Guest House for 25 years until ill health about four years ago caused her retirement. She was known to her boarders and other intimate friends as "Granny" and during the years she conducted "Violet Dale" and "Kilmarnock" she was a mother to many a young man who was boarding away from home for the first time. [...] Of her family of 14 children, only five are
living.... She had 24 grand children and 39 great-grand children. Her husband predeceased her by 18 years [...] On arrival here by train from Sydney on Friday last, her remains were placed in the Presbyterian Church and the internment took place that afternoon [...] (Narrandera Argus, January 27, 1953). (Browne 1995)

My great grandmother Alice Braid Byrne and others of her generation stood, unconsciously, at an amazing historical and sociological junction between midwifery-as-private and midwifery-as-public. In 1924 the New South Wales Nurses’ Registration Act, designed to control the practice of midwifery, passed into law (Gaff-Smith 2004). Had she so chosen, Granny, a midwife trained by her much-older sister, who was taught midwifery by their midwife mother, could have obtained her midwifery licence (as ‘untrained’ midwives were required to do for the first time by the new law) through an ‘experience’ criteria or grandmother clause (Gaff-Smith 2004:15). But Granny stopped practising midwifery in 1924 as did many other, but not all, midwives ‘without formal training’ in the same position (Gaff-Smith 2004:15). Our family does not know why Granny did not seek to legalise her midwifery through state registration. She ran a very busy boarding house, a common occupation for midwives who did not seek registration (Gaff-Smith 2004), (while she was working as a midwife, and after) until she was over eighty years old. Clearly, hard work did not worry her but she turned fifty six in 1924, so perhaps it was time to stop being on call. Most of her grandchildren had been born by then, so that may have been a contributing factor. What we do know is that with the introduction of this law, the handing down of midwifery skills in families from generation of women to generation of women stopped. Two generations would pass in my family before another midwife would be made, one trained in a hospital, inside the medicalised climate of the 1980s. As that ‘new’ midwife, I had to (re)learn years later how to be the kind of community midwife Granny could well have taught me to be. I could have learned easily from Granny what was hard for me to learn from childbearing women and independently practising midwives: that childbirth is a social, not a medical, event.

As in Granny’s obituary, midwifery is often silenced and silent in our communities (Browne 2000) and this is one of the reasons for my work here. As Butler (1992:14)
writes ‘[O]nce it is understood that subjects are formed through exclusionary operations, it becomes politically necessary to trace the operations of that construction and erasure’. Granny's midwifery is not mentioned in her obituary even though she was well known as a midwife to the women in her own family and to other rural and young (unmarried) women of the district. Her story and photo are included in a recent publication, Riverina Midwives (Gaff-Smith 2004). Midwifery's often hidden ways are due in part to the private embodied ‘nature’ of women’s business. Because it was ‘women’s business’ it was very common in early white Australia to remain silent about childbirth and thus midwifery (as it was/is in Australian Indigenous cultures), particularly in obituaries. Yet at the same time it was common for the community to be grateful for, and respectful of, midwifery work. (See multiple examples in Gaff-Smith 2004).

So while we did inherit a silence around childbearing and midwifery, I think midwifery silencing is now influenced particularly by the dominance of other health voices in Australia (and elsewhere), those of medicine and nursing. Midwifery, as both a personal presence and a health discipline, lives now in an even more complex space than in Granny’s time. It is complex work which sits in a contested social and political landscape: one where medicine, nursing and management and the accompanying technological and managerial ‘advances’ feature largely in the spaces women inhabit and those from which women are barred. Childbirth and midwifery no longer sit in private homes and small ‘lying-in’ hospitals. Yet it is still wonderful and joyous and messy and disordered, dealing with what (Shildrick 1997) terms leaky bodies, in spaces and times where ‘[w]hat leakage is dirty or threatening, and what is bountiful and fruitful, is clearly a matter of categorisation’ (Kirkham 2007:1). Midwifery includes complex ideas and social relations along with intricate and intimate biological processes, powerful and powerless scientific knowledge, personal desires and physical and spiritual outcomes. It is complex work.

**Introducing my data generation**

In a genealogical effort to look differently, to look towards difference, I took a two-pronged approach to data gathering. I worked with already generated data (using excerpts from policy and education documents, novels, newspapers, letters, e-mails
and students’ reflective journals) as Foucault (1984a) suggested for genealogical work. I also worked with data I generated (from interviews with midwives, memory stories from a collective biography workshop and my own reflective journal). Turning my poststructural researcher’s gaze upon my assortment of texts, on fragments, incomplete ideas, cracked opinions, (in)consistencies and (im)partial thoughts, I worked to foreground in midwifery what Nietzsche described as the ‘exteriority of accidents’ (Foucault 1984a:81). Moving across time and space, I employed data gathering and generating strategies, data analysis and writing as constitutive acts (Davies and Gannon 2005) in order to show that ‘[…] things could be other than they are’ (Ferguson 1991:333).

Thus, with Granny, many other midwives (more contemporary) appear in this work.\(^1\) Alison, for example, is a very important voice here. A midwife for nearly forty years, she spent much time and energy working and campaigning for change towards a more humane birthing system. Alison now leads a midwifery practice in a local hospital where childbearing women know their own midwife throughout their pregnancy, in labour and while giving birth and into the very early parenting time. Alison’s program is a culmination of her years of hard work for change towards a more women-centred model, inside a misogynist health system. The midwifery practice she leads is woman-centred, safe, effective and very popular with women. I undertook in-depth, unstructured interviews with her, and used supporting data from historical documents and other writings (letters, personal papers, e-mails) to trace her midwifery career which spans forty years and three countries. Alison’s story is used in multiple ways in this work.

A lot of other midwives and midwife-learners also people this work: midwives and midwifery students who work every day with women and their families across the spectrum of midwifery to help women undertake their precious childbearing processes. I collected data from registered midwives in two main ways. As well as interviewing Alison on several occasions, I also interviewed two other well known

\(^1\)This research was approved by James Cook University’s (JCU) Ethics Review Committee, Human Ethics Sub-Committee on 27 February 2003. Approval Number: H1511. When I transferred my candidature to the University of Western Sydney, ethics approval was transferred on the basis of the JCU approval.
and respected midwives in Canberra. One interviewee graduated some years ago, worked as a midwife for some years and then left to work in other health related fields. The other interviewee has been a midwife for many, many years. They were selected by me for interview because in my opinion they are reflexive practitioners who have given much thought to their ‘with women’ work.

As part of my data collection I also generated memory stories in a collective biography workshop with six experienced midwives. I invited them to participate in this workshop because I admire their work and respect their midwifery philosophies. Collective biography uses the research strategy of collective memory work developed by Frigga Haug and Others’ memory-work (Haug and Others 1987). Haug and her co-researchers designed memory-work to bridge the gap between experience and theoretical understanding (Koutroulis 1996). Collective biography as a research strategy has been grown and developed by Bronwyn Davies together with other researchers (see Davies and Gannon 2006). Collective biography is biographical in that it draws on memories from particular individuals and it is collective in that the way the stories are told, written and analysed to show the ways we are collectively produced as subjects (Davies et al. 2001). It provides a space for ‘[…] the telling of stories, written and spoken, [and] produces a web of experiences that are at once individual, interconnected, collective – political’ (Davies et al. 2001:169). Other researchers have taken up the original idea of memory-work and used it in a variety of ways to research across a wide field of topics (Crawford et al. 1992; Haug 1992; Renew 1994; Koutroulis 1996; Davies et al. 2001; Browne 2003). Memory-work was intended by Haug (1987) to be a responsive, adaptable research method. Collective biography grew out of using collective memories and collective analysis in different ways. I have been involved in several collective biography workshops throughout my doctoral candidature, each of which has been written and published by the participants (Davies et al. 2004; Davies et al. 2005; Davies et al. 2006a; Davies et al. 2006b). For my own doctoral thesis, though, I chose to make a major departure from the memory-work of Haug (1987; 1992) and the collective biography of Davies and her co-researchers while retaining the data collection method of collective writing of stories from memories. I gathered but did not analyse the midwives’ memory stories in a collective way, which changed the data collection/analysis method quite considerably. Instead, I treated them as documents among many others
upon which I would turn my genealogical gaze. I asked the participants in the workshop to write in the third person, a technique suggested by Haug (1987) and used successfully by me in my reflective journal and in my past research. The third person seems to give some midwives a freedom to write of complex matters with somewhat more ease (Browne 2000).

In order to collect data from a learners’ perspective, without requiring students to be involved during their enrolment, I used data from the reflective/reflexive journals of some past students of midwifery programs 1995-2003. During those years I was teaching the midwifery program in Canberra and reflective journalling was an integral part of the students’ assessment. Most students keep their journals, as they are precious to them, long after they have graduated and are working as midwives. Some students even continue journalling, although many are very glad to leave it behind as they complete their program of study. Midwifery has an oral tradition and so journalling is often included in midwifery curricula to encourage midwifery learners to write in order to reflect more deeply on their subjectification as midwife and as woman. Canberra is a city of 320,000 people, and although it is the capital of Australia it often feels and acts like a small country town. Many people know each other, or of each other, and so to achieve anonymity for both the students and women whose stories the students tell in their journals, I did not seek or want students’ work until they had graduated. I also used pseudonyms to further help protect confidentiality. The journals provided a fertile source of data from an eight year period (eight midwifery groups). Seven students, six women and one man, provided their journals and I used stories and reflections from all of them.

These midwives and students shared their wonderful \textit{and} not wonderful, brave \textit{and} not brave work, beliefs, hopes and desires with me in this journey of the midwife’s present. They gave of themselves a midwife’s present.

I also collected data from the public domain. I utilised text (stories, opinions and graphics) from the print media, educational videos, television, advertising, fictional novels, government documents, historical records, midwifery, nursing and medical textbooks and literature, midwifery and birthing marketing slogans and photographs. I wanted to spotlight the ways in which some women talk/write about their
childbearing experiences in the public domain and the ways that midwifery and obstetric discourses function in the public domain.

The other part of my data were my recollections/teaching notes/reflections/observations, personal e-mails and my own midwifery stories, personal cards and letters I received from women and students and ex-students (de-identified). My reflective journals, containing storying, recollections and observations written intermittently during my many years of teaching midwifery, also provided a source of data.

While I use the term data, I use it with caution and not in a sense that it is proof of this or that, or that it will show what is real or true. In this work my intentions are to use descriptions to read ‘the ways in which sense is being made’ (Davies 2004:4). Data is limited to being a sign, a part of the production, a constitution of the real:

Data may include accounts produced by interviewees about the topic in questions, any kind of spoken or written text relevant to the concept or category under investigation, observation of social scenes in which the subject under investigation is being produced discursively or in some other form of practice. Data are examined not as if they described or explained an independently existing ‘real world’ but as constitutive work that itself is implicated in the production of ‘the real’. Those data are analysed in terms of the binary categories and discursive regimes at play.

(Davies and Gannon 2005:320)

I used my gathered data as text, in the sense that texts are ‘sites for the construction of plural, often conflicting and contradictory meanings’ producing ‘versions of reality’ (Mellor and Patterson 2004:88). I wanted to use a variety of data and multiple data gathering strategies to help me look, and look again, at a system which is very familiar to me. I wanted to look and write against the grain of dominant discourses and look and write against the grain of resistance.

Introducing the next chapter…playing for/with/in midwifery…

Once I had collected my data from multiple places and in a multitude of ways, and after several unsuccessful attempts at making the data speak and act new
understandings of midwifery, I began out of a sense of despair and frustration to work with different ways of using my data. I had begun to work my data as Patti Lather (1991) describes the stages of deconstruction: by locating the binaries, reversing them, privileging the subordinate term, and I tried to do as Lather suggested, recognising their dependence on each other for meaning and then moving beyond the terms, by seeing that both and neither are relevant. Yet while the data work was fascinating, my early writings were, I am embarrassed to say, boring and worse still, did no justice to the data or the people from whom it came. By using more creative ways to write and think and analyse, I began to join researchers who ‘[…] learn about the topic and about themselves that which was unknowable and unimaginable using conventional analytical procedures, metaphors, and writing formats’ (Richardson 2000a:10). By writing creatively, I found myself fascinated by what the data did and by how things panned out. I tried to be writingly brave, listening to Richardson (in Richardson and Lockridge 1998:330) when she said: ‘[i]f the text is staged as literature – it doesn’t necessarily have to be great literature, it might only be “B minus” literature but there has to be an attention to the aesthetic’.

Thus, in the next chapter I present my data using literary techniques in the form of a performance as the best way to begin to depict the conflicting and overlapping discourses at play in midwifery and the ambivalence that midwifery and childbearing can bring, in the context of my poststructural and feminist work. I spent a long time in the middle years of my doctoral work trying to determine ways to present my work in a respectful way that increased understanding. Eventually, I chose to write my data into a play, to using ‘playing’ as a technique, in the sense that Lockridge says:

I think technique is basically a state of mind – how you see, how you sense life, think about life, imagine life to be, and only then how you go about bringing life into the page, making those choices that allow you to create life with words. [...] a writer in any genre begins to create a lived experience by making a basic appeal to the living senses, so that the sensory world is present for the reader in the world of words through what is smelled, tasted, heard, touched, and seen.

(Richardson and Lockridge 1998:333)
In trying to ‘create life with words’, in the play which makes up the following chapter, I combined five ways of using my data. I used my study participants’ exact words when they spoke (ie: the words of the ‘modern-day midwives’ are quoted exactly, but out of context). Second, I combined that with text and actions which I thought might be said and done by speakers in/from the past, based entirely on stories told to me. Third, I used exact words from the published literature. Fourth, in one of the poetry sections I utilised very short, jumbled snippets of text from multiple sources in the public domain. Fifth, the rest of the poetry-type work is my own. The situations and storylines in the play are fictional but (I intend) mostly credible. In the chapters which follow the play, data are dealt with in a more ‘usual’ fashion.

Writing allowed me to explore midwives’ responsibility to be open to possibilities. It allowed me to be what Butler (2004a:46) named as ‘vulnerable to the other’ so that childbearing women and their partners and families and friends may fulfil their potentials. Embracing differences and meeting the challenges of the unknown, the unknowable, can be both exciting and frightening for (women and) midwives. Doing so may open precious possibilities, possibilities which may well change lives. Childbearing women and midwives, together: each affects the other, each is meaningful to the other and, perhaps together they are more brave, more open, more able to say ‘yes’ to the future. In my thesis I explore those ethical (im)possibilities.

The next chapter, ‘Midwifery across time and space’, is a play written from my data used to bring to light/write into life some of midwifery’s complexities in a creative way and to (further) set the scene for the thesis as a whole.
Midwifery across time and space

Act 1 Scene 1

Setting: Jenny’s Beautiful New Study

Bronwyn: Take heart, Jenny. Love your thesis. Love all the characters in it. Love them into life. OK.

JB (from the fetal position under her desk): But the act of representing them weighs too heavily. I am made inert by it. Haemorrhage. They deserve me to write them well. I call myself midwife but I do not do their work. I am them but I am not them. The dark hours do not call me. I am home, warm, in the evenings. Their genes are my genes but their blood is not my blood. I am not them.

Ali: Yes you are because you understand and love us. Anyway, you cannot represent me. I do not want you to; I do not need you to. I am big and bossy. I can represent myself. Because I am doing midwifery I have no time, no energy to write midwifery. Write a midwifery JB. There are stories to be told, thinking to be done. I’ll tell you my part of the story. It doesn’t look very profound when it is written down but I’m sure you’ll turn it into something!!

JB: (Sitting up, head in hands) What if I write the wrong somethings, if I turn it/them/us/me into something you do not recognise, or worse still, something you hate. Who then will I have represented?

Granny Byrne: You think too much. Our lives are meshed, you cannot tell our stories wrongly. Midwifery loves you. She will not let you down now.

Midwifery Aside: Oh JB what a weird mix of fear and arrogance you are. Can you not see I am the relationship between you?

A knock at the front door and in come Marilyn and Rochelle, two ex-students

Marilyn and Rochelle (clambering, talking over each other): Why don’t you take your own advice? “Women need you to be good at your business”. “Remember the women need you”. We had to be brave when we didn’t want to. We had to make it up as we went along. We had to stay when we wanted to run away. “Trust the process” you told us. Just when we felt to go on was too much.

JB (whining voice): If I write from the inside, I take liberties. I write what I see. It is my midwifery. It’s like being in my classroom. If I write from the outside I run the risk of dumping on them, like everyone else does. I other them. I wish to honour them, warts and all and I want midwifery to be different. I want revolution but instead I scrape and drag.

Midwifery Aside: Oooow. She wants a revolution…how cute. Let’s call her Che. Che Browne has a nice ring to it. Do you not see JB that I am not what you want, just as you want? I am Kristeva’s subject-in-progress, Barthes’ playful text. I am difficult, changeable and simultaneously dependable, lasting… I am body and not body, I am with and not with. I am not representable in only one way. Take heart and write.

JB: But…
Act 1 Scene 2

Setting: Granny Byrne’s kitchen table November 24, 1921

Granny: Hurry up Jack, and please set a place for your mother too. She is hungry.

Jack: Is mum having breakfast with us?

Granny: Of course she is Silly Boy. Where else would she eat?

In comes Patsy with her new baby, born in the night, and sits at the table. She shows them the baby. The children all crowd around her, looking at the baby in silence, except for a few giggles.

Granny: Give me the baby, Pat. Annie, dish some porridge and pour Pat a cup of tea. Children, sit up and eat; your jobs are waiting! You can hold the baby later but not till your work is done and she has had something to drink. Jack, I want you to take this note over to your aunty’s house. Pat, eat your breakfast.

Jack runs out with the note. The children quickly finish their breakfast and go outside. In come Pat’s two sisters-in-law and her husband, Darby.

The three of them (chorus): G’day Ma!

Granny: What are you doing here, Darb? I thought you were working out on McCaughy’s? Annie, will you top up the pot?

She gives the baby to Darby, who smiles across the table at Patsy and then pats her arm.

Darby: So it’s Janet Alice then, Mum? She is a bottler! Bigger than the boys!

Patsy: Eleven pounds so the kitchen scales say. No more babies for me. She’s healthy though, cried right away. She looks like...

Darby starts to sing Redwing in his beautiful tenor voice, dancing with the baby...

Darby (singing): Now, the moon shines the night on pretty Red Wing
The breeze is sighing, the night bird’s crying...

Granny: Be that as it may. She’s big and vigorous. Off you go now, Darby, there are things to be done here. Don’t forget you’ll need to register her birth later. Put Arthur as the doctor and me as the attending midwife and place of birth as “the Wagga Road”. Pat, go back to bed, I’ll bring her in when she wakes. Annie, stop moaning over that wee bairn. You’ll have your own soon and then will be time enough to listen to our sorry stories. Pat, stop thinking about your second twin last time. I know you are thinking about him, even though you haven’t said. Nature gives and nature takes away. Just as you would expect. Pour me a new cuppa, there’s a love, Annie.

Outside, as Darby leaves, Red Wing recedes in the distance...Patsy goes down the hall, Annie begins the wash up and Granny sits down with a cup of tea and her new grandchild. The other children come rushing in laughing and pushing and singing...

Children (chanting): Baby Janet Alice, Baby Janet Alice...
Act 1 Scene 3

Setting: Supper, Delivery Suite Tearoom.

Midwifery Aside: Have a heart you lot. Give JB a hand. She has been writing this bloody PhD for years. It’s a mess. She can’t even decide on what tense or pronouns to use; we/them/I/us/past/present/future: it’s all interchangeable for her. Will you help put us all out of our misery? What do you want her to say? What should she tell them?

Shannon (yelling, throwing herself about the tearoom): Tell everyone it’s too fucking hard. Tell them there are days it just can’t be done. It’s too much. It’s too demanding. It’s just too fucking hard. Tell them that!

A bell rings and Shannon prances out to answer it.

Maureen (in a Scottish accent, softly): I want to say I’m really angry because I think I am being set up to do something I can’t do in a place I can’t do it. All this women-centred caring, whatever … I have anger at that. It’s unreachable. Then you think well, I couldn’t do that and it has done something to me trying to do it. I don’t want to feel bad about it. Tea, anyone?

Granny Byrne (from the corner of the room where she is sitting doing fancywork): Tell them from me that women and midwives must have a space where midwifery work can be done.

Maureen gets up and makes a new pot of tea. Amy deals a round of poker, the latest tearoom craze. The game begins.

Amy: A wise woman once said to me never underestimate the effect that labouring women have on you. For some reason you feel very vulnerable. How many?

Minnie (with a shake of her head for no more cards): Women are heroic creatures… my faith in their ability overwhelms me at times. I have so underestimated them.

Ali: Four. If you keep coming back every week, you keep people honest. Really, that’s what we’ve all been about, isn’t it? Keeping the bastards honest. Going back, asking ‘Why?’

Elizabeth St Pierre (from the corner of the room where she is sitting with Granny): ‘Poststructuralism does not allow us to place the blame elsewhere, outside our own daily activities, but demands that we examine our own complicity in the maintenance of social injustice’.

Maureen: One card will do. Well, I’d think you know. Haven’t I explained this to you enough? Haven’t I told you there’s the for’s and there’s the againsts in midwifery. But at the end of the day, I don’t know, I really don’t know, because it’s outside life as I know it.

Midwifery Aside: Heroic creatures; outside life as we know it. Surely this punctures the known. Barthes would be happy, but are you brave enough to see who/what will be born in this writing? Are you a gamb(o)ling woman Jen? A text of bliss. The stakes are high in the midwifery poker game.
Act 2 Scene 1

Setting: A Maternity Unit in the 1960s. A student, Ali, is being shown around at the beginning of her first shift.

Midwifery Aside: Students very soon learned the importance of having a nurse’s watch that worked when they began midwifery training.

Midwife: A first time mother has one hour from full dilatation to have her baby. One hour exactly.

Ali: What if she doesn’t?

Midwife: Remember to take every baby straight after birth to the observation nursery for an hour. Wash it in disinfectant, weigh and measure it and give it 20 mls of glucose water. Then, at the end of the hour, if its respirations and temperature are fine, the baby can go to the mother for a feed - 3 minutes each breast.

Ali: What if they aren’t finished in that time?

Midwife: You must scrub the woman’s nipples rigorously to clean them before and after feeds.

Ali: Ouch!

Midwife (sighing and looking exasperated): Are you listening Nurse Parsons? I only have time to tell you this once.

Ali: Yes Sister.

Midwife: Next, you take the baby back to the nursery and put the ray lamp on the woman’s stitches for exactly 5 minutes - no more, no less. Do I make my self clear?

Ali: Yes, Sister.

Midwife: Repeat this routine every four hours for every mother and baby. Now, ring the bell for visiting hours and come with me to the nursery. I will show you how the viewing window works.

The midwife and the student go to the nursery where the babies are lined up in straight lines in their cots. The midwife opens the curtains and they see fathers and grandparents and friends in the corridor, all holding up cards with names on them.

Midwife: Go on girl, get Baby Smith first and take him over to the window. You can’t waste time here. There are lots to show this evening.

Ali: Yes Sister.

After a short but chaotic time, the midwife rings the bell again and closes the curtain. Showing the babies is over for these Visiting Hours. There is a commotion in the outer corridor, just outside the doors of the maternity ward. A child of about five is crying and yelling.
Little girl: I want to see mummy! I want to see our baby! I want to see mummy! It's not fair! It's not fair!

Girl's father: They won't let you in. Remember I told you. You can see mummy and the baby when they come home next week. Come on now, mummy won't want you to cry.

The child leaves with her father, still yelling and crying. ‘I want to see my mummy’ and ‘I want to see our baby’ recede into the distance.

Midwife: Remember Nurse Parsons, women breastfeed their baby for three minutes on each breast at four-hourly intervals on Day 1, for five minutes on Day 2 and for seven minutes on Day 3.

Ali: Yes, Sister.

Midwifery Aside: She was a fast learner.

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**Act 2 Scene 2**

*Setting: The ‘Sunday Markets’ on International Midwives’ Day, a few years ago. A beautiful, shiny, purple and green ‘Start Life with a Midwife’ banner is raised above a stall, among craft and food stalls. A video showing a birth, with a close-up of the baby’s head being born very, very slowly and very graphically, draws a large crowd of women, men and children.*

**Voice 1 (over the PA system)**

Squeeze, release. Squeeze, release.
Warm water sloshing, trickling, comforting,
A little room now to stretch my legs
It’s my birthday.

Squeeze, release. Squeeze, release.
I hear my own heart, faster, louder than mum’s,
Dedump, dedump, dedump.
Wriggling, piloting a close passage.

Squeeze, release. Squeeze, release.
Head first, into the unknown.
Slippery, tight, water sloshes behind,
egging me on

Squeeze, release. Squeeze, release.
Flexible, curled, limb on body.
Water under pressure, prang.
More work to be done.

Squeeze, release. Squeeze, release.
I quiet, wait, listen: “How much longer?”
“Not long now. I can see the head
You are doing very well”
Squeeze, release. Squeeze, release.
Rocking, grunting, working, pushing.
Curve in front, bone behind.
“Come on baby”. I lift up my head.

Squeeze, release. Squeeze, release.
Mechanistic, hurting, loving, forgiving.
Blink, breathe, out.
Cool air, fresh against my face.

Jenny (to an old woman right up the back, off on her own a little, looking at the video):
What do you think?

Old woman: Is that what it looks like, really? I’ve been up the wrong end!

Jenny: Yes, it’s often like that, especially the first one.

Old woman (tears in her eyes): It truly is amazing.

Jenny: It is beautiful. A fresh miracle every time.

Old woman (still watching): I wish I knew that then, when I had my babies. I wish I had someone with me. I can see that would have been good. I didn’t really know anything for my first. I was on my own until just at the end. I was scared, so scared. For the others, I just knew what had to be done.

Jenny (teary): Would you like to see the video again?

Old woman: Oh, no, thank you. I’m fine now.

The old woman wanders off to the stall next door. The video is still playing, showing the woman and her new baby and family, together, laughing. A woman, her partner and her mother come up to the stall, and start reading from a ‘Thank You’ journal which Cathy, one of the midwives, has brought with her and placed on a table at the front of the stall:

Woman: Listen to this (she reads aloud): ‘We thank you for bringing our little angel into the world’.

Man: And this (reading aloud): ‘Thank you that you love what you do and that it shows’.

The man turns the page and they keep reading bits from the thank you cards and letters out loud.

Woman: ‘Words cannot express our heartfelt thanks for your expert advice, help, words, time, professionalism and friendship. We were so lucky to have you share such a special time with us.’

Man: ‘We can’t thank you enough for your assistance in helping bring our beautiful daughter into the world. Your patience and understanding will never be forgotten. She will grow into a beautiful young lady and you both can share in knowing you had a great deal in helping her make that start.’
Woman’s mother (also reading aloud): ‘You put my mind at ease and made labour a lot more comfortable with your kind words and warm heart. We would not have made it through without you. I wanted to take one of the midwives home with me when I left hospital!’

Man: ‘I can put on a brave face but inside I feel like someone has ripped my heart out. In the midst of this horrible journey we do feel lucky that you came into our lives. Words cannot express how grateful I am for your love and support during the worst day of my life. I just wanted to say thank you from the bottom of my heart. Our baby will be watching over you from Heaven, just as you held her and cleaned her and helped her Mummy.’

Woman’s mother: I know you’d probably say you were just doing your job but we think you were wonderful, and very available and reassuring to two anxious first time parents! I hope you win big on the lottery ticket we left for you, but if you do, please don’t give up your day job!

Woman: Thank you never seems to say enough.

The three wander off after talking to the midwives for a minute... A young woman passes the stall, pushing twins in a pram.

Young woman (waving and calling out from a little way away): Legend midwives!

The group of midwives standing at the front of the stall laugh and wave at the young woman. A conversation begins among the midwives about how they love their work.

Robyn: We meet so many women and their families and it’s such a special time to be involved in their lives.

Ali: We can be proud of our occupation, knowing that it’s one of the most important in the world.

Jeanne: Midwifery’s a wonderful career. I love it.

Cathy: It’s such an honour.

The stall quietens.

Maureen (to a huddle of midwives behind the stall table): But midwifery is really hard. Sometimes it’s too hard. It hurts so much to see women treated badly. Yesterday on the ward I found a woman sobbing. She discovered after the baby was born that her husband is leaving her. She can’t grieve/settle in the shared room and no one has time to comfort her. Someone else’s baby had to go back to the nursery and we were too busy to take her. And I’m supposed to stand here at the markets promoting how beautiful midwifery is and how many wonderful skills we have. How can we promote what we wish we could do when what we actually do is nowhere near it? I can’t be part of this.

Jenny: You know we have to hold on to the beauty and joy and love of the ‘easy’ women to help us have the energy for women having a hard time. If we don’t keep going, all in our own ways, things will never change.
Kate: We should ask who is directing change and for what purpose. Do we recognise that we are being directed, or is the process covert?

Maureen: I just can’t do this and not say openly how bad it is for all of us, both staff and women. Now, would birthing men, cared for by male midwives, be in these beds and accept all of this? Not on your life! I’ve just seen the worst of midwifery and I can honestly say I will never work another day like this when I finish. I’d rather never practise than to do this to people.

Ali: What sort of midwife do you want to be? Will you practise autonomously? Will you fight for women’s rights? For midwives’ rights? Even when surrounded by women who don’t seem to care, or midwives who are too tired to care? We need your energy to help us build a better birthing world.

Nola: We have to educate women to have confidence in us and work with us, at the same time gaining confidence in themselves.

Kate: We must ask all about power.

Older woman: (in passing as she browses along the stall): Oh, you girls do a marvellous job!

**Act 3 Scene 1**

Setting: Front foyer of a modern hospital.

_A glossy promotional video about the hospital is running on a large screen in the foyer. A section about the Maternity Services starts. The video has soft background music and shows women with midwives and doctors going happily about their everyday maternity work. Suddenly multiple, strident, arguing voices break in speaking over the top of one another._

Voices (over the PA system):

What do you mean you go to the women’s homes?
A medico-legal nightmare!
Oh my God.
How long has this been going on?

If the woman won’t go to hospital,
You have to leave her house.
She needs to know your boundaries.
Don't think I am not women-centred.

I’ve never met midwives with such attitudes
to doctor's authority
The superintendent midwife and her cadre of midwives:
Feminist, anti-doctor and equally anti-intervention

These are the bastards we covered for
And when we couldn't keep them from making monumental mistakes,
We mopped up the tears
And tried to restore women’s faith in themselves.
Under pressure, tired and angry,
It’s difficult to know why a midwife would want to be a midwife any more
if we can’t get some support from somewhere,
instead of this hounding business…

When you finish being angry
You see the sad and pathetic side.
Are we covered? Are we covered?
I did not feel afraid. I felt uneasy.

Act 3 Scene 2

Setting: Delivery Suite tearoom, the same hospital

Midwifery Aside: I wonder how JB is going.

JB: I don’t know what to write about the bloody doctors. I have to say something.
They fill up our spaces, our thoughts, our rooms, our practice. I need to write about
them but I don’t want to make them the baddies, although, far as I’m concerned,
they often are. The lines between the baddies and the goodies blur, I know. False
gods, these binaries. How can I show multiple positions without them taking over?

Granny (from the corner where she is doing her fancywork): I wondered when you were
going to get to them. Is ignoring them not working for you?

JB: I hate the way they hijack the agenda. They are not hijacking my play… I think
they are generally disgusting. I’d like to ignore them totally. The wankers.

Granny: Jennifer!

JB: Sorry Granny. They are obvious by their absence. They do some wonderful
work and mean no harm. At the same time, they are power mad, money hungry
snobs and they do do harm. Anyway, they are not as important as we make out.
Often it is about us, not them. They are as complicated a group as midwives. How
do I say all this without sounding like a ratbag or medical sympathiser?

Midwifery Aside: Do you think this part is difficult because you still see the medical
model through a radical feminist lens? When it comes to medicine you tie yourself
up to your modernist moorings. You even still say you are a separatist when people
want to talk about collaboration. Can you really see multiple truths? Maybe you
need to look at what being a separatist promises you? Ask yourself the hard Butler
questions:

Judith: (In a soft American accent, from the corner where she is sitting with Granny,
reading): "The question of whether or not a position is right, coherent, or interesting,
is, in this case, less informative than why it is we come to occupy and defend the
territory we do, what it promises us, from what it promises to protect us."

Retrieved 01/02/06, from http://www.partyhealth.net/node/2995.
Maureen: In midwifery we are doing something really old and something really noble. The best thing is how mysterious it is and how precious that mysteriousness...

Ali (in a conciliatory way): Why don’t we talk about it more at handover? That might help. I’ll make the tea.

The afternoon staff comes wandering in. There is general talking and laughter while the cups of tea are organised. Some minutes later, the morning shift midwives come in for ‘handover’, just as Ali starts telling a story.

Ali: The other day I was in Delivery Suite and I came out of a room to tell the registrar what was going on with the woman I was looking after. He said, ‘You aren’t following the policy. Don’t you know what the policy says?’ I bit my tongue. I wanted to say ‘Of course I know what the policy says. I wrote the fucker!’

General laughter.

Reggie: What are you doing here Brownie?

JB: Well, I’m whingeing, actually. I am having trouble with the doctors (more laughter). If I tackle them, it is like another thesis in itself, a lot of which has been written before and better than I can be bothered to write it. If I don’t deal with them, something is missing. It is like a great black hole that I don’t want to get sucked into.

Reggie: You always let them get under your skin. You always took too much notice of them. It’s better to just work with them, to get on with them. Then they leave you alone. They are all right. Weird, but all right.

Kate: You are such a boy, Reg! Typical that you think what works for you will work for us. They treat us differently. You get away with heaps because of what you are.

Reg: You see the gender monster behind every rock, Kate. Brownie isn’t a separatist, anyway, whatever that means (general laughter). I remember when she practised. She was like the rest of us only cranky with the doctors a bit more often. Actually, a lot more often! (More laughter)

Kate (getting out her black reflective journal and opening it up to the last page of writing): I’ll tell you what the medical model is doing to me. Listen to the conversation I had with my partner the other day. LISTEN:

‘Henry: How was your day?
Kate: OK. I had a CS and a PCA and I’m feeling good about PCAs. I loaded it and reset it without help.
Henry: Did you hear what you said?
Kate: (thinking, thinking)
Henry: You make it sound like machinery.
Kate: You’re right – shit, I can’t believe it.
Henry: You’re becoming institutionalised.
Kate: PISS OFF HENRY.’

General laughter, but uncomfortable looks as well.
Midwifery Aside: So Jenny is being (un)comfortable in the system what made you a separatist or what made you an academic? What did Karen Guilliland say recently about another academic? ‘She wouldn’t have a clue. She works in splendid academic isolation.’

JB: Not so splendid.

Ali: I think we try and work alongside them, up to a point. We try and do the sliding. It's kind of more than sliding... it's weaving really, isn't it? It's like a hint of mesh or net... but it has like a hint of... I can't think of the word... duplicity about it. Or what's another word? When you are doing it for your own ends to get what you want for the woman? I mean devious, I suppose.

Amy: I know the midwifery model is ‘being with woman’, but as a new student at times I felt that I was neglecting the woman. I had my head concentrating on the machines that went ping and ding and I was trying to understand what the obstetrician was saying, so I would not put a foot wrong. I felt continually pulled. Here was the medical model directly in my face with machines and the woman unable to get out of bed. And at the same time I was trying to allow the woman her freedom. It was like she was trapped and strapped and unable to let her inhibitions go. I just hope that what I did was an OK experience for the woman and the family.

A bell rings and Kate goes out to answer it, chanting:

Kate: Doctor Foster went to Gloucester
   In a shower of rain
   He stepped in a puddle
   Right up to his middle
   And never went there again.

(Laughter).

Anne: I think the relationships between medical and midwifery staff are respectful and promote each other’s differing views. I don’t hear them speaking detrimentally of the other. Differing points of view aren’t spoken of in front of the birthing woman in a way that shows conflict or disharmony. I have noticed midwives actively trying to avoid further interventions when medical staff have ordered them by suggesting other things (usually ‘wait a bit longer and see what happens’) and consulting with others. But the woman sees a united front, everyone working towards the same aim of a healthy baby and well mother, satisfied with her birth experience.

Ali (aside to JB): Where does she work? Sure, that's what we try to make it look like but is it reality?

Minnie: Here is a story. A young woman, first baby, progressing well, with her husband in attendance. The idea was for the obstetrician to “pop-in” for the “catch” between seeing women in his rooms. What happened instead was the labour slowed down with his arrival and chit-chat. He stayed and provided encouragement. It seems the couple thought that their knight-in-shining-armour was on the scene to rescue them from this suffering. They were actually asking him to “get the baby out”. She wanted to be rescued by her fully paid, more than qualified, expert specialist. The midwife and I had become wallpaper. He told her she WAS doing it...that he didn’t need to interfere. In the end (out of frustration) she pushed the baby out herself. I was in shock at having seen an obstetrician actively avoid the use of technology (to be completely blunt - it would have been to his financial
advantage) even with the time pressure of a waiting room full of “patients”. However, I was more shocked at the woman and her partner’s response to the situation. A whole new world for me.

Beth: One day I was caring for a woman labouring with a normal vaginal birth. She did beautiful, clever work. The obstetrician arrived after the baby was out. It was like he had to do something to make up for not being needed. So he was being impatient and arrogant and he pulled on the cord which snapped and then the whole thing changed: bleeding, intervention, operating theatre. I had enormous sadness. I went to the leader and explored my anger. The leader said ‘You tell him’. So I did. I spoke with the obstetrician, informing him of my concern about his management of the placenta. He looked at me. I expected anger. Instead he attempted an explanation. But he knew. What I knew then was my time in midwifery had come to a point of responsibility; my responsibility for supporting a woman, above all else.

Ali: Well, the obstetricians have just taken up a position too. It’s just that they are not as flexible as us, I think, and that’s their problem. You get past that stuff of “just because you said it I have to say the opposite”. You do that to begin with. But in actual fact sometimes they are right, just as sometimes we are wrong.

Patrick: I am coming across midwives who have lost their focus. What is it in human nature, and especially those who are weak within themselves, that they have to put down others to make themselves feel important? I was confronted again today with midwife overpowering a mother, telling her that she wasn’t allowed to go home until the midwife herself was happy that she would be capable at home. Where does the midwife get off playing these power games, and why is she allowed to do it? It seems to be very strong in midwifery. That is not to say that every midwife is like that. It just seems that we have our fair share and then some. Shame they don’t see the great side of midwifery. I have only been in the area for a month and can see it. I wonder where, along the way, they lost their sight. Maybe they never had it at all!

Amy: I have learned you have to try and do the best you can do with what you have.

Patrick: It is up and down like a yo-yo. One day working with a midwife who is open to alternative approaches to care, not only from me but within her own practice so that she is providing the best possible care to her birthing women, constantly changing her approach as she sees something that may be a little better or more efficient. Next day confronted with a midwife who wants to play power games… the epitome of what I consider to be destroying midwifery and it is right there in front of me and involving me, totally dominating both staff and women. When observed from an outsider’s perspective it looks to be an absolute joke; the power games of a troublesome three year old.

Beth: And it’s a lot about us, not anyone else. When I trained to be a midwife I did not know the full truth of midwifery. Over the next years I worked as a midwife but this period did not reduce my fear of birth, or increase my knowledge. Then I watched, listened and then studied. I had questions. I needed to learn. I saw women and midwives trusting birth, exploring ways to give birth back to women. I decided to try. Processes were changing, midwives were voicing. A newness for midwifery (true midwifery) was emerging. I worked on for another nine years. My midwifery practice has changed and is continuing to change. I had time to learn, reflect and move.
Shannon (coming into the tea room from the desk area): Speaking of moving, is anyone coming out here so we can go home?

Reg: Give it a bone, Shannon.

General laughter but most of the midwives get up to leave, some for home, some to work.

Granny: It doesn’t matter whether it is the birth of a baby or the birth of a thesis, the same common sense applies. Put the doctors in where they need to be and leave them out of the rest of it. The women and the midwives will be in there everywhere, doing everything. I don’t know why you young ones make things so difficult…

Midwifery Aside: Typical midwives; you never get from them what you think you will! They didn’t stay on the topic of the doctors but do you think that is part of the answer, JB? What should we make of this ethical conversation? A text of doubt à la Richardson? Derrida’s democracy to come? They know about a ‘belief in the world’. Would Deleuze think they are worthy of what happens to them?

Granny: I do.

JB: My issue is like Elizabeth St Pierre’s: how to be worthy of them.

Act 3 Scene 3

Late morning in Granny’s kitchen. Early December, 1921. Suitcases sit against the wall. The noise of children playing outside.

Patsy: Well Granny, I can’t find the words to thank you enough. I couldn’t have done it without you.

Granny (holding the baby): Nonsense Pat. When you go home, make the children help you. I should be right to come in to cook on Christmas Day.

Annie, Granny’s niece, comes bustling into the kitchen.

Granny: Stop and have a cup of tea, Annie, when you have made up the front room. I’m expecting one of the young girls any time now.

Patsy: Is she from around here?

Granny: Yes, got in a spot of bother, you know. I know her mother. She is not too happy but she will be all right when the babe is born. Usually works that way. It will be all right. The girl will probably go home before Christmas if she comes on when she should.

Patsy: There seem to be quite few girls like that in your front room, from time to time.

Granny: Poor silly things. Nothing ever happens to the men, of course! The girls need somewhere to go. I don’t do much, just be there. This one will be fine. She’ll go back to the farm with a new sister. More tea?
Annie comes in and sits down which changes the topic of conversation. They hear whistling and then voices out the back. Patsy and Granny stand up. They hug for a long time. In comes Darby. The children straggle behind him.

Darby: Ready, everyone?

They all go out the back door. After a few minutes Granny comes back in and begins to wash up.

Voice at the front door: Hello. Put the kettle on Granny!

In come Ali, Nola, Shannon, Maureen, Kate, Anne, Beth, Minnie, Marilyn, Rochelle, Amy, Cathy and JB

Granny: Who is looking after the women if you lot are all here? Sit down, sit down! Did you smell the cakes about to come out of the oven? Now, tell me what has been going on!

There is a gaggle of voices, laughing, talking and more laughing as the midwives sit around Granny’s big scrubbed pine table with Granny and Annie, eating the freshly baked sultana cake and drinking a fresh pot of tea. The doorbell rings and Annie gets up to answer it. She shows in a very young woman, heavily pregnant carrying a small suitcase. The young woman joins Granny and the midwives at the table. They pour her a cup of tea and the conversation continues almost as noisily as before.

Amy: Who wants a hand of poker while we’re here?

Minnie, Shannon, Marilyn, Cathy, Rochelle, Maureen and Anne (in chorus): I'm in!

Amy: We’ll cut to deal.

The older midwives, all of whom choose not to play this time, smile at each other. They sit back and watch the young midwives as they organise themselves and begin to play. Jenny gets out her laptop and starts typing, sometimes frowning in concentration, sometimes seeking their opinions of what she is writing, sometimes joining in the banter.

Rochelle and Marilyn (seeing Jenny open up her almost-complete draft): Tell us what you are finding JB!

JB: I am finding us.

Shannon: Were we lost?

JB: No, but sometimes we might as well be. We need to talk more, to say what we are thinking, what we know. When we build our house we need to be proud of it. It is made of ruins but it lasts – in many forms. We need to be proud of our usefulness. We need to begin at the end. We need to be open to everything, everything political and everything dangerous.

Maureen: (groans) That sounds like the F man!

JB: Yes it is, and the complicated poststructuralists and the wild feminists. Everyone can help us here, everyone and everything. You all know that, Granny especially.
Granny: I do, and it didn’t take me several degrees and a computer to know it either!

_Jenny groans..._

_Midwifery Aside: Memories of the future. Jouissance._

**Voice 3 (voiceover)**

Morning, evening, night.
Hello, I’ll be looking after you today...
Change a position, wipe a brow,
Shower, bath, ice to sip.
Second guessing: listen, look, write
Beautiful. Let’s call her Maeve.

Morning, evening, night.
Blink, flash, beep. Ping.
Numbers. Up and down.
Worry and hope, hope and worry
We need help in here
Someone call the registrar.

Morning, evening, night.
It hurts. I can’t do this any more
I’ll help you
Count, write, watch, cuddle.
Panic: eyeball-to-eyeball, calm
Let’s call this whole thing off.

Morning, evening, night.
Gloves on, watch, listen, scribe
I’m going to split in half
Keep going, its all good.
So smart: look what I’ve done!
Call and tell everyone.

Morning, evening, night.
Come on in and we’ll check you out.
Feel, measure, document
Baby’s happy.
Why don’t you go to the movies?
Call us when you can’t talk.

Morning, evening, night.
Breast and baby, strangers.
Milk and hunger, worlds apart.
I didn’t think it would be this hard.
Unnatural
Ring the call bell.
Morning, evening, night.
No movements. No sound. Rolling.
Sick in the pit of our bellies
I think there’s something wrong with the baby
Fear, together.
Will you call my husband?

Morning, evening, night.
What’s in it for me?
Tempus fugit; learning, in charge
Crying laughing, crying, crying laughing
Rosters, shifts, requests, families,
At everyone’s beck and call.

Morning, evening, night.
A woman left chocolates for you.
‘I couldn’t have done it without you’.
Mutual gratitude. Loved, and lucky.
Chance and planned, passionate and cool.
Who calls it?
Puncturing the known: Speaking in times/spaces in birth

Gendered subjects exist at the points of intersection of multiple discursive practices, those points being conceptualized as subject positions. The individual is not fixed at any one of these points or locations. Not only does the individual shift locations or positions, but what each location or position might mean shifts over space and time and contexts.

(Davies and Gannon 2005:320).

In ‘very particular circumstances’ (Probyn 2003:298) in the embodied time/space of growing and birthing another, a startling discourse can also be born. This (mostly unnamed) discourse in/of pregnancy/birthing/mothering is simultaneously of the profound and the profane. For some women during pregnancy or labour or in early parenting there is a discursive construction of the (almost) sacred combined with the irreverent; a concurrent position of unqualified knowledge and absurd incomprehension. Of course, this discursive practice intersects with multiple others. It is a complicated and fleeting discourse which fractures both the embodied and the social. It cuts a swathe across/through the dominant discourses in birth, making space for new and different possibilities. This discourse of the profound/profane creates and is created by the unsuspecting and the (un)suspected as it intersects with Deleuze’s ‘unthought’ (St Pierre 2000:505). In the discourses of this space/time

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women ‘find’ themselves, create themselves and re-invent themselves, just as they are found, created and re-invented. I think this complex discursive space often sneaks up on women, even when they have experienced something similar before. It embodies surprise and is surprise embodied. Here the un/known and un/knowable become momentarily doable.

This chapter traces the ways women talk, write and embody ‘different’ spaces and times in their childbearing processes. Using a range of texts, from the public domain including from the popular press, from my own data and from academic sources, I spotlight discourses which women take up as their own in maternity. I have called these discourses the profound and the profane and use them, as the women do, not as binary opposites but as a twisting, turning, plaited whole.

What I am not meaning here

First, what I am not writing about in this chapter is a collective voice for women. As Kristeva writes in ‘Women’s Time’:

*I am not speaking here of a “women’s language,” whose (at least syntactical) existence is highly problematical and whose apparent lexical specificity is perhaps more the product of social marginality than of a sexual-symbolic difference.*

(Kristeva 1981:25)

There is currently in Australia and in other ‘developed’ countries a ‘women’s language’ in birthing and midwifery, comprised, at least in part, by the (feminist) discourses of access and celebration, discourses which are, as Kristeva writes, highly problematical. The discourses of access and celebration, products perhaps more of midwifery’s and women’s ‘social marginality’ than anything else, are (cross) examined in the fifth chapter of this work: ‘The (re)politicisation of midwifery: history, circumstance, accommodation, resistance’. Of course, discourses work simultaneously but an artificial separation has been made in this thesis for clarity of writing and ease of reading.
Second, I am not writing in this chapter just about moments of ‘ambiguity or irony’ (Spivak cited in St Pierre 2000:482). I write in this chapter of discourses which I believe have revolutionary potential, even given that they are fleeting moments or, rather, because they are. The discursive and embodied moments spotlighted in this chapter often do not sit comfortably, without modification and simplification, with/in the dominant discourses of the current maternity health care system. Thus I am writing in this work, and in this chapter in particular, of what I see as the possibility of fissures into which a whole system could fall. As Gayatri Spivak writes in relation to deconstruction and to dismantling discursive structures:

[...] it must be emphasised that I am not speaking simply of locating a moment of ambiguity or irony ultimately incorporated into the text’s system of unified meaning but rather a moment that genuinely threatens to collapse that system.

(Spivak cited in St Pierre 2000:482)

In this chapter the moments of which women speak and/or which they embody disrupt unified meanings, sometimes momentarily, sometimes forever. These moments multiply the system both from within and without. (Childbearing) women live with ambiguity; they know ambivalence. In opening up spaces we may produce moments which are drastic and dramatic and, potentially, system-shattering and life-affirming. Moments in becoming. If we could see and hear and feel and taste and touch these bodies/experiences/texts-as-meaning-making, something may be different, revolutionary even.

Third on the list of what I am not speaking of here, is profound and profane as binary opposites, even though the discourses are often used in binary opposition. I include the following short discussion in order to be clear about what I am not meaning by my use of profound/profane in this chapter. In some times/spaces the profound and the profane in birth and mothering can and have been read in terms of binaries; one the light side, one the dark. A birth might be described as amazing and incredible (profound) or hard, painful and terrifying (profane). Sometimes, too, the binaries can be read as reversed and the dependent term celebrated. For example, Caesarean section in our culture now is often spoken about as a responsible ‘choice’ and a joyous, planned event, when it could once only be spoken of as a disappointing
(necessary) outcome of a ‘failed’ normal birth. In this reversal, the profane of the past (a Caesarean section) is now celebrated as the profound and, in some discourses, for example among some young ‘celebrity’ women, a normal/natural birth is becoming a profanity. A discussion about binary logic and its effects on women and their childbearing, and midwives and their work, is woven throughout this thesis. That being said, I do believe that women usually employ a complex discourse about childbearing which includes both the profound and the profane. Inside the discourse is good, bad, neither and both.

However, one part of the discourse, either the profound or the profane, can be silenced for a variety of reasons. Interestingly, in the literature and in the popular press there are often calls not to falsely make the profound/profane opposites and not to silence one part and privilege another, but to include both. For example, Naomi Wolf, a populist contemporary feminist writer, suggests that our discourse around birth and mothering is of the happy, the profound and the joyous which she says props up the whole ‘mothering system’ as the difficulties are silenced:

> When you have a new baby, what you get is a whole world; it's a world filled with gifts but also with losses. While the gifts new mothers receive are well-documented, the losses are often hidden. This is one truth that we are not told.

(Wolf 2002:5)

In her book Wolf goes on to call for all stories to be told, to be honoured, and for exposure of multiple truths in birthing/mothering, not just the happy glossy parts. From a different perspective, other writers believe that the discourses around birth and mothering speak only of difficulties and hardship and it is actually the joy, the (almost) sacred, the profound which is silenced. The following excerpt from an article entitled ‘My blissful guilty secret’ with a headline of ‘A first-time mum cracks the sisterhood’s dark conspiracy’ in the Sydney Morning Herald in May, 2006, is an example of this. Kate Duthie writes that she is amazed how most people seem to want to share only the difficult parts of birthing and mothering:

> [...] what I wasn’t expecting when I was expecting was other mothers tending to focus only on the negative aspects of motherhood. At six months pregnant I had the following exchange with a colleague I barely know. “How are you feeling?” she asked. “Fantastic” I replied. “I’m really
enjoying it.” “You are now” she countered. “But you wait. The birth’s awful and the first six months are just a fog.” [...] 

(Duthie 2006:23)

Duthie goes on to say that she knows that many women have a hard time in birthing and in becoming mothers and often they don’t want to hear about women who have an easy time but she asks: ‘For every bad story shared, shouldn’t there be an encouraging one too?’ (Duthie 2006:23). Like Wolf, although from a different perspective, Duthie refuses to be (part) silenced. Both women take up a strong position demanding their right (write) to speak into existence themselves as complicated birthing women and mothers. In doing so, they birth others as complex, multi-voiced subjects-in-process.

Like Wolf and Duthie, I do not set up profound/profane in binary opposition in this work. Binary thought here both limits and confuses what women and midwives do and are and can become. Therefore, I use the words here in the ways I believe the discourse works, in the sense that the profound/profane hold within them important ideas simultaneously; the profound as great knowledge or insight, demanding of deep thought, as intense, unqualified, deep and at the same time the profane as irreverent, shocking in the circumstances, secular, a violation of what is expected, outside (The Australian Concise Oxford Dictionary, 2004:1122, 1123).

What I am meaning here: A time/space of (im)possibilities

The processes of birthing (pregnancy, labour and birth, lactation and early parenting) can be viewed, in an ontological sense, as a poststructural undertaking. Childbearing, in its multiple presentations, opens up a space and time for new and old, for ordinary and out of the ordinary, possibilities. Pregnancy and birth are transitional states, making women Kristevan subjects-in-progress. Possibilities are unknown and unknowable until a woman is doing and being, creating and being created by her experience as a pregnant, labouring, lactating and mothering subject. For each woman, each time is different, either by degrees or hugely so. Yet collectively, women tend to experience this time/space as inside/outside, upside/downside, me-and-not-me, together and separate/d. Pregnant and labouring
women live Deleuze’s ‘unthought’ (St Pierre 2000:505), through and in a mobile poststructural moment. I believe it is not coincidental that so many philosophical writers call up pregnancy and childbirth as a metaphor/allegory to explain complex theory (for example Rich 1977; Derrida 1978; Kristeva 1981; Cixous 1991). The process of birthing lends itself to being used in this way because it simultaneously embodies (or punctures?) the known with the unknown.

In a similar way, what is written about poststructuralism could often apply to women in childbearing. For example, Elizabeth St Pierre’s words about poststructuralism could just as easily relate to women in pregnancy and birth:

Our ability to rest in ambiguity and possibility – in Deleuze’s (1988/86) “unthought” (p 97) – is a poststructural practice of freedom as is the critique of the signifiers that limit our imaginations.

(St Pierre 2000:505)

Often times a pregnant/birthing woman is pushed or goes willingly beyond the limits of her and our collective imaginations, into a time/space zone of (im)possibilities, into the birthing unthought. In so doing she embodies a (poststructural) practice of freedom and a critique of the signifiers that limit our imaginations. At that moment the old discourses/embodied practices become irrelevant to her (and us) which opens up a space for a reconsideration of her limits, for changed understanding and, possibly, for new insights. New discourses of time/space open a gap in our (patriarchal) birthing world, a sometimes surprising space which offers possibilities of being (other) rather than only othered. For women and the midwives who work with them, pregnancy, birth and very early mothering are works-in-progress.

Embodying a discourse of the profound/profane: possible transformative moments

My mother watched me coming up the path that night, the baby twisting and puking on her shoulder, and it must have been the way I walked. Or the way I stopped on the verandah and rested my hand on my hip. I’ve watched pregnant young women do it myself, before anything shows. It’s the moment the idea has taken root, the shift in the centre from the head to the belly, the careful movements. My mother watched me, her hand over her mouth, her eyes puffy
from lack of sleep. As I stepped on the floorboards that didn’t creak to catch the 6:00 a.m. bus, she was standing in the doorway and gave me her good purse that had been wrapped in tissue paper in the trunk with her money inside folded in a white hanky. As I took it she made a sound in her throat I thought was out somewhere on the edge of human, until my daughter was born, and I heard it again.

(Kennedy 2002:2)

Cate Kennedy’s fictional description of leaving home as a young, pregnant woman powerfully and poignantly puts mother, daughter and granddaughter into separate and shared places, simultaneously and (geo)graphically: out somewhere on the edge of human, and back. Her mother’s pain when she realises her young daughter is pregnant and leaving home embodies itself in sound in her throat, recognised only by her daughter when she too utters this ‘out on the edge of human’ sound, this wild noise, while birthing her own daughter. The mother notices, and then acts in a way, her own way, to mother her pregnant daughter. She parts with both the precious good purse and her daughter, both leaving on the 6am bus. Months later, giving birth moved the young woman in this short story to somewhere else but not to the edge of human. The young pregnant woman says that when she heard her mother’s strangled noise (of pain) that it was ‘out somewhere on the edge of human until my daughter was born’ (my emphasis). In making the same noise herself, she makes a discovery. The young woman realises when she makes that sound that she is not on the edge of human and so nor was her mother. The young woman did not know her mother’s noise was a recognisable sound until she had her own baby. Only then did she re-hear that noise. It became a shared noise and then a shared space/time, previously unknown and unknowable, unthought but now recognisable. Perhaps it is in hearing herself make that unfamiliar noise that she realises her mother’s pain. Perhaps she knew it before that, but what we see is that the profound and profane merge and she is moved to a new-to-her time/space which she knows has been inhabited before. The noise connects the two women, a moment in timelessness, or Grosz’s (2004:14) ‘untimely’. They are not so different really, one with a baby ‘twisting and puking on her shoulder’, the other just a few months away from that herself and yet, or because of that similarity, as she goes to the early bus they are painfully separate(d). Still, there is a sense here of the unexpected, a surprising and shared discourse and of time standing still, or being superimposed over another time. Or, as Elizabeth Grosz
writes, (the future and) the past gives way to the present in a movement that is both continuous and discontinuous:

[…] *It is an unexpected shift, the shift produced by the unexpectedness of events, which re-orient the past and whose reorientation or animation reorganises its present effects without steps, in a continuity that is also a discontinuity, a becoming.*

(Grosz 2004:258)

This discursive construction of tangled profound/profane is used by (and uses) many women (and midwives) as they confront what can feel like the enormity of childbirth. Like Kennedy’s young woman in her story, other women’s similar words in the following stories open them up to possibilities which they/we have not noticed/needed before.

Margaret Atwood writes a (fictional) account of a woman called Jeanie who some time after she gives birth to her daughter, speaks of a profound/profane transformation, or possibly a transgression, which is gradual:

[… ] Jeanie examines her, she is complete, and in the days that follow Jeanie herself becomes drifted over with new words, her hair slowly darkens, she ceases to be what she was and is replaced, gradually, by someone else.

(Atwood 1977/2001:323)

Not for Atwood a nameable moment in time/space of change, no recognisable ‘on the edge of human’ sound. She does not tell us whether Jeanie’s possibilities have been mobilised, or indeed immobilised. Either way, Atwood describes the difference but not the moment in which the difference occurs. She writes that change happened gradually. We do not know that this will be a lasting transformation, yet it seems to be one which is quite dramatic, even revolutionary. The woman who becomes ‘drifted over with new words’ and is replaced by someone else may discover this was indeed a future moment in time/space which is fleeting. ‘It is an unexpected shift, the shift produced by the unexpectedness of events, which reorients the past and whose reorientation or reanimation reorganises its present effects without steps, in a continuity which is also a discontinuity, a becoming’ (Grosz, 2004:257-258).
In the discourse of the profound/profane, I think we do sometimes see (or hear) a moment of transformation. I believe that childbirth as a rite of physical/social/spiritual passage can bring moments of revolutionary motion/stillness which calls up the untimely, those moments in which we can pinpoint transformation. This makes childbearing and its sister work, midwifery, somewhat unusual. I think that in the embodied business of birthing and mothering, along with the surprise of profound/profane, comes the surprise of capturing the moment. These moments seem (un)related to whether a woman has birthed before. Although there seems to be often some comfort in the (more) familiar with subsequent pregnancies and babies, a woman having any of her babies may invoke the discourse of the profound/profane. This capturing of a moment is often spoken of in terms of amazement by birthing women and new parents and those who work with them. Those moments do not become fixed in their recognisability, only recognisable. Subjectivities in these moments are ‘[…] a changing ensemble of openings and closings, points of contact and points which repel contact’ (Probyn 2003:298); poststructural moments of possibility.

In the following excerpt from the end of Naomi Wolf’s book on childbearing which she aptly names ‘Misconceptions. Truth, Lies and the Unexpected on the Journey to Motherhood’, she writes of the profound/profane, of Grosz’s (2004:14) untimely:

As for us: We were a new family, with one small magnetic creature and two sleep deprived adults, drawn to the needs of someone I still thought of as ‘the little one’, as if under an enchantment. I could not remember when we had last seen a movie, or worn unstained clothing, or slept through the night. I could scarcely recall the self I had been before. But the life of our new family had begun to heal and knit. For almost four weeks, the baby had been an eldritch presence in our home: we would wash and feed and dote on her. Still, we had to take her babyhood on faith, for she was still a half-alien, half-animal being, waving her little limbs, turning her smooth, warm head, suddenly, inexplicably, as if listening to bulletins, inaudible to anyone else, from home planet.

One night, though – one night: The baby and I were alone. I was sitting on the couch with her; the couch where I had slowly fallen in love with something I did not fathom, something I was imperceptibly part of.

One night I crossed over.

Branches and leaves pressed around the windows of our apartment. Wind chimes were suspended in the branches outside. The chimes shivered a little. A silver tremor of sound hung in the air.

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The little one took her mouth from my nipple, and her head turned towards the sound. Her eyes looked huge. She held perfectly still until the notes subsided. She was listening to music.

She was a human baby, listening.

Her mother held her.

‘Do you hear the bells, Rosie? I whispered. ‘Can you hear the bells?’

(Wolf 2002:232-233)

This passage of Wolf’s reveals a discourse of the profound/profane. We can see and hear Wolf’s ambivalence. We can almost taste it, it is so beautifully written. She chooses a word meaning weird or hideous to describe the baby’s being in their time/space, writing of the baby’s ‘eldritch presence in our home’. Here is a discourse almost of the monstrous, certainly of the bizarre, somewhere out on the edge of human. We can feel Wolf’s and her partner’s shock, lasting well beyond the birth, into the first few weeks of parenting. She cannot recall herself, their habits, their clothes. Their days (daze) and their nights are all different and unknown. They are now in-process, becoming, caused by this small being who was ‘still a half-alien, half-animal being’ to them. At the same time, the discourse is of the profound. Wolf feels as though they are under the baby’s ‘enchantment’. Wolf says they ‘dote’ on the baby. What is happening feels so intense, so deep, so unqualified as to be likened to being under a spell. This little eldritch presence has well punctured their known.

My oldest child is 23 but when I read this passage I am transported into my past, into a time/space of tangled love/shock I felt in my pregnancy and in the early time as a new mother. In my mind, my life divided into BD and AD: Before and After David. In my second pregnancy ten years later there were times and spaces of definite ambivalence but even after Louisa’s birth I was never overwhelmed by those moments again. I was (pleasantly) surprised at the relatively calm way she integrated into my time/space. It was as if I had been transformed some time AD into the thing/person I needed to be to be mother and to be Jenny. For me this (mobile) transition began, at least, with my first baby but that does not mean of course that a transition with a first baby is necessarily what always happens, or what happens to all women. But for me, a transition had already happened and did not need to happen again, at least in such a dramatic way, in my second mothering world. Even though I cannot pinpoint the moment, some time in David’s infancy the
spell had been broken, a moment transformed and with it my subjectivity-in-progress as a woman/mother had become recognisable, and not so worrying. Moments of the profound/profane still discursively (re)construct me and my mothering world even though I have been a mother now for longer than I was not. The fierceness and the shock of this discourse still can take my breath away as it meshes my/his/her past/present/future.

I think it is unusual in general to be able to name the moment of movement but the embodied complexity of childbearing seems to give a heightened insight, a voice to the possibility of a surprising moment, a chance for some to name the untimely, to reveal a revolutionary moment. When Naomi Wolf writes ‘One night I crossed over’ she writes indeed of a transformative movement/moment. In the transformation, ‘little one, the baby’ becomes ‘Rosie’ and in that motion/moment, Wolf becomes a mother: ‘Her mother held her’. Even here, though, Wolf’s ambivalence is evident as she swaps back to the third person. She is both ‘I’ and ‘her’. Rosie and the bells make an untimely moment, even if it is one which may not always or necessarily last in the dailyness of a new mother’s world. Of course, it may.

The following story from my practice journal shows another transformative moment in a discourse of the profound/profane. Elle had been labouring throughout the night and by early morning was very disappointed by her (lack of) progress. She rested and tried, I think, to (re)capture her birthing self. Then she went into several hours of hard labour, with me as her midwife telling her she was doing well. This conversation then took place in the early afternoon:

Elle: How am I going Jenny? Do you think I am getting anywhere? Is it really happening? Am I really doing it now?

Jenny: You are doing beautifully.

Elle: But am I really labouring?

Jenny: Can you hear those grunting noises, Elle?

Elle: Yes, I can hear them.

Jenny: You know only William and I are in here with you Elle. William is not grunting and nor am I.

William, the farmer, smiles

Elle: That noise is mine, then?
Jenny: Yes, Elle. That noise is yours.
Elle: Then I'm doing well, aren't I?
Jenny: Yes, Elle, you are doing very well.

A baby girl is born a short time later.  

JB's journal

In this story, Elle is labouring hard with her first baby, pushing involuntarily; her body pushing her baby further down through her pelvis with every pain. She is making what is a ‘classic’ noise of second stage labour, short guttural grunting sounds, made with the effort of ‘involuntary’ pushing at the height of a contraction. Women are often surprised by this noise. Some are embarrassed and frightened by the noise’s ‘animal’ quality, especially women who have a need/desire or pressure to be polite. Many women are overwhelmed by their inability to stop either the bearing down or the noise which accompanies it. For other women who recognise such sounds, and for many midwives, grunting is a beautiful noise. The beauty of the noise comes partly because it means progress and therefore usually a baby soon, but also because the noise itself is out there, wild, out somewhere on the edge of human, surprising, wonderful. William, Elle’s partner, a farmer, recognises Elle’s noisy space/time as heralding birth and he smiles.

When I asked Elle could she hear the grunting noises, she was not surprised by them, so she had been hearing them but she had not recognised that wild grunting sound as her own. She asks: ‘That noise is mine, then?’ Elle is a labouring woman; she is also a newly graduated midwife. With the recognition of the noise (but interestingly, possibly not before) she says: ‘Then I am doing well, aren’t I?’ Of course, she may have known she was progressing well, she may have only asked for reassurance, or it may not have really mattered. Because she thought hours earlier that she was near giving birth and wasn’t, she may have lost her confidence both in her ability to labour and in her ability to judge her labour. But birth has a way of just going on, taking us with it (or not), with or without recognition. Many women do not ask about their noise, just as some do not ask about their progress, and mostly as midwives we do not comment unless we see that it is necessary at the time. Elle and I knew each other quite well and yet I did not speak of this noise until Elle asked.
When I did speak I chose to use humour in which to couch my answer in order to create a space, a possibility, for Elle to still work it out for herself. It is hard to be sure (even on discussing it with her later) but Elle did seem to come to an understanding with my words and her recognition of her embodied noise. She manages her moment of becoming, her time/space of Richardson’s (2000b) doubt.

That is how it seemed at the time, but what do I really know? But so beautiful to me is the memory of that space/time/noise that as I type this I am teary and goose-bumpy. As I type, I (re)construct Elle in a space/time of her/our own, a space I recognise as both a birthing woman and midwife. I love that space/time/text and the possibilities it brings.

Julia Kristeva writes a space/time of her own in the following paragraph from ‘Women’s Time’:

\[
\text{Pregnancy seems to be experienced as the radical ordeal of the splitting of the subject: redoubling up of the body, separation and coexistence of the self and of another, of nature and consciousness, of physiology and speech. This fundamental challenge to identity is then accompanied by a fantasy of totality - narcissistic completeness - a sort of instituted, socialised, natural psychosis. The arrival of the child, on the other hand, leads the mother into the labyrinths of an experience that, without the child, she would only rarely encounter: love for an other. Not for herself, nor for an identical being, and still less for another person with whom “I” fuse (love or sexual passion). But the slow, difficult, and delightful apprenticeship in attentiveness, gentleness, forgetting oneself. The ability to succeed in this path without masochism and without annihilating one’s affective, intellectual, and professional personality - such would seem to be the stakes to be won through guiltless maternity. It then becomes a creation in the strong sense of the term.}
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(Kristeva 1981:31)

In using maternity metaphorically to explore the issues of women and feminism, Julia Kristeva has given us a fascinating discursive picture of maternity itself. In ‘Women’s Time’ Kristeva (1981:31) draws a picture of pregnancy which is both of the self and other ‘[…] the radical ordeal of the splitting of the subject: redoubling up of the body, separation and coexistence of the self and of another, of nature and consciousness, of physiology and speech’. Here Kristeva constructs a time/space inhabited during the embodied time/space of pregnancy, during labour and in
mothering. She writes of pregnancy (and women’s place in society) as ‘a sort of instituted, socialised, natural psychosis’ (Kristeva 1981:31). It is not enough for Kristeva to choose ‘psychosis’, a ‘mad’ word, as mad words have so often been employed in the past to describe difficult (childbearing) women. She writes not of an ‘ordinary’ kind of severe mental derangement which comes with delusions and loss of contact with external reality (The Australian Concise Oxford Dictionary 2004:1137) but a psychosis that is socialised and natural and instituted. Again, she does not write passively of institutional psychosis, she uses the actively ‘instituted’. Kristeva writes of a very complex space/time. Psychotic, just as Elle is able to both hear her grunting and not hear it. Psychotic, just as Cate Kennedy’s pregnant young woman’s noise and that of her mother. Psychotic, as Wolf’s self she could scarcely recall. As each of these women occupy their complex and not-fixed space/time, they are complicately subjects-in-process.

Hélène Cixous writes poetically about pregnancy, birth and mothering in a metaphorical way in the ‘Laugh of the Medusa’:

We won’t advance backward any more; we’re not going to repress something so simple as the desire for life. [...] There are thousands of ways to living one’s pregnancy: to have or not to have with that still invisible other a relationship of another intensity. And if you don’t have that particular yearning, it doesn’t mean that you’re in any way lacking. Each body distributes in its own special way, without model or norm, the non-finite and changing totality of its desires. Decide for yourself on your position in the arena of contradictions, where pleasure and reality embrace. Bring the other to life. Women know how to live detachment; giving birth is neither losing nor increasing. It’s adding to life an other. Am I dreaming? Am I misrecognising?

(Cixous 1991:346)

Cixous ironically calls in the complexity of pregnancy and giving birth and mothering (and feminism) as ‘something so simple as the desire for life’. In doing so Cixous opens up a space here of ‘another intensity, of the arena of contradictions’.

When she says to ‘bring the other to life’ she means, of course, not just the baby as other, but the other of/in us all, the woman-other in every woman and that which has been othered by the maleness of society. For this discussion, though, I am fascinated by her questions. She sounds unsure, unconvinced, split, asleep, awake, psychotic. Just as Elle asks: ‘That noise is mine, then?’ So too does Hélène Cixous ask: ‘Am I
dreaming? Am I misrecognising?’ In that moment she seems unsure if she is awake or asleep, while in a place so simple as the desire for life in an arena of contradictions. In asking those questions Cixous joins in that moment, the discursive time/space of unthought possibilities. The time/space of poststructural doubt (Richardson 2000b).

In another of her works, Laurel Richardson also places herself (and is placed) in this time/space of unthought possibilities and doubt when she asks a question in relation to her mother-self, a question on the heart:

In the near light of morning, I know that the most difficult question will not be categorised as theory or research or current events, but rather lies at the heart of the matter - on my heart. What does it mean to me to be "mother"? (Richardson 1998:464)

In order to ask this question, one written on her heart, Richardson calls up the time/space of the pre-dawn of the day, a time of renewal, of new life; often a time of birth; the ‘witching hour’ of exhaustion and silliness on a night duty shift; a space of worry in the dark wakefulness; the near light of morning (my emphasis). In this time/space, Richardson asks not what it means to be a mother, but what it means to her to be mother. She calls this her most difficult question and it is one which does not come as her children are babies, it arrives (or has stayed) years later. Her words bare the question written on her heart. I wonder what other words and pictures are layered over and under that question, are layered under and over my own (mothering) questions. In the early pre-dawn, what means m(other)? Her promise is there in the hours both darker and lighter. Richardson still writes/speaks herself (and is written/spoken) into the space/time of mother-in-process, meaning-in-process, subject-in-process. Her words join her (and me) with the unknown, the unthought, in a moment where past, present and future meet.

Adrienne Rich (1977:36) wrote of herself as mother as being still in a state of ‘uncreation’ herself. Rich re-constructs the idea of creation as not only applying to the baby but to the mother as well and in doing so writes/spokes herself (and is written/spoken) into the space of subject-in-progress. This is a surprise to her. In a
beautifully poetic way Rich calls up the complex time/space of the discourse of the profound/profane:

Most of the literature of infant care and psychology has assumed that the process toward individuation is essentially the child’s drama, played out against and with a parent or parents who are, for better or worse, givens. Nothing could have prepared me for the realisation that I was a mother, one of those givens, when I knew I was in a state of uncreation myself. That calm, sure, unambiguous woman who moved through the pages of the manuals I read seemed as unlike me as an astronaut. Nothing, to be sure, had prepared me for the intensity of relationship already existing between me and a creature I had carried in my body and now held in my arms and fed from my breasts. Throughout pregnancy and nursing women are urged to relax, to mime the serenity of the madonnas. No one mentions the psychic crisis of bearing a first child, the excitation of long buried feelings about one’s own mother, the sense of confused power and powerlessness, of being taken over on one hand and of touching new physical and psychic potentialities on the other, a heightened sensibility which can be exhilarating, bewildering, and exhausting. No one mentions the strangeness of attraction - which can be as single-minded and overwhelming as the early days of a love affair - to a being so tiny, so dependent, so folded-in to itself - who is, and yet is not, part of oneself.

(Rich 1977:35-36)

In Rich’s profound/profane time/space we again see a woman’s displeasure at the silencing of one part of the discourse. Rich also calls up the psychic crisis of bearing a first child. The unambiguous woman becomes embodied ambivalence: exhilarated, bewildered, exhausted, attracted, repelled, powerful, powerless, with heightened sensibility.

Rich’s text, in a similar movement/moment to the others here, calls up uncreation as the unthought of Deleuze, the Kristevan subject-in-progress, Richardson’s moment of doubt, out on the edge of human; a moment of possibility. A moment, indeed, pregnant with possibilities…

In very particular circumstances…

In the (psychotic) moment of uncreation, of grunting, in the light darkness of the predawn, possibilities open up; sometimes a fleeting moment is captured, sometimes a transformation is trapped, sometimes only briefly. Somehow the women in these
texts find ways to become, or to be becoming, by knowing, even without knowing, or perhaps because of not knowing. In the time/space of the profound/profane, of possibilities previously discarded or unthought, they move and are moved, often/sometimes without their understanding or consent.

The discourse of profound/profane carries within it a sense of knowledge without words, embodied knowledge which can be (im)possible to articulate, often (im)possible to remember clearly. In this discourse the profound and the profane are not binary opposites but a knitted embodied experience-speak, born in and out of surprise, creating spaces for new and old and different possibilities. Sometimes the moment of movement, of transformation, or transgression, is clear. Mostly, only the moment is noticed and recognition of the change comes later, or not at all. The profane/profound in childbearing is a complicated and fleeting discourse fracturing and intersecting with both the embodied and the social. Elspeth Probyn writes:

*The interest in returning to the ideological underpinnings of the very notion of the subject is that it turns attention to the ways in which subjectivities are produced under very particular circumstances. [...] We need to think of subjectivity as an unwieldy, continually contestable and affirmable basis for living in the world. Subjectivities are then a changing ensemble of openings and closings, points of contact and points which repel contact.*

(Probyn 2003:298)

Women in pregnancy, during labour and giving birth and in the early parenting time inhabit a world of ‘very particular circumstances’. There the discourse of the profound/profane opens up a space/time for birthing women (and holds them in that space/time). It re-invents a moment of possibility, a moment previously unknown and unknowable. There is a form of timelessness and the (un)timely; a space, perhaps, to do body work. In puncturing the known: women speak in and are spoken into surprising times/spaces in birth.
Bronwyn  This made me cry a lot.
        My whole face cried, not just my eyes.
        I had to turn my face to the coffee shop wall.

Jenny  As midwives we need to say sorry for all the times we were and are with system, not with woman.

Bronwyn  I am healed from my birth experiences
        This is like someone poking an old scar which remembers.

Jenny  Still, I have caused you pain by my stories, my text.

Bronwyn  No, not you.
        It marks a difference between my experience and others'.
        My mother could neither see her daughter Nor would she/could she
        Sacrifice.

Jenny  I see you and other women
        Past, present and future

Bronwyn  I remember being told to 'Shut up' when I was making a noise,
        by a stranger who did not know me or care less

Jenny  I am sorry
        (I wish I could have been with you)

Bronwyn  I do not feel self pity, my wound is healed.
        It is that I see the profound gift
        the mother gives the midwife gives
        because of the real likelihood of its absence.

Together  This was a pain no one should have to bear.
The next section of this work deals with midwives’ immersion in the profound/profane and the effects of that immersion, the mobilisation of ‘with woman’.
‘With woman’, worth doing

For me, the experience of the impossible is not simply the experience of something which is not given in actuality, not accessible, but something through which a possibility is given. That is why in many different contexts [...] such as the concept of forgiveness, of the gift, of responsibility we find this experience of the impossible. I have to say that what makes the gift possible, for instance, is its impossibility. For a gift to be possible, it must appear as impossible. If I give what I can give it is not a gift, if I do what is possible for me, if what I’m doing and deciding is simply what I can decide or what belongs to my possibility, if this is in me, then this is not a decision. [...] So in order to give or forgive, I have to go through the experience of the impossible [...]. For a decision to be a decision, it has to be, to look impossible for me, as if it were coming from the Other.

(Derrida 2001:64-65)

Midwifery mobilises a discourse of ‘being with woman’ to (re)invent spaces and times in which to do midwifery work. Midwifery’s discourse is of being with woman in connected usefulness, a discourse which plays out on the practice field of (modern) maternity care in three major ways: in the minutiae of midwives’
embodied work with women; in the long-lasting and on-going tussle for access to the public domain; and in a sometimes public, but more often private, celebration of womanhood. The ‘with woman’ discourse creates, and is created by, working in the profound/profane times and spaces of the known/unknown, times/spaces ‘outside life as we know it’, in which special and (extra)ordinary events, feelings, sightings, understandings and opportunities can be fostered, protected, experienced and created, even when they are not (clearly) understood. Inside this special time/space of women’s work together, the sister works of childbearing and midwifery, bodies and body-work take on particular meanings. What was (previously) unknown, unthought (Deleuze in St Pierre 2000:505) and thus outside the range of the possible, may become in this ‘outside’/inside space, doable, even normal, knowable and wonderful. Sometimes the unknown, the unthought becomes bizarre, laughable, horrendous, terrifying, impossible, abject; not-doable. Midwifery holds within its discourse of being with/being useful all of these possibilities. As Jacques Derrida (2001:64) says, here ‘[…] a possibility is given’. Because of childbearing women, inside midwifery the (im)possible awaits.

Midwifery speaks and is spoken into a complex gendered social and embodied time/space in our society (as in many others). Aligning with women in a society which is ambivalent about women is always complicated, sometimes quite unsafe. Aligning with women in our medicalised society during the processes of childbearing is even more complex and potentially difficult and at the same time holds within it the possibility of irresistible joy. Intersecting with that complex mix is midwifery’s belief that we have truth on our side, which Jane Flax (1992:458) writes is ‘a recurrent element in justificatory schemes’. The combination of those alignments and beliefs produces midwifery in its own complex space/time: an embodied and social place of ‘truth’, a truth simultaneously (knowingly and unknowingly) joined with, and pitted against, strong social and political forces: the dominating discourses of science, technology, obstetrics and, in Australia, nursing as well. Discourses in midwifery help create and are created by particular profound/profane times/spaces for childbearing women and midwives: the (im)possible. In (re)birthing that ‘special’ gendered discursive space/time for and with women, midwives also (re)birth themselves as midwives, ‘in each moment of speaking and being […] inside the male/female dualism, socially, psychically, and physically’ (Davies 2000:85). Of
course, the ways in which midwifery has been spoken (in) and thought (of) and practised, changes in different historical moments and in different embodied spaces as midwifery moves from inside (the home) to outside (the hospital) and back and forwards in the times/spaces in between. Currently, constructing midwifery as ‘being with’ aims to move midwifery away from the medicalisation of childbirth towards a (re)turn to more palatable times/spaces.

In this chapter I investigate how the ‘being with/being useful’ discourse leads to (and from) a complicated intersection of other discourses which brings midwifery to a special position of truth-holding (which is further investigated later in this work). I ‘unpack’ the ways in which midwives and students of midwifery come to be constituted as legitimate and recognisable members of the midwifery discipline, a theme continued throughout this work. I look at the ways midwifery subjectivities, like all others, ‘[…] are not abstract entities; they are always conducted in situ. They are also hard-won’ (Probyn 2003:293). I seek to understand the ways in which midwifery is spoken in (to) the present by recognising the different ways midwifery has been thought of and practised in different historical moments, and I seek to show how midwifery discourses create and are created by midwives’ work in the space of the unknown.

The discourses of being special, different or unknowable help to manage the un/manageable work of pregnancy, labour and birth and early parenting and its sister work, midwifery. Childbearing situates women and midwives (as they also situate themselves) in a particular space/time together, a place of (im)possibilities, of (un)becoming, a place/time which is often outside/on the edge, a place that is both known and unknown. Hélène Cixous writes about the un/known in literary writing in the following passage but she could well have been writing about the shared known/unknown of childbearing women and midwives:

_The thing that is both known and unknown, the most unknown and the best unknown, this is what we are looking for […]. We go towards the best known unknown thing, where knowing and not knowing touch, where we hope we will know what is unknown. Where we hope we will not be afraid of understanding the incomprehensible, facing the invisible, hearing the inaudible, thinking the unthinkable […]._

(Cixous 1993:38)
The discourse of ‘being with/being useful’ helps midwives construct ways in which they ‘will not be afraid of understanding the incomprehensible’ (Cixous 1993:38). ‘Being with/being useful’ opens times/spaces where ‘[…] facing the invisible, hearing the inaudible, thinking the unthinkable’ (Cixous 1993:38) are imaginable and manageable, spaces/times which are special/different/outside the known and in so doing creates a (midwifery) truth and at the same time midwifery possibilities.

Inside these intersecting discourses the (blurry) lines are drawn by (some, many) midwives between that which is ‘with woman’: midwifery, and that which is (sometimes, mostly, often, always) not: science, obstetrics, technology and nursing. The midwifery discourses of being with/being useful and being special currently galvanise political desire and action towards achieving access to midwifery for all childbearing women at the same time as they lead to the celebration of the ‘essence’ of woman, a salute to her strength and ability – both birthing woman and midwife-woman. The politics of access and celebration (discussed in the following chapter) in turn, or out of turn, strengthen the discourses of connection, usefulness and special-ness and the profound/profane. Along with the possible in/of the dailyness of midwifery work, the midwifery discourses of access and celebration are born inside the moments of the (un)known, the (im)possible. Inside/outside those moments childbearing and midwifery are constituted as worth doing, worth celebrating and worth fighting for.

**Being with/being useful**

Midwifery’s discourse is not only of being with but of being useful; connected usefulness both in a practical and personal sense. The word midwife comes from the old English ‘mid’ meaning with and ‘wyfe’ meaning woman (Fraser and Cooper 2003a:3). ‘With woman’ means being ‘present’ for the woman both in body and in spirit (Berg et al. 1996:13). It includes sharing parts of a midwife’s self in a friendly way, believing in the woman and her abilities and working honourably so the woman sees the midwife as trustworthy (Pairman and McIara-Couper 2006). Midwifery, being with, means helping in a multitude of practical ways: offering information,
observing, comforting, checking, advising, implementing treatments, documenting, second-guessing, consulting and referring, and it includes trusting, and thus not disrupting, a healthy process (Page 2000b; Leap and Pairman 2006). Thus the discourse of being with/being useful also holds within it the concept of doing/not doing. Midwifery’s sense of itself as a practice-based discipline (underpinned as it is by a great deal of knowledge about childbearing and women), dominates midwifery’s other discourses of/about midwifery, as it has always, from the current ways of learning midwifery at universities, back through the days of ‘hospital-based training’ to our midwifery forebears who passed along their knowledge and skills to other appropriate women.

In relation to the multiple discursive practices surrounding being with/being useful, Alison Chandra, a very experienced and capable ‘with woman’ midwife (named elsewhere in this work as just ‘Alison’), provides the following guidance from a conference paper. Alison can be read as shifting the power to the woman while maintaining the responsibility on the midwife to provide useful information, when she says:

_The woman provides the answer. She is responsible for herself and her baby. She is also accountable for her decisions. However her care choices can only be made after sensible discussion and presentation of any evidence we have of likely outcomes following a particular plan of care. Local facts and figures are even better if you have them readily available_[...]. _

(Chandra 2003b)

Of course, discourses move and shift and work in complex ways. Scientific evidence can be seen as a way to protect women from less-than-desirable practices which are based on opinion, and/or scientific evidence can be seen as a way to strengthen the authority of powerful (medical/scientific) discourses (Tracy 2006b) at the expense of the less powerful (women and midwives) in the health care system. Alison’s plea to use statistics can be read as her way of working from inside to subvert the current order of the ‘scientific’ health system by using statistics to show midwifery as safe and useful; winning by beating the opponents at their own game and thus being able to be ‘with woman’ and useful. Alison’s being with/being useful discourse can also be read as a strategy to turn the woman (and Alison) towards positions of responsible (consenting) neoliberal subject. ‘The illusion of autonomy, a crucial element of
neoliberal management’ (Davies and Bansel 2005:51) is obtained for the woman and can be achieved by midwives who use evidence.

Being useful is highly valued by midwives. Bronwen Pelvin writes in the recently published first ever Australian and New Zealand midwifery textbook about practicality as one of a midwife’s very important qualities:

Midwives are often known and respected for their sense and practicality. Practicality is derived from experiences and actual use rather than from theory. The involvement of midwives with women in their everyday lives affords them a wonderful opportunity to see women coming up with practical solutions to the management of pregnancy, labour and the care of the newborn. As women, midwives have often had these experiences themselves and can report on what they have found helpful. They can also report what they have noticed in other women’s childbearing experiences and contribute to the dissemination of knowledge. In this way midwives act as conduits of sensible, useful and effective responses to the situations women encounter as they journey through their childbirth experience.

(Pelvin 2006:226)

Pelvin, in this short paragraph which is part of a chapter called the ‘Life Skills for Midwifery Practice’, takes up the historical discourse of women handing down wisdom to other women by ‘the involvement of midwives with women in their everyday lives’. She brings together the discourses of being with and being useful, saying midwives are ‘conduits of sensible, useful and effective responses […]’. Pelvin’s words highlight a very common midwifery ‘truth’ that it is experiences and reality that really make a midwife useful. Some midwives even use a discourse of ‘real midwifery’ (Foureur and Hunter 2006:104-107). Others write that midwifery is a practice-based discipline (Page 2000b). In actually being involved with women on a day-to-day basis, midwives learn from women (and themselves as women) and can pass information on which may in turn help other women. In her chapter Pelvin also lists other desirable qualities for midwives apart from practicality: ‘robustness, empathy, companionship, honesty, commitment, integrity, decisiveness, curiosity, boldness, reflectiveness, friendliness and generosity’ (Pelvin 2006:226,227). This comprehensive list of qualities can be read as a ‘recipe’ for being with/being useful and the taking up of these qualities as a way of constructing oneself as midwife.

Other midwives-authors, for example, Nicky Leap and Stephanie Vague (2006:417),
consider being with/being useful so important and so helpful that they elevate it to an art form, writing of ‘[…] the midwifery art of being with women in pain in labour’.

Included in the being with/being useful discourse is the art of doing nothing (except being with) well. Lesley Page (2006: foreword), a well known British midwife-academic, constructs midwifery as a ‘position of ‘being with’ rather than ‘doing to’. Sally Pairman, a New Zealand academic who was instrumental in instituting a women-centred curriculum in New Zealand in the 1990s, and her co-author Judith McAra-Couper, also take up this idea of watching, waiting and not interfering unnecessarily when she writes:

…”midwifery expertise is as much about knowing when not to interfere in the physiological process of pregnancy and birth as it is about recognising when and how to intervene in a way that will facilitate and enhance the woman’s ability to give birth or to confidently mother her new baby.

(Pairman and McAra-Couper 2006:238).

Being with/being useful is a complicated discourse holding within it both doing and not doing, work sometimes called ‘holding the space’ (England 2006). Holding the space and doing little else might include such embodied examples as: waiting longer than usual for something to happen in birth as long as all is well; being with a birthing woman but only knitting (England 2006; Walsh 2006) (see below a photo of Dr Beryl Rich, the medical practitioner who was at the birth of my own child at home, personifying the concept of this (perhaps not so) ‘unusual form of labour support: sitting in the corner knitting’ (England 2006) while the woman, midwife, partner and support people are busy); seemingly reading the paper while a new mother bathes her baby alone for the first time; protecting the labouring woman’s space by suggesting the woman sit for a while on the toilet, knowing other health practitioners will not enter an ensuite bathroom in the same way as they feel free to go into a birthing room; meeting other practitioners at the door of a birthing room so that conversations happen were they cannot disturb the labouring woman’s space; and of course the ultimate holding of the space, attending births at home. Not doing can be quite active, or not.
At present in midwifery philosophy, teaching and practice ‘being with’ is overt. This discourse is obvious in legal and professional documents, in some classrooms from the beginning of a student’s program until the end and in practice settings. The newly re-written Australian College of Midwives (ACM) Philosophy Statement says:

*Midwife means ‘with woman’. This meaning shapes midwifery’s philosophy, work and relationships. Midwifery is founded on respect for women and on a strong belief in the value of women’s work of bearing and rearing each generation. Midwifery considers women in pregnancy, during childbirth and early parenting to be undertaking healthy processes that are profound and precious events in each woman’s life. These events are also seen as inherently important to society as a whole. Midwifery is emancipatory because it protects and enhances the health and social status of women, which in turn protects and enhances the health and wellbeing of society. Midwifery is a woman centred, political, primary health care discipline founded on the relationships between women and their midwives [...].*  
(Australian College of Midwives 2005)

The ACM, as the national Australian professional body for midwives, uses ‘with woman’ to construct women as important, childbearing as ‘emancipatory’, midwives as special and valuable and therefore, midwifery as necessarily political. ‘Being with’ is constructed as being useful in many ways.

In the recent past, much work has been done across the spectrum of midwifery in practice and in the midwifery support systems, teaching, research and management to assist women and midwives to form active and meaningful relationships with each other (Page 2000b; Pairman and McAra-Couper 2006). In the 1990s academics and midwives re-wrote midwifery curricula to use the concept of ‘with woman’ as the philosophical basis and as a model for practice (Guilliland and Pairman 1995; Browne and Lohse 1996; Barnes 1998). In practice in the last twenty years structural changes such as birth centres, team midwifery, know-your-midwife schemes and one-to-one midwifery programs and ‘case load’ midwifery practices have been initiated to help individual women and midwives know each other well (Chandra 2003a; Page 2003). Research is showing better health outcomes for women who receive continuity of care throughout pregnancy, labour and birth and the postnatal period (Hodnett 2000). Systemic reviews of midwifery continuity are currently under way (Hatem et al. 2004). ‘Being with’ has come of age (in our age).
Strangely, perhaps, given the word itself means ‘with woman’, emphasis on the relational aspect of midwifery work comes in and out of fashion. Midwifery curricula of the second half of the last century were usually medicalised and rigid in their adherence to highly structured ways of thinking and doing, based on routines and rules. There was no or little emphasis on ‘with woman’ in published midwifery lecture notes commonly used at the time in Australia (see for example the Royal Hospital for Women 1986 Midwifery Notes where 'with woman' is not mentioned). How the ‘with woman’ discourse is played out in learning and practice over time is a complex matter. Published in 1980 at a time when the effects of the medicalisation of childbirth were becoming increasing obvious, the first edition of Helen Varney’s (1980:3) American midwifery text, ‘Nurse-Midwifery’, contains a reference to ‘with woman’ in the opening paragraph and yet at that time the United States of America was not, and still is not in many places, familiar with or desirous of midwifery (Davis-Floyd and Sargent 1997; Wagner 1997), even though American midwives and nurse-midwives do exemplary work (Jackson et al. 2003). By 1989, the British midwifery text commonly used in Australia, written by new editors instead of the older original author, Margaret Myles, and renamed ‘Myles Textbook for Midwives’ opened with Chapter 1 ‘The Midwife’ (Bennett and Brown 1989). Previous editions, for example in 1964 (Myles 1964) and in 1971 (Myles 1971) opened with Chapter 1 titled ‘The Female Pelvis: The Genital Organs’ which shows those editions’ medial/scientific/anatomical approach and the only mention of the midwife meaning ‘with woman’ was in Chapter 40 under the title of the ‘History of Midwifery’ (Myles 1964; Myles 1971). ‘Sensitive Midwifery’ (Flint 1986), a revolutionary book about how to be ‘with woman’, written by a British homebirth midwife, was published in 1986. In the United States, two influential midwifery texts which discussed moving the emphasis from the medicalised health system (back) to an emphasis on woman were published earlier, ‘Spiritual Midwifery’ from Ina May Gaskin (1977) and Elizabeth Davis’ ‘Heart and Hands’ (1981). Many other books and articles were written after this time and yet it took years for change towards a woman centred philosophy to begin in any conspicuous way in the health and midwifery education systems in Australia (a similar picture is apparent in some other medicalised maternity health systems across the ‘developed’ world).
My own hospital-based midwifery education undertaken in 1986 after registration as a nurse is an example of how medicalised the teaching and practice environments were for students of midwifery. (Of course, there were variations between institutions across the country as to the degree of emphasis on medicalisation, a situation which is still apparent today in maternity units and hospitals in Australia.) Even though new, women centred midwifery texts were published before or during the year I undertook my midwifery education, I did not read them until I started teaching. These midwifery texts which became classics were never mentioned in our 1986 classroom and did not make the recommended reading list which included medicalised texts like ‘Obstetrics and the Newborn’ (Beischer and MacKay 1986). The approved midwifery curriculum in Canberra only reflected a ‘with woman’ stance when it was rewritten by a group of midwives and educators led by me in 1996. When I undertook my midwifery training (a word I use advisedly in this context) in 1986, I could not have said what the word midwife meant, even in a test. Even though in my hospital classroom we were expected to learn to be useful to women and be sensitive to their needs, as we were taught by a particularly fine woman, Phyll Groves (now Dr Phyll Dance), there was no discourse of ‘being with woman’. We were, however, introduced to ‘The Sociological Imagination’ (Mills 1970) as Phyll’s attempt to humanise a very medicalised curriculum by helping us to see the individual women we were working with as social and cultural beings. Unfortunately for my sociological imagination, all I remember doing is arguing with Phyll about Mills’ sexist language and I engaged with it more than most of my co-students. Even though I considered myself to be a radical feminist woman in 1986, when it came to health I, like all in my cohort of nurses-becoming-midwives, was firmly enmeshed in the medical model. Around this time my sister, Mary, expressed a desire to birth her fourth baby at home. I was less than enthusiastic. Seven years later when I decided to birth my second baby at home, she was very supportive.

‘With woman’ took many years to become part of (many) midwives’ discourse, (again) because in much of the last century, dominant learning discourses in maternity placed more emphasis on the germ theory than on relationship theory and much was made about what could go wrong, rather than what could go right (see for example Beischer and MacKay 1986). This change in discourse went hand in glove with the 20th century obstetric argument for a ‘scientific’ view that childbirth should
no longer be considered a natural process and that every birth should be attended by a doctor to guide and manage it (Arney 1982:37) (my emphasis). Foucault (1973/1994:17) wrote that the ‘dispute between active medicine and expectant medicine’ is an old one which in France can be traced to 1786. Of course, Foucault was not looking at midwifery when he wrote ‘The Birth of the Clinic’, but much of what he exposes in his work on medicine and hospitals can be equally applied to our understanding of midwifery and obstetrics and our current modernist Western tendencies. The following example of ‘active’ medical thinking comes from a set of typed notes given out in a lecture in my midwifery education in 1986 by a consultant obstetrician, about women having a ‘normal’ labour and birth when their previous child was born by Caesarean section:

Trial of Labour
When we discuss trial of labour it is important to realise that every patient in every labour is really having a trial of labour. This means that we are allowing the patient to have contractions of the uterus in the hope that successful vaginal delivery will result. [...]  

(Hehir 1986:1)

While actually trying to provide an opportunity for women to birth normally after Caesarean section, an opportunity often not provided even now in Australia, these notes construct labour and birth as a test and women as having to pass it. If a woman does not pass the test it is because she is in some way deficient, either bodily or psychically. Historically, women’s bodies have often been constructed as unable and/or incapable (Ehrenreich and English 1973) and this is still often the case today. Susan Maushart wrote recently in her exposé of childbirth:

Yet childbirth has become not only an athletic event but also an aesthetic one, an arena for personal expression, an opportunity to sculpt transcendence from a fleshy medium of blood and bone and muscle. ‘As a woman lives,’ wrote psychotherapist Gayle Peterson, ‘so shall she give birth.’ At one level the idea is inspirational. At another, it is a throwing down of the gauntlet. A dare. In childbirth, we have come to believe, we show what it is we are made of - and we hope like hell it’ll turn out to be the right stuff.

(Maushart 1997:110).

In the past few years a new movement within midwifery has actively worked to change language, including and especially that of trial/failure for women. The campaign to replace misogynist terms such as ‘trial of labour’, ‘failure to progress’
and ‘incompetent cervix’ for both midwifery and medical purposes (Chandra 2003a) met with quite an amount of success (Leap and Homer 2003). However, I believe like Maushart that in our complicated birthing world, giving birth is still often (possibly always) constructed as a test for (and by) women. These tests come in a physical sense of every birth being ‘normal only in retrospect’, a medical dictum (Foureur and Hunter 2006:98) still alive and well in maternity care today, or as a test more in line with Maushart’s psychological dare which is grounded in the physical, or both.

To return to the issue of emphasis on what could go wrong as implied in this quote from my Trial of Labour notes, two further issues are important here. Not only do these words construct a power situation where obstetric work and knowledge dominate over the woman (and her midwife) (Leap and Homer 2003) by ‘allowing the patient to have contractions’, even more importantly the underlying message contained within the statement is that all women should be considered to be having a ‘trial of labour’, no matter how healthy they are or how capable of giving birth. This very much undermines the body work of all childbearing women and the midwifery work which accompanies it. It is arrogant in the extreme. More importantly for new students of midwifery, such a discourse sets up a distrust of all women and all labours, and example of medicalisation in practice, medicalisation which Foucault understands as being increasingly invasive and inclusive:

Medicalisation - that is, the fact that starting in the eighteenth century human existence, human behaviour, and the human body were brought into an increasingly dense and important network of medicalisation that allowed fewer and fewer things to escape.

(Foucault 1994:135)

Such is the power of the dominant medical discourse. A distrust of both women and birth becomes the norm, the truth, an actively supported and insidiously taken up truth (Wagner 1997). Fewer and fewer things escape.

Immersion in the medical discourse means that women become thought of as capable only after they have proved themselves able to give birth. This privileges the philosophy of birth as a risk, as ‘normal only in retrospect’ (Foureur and Hunter 2006:98). Fetal ‘surveillance’, for example electronic fetal monitoring and fetal
ultrasound and induction of labour, and Caesarean section, are examples of technological interventions which were designed for individual ill women, or well women with ill babies. There interventions are now frequently used for well women with well babies, providing little health benefit and sometimes (or perhaps, often) health disadvantages (Wagner 1994; Tew 1995; Alfirevic, Devane and Gyte 2006). Using technology indiscriminately both causes and exemplifies a distrust of women’s abilities to grow, birth and feed a baby. Constant distrust of women and their childbearing abilities feeds their own distrust of themselves and their bodies. They too begin to think everything is only ‘normal in retrospect’, instead of what I think is a woman’s usual post birth position, in part at least, that of overwhelming relief. This belief in normal only in retrospect, grown out of the medical model, is still ingrained in the maternity system, even though many midwives and some medical officers subscribe to the opposite view of ‘normal until proved otherwise’ (Porter 2003:219). These polarised stances are seen by some as inappropriate, as Rick Porter, a consultant obstetrician in Bath, England, says ‘[b]lind faith in normality is as inappropriate as unbending insistence that ‘pregnancy is only normal in retrospect’ (Porter 2003:219).

All through the medicalisation of childbirth, midwifery and other discourses of ‘being with’ survived (underground), sometimes even thrived, either as separatist discourses or as active and/or passive resistance to dominant discourses. Some midwives (and obstetricians) in the last century managed to keep hold of a strong with-woman discourse and continued to constitute (and be constituted by) childbearing more as a social event than a medical one (Leap and Pairman 2006). This was even while, or because, medical scientific and technological discourses in childbirth grew progressively to dominate all others (Foucault 1994), including midwifery (Tew 1995; Papps and Ollsen 1997; Murphy-Lawless 1998; Leap and Pairman 2006). In the past, as now, with-woman practitioners had a strong belief in what they often labelled ‘real midwifery’. This term is still used by midwives today. For example, Marion Hunter undertook research into the effects of the place of birth. She and Foureur (Foureur and Hunter 2006) write about what the midwives in her study called ‘practising real midwifery’ which they said they can do in small maternity units where they could be ‘with woman’, rather than ‘with machine’:
[...] the midwives felt truly autonomous, able to take time to let labour unfold rather than rush women along as if on a conveyor belt, able to give the woman time to settle into her labour before intruding with a vaginal examination to assess progress, and more able to tolerate the woman making noise without fear that they would be regarded as a less than competent midwife [...] Despite the additional responsibility and feeling that they would 'carry the can' if anything went wrong, they were unshaken in their belief in the normal process of birth and had the confidence to enable the process to occur with minimal intervention

(Foureur and Hunter 2006:104)

It was ‘real midwives’ such as these who said to us as new students in the obstetrically dominated hospital and era of my midwifery education: ‘See your hands? They are for sitting on until you have a good reason not to!’ Role modelling a belief in women and natural processes sometimes came from obstetric sources as well. I remember being ‘scrubbed’ with an obstetrician who had many, many years of experience, to ‘do a delivery’ in my midwifery training. The midwife had made an error and called him in to the hospital to attend ‘his private patient’ too early. Calling an obstetrician too early for a birth was usually a cardinal sin and a major midwifery mistake. Indeed, part of the discourse of being a ‘good midwife’ was knowing when to call the doctor (and still is in many places) otherwise he/she is kept waiting at the hospital, inconvenient both for him/her and for all the women waiting for antenatal visits in the consulting rooms. Mostly, if that happened, the obstetrician would make a big fuss and either leave again and have to be called back amid much drama, or find an urgent reason why the baby should be born now and so ‘deliver’ her or him without waiting. However, obstetrics also holds within it overlapping and contradictory discourses. This obstetrician belonged to ‘the old school’, that of ‘expectant medicine’(Foucault 1973/1994:17), one of those doctors whom Marsden Wagner (1997:386) describes as belonging to a group of ‘conservative older physicians, trained before the high-technology take-over of obstetrics, [who] may prefer a more cautious and humanistic approach to health care’. So we both waited quietly (still in green sterile scrubs) while the midwife worked with the woman until she was ready to give birth. The obstetrician quietly stood up from sitting on a very hard metal stool in the corner of the room, seemingly unnoticed by the woman, where he had been waiting, calmly, kindly, wordlessly for an hour and together he and I attended the woman. The only thing that was missing was some knitting (and a
stool for the student midwife to sit on...). I learned much about waiting that day and something (new) about obstetrics.

Undergraduate medical schools were still teaching the doctrine of ‘masterly inactivity’ (Fitzgibbon 1923:110) well into the 20th century in caring for birthing women, a position the obstetrician above took up. However, in the middle and later years of the century, the discourses of obstetric ‘doing’ and ‘managing’, for example ‘active management of labour’, became a common way of referring to accelerating women's ‘progress’ in labour (Arney 1982; Tew 1995). Interestingly, in the most well known and far reaching piece of research into managing a woman’s labour by speeding it up, undertaken in Dublin in the 1970s, labouring women had a midwife with them constantly (O’Driscoll and Meagher 1980). As this research was quickly implemented into practice all over the Western world (Murphy-Lawless 1998), with varying degrees of vigour, the one midwife to one labouring woman ratio was discarded and millions of women’s labours were commenced or sped up without the benefits of having a midwife with them at all times (Goer 1999). In the implementation of the medical findings of this research outside Ireland, the accompanying requirement for the constant presence of ‘the nurse’ [midwife] was ignored and so most countries went ‘without the most important aspect of the package’ (Page 2000a:106). Today research is showing us again the value of the presence of a labour companion (Hodnett et al. 2003), especially one with whom the woman has a continuous relationship (Hodnett 2000). ‘Being with’ can be shown to be scientific...

Some midwives and other health practitioners, like the previously mentioned obstetrician patiently waiting for the woman to be ready to give birth, resist the dominant discourse that faster is better, and either hold on to, or re-learn, ways of being ‘with woman’ in a complicated health system. Nola, a very experienced and much loved Canberra midwife whom I interviewed for this thesis, told the following story when asked how she became a ‘woman-centred’ midwife. She talks of her time on long term night duty working in a team of three:

For 17 years after my midwifery training I was the best "Obstetric Nurse" in Australia. I was so accustomed to doing exactly what I was told - when I was told. The "boys" [obstetricians] loved me! Then I met [two midwives] - they
taught me how to be a midwife. They taught me to have confidence in women and confidence in myself. […] After working with them on nights (and later, Alison) my confidence grew. Because of their confidence in me, my own grew. I was prepared to take on the “boys” (albeit with loose bowel for some time).

I had experienced the hierarchical teaching method within the Catholic system and promised myself then that I would never treat a human being the way I was treated, so [back on day duty] student midwives gravitated toward me – knowing they wouldn’t suffer the violence I suffered. I also observed (in some hospitals) the treatment of women in labour by men and can honestly say I’ve never made a woman feel inadequate/uncomfortable and women seem to sense that.

Nola’s construction of herself as a midwifery subject is a complex, ambivalent project. She explains that she was both a good ‘obstetric nurse’ and at the same time she treated women with respect, never making them ‘feel inadequate/uncomfortable’. Describing someone as an obstetric nurse is a serious insult in some midwifery circles, as it usually means not being with woman, the ultimate crime. Nola also says ‘the boys’ loved her which is more evidence of not being with woman. This is a familiar ambivalent space/time which midwives occupied especially in the 1970s and 1980s before the resurgence of midwifery, a time when the effects of systemic medicalisation of childbirth were structurally even more obvious than today. This ambivalence is very much part of midwifery today and is a constant theme in this work. However, I think Nola is quite hard on herself here. In our ironic Australian way she insults herself quite badly by saying she was an obstetric nurse. I am not sure she was, actually. Nola’s picture of herself suggests she had been with women but in a different way, perhaps. She decided she would never treat a human being the way she had been treated in her education; she saw and understood male practitioners’ abusive behaviour towards women; and she clearly says that she ‘never made a woman feel inadequate/uncomfortable and women seem to sense that’.

Nola’s earlier midwifery is a complex practice time/space where multiple discursive practices collide. Then, after seventeen (un)comfortable years, Nola begins to learn a new midwifery way. On night duty Nola becomes immersed in another discursive practice, that of confidence in women’s abilities; that of ‘midwife’. Nola does not say but we can surmise that she began to feel inadequate/uncomfortable with herself. She re-constructs herself (and is re-constructed by her midwife-colleagues) as a midwife who aligns with the women, not with ‘the boys’ and in that re-aligned space/time, following instructions becomes not-doable. Nola uses (and is used by)
the new-to-her discursive/embodied space/time to open up the Deleuze’s unthought (St Pierre and Pillow 2000a:505) and in the moment(s) of so doing, becomes midwife.

Night duty provided a space/time where the other two midwives and then Nola could take up a discourse of midwifery, even in the time of strong medical dominance in the 1980s. Night work is often less constrained by rules and less watched by management and medical officers. The wee hours of the night belong to shift workers, much more than those just on call (such as obstetricians and medical registrars). Power dynamics change in the dark and people often form a working closeness with those they work with (Drew 2005) which an ordinary rotating roster (where people work with different people each shift) does not always foster. Nola writes of her team ‘they taught me how to be a midwife. They taught me how to have confidence in women and confidence in myself’. Nola’s midwifery friends created a space in time for women to do their body business, unhurried and without unnecessary ‘help’ and in doing so create a similar space for Nola. Here, in the calm of the night duty ‘witching hours’, she learns an embodied lesson: that it is usually better to support women and leave their labours alone than it is to support their labours and leave the women alone. Women birthing at home is another classic time to learn the same midwifery lessons (Wagner 1997) (as I found out for myself on the occasions I shared attending women birthing at home with Megan). Nola relearned her midwifery after seventeen years of work from lessons taught by women and supported by other with woman midwives (one of whom was a man) inside a very medically dominant model. From this inside/outside space of freedom and resistance Nola’s new position as midwife brings with it the courage to stand up for women, even though it is embodiedly frightening. She says with humour ‘[b]ecause of their confidence in me, my own grew. I was prepared to take on the “boys” (albeit with loose bowel for some time)’. Nola constructs midwifery as worth doing and women as worth fighting for and herself as able to do both.

As we see from Nola, ‘being with’ drives (and is driven by) a powerful relational discourse in midwifery. Once learned and taken up as their own, ‘being with’ becomes part of both midwives’ and students’ language and psyche. In the following
story, at the very beginning of his midwifery education, Patrick is ambivalent in taking up a ‘with woman’ position:

Unlike other areas that I have worked, I am really finding the time to generate a bond with the mothers and families and it actually feels funny to be leaving them at the end of a shift to somebody else's care, as it feels like I am abandoning them before they are set with all that they need. Something that I am going to have to work on.

(Patrick’s journal March)

On one hand Patrick is enjoying having the time to ‘generate a bond’ with the women and families he is working with on a midwifery ward. Patrick had come to midwifery from a very busy, often dramatic area of nursing where everyone had a short stay. In midwifery he has the time to make relationships, important relationships which make him feel ‘funny to be leaving them at the end of a shift’. Patrick’s choice of such strong words ‘abandoning them’ tells us that he views being with and being connected important and valuable. In naming his relationship with the women and families a ‘bond’, he embodies a two sided relationship, an attachment, one with ties that bind. Here Patrick creates a new-to-him discursive space/time in which to do his work. ‘Bond’ also holds within it a suggestion of bondage and this seems to be the case for Patrick. He says he has work to do about how he feels. It is not absolutely clear what Patrick means by this. He could mean he wants to stop feeling like he is abandoning the women and families when he leaves to go home at the end of a shift, or he may mean he is unused to midwifery work which is not neat and ordered and so he does not feel like he has completed his work at the end of a shift, or could be meaning he wants to work on stopping forming relationships. The former seems more likely from the words he uses in his reflective journal but either way, Patrick knows he has work to do in relation to midwifery relationships because of how connected he is feeling. Patrick includes families in his description of the bonds he forms with women. Clearly, he feels empathy with men in this situation, as well as the women, presumably in part to being a (new) male in a predominantly female environment. However this passage is read, Patrick is in the space/time of being with/ being useful and it is a new and (un)comfortable space. From an acute nursing background where strong relationships are possible but less likely due to more time constraints and possibly less emphasis on equal relationships
between client and carer, Patrick now takes up ‘being with’, even if he does so ambivalently.

In the following story Minnie, a relatively new and (newly) pregnant student, also describes a complex taking up of the being with/being useful discourse in a situation in a birthing suite:

Did I say I was more scared of breast-feeding than birth? I think I’ll review that statement. [...]. I told my husband if I saw another birth like yesterday’s I think I’ll quit. Today, it got worse.
Meet Ros. This her first birth experience involved an epidural, Syntocinon infusion, meconium liquor, decelerations in foetal heart rate leading to a transfer to Operating Theatre for trial mighty vac birth with the option of a caesarean section. With an enormous effort from Ros - pushing even though the epidural was well and truly wearing off - the baby was born with the help of a mighty vac and an enormous episiotomy. It was flat as a tack (Apgar 4 then 8) and transferred almost immediately to the newborn nursery with the Midwife and Dad. Ros was left high and dry in brightly lit, sterile theatre with her legs in stirrups in front of a few casual onlookers while the doctor stitched her up. I could help. She held on to my arm as if she were sinking. We just chatted. Somehow she managed to still have (though fragile) a sense of humour. I was incredibly proud of her. The reason I won’t quit is because of her.

(Minnie’s Journal April)

Minnie describes a very practical way of ‘being with’ in this journal story. She was considering quitting midwifery because of what she had seen. Then she sees something worse. Minnie writes of a woman who, after a period of amazing effort and at a time of great vulnerability, is left by those who were supporting her, her partner and her midwife. Not only do the two people to whom she is most connected leave her, not just in a delivery room, but worse still in the operating theatre, they also take away her new baby who is unexpectedly unwell. Through Minnie’s words we see and feel the woman bereft, terrified and bewildered. Using a metaphor of a boat being pulled up the bank right out of the water, Minnie describes the woman’s abandonment, saying the woman was ‘left high and dry’. Minnie is new to midwifery and cannot do a lot of the midwifery work yet which is probably partly why she was not sent to the nursery with the baby and that left Minnie and the woman together in the operating theatre with other practitioners. Minnie does not say so but she too is probably left feeling ‘high and dry’ when the midwife and the woman’s partner leave but she concentrates on the woman. Minnie sees the
woman’s situation with Minnie’s own new (midwifery) eyes. She is the kind of
person who notices others and she has time to do so, given that she is mostly
observing in this situation. She has also been well schooled in the ‘with woman’
midwifery position from the first day of her midwifery education program. So
Minnie constructs herself as useful: ‘I could help’. She continues the boat metaphor:
‘She held on to my arm as if she were sinking’ and then, a statement of friendship,
togetherness, ordinariness: ‘We just chatted’. Reading Minnie’s words we see a
connection forming. We do not know whether Minnie felt helpful in a lay person-to-
person sense or more in a midwifery sense but we can see her actively creating a
time/space in which to do with-woman work, even in the midst of (or possibly,
because of) the bright lights, sterile hospital equipment, fear, pain, a compromising
body position and (im)perfect strangers. Minnie and Ros connect in the midst of all
this and in front of ‘casual onlookers’. This connection provides Ros with distraction
and comfort; a lifeline. Minnie writes: ‘I was incredibly proud of her’. While being
proud of someone whom one potentially has power over can be read as patronising,
here Minnie seems to be very respectful of the woman for managing the
unmanageable. Minnie is very impressed and pleased for the woman for being able
to do that. Minnie, too, has found a way to manage her own (midwifery)
unmanageable. By noticing need and responding with connection and usefulness,
Minnie becomes ‘with woman’. In so doing, she positions herself as being able to
stay in midwifery. In this moment of being with/being useful she is midwife,
because of Ros, because of Minnie.

Months later, the same student, after weeks of working in two different birthing
areas, makes this entry in her journal:

The birthing woman had complications [...]. [The registered midwife]
encouraged me to be the primary midwife, doing all the care for this woman
including writing the notes. The midwife was in the room the whole time [...].
Though I felt a little flustered at times (trying to do the fetal heart rate, plus
notes, plus be "with-woman") I did not feel abandoned. [...] the lustily crying
baby [and placenta was born] without a hitch. The midwife's confidence in me
could have been frightening, instead - though I was very surprised by it - I
realised she had challenged me. It helps that she also believes in the birthing
process: that this woman could do it - whether the student manages to write
the notes in order or not.

(Minnie’s journal, June)
Minnie now reads herself as gaining both midwifery skills and knowledge. She is in the position of being the primary midwife, albeit with a lot of (appropriate) support and assistance from the midwife. Minnie no longer has the ‘luxury’ of just observing. She is very busy with this woman in a complicated birthing situation which made Minnie ‘a little flustered at times’. In her busyness, Minnie ironically includes forming a midwifery relationship on her list of things to do: ‘the fetal heart rate, plus notes, plus be “with-woman”’. However, just a few lines down we see that being ‘with woman’ is not just an added chore. Minnie’s constitution as a midwife includes being with, a position the midwife herself has taken up. Minnie’s irony about her inability to get the documentation written in the right way/time/order shows her own embodied ‘with woman’ priorities. She constructs the woman’s embodied work as most important, more so than Minnie’s story-writing duties.

Being with/being useful has become a benchmark for midwifery. Being with/being useful becomes the way in which midwives judge whether midwives are midwives and even whether midwifery is midwifery! In another story from Patrick’s student journal he makes a ‘midwifery’ judgement:

Only one week to go and then moving on [...]. Until then I am still coming across midwives who have lost their focus. Why is it that in human nature, and especially in those that are weak within themselves, that they have to put down others to make themselves feel important? I was confronted again today with the [...] midwife overpowering the mother and telling her that she wasn’t allowed to go home until the midwife herself was happy that she would be capable at home. Where does she get off playing these power games, and then why are they still allowed? It seems to be very strong in midwifery. Sure you see it in other areas from time to time but it seems to be common here. That is not to say that every midwife is like that, it just seems that midwifery has its fair share and then some. I guess that it has a lot to do with the fact that most midwives seem to be very narrow minded. They only see what they want to see and are full of their own “professional” importance, instead of seeing the beauty of just being with and supporting the new family. Shame they have their heads too far up their own arses to see the great side of midwifery. I have only been in the area for a month and can see it. I wonder where along the way they lost sight or maybe they never had it at all?!

(Patrick’s Journal April)

Patrick uses ‘being with’ to critique what he sees as wrong in midwifery. He holds some of the midwives up against the ‘with woman’ standard and they fail,
dramatically. In this reflective journal entry Patrick sees power being used against the women with at best unpleasant, at worst devastating, consequences. We do not know if the woman in this story still went home or if she was perhaps happy to stay in hospital longer after some advice from the midwife who considered that she did not have enough milk yet. Either way, Patrick, a new student who has taken up a ‘with woman’ position, is very unimpressed with this and other midwives. We do not know if the midwife sees herself as taking up a with woman position by ‘helping’ with the woman’s decisions about lactation assistance but we clearly see Patrick does not consider this her position and we can hear anger in this journal entry and almost a sadness. He writes about some midwives as having lost the ability to see the beauty in ‘being with’ – or have they never had it at all? Patrick constructs a lonely discursive space for the woman who is being harassed by the midwife and at the same time, interestingly, a lonely discursive space for the not-with midwives. It is clear that the new Patrick is having a good time and that he does not feel like the outsider; he can see the ‘great side of midwifery’. Once I would have analysed such a comment as gender based and related to male nurses’ [and male midwives’] tendency for healthy self esteem but now I (also) think that after many years, ‘being with’ is becoming the dominant discourse in midwifery and those not inside it are viewed by the students as being outsiders.

This complexity of being with/not being with causes much concern to midwives, both students and midwives brought up in a midwifery with woman model and midwives who were ‘trained’ in a more medical model of care. The maternity practice arena can be viewed as Ardner’s (1978; 1989) wild zone where what is considered acceptable is often gendered and power-based. In the dailyness of childbearing and midwifery (and obstetrics) being with/being useful can become not just a matter of practice, but a matter of philosophy, of ethics. Beth describes her change in a memory story about responsibility:

She came to work. She cared for a woman labouring, with a normal vaginal birth following. Beautiful, clever work. The obstetrician arrived for the 3rd stage [the birth of the placenta]. He pulled the cord - snapped, bleeding, intervention. She had enormous sadness. She went to her leader and explored her anger. Her leader turned to her and said - you can tell him. She did. She spoke with the obstetrician, informing him of concern about his management of the 3rd stage. He looked at her. She expected anger, instead he attempted a
reasoning [...]. He knew. Her time in midwifery had come to a point of responsibility. Her responsibility for supporting a woman.

(Beth, memory story)

Beth speaks herself into a position (and is spoken there by her leader) of being able to talk to the obstetrician about his actions in delivering the woman’s placenta. Practitioners of both midwifery and obstetrics are skilled in the processes of helping the placenta come away and controlling a woman’s bleeding afterwards, so this area is one where a midwifery discourse can challenge the more dominant discourse of medicine. (Issues of technique relating to obstetric work such as a forceps delivery or a vacuum ‘extraction’ might be even harder to discuss.) Beth takes umbrage at the obstetrician for, as she sees it, causing problems by unnecessarily interfering in a healthy process. Beth feels enormous sadness and anger about his actions, especially because she had seen the woman do ‘beautiful, clever work’ to birth her baby. Beth does not say whether she believes the obstetrician’s technique was faulty or rather that he was ‘just’ impatient. However, something he did clearly upset her, because a cord snapping with its sequelae of medical interventions can happen through no fault of the practitioner, of which Beth, an experienced midwife, would be well aware. Here, though, Beth is sad and angry. She speaks with her midwife-manager and together they decide Beth can speak to the obstetrician. I think Beth would have been expecting her manager to speak to the obstetrician. It is not uncommon in midwifery for the midwife-manager to confront an obstetrician about practice issues. Instead her manager opens up a new possibility by saying, ‘You can tell him’, and provides a time/space for Beth to speak herself as being with/being useful. We get the impression from Beth that she had not queried an obstetrician’s actions or competence before. In this story we see a moment where Beth crosses over to be ‘with woman’, and the obstetrician knows it, just as she does. Because they both know a change has happened, anger will not work for him as it usually would, and so he tries another tack, reasonableness. In this moment of (dis)comfort the obstetrician tries a discursive tactic which often works in a system based on unequal power relationships. He constructs Beth as ‘one of the boys’; as being in the club and therefore understanding that sometimes-less-than-perfect practice is accepted without criticism. But Beth has sided with the woman and (in this moment) there is no turning back. Beth herself sees a change happening: ‘Her time in midwifery had
come to a point of responsibility. Her responsibility for supporting a woman.’
Clearly, this ‘with woman’ is not an old and comfortable or easy position for Beth.
She expects the obstetrician to be angry, not to reason with her as he did. However,
his attempt at a reasoning simply does not work. We get the impression that Beth, to
the surprise of both, is the powerful person in this exchange between the obstetrician
and the midwife and that she will take up this (unfamiliar, uncomfortable, necessary)
position of ‘with-woman’ again. While Beth’s response is an example of power
exercised at the level of the one-to-one (Foucault 1973/1994; Foucault 1984c), more
importantly here Beth’s moment of enormous sadness and its aftermath is a moment
of becoming, of becoming ‘with woman’, in ‘an unexpected shift, the shift produced
by the unexpectedness of events’ (Grosz 2004:258).

Sadness and personal pain often accompany both being with and being useful and
contributes to the ways in which midwives construct themselves (and are
constructed). The following story brings to the fore the complexity of the double
discourses of ‘birth as natural’ and ‘midwives as useful’. Shannon describes the pain
of being with in the following paragraph:

The wee baby […] is OK. She went home a week ago. Breast feeding is not
fabulous and she is losing weight. I think they will probably re-tube the wee girl
and add some calories or something. In the meantime her mum wasn’t expressing
so often and is very stressed so her back up milk supply has dwindled. I am out
of my depth - I have told her that and where she should go from here. My
emotional attachment and sense of failure remains. She had an MRI yesterday -
the hospital told them it takes 7-10 days for results and they will see a doctor
to get them - we all know that they can get results in an a couple of hours - so
the stress of waiting is just extended for another week. I know that the
results will be bad; she is not a normal baby. How bad? How impaired? I don’t
know; they will love their baby regardless. Life is never the same is it?
Regardless of outcome, I feel like a fraud I don’t know how I ever thought I
was competent to care for any woman and her baby. People used to say to me
when I was running out to a birth ‘good luck’ - and I used to tell them, ‘it’s not
good luck, it’s good management’ - well, I think I am a lousy manager who was
scraping by on a whole lot of good luck til now.

Shannon, e-mail

I feel sick every time I read this. This wee baby was born unexpectedly unwell in
hospital after a slightly complicated labour at home with Shannon as the midwife.
The baby’s parents are managing beautifully and in no way blame Shannon for not
doing a good enough job. Shannon told me that when she said to the father ‘I wish I
had done something differently or transferred earlier. Maybe I missed something’,
he reassured her, ‘You didn’t miss anything. We all heard her heart beat. It was
fine’. No one else is blaming Shannon, either. But Shannon has known the woman
and her partner for many months. She was their specially chosen midwife, as is
commonly done in home birth (Davis 1997) and they have built a close relationship.
Birth at home is uncommon in our society and to choose it makes both a personal
and political statement and usually brings women (and men) and midwives closely
together (Davis 1997). A midwife who works with women at home can become part
of the family. (In my own family, Megan, who midwifed for me when our Louisa
was born at home, is still much loved by us all. She holds a very special place in my
heart.) This wee baby girl is still sick three weeks after birth although she has been
discharged from the hospital nursery and is now at home with her parents. Unusually
for a baby of this age, Shannon is still visiting them quite often at home to provide
support, especially to the woman. Shannon is so sad and sorry for the family. She
feels responsible although no one else thinks she is and in one way Shannon knows
she didn’t miss anything. In another way she wonders… has it been luck not
(midwifery) management that kept the other women and babies she looked after
safe? That fear and her sadness for the family leave her feeling very vulnerable:
‘My emotional attachment and sense of failure remains’. ‘Being with/being useful’
is fraught with difficulty for Shannon here. She doubts her usefulness and
competence during this woman’s labour and baby’s birth and that makes her doubt
her usefulness and competence altogether. She feels helpless and useless, fraudulent,
previously running on luck. She mentions that even the mother’s lactation issues are
too hard for her (although they would be for most midwives at this point) and we can
hear her frustration that she cannot even make the hospital hurry with the baby’s test
results. If the baby girl was well, Shannon would have been getting ready to say
goodbye to this family. But Shannon’s ‘being with/being useful’ construction of
herself as midwife means she continues to provide support because of the baby’s
illness and the woman’s need. Perhaps, too, Shannon’s own need to see the situation
through until there is a diagnosis and prognosis keeps her going back and back to the
scene of responsibility and pain as well as fond regard and connection. Shannon
does not doubt that this woman and man will love their baby girl regardless of
whether she is going to be well or ill in the future. Shannon, as a midwife prepared
to go against the grain of medical and nursing dominance and societal disapproval to work with women who want to give birth at home (Davis 1997), constructs herself as a brave ‘with woman’ practitioner who believes in birth as a normal process. However, Shannon’s midwifery sense of herself as a good midwife is shaken by a run of complicated births, with this baby the latest, and now her discursive construction of midwife falters; she feels like a ‘fraud’. Luck creeps into her discourse, never part of her midwife-self before. As Shannon moves back and forth between her ‘birth as natural’ discourse where things do go wrong and her ‘midwives as useful’ discourse where midwives stop things going wrong, she becomes (perhaps momentarily) snagged on her failure to be useful. In her pain and fear she wonders (as I do) whether her love for herself and midwifery are intact. Can she ‘be with’ again?

Like Patrick’s being with being out of step with some of the midwives on the ward, like Beth being scared when speaking to the obstetrician, like Nola being ‘loose of bowel’ when taking on ‘the boys’, like Minnie connecting with the birthing woman amidst strangers in an operating theatre designed for surgery not birth, Shannon’s seemingly unresolvable situation embodies being with/being useful. Even as she feels worse than useless, Shannon still visits the woman and partner and baby at their home and she is welcome/d (and I suspect, useful). She queries how it will all turn out: ‘How bad? How impaired?’ and realises she cannot know that. She seems partly to comfort herself with a belief that the parents will love their baby regardless (as some parents may not in similar situations) and not knowing (yet) seems, as well as being a huge frustration, to provide a window of hope…

Other midwives take up this position of not knowing everything as being an integral part of midwifery. As part of the International Confederation of Midwives’ (ICM) Code of Ethics explanation about what a code of ethics cannot do, the issue of not knowing is addressed:

*What can't a code do? […] Finally, a code cannot remove from midwives the responsibility and pain of living and acting, at times, in situations of ambiguity or 'not knowing', of having no in-built guarantees about what, in a given case, constitutes 'right action'*.  
(International Confederation of Midwives 1999)
The discourse of being with/being useful holds within it the possibility (or, the probability, or the certainty) of ‘not knowing’. This can be a useful discourse for midwives as it saves them from operating in a state where they always have to know what is going to happen (Pelvin 1996).

**Being with: connected and useful and not just for birthing women**

Midwifery speaks not just of being connected and useful but of being special and different because of this connection and usefulness to women and their babies. Some women certainly construct (some) midwives as useful and connected, as the following small sample of words from thank-you cards kept by Cathy, a local community midwife, over a period of nearly ten years shows:

>We thank you for bringing our little angel into the world [...] Thank you that you love what you do and that it shows [...] Words cannot express our heartfelt thanks for your expert advice, help, words, time, professionalism and friendship. We were so lucky to have you share such a special time with us. [...] We can't thank you enough for your assistance in helping bring our beautiful daughter into the world. Your patience and understanding will never be forgotten. [...] You put my mind at ease and made labour a lot more comfortable with your kind words and warm heart. [...] We would not have made it through without you. [...] I wanted to take one of the midwives home with me when I left hospital! Legend midwives! [...] You were there for me [...] I can put on a brave face but inside I feel like someone has ripped my heart out. In the midst of this horrible journey we do feel lucky that you came into our lives. [...] Thanks for all your help during my labour even when I was at my worst! [...] Words cannot express how grateful I am for your love and support during the worst day of my life. I just wanted to say thank you from the bottom of my heart. Our baby will be watching over you from Heaven, just as you held her and cleaned her and helped her Mummy. [...] I know you'd probably say you were just doing your job but we think you were wonderful, and very available and reassuring to two anxious first time parents! I hope you win big on the lottery ticket we left for you, but if you do, please don't give up your day job! [...] Thank you never seems to say enough.

(Extracts from ‘Thank you’ cards from women pasted into Cathy’s reflective journals 1998-2006)

Being with/being useful is valued by, and valuable to, women and at the same time it is also valued by, and valuable to, midwives. The discourse ‘of being with’ and being useful extends from its woman/midwife meaning-making to construct a
‘special’ time/space for midwives to be with (and be useful to) each other. Alison, who has been a midwife for more than thirty years, says that midwifery promises us several things:

the opportunity to do something good and something useful and to bond with women (and families) [...] and it provides] an amazingly special bond with other midwives, like-minded ones and even with those that aren’t, there is still a connection - it’s the sisterhood stuff [...] and the opportunity to] be proud of our occupation knowing that it is one of the most important in the world.

(A Alison, interview)

Ali’s discourse of special and worthy is a common one in midwifery. Midwives both speak and are spoken into a discourse space/time of different and special. We see Ali’s discursive construction of connection extend the bond midwives have with women into the bond midwives have with each other. She calls it ‘amazingly special’. She tells of a tie so strong that it even includes, for her, midwives who are not like-minded. She includes in her sisterhood all the midwives who do not think like she does. She is not constructing a happy, homogenous family here. She is embracing midwifery in all its difference, all its complexity. In constructing midwifery in this way, Ali’s experience allows her to keep hold of the idea of connection, of being with, even while managing complex philosophical and practical otherness. She embraces difference; connection is worth it.

Maureen, too, takes up the position of special togetherness which is worthwhile:

[There is t]he sense of huge purpose. The sense of we are in this together. That is both the midwives and the women. A sense of meaning in your work. That you have meaning, that you have purpose. That it is real and it's shared. Shared work. The laughs that you have with people. Women, families. The fun that you can have often at times when maybe it's not that easy to have fun but you can still, umm, share the intimate moments with people and make fun of it but make fun with them. The baby's not sleeping or they are crying you know we can make a joke about their partner or just laugh things off. I like that. [...] That midwives always talk things through. It doesn't matter how busy you are you seek each other out. What do you think about this? or what do you think about that? So even though you might be working on your own with five or six postnatal women or with one woman you never really feel on your own. I never felt I was on my own even when I was on my own. Never. I think the other thing is I felt like we were doing something really old, something really noble, something old and for me the best thing was how mysterious it was and how precious that mysteriousness was from quick-fix, globalisation, packaged, sanitised world that we live in [...].

(Maureen, interview)
For Maureen, the sense of special purpose and the connection with women and midwives belongs on the list of good things in midwifery. Maureen values the sense of meaning in midwifery work. She says it is ‘real’, ‘shared’ and ‘fun’. Maureen also connects with the timelessness of midwifery work and she values that highly. She chooses words like noble, old, mysterious, special. Maureen also introduces here the discourse of the (extra)ordinary: ‘[…] for me the best thing was how mysterious it was […]’. Out of this long list of things she liked (she had an equally long list of what she didn’t like), what she valued most was that she didn’t/couldn’t understand all of it. Maureen embraces the unknown, the unknowable. She constructs midwifery as not knowing everything, preferring that to what she calls our quick-fix sanitised world. Protected from loneliness, she embraces her ‘special’ position of being with/being useful and the feeling of connection with other midwives and midwifery.

At other times and spaces midwives just revel in the joy of being with and being (somewhat) useful. Alison asks another kind of not knowing/not understanding question when she writes of a woman’s labour in the following way:

I had the joy of observing a beautiful labour and birth last week which restored my faith - one of our medical officers who asked me to care for her and her husband (senior lecturer in law at the [...] university - not that I let that get in the way of a good time!! Always makes you think, though, doesn't it?! Peta’s dad is a general practitioner in the UK and used to do births as well and his wife is a nurse and they came out for the birth - talk about pressure!). Anyway everything went perfectly (why wouldn’t it? - Peta was A positive, had no stretch marks and it was a full moon!!... say no more) until the last hour when wee Amelia decided to go posterior on us but I squeezed Peta's hips during contractions [...] and I popped her into the bath when she started muttering about morphine and epidurals and in no time at all there was Amelia Alice. It was funny because we hadn't really talked about water birth, I just presumed she would have trouble ridding herself of all that medical stuff - but I said 'We have about 30 seconds to decide where you want to be and she said 'Well, I'm not getting out' and that was that. I did feel a teeny weeny twinge of guilt about informed consent, I must say but that didn't last long! [...] They went home that morning and I went to bed (having been up for 30 hours or more - oh dear, I don't spring back quite like I used to!). They have done beautifully and I weighed her today, just Day 6, and she is 45 grams off her birth weight - feeding all night and sleeping all day - just luscious. It is such a privilege to be around/on the periphery of this wee family - why can't everyone labour, birth and 'postnate' like that????

(Alison, e-mail)
Alison clearly has a wonderful midwifery time at this labour and birth. She is still ‘high’ from this experience the next day as she writes this story in an e-mail to me. Alison ironically positions herself as being able to manage the challenge of caring for a medical doctor who is married to a lawyer. Of course, in line with her construction of herself as an (almost) fearless midwife she does not ‘[…] let that get in the way of a good time!!’ Alison does not want her practice to be affected by legal pressures because as Rick Porter (2003:219), a consultant obstetrician in Britain, says: ‘Inappropriate restriction of midwife activity on spurious medico-legal grounds creates a spiral of dissatisfaction and dysfunction.[…]. This is unnecessary and wasteful of a precious resource: midwifery skill’. Be that as it may, much is now made of risk and informed consent and the possible legal sequelae if something damaging happens. However, Alison holds her position of being both with woman and being useful all through the woman’s labour, but even Alison, after nearly forty years as the champion of what women want in birth, says with irony about this situation ‘Always makes you think, though, doesn’t it?!’ Here we see Alison being with and being useful. The woman needed Alison to help her birth well and joyfully and Alison used her skills and knowledge in order to help. Alison intimates that this medical woman and her legal partner could have had enough fear to stop anyone birthing well, but it was not so. Clearly, Alison kept her judgements about this woman open to a range of possibilities from the conservative end of the medical model to someone who would listen to her body and act accordingly. The birthing woman chooses the latter when she is ready to give birth and is still in the bath for its pain relieving effects with the very definite words ‘Well, I am not getting out’. Alison uses such words as ‘joy’, ‘beautiful’, ‘restored my faith’, ‘perfectly’, ‘luscious’, and ‘a privilege’ when she writes about this time/space of midwifery, a time and space with which she is very familiar. Then, at the end of this story, Alison asks a complex question of not knowing: ‘Why can’t everyone labour and birth and ‘postnate’ like that????’ Alison’s four question marks strengthen her query and her inability to answer her own question. Alison knows so much about midwifery, almost everything worth knowing, many people would say, but even she does not know the answer to this question. Not knowing seems to make this story more precious for Alison and it makes (her) midwifery worth doing, worth celebrating and worth fighting for.
Maureen spoke to me, her old teacher, of not knowing but still doing:

Well, I'd think you know, haven't I explained this to you enough? Haven't I told you here's the fors and there's the againsts - many againsts. But at the end of the day, I don't know, I really don't know because it's outside life as I know it. But if you've done a good job of empowering someone, then it's quite reasonable if they make a decision that you don't like. You should be proud of that. That... that caused a bit of... that took a bit of learning. That didn't come overnight. That probably took quite a few years to think that's what a good midwife is - to support someone who makes the choice that you probably wouldn't have made yourself. Now that's probably something to be proud of [...] 

Maureen, interview.

Maureen embodies the idea of not knowing by working in a way that manages it. Like Alison, she finds a way to work with women and, at the same time, not understand. In this time/space of being ‘a good midwife’ Maureen constructs (as she is constructed by) a moment of difference. She celebrates difference. It is something to be ‘proud of’. A good midwife becomes one who works with a woman but does not necessarily act in the same way that the woman would. A good midwife does not need to understand in order to be with and be useful. In this way for Maureen a midwifery relationship becomes doable with/for all women. It also becomes not doable and that too is acceptable. Maureen constructs both women and midwives as having agency in the sense that agency ‘[...] entails the capacity to recognise multiple readings such that no discursive practice, or positioning within it by powerful others, can capture and control one’s identity’ (Davies and Gannon 2005:318-319).

**Midwifery’s (own/shared) profound/profane**

Maureen’s words place midwifery it its own (shared with women) profound/profane discursive space/time. Maureen’s words speaking into existence other midwifery (im)possibilities. As I sit in my study and attempt to unpack Maureen’s words ‘It’s outside life as I know it’, I wonder, not for the first time and not for the last, how can a job be described as being ‘outside life as I know it’? Maureen’s words are a one-off for her but the sentiment behind, through and underneath them is threaded
throughout multiple midwifery discourses. Those words raise many questions for me and for the subjectification of midwives. What would be inside life as I know it? What would be outside death as I know it? Or, outside life as I do not know it? Outside life as you know it? What does Maureen construct by her words and why do they resound so loudly throughout this work and the work of midwives?

Maureen speaks midwifery as being or taking us outside the bounds of the ordinary (in) life. She suggests that what we see and do in midwifery takes us to another place, another place of doing and being. Where is that other place? What does it look like? How do we get there? With whom and how do we go? What happens when we are there and what happens when we come back? Can we come back? Under what conditions, our return?

What if Maureen’s ‘outside life as I know it’ relates not to space or position as above, but to time? (Un)known time? What if midwifery takes us outside a timed life as we know it? Could midwifery be in another time zone, or indeed, timeless zone? How can we think and feel our way though such a preposterous idea? But if we could, would that then make more sense? Would that then be inside life as we know it? How then could our dreams of the future make ‘[…] projects endless, unattainable, ongoing experiments rather than solutions’ (Grosz 2004:14)?

Perhaps life ‘outside life as we know it’ tells of body work? In midwifery are we ‘outside’ bodies as we know them? Or are we ‘outside bodies’ as we know them? Do our bodies which understand women’s bodies not belong on the inside? Do our bodies which do not understand women’s bodies not belong on the inside? Do we, in understanding and valuing body work, place ourselves in the outside in order to do our work, just as we are placed there? Do the borders offer a freedom not found in the middle?

Could it be that while midwifery is outside life as I know it, it can be learned and that is why people stay? Could it give a glimpse of the unknown as knowable or at least, doable? Or instead, what if it means that while it is outside life as I know it, the mystery is what matters and that being outside life as I know it is good. Is it a gift to see something which we do not have to know, indeed which is not ours to know? Do
the words create a space where midwives and women hang together on the inside/outside but others do not understand? Like a form of a club? À la Judith Butler’s (cited in Bell 1999) advice to look at what something precious promises us and protects us from, does midwifery promise us connection and protection from loneliness, especially out in the unknown where women (Leap and Vague 2006) and midwives go?

Maureen and the other students in her group used to talk about how they saw women seemingly disengage from their physical setting when awful things were happening to them in birth or when they couldn’t manage what was happening to them, or when they were in pain and/or ‘just’ doing their healthy labouring work (Leap and Vague 2006). The group called this going ‘up the mountain’. In that student group, ‘up the mountain’ became a code, an accepted way for them, as new midwifery practitioners, to describe what was otherwise indescribable. Watching women in emotional pain or out of the ‘ordinary’ physical pain is very tricky for midwives, especially if they construct themselves or if they are constructed as not being in a position to fix it, or even speak of it. This group of midwifery students also sometimes used this phrase to describe themselves, when they were sad or in pain from what they had seen, or done or could not do. Oddly, perhaps, going ‘up the mountain’ also became a way to describe indescribable joy or connection, as in going up the mountain together to do good midwifery work: a space of their own, a time and space in which to be with/and be useful. As Nicky Leap and Stephanie Vague (2006:418) write of women in strong labour ‘disappearing into their own world’ (see here a visual example of that ‘own world’ during the later stages of my own non-medicating labour with Louisa, being minded by Adrian, in a state between contractions of not-sleep but not-present). Describing childbearing women and midwife-women as going up the mountain exemplifies this ‘outside life as I know it’ discourse, a discourse which intersects with ones of joy, usefulness, connection, pain, fear, not knowing, bodies and the (im)possible. It calls into play Derrida’s (2001:65) dare:
Midwives use ‘being with’ to move away from/go beyond the medicalisation of childbirth to (re)turn towards other times/spaces. The ‘being with/being useful’ discourse holds within it knowing/not knowing and doing/not doing and opens up (im)possible times/spaces in which to conceive midwifery work. Intersecting with the ‘special and different’ discourse and played out in the un/known dailyness of women’s and midwives’ embodied work, midwifery is constituted as worth doing, worth celebrating and worth fighting for.

The following chapter traces midwifery’s path towards its immersion in the (feminist) discourses of access and celebration and the effects of that immersion: demands to increase childbearing women’s and midwives’ space/time in the public domain and the desire for and actions towards (further) valuing of childbearing women and women-midwives because of who they are and what they do.
The (re) politicisation of midwifery: history, circumstance, accommodation, resistance

The strength of the tacit oppression of women in the health care system should never be underestimated.

(Malterud 1993:371)

[...] there is nothing more exciting, more exhilarating, than playing a part, however big or small, in the action of your times. If you don’t like your life then invent one you do like. Again and again. The important factor is that you tell the truth about it, however difficult or painful, especially to yourself. If, in doing that, people berate you, or label you, or find you too strong, or too different, or too difficult...well. The only answer is...tough.


Feminism (still) holds a complicatedly simple promise: to improve the lives of women. ‘Better birth’ advocates and midwives, including my local midwifery
friends and I, have worked tirelessly, and tiredly, for years for what they and I thought, and still think, is worth celebrating and worth fighting for: a society which values both women and midwives for their precious contributions and which therefore grants them agency and recognition in the public domain.

In this chapter I draw parallels between the ‘generations’ of feminism and political action in midwifery by using Julia Kristeva’s (1981) work ‘Women’s Time’ as a way of further opening up the discourses at play in midwifery. I read the celebratory discourses in midwifery as being similar to radical feminism which is a counter force to patriarchal discourses (in the maternity health system) that constitute women and midwives as less than (medical) men. I read the access discourses in midwifery as being similar to liberal feminism in which women (and midwives) seek equal access to the public domain as their right as capable, contributing human beings.

I have made an artificial split between this chapter where I discuss liberal and radical feminisms in relation to midwifery and the next chapter in which I explore poststructuralism in midwifery practice. The split is artificial/constructed (as all tests are) because, while there is a sense in which midwifery is caught (up) in the discourses of access and celebration, I believe, as Kristeva does, that the discourses and practices of (feminist) poststructuralism are entwined with those of radical and liberal feminisms:

So it can be argued that as of now a third attitude is possible, thus a third generation, which does not exclude - quite on the contrary - the parallel existence of all three in the same historical time, or even that they be interwoven one with the other.

(Kristeva 1981:33)

As we have seen in previous chapters, midwifery discourses are complex, overlapping and conflicting and are not necessarily straightforwardly opposed to patriarchal discourses. Some midwives (or, midwives sometimes) take up strong feminist positions while others would never position themselves as having any use or desire for feminist theory or practices. While some midwives actively embrace a (powerful) discourse of ‘with woman’, still other midwives (or
again, perhaps, midwives at other times) take up positions of power, as they are taken up by these same positions, using patriarchal, racist and classist discourses which constitute women as lesser, as other. Midwives, of course, occupy these and multiple other subject positions simultaneously as of course do feminists (Spivak 1993; Weedon 1999; Lather 2002).

I believe undertaking an examination of midwifery in the light of feminism is illuminating, despite the complexity of the task (or, perhaps, because of it). It is an important task because of feminism’s influence on the directions of midwifery in the past thirty years. It is also useful because feminist theory sheds light on our understandings of midwifery theory and practice (Stewart 2003) (and the reverse may also be true). Thus, this chapter traces midwifery’s path towards its immersion in the discourses of access and celebration. In seeking to trace this journey I also look at the effects of that immersion, the effects of the demands to increase childbearing women’s and midwives’ space/time in the public domain and the desire to raise the profile of both childbearing women and women-midwives, based on a belief in the essential essence of womanhood. Finally, I ask, are we snagged on these discourses that have served us relatively well?

First and second generations: liberal and radical feminisms

In using Julia Kristeva’s (1981) ‘Woman’s Time’ to foreground feminisms’ work in and for midwifery, I do so understanding that Kristeva is not without her critics in relation to feminism. On the contrary, many (feminist) writers whose work I use criticised Kristeva (see for example Butler, Spivak and Grosz in Ives 1997). Kristeva is criticised especially but not exclusively for connecting women essentially to maternity (Butler 1989) and for her rejection of feminism (Moses 1998). However, because she was my introduction to what I once called my brave new world (Browne 1999), and because I believe she has much of value to say for and to us, I use Kristeva’s work in this chapter and throughout this work (a position many feminist writers still take).
In ‘Women’s Time’, Kristeva (1981) suggests that there are three ‘generations’ of feminism. The first phase seeks universal equality for women and overlooks sexual difference and is thus aligned with liberal feminism. This phase is described as ‘conformist’ feminism, where ‘women are integrated into the status quo’ (Weedon 1997:86). Kristeva’s (1981) second ‘generation’ seeks a uniquely feminine language in response to patriarchy, a phase which aligns with radical feminism. This phase is described as ‘separatist’, where women reject the status quo for ‘a separatist women’s culture’ (Weedon 1997:86). These feminisms grow out of women’s exclusion from the ‘sociosymbolic contract’ (Kristeva 1981:34). In her third ‘generation’, Kristeva seeks to explore multiple identities, including multiple sexual identities. This phase can be seen as aligning with poststructural feminism. Davies and Gannon explain it thus:

Feminist poststructuralist theory can be taken as a third feminism, historically following on from, but not replacing, liberal feminism and radical feminism (Kristeva, 1981). Whereas liberal feminism mobilises a discourse of individual rights in order to gain access to the public domain, and radical feminism celebrates and essentialises womanhood in order to counteract the negative constructions of women and girls in masculinist discourse, feminist poststructuralism seeks to trouble the very categories male and female, to make visible the way they are constituted and to question their inevitability.

(Davies and Gannon 2005:318)

Theorising the complexity of women aspiring to gain a place both inside and outside the ‘linear time of identities’ (Kristeva 1981:19) helps us read women’s (and midwives’ and birthing women’s) simultaneous insertion into, and refusal of, a system of imposed limits:

‘[...] it is the mixture of the two attitudes - insertion into history and the radical refusal of the subjective limitations imposed by this history’s time on an experiment carried out in the name of irreducible difference - that seems to have broken loose over the past few years in European feminist movements [...]’.

(Kristeva 1981:20)

I believe such theorising is helpful in further understanding midwifery and this is my task in this chapter.
Liberal and radical feminisms as theories for midwifery

Feminist change happened, and still happens, from outside midwifery. As women demanded their ‘rightful’ place in society, at the same time as they refused to be defined solely in terms of society’s dominant discourses, so also did (feminist) change happen in our maternity health system. A ‘mixture of the two attitudes’ (Kristeva 1981:20), liberal and radical feminism, took hold in the midwifery movement in the past thirty years, causing major upheavals in midwifery and the maternity care system. Women and midwives demanded admission in new ways to a very male - and medically - dominated maternity system at the same time as they refused to be constrained/constructed by how society and that same (male) maternity system positioned/read them (Reiger 1999). Feminist storylines now connect the dailyness of midwifery work to social and political action for access and to the personal and political celebration of womanhood.

Feminist change also happened, and happens, from within midwifery. Midwives’ philosophical, political, embodied and social (re)alignment with women which accompanies, and which is accomplished by, taking up a ‘with woman’ discourse brings with it (surprising) new ways of seeing and thinking (in) the world. These possibilities arise in part from midwives reworking their understandings of women’s ‘lot’ in our society. Once students/midwives open themselves up to new possibilities for (and by) understanding the world through women-centred lenses, they are often both shocked by what they (re)see and hear (anew) and are spurred on to work for change. This in turn opens up previously unimagined spaces/times both of pain, anger and power(lessness) which aligning with women can produce in our society and in the world of childbirth, and of joy and strength from a sense of belonging that a (new) alignment with women and midwifery can bring. This opening up of possibilities, this venturing into the previously ‘unthought’ (Deleuze in St Pierre 2000:505), often brings another midwifery surprise: the value and usefulness of feminism.

Midwives come to utilise feminism in a variety of ways. Some midwives, or perhaps more accurately, midwives sometimes, first take up liberal or radical feminist
positions and are then propelled into midwifery action. The reverse is also true. Some midwives, spurred into action because of what they see and do in the practice arena, search for a theory to help them manage their political action and they find liberal or radical feminism. In these ways midwives take up the fight for access both for childbearing women to midwifery services and for women and midwives to the public domain: through legislation, education, funding and public recognition. Often tied up with these struggles in midwifery is the celebration of the essence of womanhood, a more radical position, where women are seen as special and valuable because they are women, in particular because of their remarkable processes around pregnancy, childbirth, lactation and mothering. Whether they come more from a stance of radical or liberal feminism, midwives in both these feminist groupings construct childbearing women as benefiting more from midwifery than medicine. They constitute midwifery as keeping women safer during their physiological processes and as keeping them more emotionally intact, connected in embodied ways to themselves, their babies and the earth, and thus more ready to mother.

To add to this complex mix of theory and practice, I believe that many midwives have an ambivalent relationship to/with both the liberal and radical feminist discourses. Even though midwifery often employs these discourses and is employed by them and they shape the way midwifery is now viewed and views itself, midwifery also frequently ignores the possibilities held within (feminist) discourses. Likewise, childbearing and midwifery, like other women’s service disciplines, are viewed by some feminists as something best to avoid at all costs. Maternity has long been a site of dispute in feminism (Kevin 2005). Judith Butler (1992) articulates the multiple positions of feminism towards childbearing in the following way. She says that some people claim ‘an ontological specificity to women as childbearers that forms the basis of a specific legal and political interest in representation’ and that other people understand maternity as ‘a social relation that is, under current social circumstances, the specific and cross-cultural situation of women’, while still others work to ‘establish a feminine specificity that makes itself clear in women’s communities or ways of knowing’ (Butler 1992:15). All these positions are at work in the midwifery practice arena.
‘Worth fighting for… access to the public domain…

Liberal feminism, in which hope for change is based ‘[…] in powers of reason and moral enlightenment, which it sees as key features of human nature’ (Weedon 1997:79-80), translates in midwifery into a quest for increased choices for and by women. Liberal feminism presumes women to be capable and desirous of making choices and so a range of appropriate options makes a fulfilling life. This feminist stance believes that ‘[g]iven equal opportunities guaranteed through law, individual women could achieve equally with men’ (Lane 2006:53). In midwifery, liberal feminism leads both to a desire for midwifery equality with the medical profession and to equality for childbearing women in terms of access to appropriate health funding and structures. Here midwifery finds a place inside the scientific model for a new truth about women as capable: bodily, philosophically and in terms of intelligence. A good life is a matter of good opportunities.

In the recent past, midwifery’s political energy worked to gain and increase access in/to the public domain for childbearing women and midwives. Medicare funding, indemnity insurance, visiting rights to public hospitals, publicly funded continuity of midwifery models of care, birth centres, community midwifery programs and home birth in the public domain, legislative recognition of midwifery as a separate profession to nursing, and educational changes, first to take midwifery education out of hospitals and into universities and now for undergraduate degree programs in midwifery, have consumed midwifery politics for several decades, with quite an (amazing) amount of success.

Other struggles for access continue. For example, midwifery strives to gain a presence in the multimedia and yet midwives are rarely asked by journalists for comment on childbearing or even midwifery. Access to high level government committees and policy-making bodies is also blocked by medicine, nursing or the bureaucracy, either medicine given the job to speak for the whole maternity health system, or nursing often asked to speak for both nurses and midwives (or just nurses). In terms of education, some states now have undergraduate (not post-nursing) midwifery degrees, yet this comprehensive midwifery educational qualification is not available in all Australian states and territories, including in the
territory in which I live and work, where it is under consideration. Even where a Bachelor of Midwifery is available, it is not yet the way the majority of midwives undertake their pre-registration educational qualification. Further, medical education for clinical practice is funded at a much higher level than is midwifery education (and nursing education) and so midwives’ clinical educational preparation is shorter and less comprehensive than obstetricians’. Midwives do not have access to reimbursement for services through the Medicare payment system, yet medical officers can be reimbursed for the same maternity work. Another example is a lack of access for women to private midwives through the public and private hospital systems. Midwives do not have access through ‘visiting rights’ to public hospitals and so women still cannot easily choose their own midwife.

I use ‘visiting rights’ here to exemplify the limited success of midwives’ liberal feminist strategies for establishing equal rights in the maternity health care system. Some years ago several senior midwives wrote a proposal for visiting rights for midwives to a local public hospital, a system which had been in place for several years in some states. The proposal, which took years in its inception and consultation process, went before a committee of four male medical officers, a committee that was designed to scrutinise medical officers’ applications for visiting rights to the hospital. The midwives who wrote the proposal were not able to present their case in person to the committee. One obstetrician was given the opportunity to support the proposal when he tabled it. The meeting was protected under medical privacy laws and thus the minutes of the meeting were not accessible. There was no right of appeal against the decision. ‘The proposal did not attract support’ said the committee. This was before the so-called indemnity insurance crisis in midwifery. Currently, with the six-year unavailability of indemnity insurance for midwives in Australia, no such proposal could be approved because ‘visiting rights’ for all practitioners depend on the applicants having their own indemnity insurance cover. Insurance is currently available for private obstetricians (specialist medical officers who use the system of visiting rights to gain access to the public hospital system) but not for midwives, even though self employed midwives are rarely sued. This is one example of the battle for access in the public domain, a battle reaching back three hundred years to the birth of organised medicine (Foucault 1973/1994).
…and worth celebrating…woman’s essential value

Radical (feminist) discourses in midwifery understand that the patriarchal rendering of women as weak and incapable ( Ehrenreich and English 1973; Lane 2006), and its accompanying refusal of women’s and midwives’ potential personhood, are constituted in many (strange) forms in the maternity health system today. Patriarchal attitudes and beliefs help grow a health care system that engenders disrespectful and dismissive attitudes and actions towards women and that also often refuse or undermine women’s subject positions as capable childbearing women and as accomplished health care workers (Lane 2006). They nurture organisational discourses that actively and passively relegate women to positions of meekness and obedience, just as they foster processes and systems that privilege men and male attributes (Gordon 2005). Patriarchal beliefs foster discursive constructions which are, at their worst, abusive and violent towards women.

Opposition to the patriarchal ‘nature’ of the birthing system has fostered the growth of the radical (feminist) discourse in midwifery as the new (or old) discourse of resistance. This discursive opposition is manifested in the celebration of womanhood:

If I may, a few words of advice. Mothers, believe in yourselves, claim the authority of intuitive knowing and women’s mysteries, and use this to make the experience of giving birth ever more free and fulfilling for your daughters. Midwifery students, go for your dreams, aim high, and don’t be afraid to take risks for what you believe in. Experienced midwives, reanimate yourselves in the Womb of the Mother, extend the weaving of the web, and speak the truth with grace and conviction.

(Davis 1997:xxi)

Celebratory discourses, what Kristeva (1981) calls the refusal of subjective limitations, appeal for the celebration of the uniqueness and special-ness of both childbearing women and midwives. Elizabeth Davis, a well known ‘holistic’ American midwife, celebrates, and suggests harnessing, the knowing which comes from women’s mysteries. She calls on women, students and midwives to use their knowledge and beliefs for freedom and truth. Davis’s words are a rallying cry for
the celebration of Woman and Experience and a call to spread the word (Davis 1997). She calls up the essence of Woman, with the midwife as the High Priestess:

_No doubt about it, midwifery is a way of life, both gruelling and transformative. The intensive and unpredictable nature of this work soon persuades the novice that midwifery is much more than the joy of catching babies. It works a woman on all levels, either disintegrating her or bringing her to essence._

(Davis 1997:221)

Midwifery as transformative is taken up by many midwives. Davis’s belief in the core of midwifery as life giving and life changing is common among midwives, going hand in glove with the women and midwives as special and different and worth loving discourse:

_In the end, what is at the heart of our work? What makes the difference in crisis, and keeps us coming back for more? Pure and simple, it is the transformative power of love. No matter where midwifery takes you, do not forget this! Be who you are, and do what you can to keep your love alive._

(Davis 1997:224)

With the advent of radical feminism, this essentialising form of midwifery grew up and/or became visible. Women’s strength and the embodied possibilities of birth took hold in the midwifery imagination. Beliefs such as a love of women’s bodies based on what they were able to achieve (especially physically), strong women making strong communities (the woman as placenta of the family), women-centred midwifery, the partnership model of midwifery and acceptance and protection of lesbian couples (also related to issues of access) became fashionable.

Celebratory discourses which essentialise women are alive and well (in midwifery) and they will go on being so as long as women are negated, made invisible and constituted as a lower order of being (Davies 1989; Weedon 1999). Internationally, nationally and locally, consumer movements and midwifery employ the ‘woman-as-special’ discourse to underpin campaigns to increase birthing options for childbearing women by raising awareness of, and access to, midwifery.
For example, in my local area, the Australian Capital Territory, ‘ACT for Birth’ was the title of a public awareness and lobbying campaign in the late 1980s. In the middle of the 1990s midwives picked up the call with the ‘Start Life with a Midwife’ awareness-raising campaign, which included promotional graphics drawn by a then midwifery student Kate Lohse (see above and at the beginning of each section) and with midwifery conference titles such as ‘Birth among Friends’. This celebratory discourse continues into the 21st century. The next national conference for the Australian College of Midwives, to be held in September this year, has as its theme ‘Big, Bold and Beautiful’ and it says of its logo ‘the magenta woman is capable, joyous, grounded and she reaches for the stars. She represents both women and midwifery’ (Australian College of Midwives 2006).

**The ‘hysterisation’ of women and its effects**

How is it then that midwifery’s struggles for access and its need for celebration are so long term, and seemingly endless? The answer begins late in the 17th and early in the 18th centuries when poor childbearing women (and poor midwifery) were caught up with the entry of sick human bodies into the public gaze and organised into learning experiences for (wealthy) science and medicine (Foucault 1973/1994).

At the beginning of the 18th century new discourses about women’s bodies began to reorganise the social norms of femininity and to construct the ‘[…] patriarchal subjection of women and their exclusion from most aspects of public life’ (Weedon 1997:105). In his analysis of the formations of our beliefs about sexuality, Foucault (1981:104) wrote that women’s bodies were subject to a process he called ‘hysterisation’, whereby women were constructed as both mother and ‘nervous’, that is physically weak. In being given, and in taking up, a helpless and weak subjectivity, women’s bodies acquired new meanings. Under these new meanings women’s bodies became known through medical knowledge (Donnison 2004) and subject to modern science (Ehrenreich and English 1973; Weedon 1997), an
institution which is discursively constructed as helpful and strong. Strong and helpful men, then, came to be seen as the rescuer of weak and helpless childbearing women and incompetent and worthless midwives. Incompetence (and drunkenness) of midwives was spotlighted in the popular literature of the times, for example Charles Dickens’ midwife-character, Sairy Gamp, in his 1844 novel ‘Martin Chuzzlewitt’ (Donnison 2004:1080) and brought the ‘disrepute’ of female midwives to the public’s notice. The fight for midwives into and in the public domain in our society is a long story, as long as men have been involved in birth. Some midwives have always criticised medicine, particularly obstetrics, for its hegemonic view, its irresponsible use of technology and its inability to communicate well. As early as the 18th century Elizabeth Nihell, a famous Paris-trained London midwife, wrote a ‘Treatise on the Art of Midwifery’ a scathing attack on obstetrics and its manipulative technologies (Drife 2002:312). However, it appears that no amount of complaining by vocal midwives could stop the tide turning towards obstetrics [‘men-midwives’].

Increasingly, women and their unborn babies were subject to the public gaze (Duden 1993), and the accompanying position of ‘saviour’ brought medical men higher status, better education, greater influence and financial rewards (DeVries 1993:144), which in turn gave medicine extra confidence in its necessity and usefulness in childbirth. In 1847 Tyler Smith, a lecturer in the British Hunterian School of Medicine, exemplified the extreme end of the spectrum when he said ‘All midwives are a mistake and it should be the aim of every obstetric practitioner to discourage their employment’ (Donnison 2004:1081). As a consequence of increased status, power, education and money, obstetrics seized the position of truth about childbirth and its discourse is not only of knowledge but also leadership and decision-making (Papps and Olssen 1997). Julia Byford (1997:17) writes that, in fact, ‘it was the ideological power of the claim to greater expertise rather than the actual expertise that justified male participation’. Obstetricians even used false interpretation of the statistics about the increased safety of hospitals over home birth to influence public health policy in Australia and the United Kingdom and this contributed to the general public coming to believe home birth was no longer a safe option (Foureur and Hunter 2006).
Consequently, midwifery has a strangely ambivalent relationship with the public domain. In the dominant half of the public/private binary of maternity care (hospital/home), hospitals are (still) seen by most of Australian society and most practitioners in the medical and midwifery disciplines as safe, clean and modern and the private domain, birth at home, as risky, germ-filled and old-fashioned (or, alternatively as the domain of selfish/self-centred ‘yuppies’). Historically, the move into the ‘clinic’ is recorded as being in everyone’s best interests, even though there was no evidence of the safety of hospitals and indeed, much to suggest that women and their babies were safer at home (Tew 1995; Foureur and Hunter 2006).

Before the rise of medicine and the hospital, midwifery had always been located in the private domain of women. Women throughout history were experts in birth, contraception, illness and dying and women having babies were attended by women (Arney 1982; Donnison 2004). Women birthed for hundreds of years in the same ways, either in their own, or someone else’s, home and, in almost every culture, the way to be ‘with woman’ was handed down from generation of women to generation of women (Browne 1995). This was certainly so in Australian Indigenous cultures (Kildea 1999; White 2006). In early white Australia, midwifery was sometimes learned from necessity and experience (Adcock et al. 1984; Gaff-Smith 2004) because of the ‘tyranny of distance’ and a small white population. In the early decades of the 20th century, most white Australian midwifery, registered and unregistered, happened in the home or in small midwife run private maternity homes (Adcock et al. 1984; Gaff-Smith 2004).

Early Australian midwifery practice of the 19th and early 20th century was demonstrably at least as safe, or more so, than medical officers’ practice (Barclay 1985). Despite this, people in Australia started to believe that medicine provided a superior service (Barclay 1985). Women were encouraged to birth in hospitals to improve women’s and especially babies’ health by bringing birth into the scientific, medical and nursing arenas. There is anecdotal evidence of women early this century feeling very uncomfortable about having to birth in hospital. When I was researching the midwifery story of my great-grandmother, a very old woman in
Granny’s rural town told me that her mother hadn't wanted to have her babies in hospital ‘because that's where sick people went’ (Browne 1995:7). Her mother did go to hospital to give birth but for her, as for many women, feelings of ambivalence accompanied this change. In some places so much adverse publicity was given to the actions of incompetent midwives, that many reputable midwives were made to feel disgraced by disreputable people claiming the title of midwife (Tew 1995). The handing down of midwifery skills from generation to generation of women in families stopped and yet little improvement in health outcomes was made until general maternal health was improved and sepsis and haemorrhage could be treated successfully (Tew 1995).

With the change from the private domain to the public sphere, the profile of the midwife changed as well (Browne 1995). Midwives took up the discourses of science and safety and sought higher status by grounding their practice in science (Browne 1995) and in the process, changed from the community-based ‘traditional matron who had learned much, or little, wisdom from life... to the intelligent spinster who would first learn from academic teaching and then from other women's experience’ (Tew 1995:51). Over time, it became accepted in Australia that midwifery training was necessary to fully complete one's nursing training, and midwifery became a necessity for promotion or to work in small district or country hospitals (Barclay 1985). Midwives’ language became that of illness, disease, routines and hospitals and they left ‘behind’ the community based model which put women at the centre of their work. ‘With woman’ became less fashionable and ‘with system’ became more desirable as institutionally trained midwives replaced those who were informally trained, and midwives’ role became increasingly subordinate to that of doctors (Tew 1995). Midwifery began to look more like (modern) nursing which has its origins in both religious and military models (Alavi and Cattoni 1995; Gordon 2005). With the move of midwifery teaching and learning to hospital Schools of Nursing in the early to middle part of the 20th century, where medical officers gave many of the lectures, the obstetric view of birthing was integrated into the midwifery curriculum, a situation which was often reinforced in the practice areas.
Midwifery today… still complicated after all these years

The public domain of maternity care changed over the last hundred years to become a model based on science and medicine. Therefore, midwifery is practised mainly in hospitals in Australia (as it is practised in many but not all ‘developed’ countries, two noteworthy exceptions being Holland and New Zealand). In the past thirty years multiple demands for a return to a more social model of maternity care have been made and some have been realised. The changes take midwifery back to a more community and woman focused discipline. Because of those demands, midwifery is considered to be in a state of transformation at the beginning of the 21st century (Donnison 2004; Page 2006).

The changes in maternity and midwifery occurred alongside the second wave of feminism which gave voice to demands of women as consumers and to midwives as providers of maternity health care. Leading international and local leaders of the birth reform movement based their campaigns on the belief that childbirth was fundamentally about women’s right to manage their own reproduction, rather than be dictated to by a medicalised health system and inflexible health practitioners (Reiger 2001). Midwives and women together, and separately, called for major change to the birthing system to reflect women’s right ‘[…] to accurate information and effective choice, and to respectful care when they have babies’ (Reiger 2001:285). In the late 1980s and 1990s every Australian state and territory held an inquiry into maternity services; see for example, (NSW Department of Health 1989; Health Department of Victoria 1990; ACT Health 1993). Each inquiry found similar problems in the Australian maternity health system. Women felt a lack of control and choice in pregnancy, labour and birth and postnatally, a situation they wanted remedied. The voice of the consumer movement in Australia became stronger in carrying the message about the demands for choice and for midwifery (Maternity Coalition 2002) and, since the second wave of feminism, many people have been critical of the results of obstetric practices on women in pregnancy and childbirth and the limiting effects of obstetric discourses on midwifery (see for example Wagner 1994; Tew 1995; Davis-Floyd and Sargent 1997; Murphy-Lawless 1998; Cahill 2001; Foureur and Hunter 2006).
Some childbearing women and their partners, midwives and medical officers refuse to fully embrace the ubiquitous discourse of medicine. They offered resistance from within and took up new discourses from without. This instigated changes (Wagner 1997) which are apparent both inside and outside midwifery and, to a lesser extent, inside obstetrics (Johanson, Newburn and Macfarlane 2002). There are calls for change in obstetrics from parts of the medical fraternity; for example one prestigious journal’s editorial about evidence for care recently concluded with the words: ‘We need to create a culture that is comfortable with estimating and discussing uncertainty’ (Alderson 2004:477). In Canberra, campaigns to increase the profile of the midwife became part of midwifery work and learning in the 1990s (as discussed in the introductory chapter of this work) with banners, as in the photo on the first page of this chapter and the logos drawn by our midwife-artist Kate Lohse, shown above, promoting the value of women and midwives. While midwives have been, and still are, complicit in the medicalisation of childbirth in part because of their lost autonomy, midwives in the past twenty years have begun to reclaim their perceived rightful place as ‘with woman’.

Overall, though, with obstetrics’ continuing ownership of the authoritative knowledge in childbirth (Davis-Floyd and Sargent 1997), knowledge that views the body as fragmented, its processes mechanistic and that distrusts women as capable birthers, comes also obstetrics’ ability to capture and hold the high moral ground of maternity care (Papps and Olssen 1997). Obstetric dominance thus reinforces Foucault’s *hysterisation* of women, a discourse manifested in multiple and ever changing ways in our current system, and one which limits other discourses’ availability not only to childbearing women and midwives but also to medical officers, policy makers and health managers. The dominance of this discourse also lets it proceed relatively unchecked, unopposed and sometimes seemingly out of control, as was evidenced in the inquiries into birthing in this country (NSW Department of Health 1989; Health Department of Victoria 1990; ACT Health 1993). In maternity care, many inroads into a more woman-friendly system have been made, yet processes and structures which are disadvantageous to women are still embedded in our healthcare system and have been since its inception (Foureur
and Hunter 2006). They often remain unchallenged and hard to challenge. Practices and discourses which demean women and midwives are evident even in institutions where people actively work towards a woman-friendly environment and in spite of the major changes that have been implemented in the health system in recent years.

With the help of feminist theory and practice, many midwives have (further) increased their understandings of the complexities produced in the health system by historically gendered, unequal power relations. While such understandings have become integrated into (some) midwives’ and students’ daily work, other midwives and students, and indeed, even those of us with well worn feminist frameworks, can be shocked and appalled by what happens to women and midwives-as-women (and sometimes to doctors-as-women) on a daily basis. In a patriarchal health system such as the maternity healthcare system in Australia, anti-woman positions often feel ‘normal’ both in our society in general and in particular in the dailyness of our work with childbearing women. This immersion makes seeing alternative ways of speaking (in) the maternity world very difficult. It also means that just swapping the medical model for another one, for example midwifery, is both very complex and fraught with danger. As Jo Murphy-Lawless writes:

*There are many problems with the social model of birth based on midwifery care, not least the problem of how independent it can be as a system of childbirth management. Inside hospitals, it is extremely difficult to allow its constructs to work in the face of obstetric norms, while outside the hospitals, the possibility of something ‘going wrong’, of which death is the worst scenario, operates as a threat against the midwife herself by putting her professional status, her livelihood and her self-esteem on the line.*

(Murphy-Lawless 1998:261)

There are many ways in which patriarchal and patronising discourses, especially those based on ‘obstetric norms’, are at play every day in our maternity health system. Some current examples from a list which could take up the majority of space in this chapter include the following: woman-unfriendly hospital policies, despite evidence of the harm coming from practices advocated in those policies; examples include fasting in labour, restricted visiting, the use of physically restrictive technology, no provision of one-to-one support in labour, restriction of the use of water in labour and birth and the use of medical tests which cause physical and
emotional distress but do not improve health outcomes. The system is often fetus-centred and baby-centred which means that women can feel relegated to the position of incubator (Duden 1993). Health practitioners frequently treat women patronisingly (Bergstrom et al. 1992), as if they are not able to make decisions for both themselves and their babies. The very recent past includes many maternity procedures and treatments which were not in the best interests of the woman, (see, for very comprehensive reviews Wagner 1994; Tew 1995). A small sample is: confinement to bed in labour (especially the requirement for a woman to lie flat on her back), the regular use of stirrups for birth, the lack of privacy in labour and while giving birth, routine episiotomy to enlarge a woman’s birth canal, the use of forceps for birth without adequate pain relief, the removal of the baby after birth and her or his placement in a well baby nursery, strict confinement to bed for many days in the postnatal period, the liberal non-consensual use of artificial formula for well babies and the practice of ‘witnessing birth’ for students which meant multiple strangers in a woman’s birthing room.

Patriarchal attitudes can be seen in the wider health system as well, attitudes which raise issues and questions for midwives and other reformers. Why isn’t there national public health support in Australia for home birth for well women when home birth is proved to be as safe, or safer, than birth in hospital and always was (Drife 2002; Foureur and Hunter 2006)? Why can midwives not access Medicare rebates for birth and postnatal visits, when general practitioner medical officers and obstetricians can? What kind of country actively coerces women of childbearing age to join private health funds when large studies, for example (Roberts, Tracy and Peat 2000), show maternity health outcomes for women in the private health system in Australia are clearly inferior? How can we ignore the fact that Australian women, like those in many other countries, are poorly supported to breastfeed their children for any length of time, when we know that breastfeeding protects children from a range of long term diseases, eg: diabetes and asthma and conditions such as childhood obesity? How can we tolerate a society where the petrol to drive from one part of a job to another is tax deductible but child care is not fully a deduction? How can we justify not funding one midwife for each labouring woman when available evidence (Enkin et al. 2000; Tracy 2006a) shows that labour measures which rely on good staffing levels, for example, non-pharmacological pain relief and good
hydration enhance a woman’s experience and her health outcomes and those of her baby?

Remaining respectful of those professionals who people our very complex maternity health care system, I continue in this chapter, writing to foreground the influence institutional discourses and practices can have on those positioned as subordinate (childbearing women and midwives) and to understand the impact of these discourses and practices as they set the conditions under which practitioners come to the political and personal work of trying to achieve access for women and to celebrate womanhood. The extent of women’s disadvantage in the health system is really quite shocking. Thus, I choose the following stories to turn a spotlight on the extent of complexity of discourses in maternity.

In the first story Alison tells of one time of many when she was extremely frustrated by women-unfriendly practice, something that she spent many years and much energy trying to rectify. This occurred ten years ago when midwives were first working towards major practice change. Alison is speaking of an obstetrician:

He went off his face because I hadn’t given a woman an enema when she had a blood pressure on 110. There was no way I was going to. I never gave them anyway, even more so I had good reason not to give it. I got so angry. I thought I’m going to throttle the bastard and I left the room. In my pocket – it was a scrub suit so it must’ve been the early 90s - I had my artery forceps and a pair of scissors and pens and stuff. I just picked it all up and I threw it at the wall. I said “oh you fucking bastard”. People came running (laughs). I went out on the balcony and cried my eyes out and smoked cigarettes. I think I got someone else to go into the room. I wasn’t going back in there with that bastard. I felt bad about the woman but I went back to her and told her why I’d left. She said “Oh, no that’s fine, I knew you were cross”. Her partner couldn’t really see what the palaver was about - shaves and enemas and stuff.

Alison, Interview

Alison is clearly furious, having never thrown her ‘scissors and pens and stuff” at a wall before or since. She was angry with the obstetrician, just as he was with her. They both knew what was at stake here: his authority (from a distance) to prescribe, to dictate, to order the practices and procedures which were his preferred options but not, according to the research and to Alison’s experience, in the woman’s or baby’s best health interest or indeed, comfort. Millions of enemas were given in this
country (and in other countries of the ‘developed’ world in the 1950s, 1960s, 1970s and 1980s) as a preparation for birth. This common custom and practice was unfounded, uncomfortable and embarrassing for the woman (and the midwife) and by the time of these events, most midwives and obstetricians had stopped giving enemas based on a move towards evidenced based practice.

This story is not only about a woman’s comfort and embarrassment or about her (in)ability to choose what she wants, it is also about power couched in ‘best practice’. Both professionals discursively construct themselves as the one with the knowledge to help the woman make good choices for herself. Yet in the moment of the situation both have power and they are both powerless. The obstetrician demands the right to make it very clear what he expects (out of step though it might be with current wisdom) and to make Alison’s life miserable if she does not comply with his so called ‘standing orders’ (practices that individual practitioners prescribe for women without seeing them first). However, in another way the obstetrician is powerless. He believes in giving enemas but he does not give them. By the time he arrives for ‘the delivery’ it is too late to give the enema, something Alison clearly knows. Herein lies her power. She is with the woman, as he is not, and she is the one who takes the woman’s blood pressure and so Alison has a reason to justify not giving the enema (as it could theoretically make the woman’s blood pressure higher). Her actions are supported by a then-new collection of maternity research studies (Chalmers, Enkin and Keirse 1989), but Alison does not say whether that is why she ‘never gave them anyway’. Either way, Alison does not offer an enema and the woman does not request one, of course, as enemas were (understandably) strongly disliked by most women. Because it is a midwifery action, it is very hard for the obstetrician to enforce his rules. He tries to by being threatening and abusive, partly to show Alison what will happen next time she chooses to take this path. However, he and Alison both know that if Alison stays strong he cannot fix this situation to his liking. He can constitute himself as the ultimate authority on childbirth, so one choice for him is to ‘go over her head’ and report her to her boss, a strategy which may or may not succeed. Alison is a very experienced labour and birth midwife with the scientific evidence in her favour. So reporting Alison may not work for the obstetrician, although it is a disciplinary tactic used relatively frequently and with some success. His other choice is intimidation, which also may or may not work.
Intimidation works often enough for obstetricians to (still) use it regularly as a strategy. Intimidation is often used in retrospect as a punishment for ‘disobedience’ as it is here, a form of disciplinary power where the body can be manipulated and, as Foucault claims, ‘nothing is more material, physical, corporal than the exercise of power’ (Foucault in Brush 1998:27). Examining the interactions between Alison and the obstetrician highlights the exercise of power as being multi-directional and (always) contested. The obstetrician’s problem is how to actually make the midwives do what he wants, what he believes is right, what he believes is good practice, even when he is not physically in the hospital. There are authoritative structures in place, standing orders, for example, and a hospital hierarchy, but that doesn’t always work well with midwifery. This is ‘normal’ childbirth and it is not only the territory of obstetrics. Indeed, most midwives and many obstetricians (see for example Porter 2003) believe it is not the territory of obstetrics at all. In this situation, different from ‘real’ obstetric work such as Caesarean section or forceps, his power lies with discursive construction of himself as the authority on birth, all birth (Davis-Floyd and Sargent 1997) but for it to work, Alison has to recognise him as such and act upon that recognition. Alison makes no move to recognise his expertise. She seems to feel compromised even though she ‘won’ the first, and what she sees as the important, round. She is furious that she cannot stop him yelling at her in front of the woman and her partner. She feels so frustrated that she leaves the room, a big call in midwifery. Leaving a woman’s birthing room is the last line of personal defence for a midwife. It does not feel like a with woman position because if she leaves the woman and her partner alone with the yelling obstetrician, the woman may become the object of his anger. If that happens, the midwife can then be read as being abusive in abandoning the woman. So Alison, perhaps, asked another midwife to enter the birthing room as support and protection for the woman. However, as both the obstetrician and Alison know, removing herself is a powerful action. It is an action in which she can be recognised as a midwifery ‘hero’ and in which she can constitute herself as strong midwife. She makes a statement, to him, to herself. She will not witness this, even as she cannot stop it. The obstetrician’s powerful stance is underpinned by there being only one of him (he is not replaceable in the room, as was Alison). He knows what is necessary for all women and he acts upon that knowledge, even if he has to be abusive to make his point.
Liberal feminism responded to situations like these by working for change to the ways in which structures restricted women’s rights, including restricting their access to a broader range of (more humane) health care choices. In the health system this has led to changes in the way maternity care is delivered. For example, new models of care run by midwives, not obstetricians, are becoming more common (Chandra 2003a; Kirkham 2003), many (but not all) the medical and midwifery practices which have no basis in scientific evidence as being beneficial to women’s or their babies’ health (Enkin et al. 2000) have been ceased (for example, perineal shaves and enemas); evidence based practice is now part of the health discourse, including in obstetrics (Johanson and Lucking 2001). Alison herself spent hundreds of hours rewriting maternity unit policies in order to provide a system in her hospital which is more centred on the woman and less on the system (Chandra 2003b). In her unit, these policies are shared ones between midwifery, obstetrics and the nursing and medical management systems, so to achieve consensus is time consuming and requires much patience and energy. New policies can make a difference as they become the new set of ‘rules’, rules which cannot totally dictate an individual (obstetrician’s or midwife’s) practice, but which can form some sort of agreed standard of care, a basis from which to argue, at least. Alison stated her belief in the value of policies and standards when she gave a presentation to registered midwives:

_Sometimes one person may write them with minimal consultation aiming to control practice, or they may not be evidence-based (Pearse, 2003). If you find your unit policies are too restrictive or you do not think they are up to date, take the initiative and update one or two instead of complaining about them. Experts do not have divine rights over others in policy making, decision making or anything else. They are there to offer an opinion, give advice and support._

(Chandra 2003b:5)

Alison, in true liberal feminist style (a style which many of us take up), challenged the ‘divine rights’ of the powerful male to organise the world and in doing so found a space in the status quo for new woman-friendly policies. While liberal feminism tends to ignore women’s bodies and focus on equal rights for women as abstract individuals (Weeldon 1999), the fight for ‘abstract’ women in midwifery affects bodies as well, due to the nature of our work. New ‘rules’ about women and access, mean new rules about women’s bodies.
Apart from the discourses of power and powerlessness in this story, we also hear a sense of isolation, of professional and personal loneliness, and yet of strength as well, from both Alison and the obstetrician. Alison is brave and knows her work well. She takes up a with woman position and decides to follow her own judgement. She does not give the ‘ordered’ treatment. The woman acknowledges Alison’s anger with ‘Oh, no, that’s fine, I knew you were cross’ but the woman does not seem to grasp the seriousness of the situation for Alison (which is obviously reasonable given that the woman is caught up in her own birthing time/space). Alison probably sheltered the woman from fully noticing what was happening as, I imagine, she would not want the woman caught up in a professional wrangle (and of course, I suspect the woman had her own processes on her mind!). The woman’s partner seems dismissive of the importance of the situation for Alison because he ‘couldn’t really see what the palaver was about – shaves and enemas and stuff’. Alison is reduced to smoking, something she does not normally do. In another sense, Alison is strong and brave, strong enough to go back to talk with the woman and her partner, re-establishing her with woman position. She goes back into the birthing room and uses her own (coercive) power to re-establish herself as midwife. It seems very hard work on Alison’s part for a small but very important gain but as Chris Weedon explains: ‘It may well take extreme and brave actions on the part of the agents of change to achieve even small shifts in the balance of power’ (Weedon 1997:108). The obstetrician also stands up for what he thinks is right, using his coercive power to try to achieve the care he believes is in the woman's best interests. Yet he is reduced to yelling (‘he went off his face’), powerless to do anything else in the moment, rendered ‘powerless’ by Alison’s use of her own power. We get the impression, though, that he will be back, that Alison has ‘won’ the battle but not the war.

Radical feminism reads situations like the one above as being patriarchal and misogynist. In radical feminist terms, patriarchy is ‘founded on a fundamental polarisation between men and women in which men exploit women for their own interests’ […] as aiming at ‘securing male control of women’s bodies: our sexuality, procreative power and labour’ (Weedon 1999:27). Radical feminism is a political movement which breaches the public/private divide and ‘focuses on the personal as a
key site for political action’ (Weendon 1999:27). In midwifery, radical feminism translates into positions of resistance, positions from which both women and midwives can say that childbearing women and their babies and their midwives do not deserve treatment like this. They do not deserve it, not because all people are equal and deserve equality before the law, but because women and women’s bodies are special and so deserve special treatment. In the story above Alison reads the birthing woman as a capable birthing body which requires no interference from either her or the obstetrician. Further, she actually reads any interference as harmful to the woman’s natural, healthy bodily processes and thus she positions her (radical feminist) midwifery self as the woman’s guardian, diametrically opposed to the dominance of medicine, a position which requires strength and courage. Aligning with woman has often put a midwife at odds with (male) authority, a situation which can bring her further into a subordinated position and which may have (un)foreseeable consequences in a system where the discourses of medicine and nursing and management dominate.

The strength of an attack out of a dominant discourse and the vehemence with which it comes can be shocking and damaging. The following excerpt is from a recent complaint made by a group of obstetricians about the ways in which midwifery and obstetrics is changing for the worse in their opinion. Change instigated by other people can produce reactive disciplinary actions from those who see themselves as actually being in control or as having primary authority. While the complaint was swiftly dismissed by an external adjudicator as having no basis in fact, in the process an obstetrician wrote the following about a very senior midwife (whose confidentially has been maintained here):

The difficulties began... with the appointment of a superintendent midwife, who was, and is, quite obsessively opposed to any intervention [...]. The fact that this opinion means she wished to impose a standard of obstetric practice upon patients that was outdated almost 50 years ago doesn’t seem to concern her. Over a period of time this lady appointed around her a cadre of midwives who I can only describe as feminist, anti-doctor, and equally anti-intervention. The remaining midwives who are enthusiastic on progress in obstetrics either left the hospital, or because of superannuation implications, reluctantly remained. Most of them I believe to be extremely dissatisfied with the situation in which they find themselves. The [obstetricians], having ultimately total control of the [unit], kept this potentially very dangerous situation under control, albeit with some difficulty.
This obstetrician constructs the midwife and others of a particular bent as dangerous. Even though it was obvious that his intention was to complain officially in a very serious manner about the senior midwife, it is hard to know who the obstetrician insulted most. He demeaned the senior midwife (he is libellous, in fact) who clearly was the target. Equally he targets the ‘cadre of midwives who [were] feminist, anti-doctor, and equally anti-intervention’. He even insults the midwives of whom he supposedly approves, the remaining ‘unhappy’ midwives, saying they put financial gain before their work ethic. Midwives have probably always been called all sorts of unpleasant words, in the name of keeping ‘this potentially very dangerous situation under control, albeit with some difficulty’. As early as the 18th century, an obstetrician wrote of Elizabeth Nihill, an English midwife who wrote publicly in a scathing way about men in midwifery (named obstetrics from the 20th century onwards) and their use of instruments:

[…]
this honest woman who talks so much of tenderness, delicacy, and decency, sets up her throat, and with the fluency of a fishwoman, exclaims against the whole body of male-practitioners […] [and yet she did her midwifery training] at the Hotel Dieu at Paris, the most dirty, slovenly, inconvenient, indecent, shocking receptacle for the sick in all of Europe […]

(Klukoff 1970:32, 36)

Midwives (and obstetricians) have been called many unpleasant names in my twenty years in midwifery and Alison’s thirty five years. I suspect that ‘feminist’ is a modern version of ‘fishwoman’. Constructing someone as ‘feminist’, though, leads the field in the maternity health care system for the name-callers as the worst insult (sometimes introduced by adverbs such as ‘ratbag’ or ‘hairy-arm-pitted’, depending on the size of the insult or the apparent crime). While being called a ‘ratbag feminist’ quickly became a joke and a compliment inside our own local midwifery discourse of resistance, to actually put such words in writing about a well respected senior midwife in a very formal and serious situation shows the personal and collective power held within the obstetric discourse. The fact that it sparked an official enquiry (albeit a brief one) shows the power that obstetrics (still) holds in the health (and perhaps legal) system. Obstetric knowledge remains authoritative (Davis-Floyd and Sargent 1997). Clearly, this obstetrician either believed what he wrote or it served his purposes to write it, or both, but the venom in this extract
highlights what Malterud (1993:371) wrote some years ago, that ‘[t]he strength of the tacit oppression of women in the health care system should never be underestimated’.

I had a very long confidential conversation with the midwife in this story about this complaint and the compromised position in which she was placed because of it. We analysed the situation in terms of both liberal and radical feminist discourses. We read the obstetrician as both trying to block her access to childbearing women and childbearing women’s access to midwifery. We also read him as trying to re-establish obstetric authority in a world which is changing, in parts at least, away from the dominance of the obstetric model. I wanted her to construct herself as even more difficult and, using her ‘liberal’ rights, to sue the obstetrician for defaming her good name but the midwife said he was not worth the effort or the money and she did not want to give him or his complaint any further credence. She was shocked and upset though by these and other lies documented in the official complaint. She wrote me the following e-mail:

When you finish being angry you can see the sad and pathetic side of it all. Not once, of course, have the views and preferences of women even been hinted at, let alone been acknowledged! And these are the bastards we covered for and kept from making monumental mistakes whenever we could, then, when we couldn’t, we mopped up the tears and tried to restore the women’s faith in themselves [...].

In this e-mail, we see the midwife mobilising a discourse of ‘being with woman’ to make this personal and professional attack on her, her staff and on birthing women, manageable. Her lack of respect for the obstetrician comes from her view that he undervalues women and dismisses their right to choice. ‘Being with’ gives the midwife a useful discursive position, inside both the liberal and radical discourses. As for me, as I type this I am angry all over again. I find myself slipping (un)comfortably into my own radical feminist and liberal discourses, even as I am trying to ‘unpack’ what happened here from multiple positions. The midwifery position of ‘being with’ often sets up a (radical feminist) binary opposition of being against, a position I want the midwife to take up when I suggest she sues the obstetrician (mine is also a liberal feminist position to use laws to obtain justice). Of course, this binary being with/being against is not stable and I can also read the
opposite of the midwife’s ‘being with’ as ‘being without’ (Browne 2000). The midwife has lost ‘face’, reputation and possibly a sense of a shared maternity goal here. At its worst outcome, she may lose her job and her access to childbearing women and midwifery. ‘Being without’ could well have become a reality, as it did for a high profile home-birth midwife in Sydney, Maggie Lekky-Thompson, some years ago when she was deregistered as a midwife for several years after a long complex legal battle in the NSW Health Care Complaints Commission, begun when ‘several doctors filed complaints […] and recruited a few families to also complain’ (Wagner 1998:1).

The obstetrician who filed this complaint is one of several who, in a seminar in the early 1990s, under fire from obstetric colleagues from other parts of the country for having such high intervention rates in childbirth, said words to the effect of, ‘Oh, it’s different here. Women in the ACT have different shaped pelvises and that is why they need our help to deliver’ (ACT for Birth 1994). Women’s bodies as deficient is a common discourse in maternity care, based as we have seen, on the ‘hysterisation’ of women, starting with the childbirth’s move into the arena of scientific and medical learning (Foucault 1973/1994:85). The really frightening thing for the midwives in the auditorium that day, including me, was we could see they were serious. ‘Different shaped pelvises’. Even though those words were said in the early 1990s it is still a standing joke in local midwifery circles. Of course, we also know it is not funny. A group of practitioners who have the confidence to suggest (out loud and in public) that the anatomy of well women living in a particular city was the reason for bad obstetric practice is a force to deal with indeed.

Discourses overlap and compete, which makes our birthing world, like all worlds, less than simple. As Chris Weedon explains: ‘While a discourse will offer a preferred form of subjectivity, its very organisation will imply other subject positions and the possibility of reversal’ (Weedon 1997:106). Binaries are unstable and open to challenge (Flax 1992) as discourses do not exist simply as binary opposites (Weedon 1997). As seen in the above stories, obstetrics/midwifery, right/wrong and
ethical/unethical can appear to be operating as opposites but they are unstable and open to challenge. Just as midwives take up (and are given) subject positions inside particular discourses, including dominant ones, obstetricians or other medical officers can take up as their own a with-woman position, a more ‘marginal’ position in the health system (Wagner 1997). In midwifery we often act and speak as if we are a cohesive group and life would be much more simple, perhaps, if this were so. Our medical colleagues could happily be the powerful baddies and midwives could unhappily be the powerless goodies (a position I can easily slip into, even when I am trying very hard not to). We could (just) throw the responsibility for misogynist values and practices at the feet of men, especially medical men and continue playing the good midwife. However, everybody in the maternity health care system is seeped in the institutions and practices and modes of action which position some people as superior and others as subordinate and so, of course, midwives are not exempt from perpetrating abuse of women. A young midwife told us the following story at a Christmas dinner for her group, as a way to try to explain to me, their teacher, how complex her year as a newly graduated midwife had been:

"I was writing my reports when a 15 year old pregnant girl and her mother came to the desk where the midwife-in-charge was. The mother explained to the midwife that her daughter had had some bleeding. The girl didn't look at us, but kept her head down, looking like she wanted to be anywhere else. She was fidgeting, sort of wringing her hands. The midwife-in-charge walked over to where I was sitting, about six feet from the mother and daughter and clearly in their view, bent over and whispered: 'It fucks, but it can't speak'."

‘How did you feel?’ I asked the midwife after we had discussed the story from the pregnant girl's and her mother's point of view. ‘I felt sick and dirtied’ said the new midwife.

JB’s journal

Disrespect for women in the system is not the province of men nor of our medical colleagues, nor is it something which belongs in the past, as this incident happened this century. The night I heard that story I couldn’t sleep. In fact, I couldn’t sleep properly for weeks. In choosing this story for inclusion here, I do not mean to indicate that this form of behaviour is acceptable to most people within the maternity health system. I believe that this event would be thought disgusting in the wards, offices and tearooms in every maternity unit in the country (and world) by both midwives and medical officers. However, it did happen and the system still stands,
and so it raises questions. Under what conditions could these words be spoken? How could the midwife-in-charge both feel able to utter those words *and* say them, even in a whisper, to a brand new midwife? How is any system able to make one of its own feel ‘sick and dirtied’? Under what conditions could these words be spoken in seeing-distance of the physically unwell and presumably distressed, certainly already embarrassed pregnant young woman and her probably compromised mother?

Multiple readings of this story are possible. We could decide the senior midwife is a bitter woman making a moral judgement about what she perceives as the young woman’s sexual promiscuity. Or, we could theorise that she wants to exert her power over the new midwife as a form of disciplinary control so the new midwife understands the moral order of things in her ward. We could say the senior midwife judges the mother as deficient in ‘allowing’ her daughter to become pregnant and therefore she is morally inferior to the midwife and not worthy of her respect. Or perhaps the senior midwife wanted to be smart, to shock the new midwife with her ‘worldliness’ and her understanding of today’s youth. We could understand what happened as a dare for the new midwife, a test to see how far the senior midwife could push her before she retaliates. The story can be read as the senior midwife being naïve and privileged. She does not seem to be able to imagine the young woman might have been raped or the victim of incest. Nor does she read the young woman as being capable of actively choosing to be fertile and (re)productive. The young woman is read as disgustingly sexual and all else is negated. We could read the senior midwife as an ill individual who needs psychiatric help. Or she could have ‘just’ been joking. We could make other discursive readings as well about the rationalities that make those words sayable and doable and I have not even considered it here from the young pregnant woman’s perspective, or that of her mother, even though when this story was told at dinner, those perspectives took up more than half the ensuing conversation.

However this story is theorised, with those six words and the embodied action of moving into the young midwife’s space and whispering, two things happen. The young midwife becomes an (unwilling) accomplice, part of the abusive discourse. Secondly, *in that moment*, the new midwife and young pregnant woman (and her mother) have their options for personhood reduced. As Davies writes:
The domination of others by those positioned as having authority, or higher status, or greater moral righteousness, or greater strength, is always potentially exploitative and self-serving, and as such may have the effect of denying those in weaker or subordinate positions access to a viable life.

(Davies Forthcoming)

This is a very complex event and we do not know why the young midwife first broke her silence by choosing to tell a group of her closest peers with whom she learned midwifery and her teacher as well. Nor have we considered the reactions of those of us around that Christmas table. However, by speaking of these events aloud, even though it was to us and not to the senior midwife, and even though it was some time later, the new midwife offers resistance. Foucault describes the relationship between discourse, silence and power:

Discourse transmits and produces power; it reinforces it but it also undermines and exposes it, renders it fragile and makes it possible to thwart it. In like manner, silence and secrecy are a shelter for power, anchoring its prohibitions, but they also loosen its hold and provide for relatively obscure areas of tolerance.

(Foucault in Weedon 1997:107)

At dinner, we see the new midwife seeking ways to deflect the other midwife’s words. She seemingly understands power in the Foucaudian sense in her complex position, telling her story at dinner perhaps because she knows that in remaining silent about this event she may ‘shelter’ the midwife’s power. She also seems to understand that keeping her silence in the moment of this story loosened the midwife’s hold on power and provided the new midwife with a space for ‘tolerance’ (Foucault in Weedon 1997:107) inside a nightmarish situation.

The stories above point to discourses and practices within maternity health care which are clearly not based on a love of and respect for women. Working inside and outside this complex system, and using feminist actions and philosophies, childbearing women and midwives sought new discourses to make changes to a system which they saw (and see) as less than perfect. We were not happy with our ‘necessary and sufficient conditions of life’ (Butler 2004b:205). The complexities of the maternity health system mean that liberal and radical feminisms make a
difference to childbearing women and midwives, but not enough difference to produce viable lives for all.

Towards a third generation for midwifery?

Midwifery’s work with, for and mostly by women, while being connected to other gendered groups – the still male-dominated medicine and the still female-dominated nursing – can be a catalyst for change for those involved in it. Judith Butler (2004b:204) writes that while everyone probably agrees that feminism is about the social transformation of gender relations ‘[…] yet the question of the relationship between feminism and social transformation opens up a difficult terrain’. The terrain is difficult in midwifery. Finding ways to speak which resist dominant ways of thinking, speaking and being in the health system propelled, and continues to propel, childbearing women and midwives towards the feminist discourses of access and celebration. Over the history of midwifery, discourses (mostly) contain within them the demands for what midwifery sees as best for women. Often these demands are in opposition to what medicine/obstetrics sees as best and they have sometimes also been in opposition to what women see as best. In some ways these opposite positions can feel inevitable. Feminism(s), however, increase midwifery’s understandings of the ‘sites of contest’:

_The most powerful discourses in our society have firm institutional bases, in the law, for example, or in medicine, social welfare, education and in the organisation of the family and work. Yet these institutional locations are themselves sites of contest, and the dominant discourses governing the organisation and practices of social institutions are under constant challenge._

(Weidon 1997:105)

While individual women and midwives (and perhaps collective midwives) have challenged obstetrics [‘male-midwifery’] from its inception (Klukoff 1970; Drife 2002), many emancipatory changes made in and around childbearing and midwifery in maternity care can be traced to the social transformations from the ‘women’s liberation’ movement of the past forty years. (Other changes which have been seen
by some people as liberating, for example chloroform for pain relief, were made earlier than the second wave of feminism).

However, midwifery has a love-hate relationship with feminism, when midwifery sees itself as having any relationship with feminism at all. Because so much second wave liberal feminist work was concerned with women ‘[…] forgoing domesticity in favour of competing fairly with men for public sector roles’ (Lane 2006:53) and radical feminist work being concerned that ‘[…] women’s oppression was rooted in the biological capacity for reproduction […]’ (Lane 2006:53), a discourse of women’s processes as independent, strong and achieving in childbearing appears only in the cracks of feminist literature. Midwifery’s discourse of connection to women as the bearers and ‘rearers’ of children contrasts to feminism’s ambivalent relationship to women both as mothers and women as carers. Many feminist writers see the advantage (or necessity) of breaking free from the maternal (Butler 1992) and thus the midwife’s discourse of helping women be strong and able in that process has been largely silenced in feminism. In the recent past, the promotion of natural childbirth and breastfeeding has been viewed as integral to midwifery but as having little to do with feminism (Kitzinger 2001a:v). Indeed, some authors say feminism forgot women-as-mothers and their political struggle for their specific ‘rights’ and needs almost entirely, even though there are important examples of consumer organisations and organised feminism working together to achieve change, for example state and territory enquiries in the 1980s and 1990s in Australia into childbearing (Reiger 2001:285). Kerreen Reiger continues:

*Optimal birth and breastfeeding remain in a marginal area - no longer just personal matters, but not fully accepted as a matter of public responsibility either. However, if we take seriously the arguments put to, and endorsed by the government reviews - that reproducing the next generation is a collective matter, a shared responsibility - much stronger demands can be asserted […] A more fundamental reorientation of thinking is required which reformulates women’s needs in maternity care as matters of social justice, human rights and collective well-being.*

(Reiger 2001:285)

In turn, midwifery has struggled with feminism, both using it and ignoring it, a situation discussed in the midwifery literature (Trego 2005), often in the form of a
plea or suggestion to use feminist theories or to continue to use them (see for example Cutts et al. 2003; Stewart 2003; Cragin 2004). I believe that without the feminist movements of recent generations, midwifery would not be in the improved position in our society it is today but this is not necessarily a commonly held view among midwives and so midwifery’s story also diverges wildly at various points from feminism’s path. Midwifery’s convoluted connections to nursing as caring and medicine as curing compound the problematic in the feminism/midwifery liaison.

Even though an argument has been made that midwifery is ‘intrinsically’ feminist as it relates to and for women (Guilliland and Pairman 1995; Thompson 2004), the midwifery discipline has been slow to embrace feminist principles and actions en masse. While some women [and midwives] ‘pursue feminist goals but reject the feminist label’ (Hunt 2004:6), many midwives shy away from feminism, seeing it as radical and oppositional to caring for women and babies. Therefore, while many midwifery clinicians, academics, managers and authors do embrace and use feminist ideas, I believe that feminism is still viewed by many (or most) within the discipline with some suspicion. In my experience, many midwifery students who are nurses (first) are hostile initially to the ideas contained within feminist philosophies and only change their opinion about the place of women in our society after broader reading and working closely with pregnant, labouring and lactating women. However, feminisms have been integral to the ways in which midwifery philosophy and practice developed in the recent past (Guilliland and Pairman 1995). We have mobilised feminist discourses, as we have been mobilised by them, in teaching, in practice and in research. Sometimes our use of feminism is obvious, sometimes it is less so. Sometimes we have employed its strategies and beliefs without its labels. Either way, midwifery and feminism are intertwined now.

The discourses and practices of access and celebration have had varying degrees of success, even though many of us (including me) thought they would solve all our problems. The gains, such as women-centred hospital policies and decreasing rates of intervention in childbirth, are proving not to be necessarily permanent, either, a situation alluded to in a recent conversation between Alison and me:
Alison: I didn’t think it would be undone; all our hard work, just being undone while we watch it.

Jenny: I was naive. It never occurred to me that any of the changes we fought so hard for wouldn’t last. Sarah and Louisa [our daughters] will have to do it all over again.

Alison: I hate the bastards for changing it back but mostly I hate how fast it’s happening. The least they could do is wait til I retire.

Jenny: It’s like being buried before we’re dead.

Kristeva’s first and second generations have been useful responses/readings of how (current) (dominant) discourses constitute women and midwives. Public consciousness raising, new curricula, changed laws, individual and collective actions and protests and a heightened awareness of the value of women and midwives are important and useful changes which have been both flamed and smothered by midwifery’s long history of independence and (resistance to) obstetric dominance. However, changes which allow and promote women’s (and men’s) personhood in all its configurations do not seem to be happening by employing only liberal and feminist discourses and even the structural and discursive changes we were involved in both locally and nationally in relation to practice, education and funding no longer seem secure (which they never were, but we did not realise that). For example, rates of Caesarean sections are increasing now after a period of decline in the 1990s in our local area. Also, in Australia, some politicians, bureaucrats and members of the public still intimate that perhaps nursing education (and therefore midwifery education) should be funded through hospitals like it was ten to twenty years ago, as if the tertiary education sector is inappropriate for them. Discourses of change, for example choice, control and consumer rights, have been taken up by members of other health care groups and so the changes related to midwifery and women’s campaigns on those fronts have also lost ground. As Shelia Kitzinger (2001b:284), the influential British social anthropologist, writes: ‘[t]he language of choice has been appropriated by obstetricians’.

How then can we make moves towards theory and practice which will help us (lasting)ly grow possibilities for all people, collectively and individually? How can we manage what has been a problem for feminist research, the ‘[…] desire to
validate and affirm what is “truly feminine” without having those qualities be reproduced as limiting stereotypes’ (Pillow 2002:23)? How can we re-work our actions for change to include the (im)possible, the (un)known, the (un)thought? How can we open ourselves up to possibilities hitherto dismissed or ignored as not appropriate for childbearing women or midwives? Where can we look for new questions which might lead us to new answers? As Kristeva asks:

_"No longer wishing to be excluded or no longer content with the function which has always been demanded of us (to maintain, arrange, and perpetuate this sociosymbolic contract as mothers, wives, nurses, doctors, teachers ...), how can we reveal our place, first as it is bequeathed to us by tradition, and then as we want to transform it?"

(Kristeva 1981:23-24)

We come, I believe, both in this work and in midwifery, to a point of wanting/needling something else as well as that which we already have and use; a third generation to further our understandings of our birthing and midwifery worlds and in order to (re)invent viable lives for childbearing women and midwives. We come to ‘[...] Kristeva’s theoretical starting point’ where ‘the subject must be thought in entirely new ways’ (Jardine 1981:11). Kristeva asks another question which is useful for midwifery as it holds on to liberal and radical feminisms and begins a new-to-midwifery discursive and embodied turn:

_"What discourse [...] would be able to support this adventure which surfaces as a real possibility, after both the achievements and the impasses of the present ideological reworkings, in which feminism had participated?"

(Kristeva 1981:34)
Jenny: ‘Hey dad, the senior nurses at our local hospital staged a coup and made the Director of Nursing resign because they didn’t think she was doing a good job! It was a massive fuss!’

Steve: ‘It won’t do any good, Jen. They’ll just appoint another one.’

That’s exactly what happened.   

JB’s journal

The following chapter looks at the Kristevan third generation, or midwifery as a (feminist) poststructuralist practice of responsibility/freedom.
An ethics of responsibility:
working in/from the (im)possible, the (un)known

Consequently the time has perhaps come for each and every woman, in whatever way we can, to confront the controversial values once held to be universal truths by our culture, and to subject them to an interminable analysis. In a sense this may be a theoretical task; it is above all a matter of ethics.

(Kristeva 1987:116-117)

In this chapter I bring to the foreground the ways in which midwives think and act against the grain, in order for me to consider an ethics of responsibility for midwifery. Here I work to unpick midwives’ ethical responsibilities towards difference and away from sameness, rules and order. While midwifery does not generally recognise itself as poststructural, I believe that midwifery (on a good day) is a poststructural practice. In this chapter I spotlight moments in which midwives (already) move in poststructural ways and in doing so I argue that if midwifery is a poststructural practice, as I believe it (sometimes) is, then a serious reflexive turn for midwives informed by poststructural theory is easily imaginable and desirable. It is also responsible.
Feminist poststructural practices promise the possibility of a more viable [midwifery] life (Butler 2004b). They promise us (momentary, uncomfortable) release from humanism’s ways of fixing identity and meaning, from its knowing rationality (Weedon 1997). Feminists ‘[…] use poststructural critiques of language, particularly deconstruction, to make visible how language operates to produce very real, material, and damaging structures in the world’ (St Pierre 2000:481). I believe that theorising midwifery using poststructural ideas helps the understanding (and legitimisation if that is what we seek) of childbearing women’s and midwives’ work in the (un)known, the (im)possible and, in so doing, provides a new framework for practice. Poststructural theorising moves midwifery towards openness. It moves midwifery towards difference, in the multiple senses of Derrida’s play with/on to differ (in space) and to defer (to put off, to postpone in time), where difference functions as a moment of doubt; difference in ‘[…] neither time nor space and makes both possible’ (Bass 1978:xviii). Feminist poststructural theory and practices open the doors and windows of midwifery’s house and let the winds of difference blow away the order we seek/demand/grasp as midwives caught up in modernist discourses of the medicalisation of childbearing. I believe that childbearing women and their families can benefit if midwifery makes this reflexive, theoretical turn. They, too, may increase their possibilities for (more) viable lives, which in one sense is what matters most to midwives. It is theoretical work that needs to be done, this work surrounding the bearing and rearing of children. It has an importance for us all, as Judith Butler recognises:

*Part of rethinking where and how the human comes into being will involve a rethinking of both the social and psychic landscapes of an infant’s emergence. Changes at the level of kinship similarly demand a reconsideration of the social conditions under which humans are born and reared, opening up new territory for social and psychological analysis as well as the sites of their convergence.*

(Butler 2004b:4)

After many years of working with and through poststructural theory and practices, I believe there is much to be gained, however uncomfortable it might/will be, by (further) opening up midwifery to a third generation, to the possibilities held within Kristeva’s (1981:33) ‘fluid and free subjectivity’. Elizabeth St Pierre (2000:478)
says this is difficult but important ethical work: ‘Surely this is the hardest work that we must do, this work of being willing to think differently’. We have seen in previous chapters that childbearing women and midwives work often in surprising spaces/times, in the profound/profane, the (im)possible, the (un)known, and yet at other times/spaces they are constituted, as they constitute themselves, as being closed to possibilities, as wanting order and assurances with which to keep the birthing world knowable and, thus, manageable.

In this chapter, then, I undertake overlapping and intersecting work. First, the chapter moves through a theoretical exploration of the (poststructural) responsibility of becoming (more) open to possibilities, to the unknown. I look at how midwives in practice both take up and resist ways of being which fracture and multiply the known, arguing that as midwives we have a responsibility to do (im)precisely that work. By looking at some of the ways midwives use a more poststructural perspective in practice, I explore the possibilities for further disrupting midwifery’s signifying processes, for increasing midwifery’s possibilities and for finding new and useful ways of being in the world. In disrupting our ‘safe’ midwifery world, I also seek to interrogate Butler’s (cited in St Pierre 2000:478) awkward poststructural question of why we ‘[…] come to occupy and defend the territory we do, what it promises us, from what it promises to protect us’. My second mission is to contribute to the subjectification of midwives by my writing, a broad task of this thesis, but one which has particular relevance in this chapter. By using poststructuralist writing strategies to resist and subvert discourses through which we are constituted (Barthes 1977) and through which midwives constitute themselves, I explore the folds, the possibilities, held within the uncomfortable idea of ‘multiple midwiferies’. Just as working in (un)comfortable spaces with childbearing women can bring midwifery to an (un)comfortable space of its own, a space where theorising and practising differently becomes possible, so too, working in my own (un)comfortable writing space opens up midwifery, and me, to a different theorising which perhaps may move us towards a ‘new image of thought’ (Deleuze 2004:93) for our precious craft.

In this chapter I suggest that we, midwives and midwife-academics, and everyone in the maternity health disciplines, bear a responsibility for a reflexive examination of
how our knowledge is continually constructed and how those constructions affect us and our day-to-day work with childbearing women. Using what we learn from childbearing women in the spaces/times of the (un)known, the (im)possible may be useful poststructural tools to look at ourselves and our practices. As well, using what we learn from looking at ourselves and our practices may be useful poststructural tools to teach us how better to ‘be with’ childbearing women in the (un)known, the (im)possible. There is an urgency to undertake this complicated, useful, discomforting and, I would suggest, necessary, work. This is our midwifery responsibility.

(Moving on from) Midwifery as ‘truth on our side’

Claiming to own the truth is ‘a recurrent element in justificatory schemes’ (Flax 1992:458). Midwifery discourses function as/in an embodied and social place of ‘truth’, a truth simultaneously (knowingly and unknowingly) joined with, and pitted against, the dominating discourses of science, technology, obstetrics and, in Australia, nursing as well. These discourses all have a hand at speaking midwives into existence as midwives and in creating midwifery’s belief in itself as an ‘unquestioned good’ (Spivak 1993:47), as having truth on our side. Whether because of a desire or a need for survival, or because of a desire or a need to thrive, or both, I believe midwifery does speak of itself as a truth, in the sense that Jane Flax writes:

A belief in the connections between truth and knowledge at this point in Western history seems far more likely to encourage a dangerously blind innocence rather than to prepare the ways for freedom or justice. We should take responsibility for our desire in such cases: what we really want is power in the world, not an innocent truth. The idea that truth is on one’s side is a recurrent element in justificatory schemes [...]. We are often seeking a change in behaviour or a win for our side.

(Flax 1992:458)

Midwifery politics and practices, often (un)consciously, seek power in our world and a win for our side. Midwifery often sets itself up (as it is set up) in binary opposition to obstetrics, and in so doing, produces inside its own discourses what Lyotard calls a (grand) narrative about emancipation (cited in Weedon 1999:109). In the ‘midwifery as truth’ model, midwifery locates itself in opposition to obstetric power,
to save women (and midwives) from the practices and power games of the medical model. In this way midwifery creates a discourse of emancipation; a grand narrative of liberation from obstetric (and in some times/places, nursing) oppression.

Midwifery, as truth and therefore as salvation, constitutes two kinds of midwives in the practice arena, as we saw in the previous chapter. Some midwives, or perhaps more accurately, midwives sometimes, move towards more liberal or radical feminist positions and are spurred into political action. They fight for access and celebrate womanhood. They want to change the known because they hold the truth about maternity care. They construct childbearing women as benefiting more from midwifery than medicine. They constitute midwifery as making women physically safer, more emotionally rounded, more connected to their own bodies, more ready to mother and more useful to themselves, their babies and to society as a result. They celebrate knowing the woman. Other midwives, or again perhaps more accurately, midwives sometimes, who make up the second (mobile) group, batten down under the weight of the dominating discourses of obstetrics and nursing and become midwives who value certainty. They honour knowing what to do for and to women. Midwives in this space/time constitute themselves as valuing the medical model. They see childbearing as a (potentially) dangerous medical condition and utilise a more mechanistic view of the body from which to carry out their work (Davis-Floyd 2001). The midwives in this group are often informally referred to, inside the midwifery discourse, as ‘obstetric nurses’. This is a term I find both less than accurate and less than kind. In my view midwives in this group are taking up one of the available midwifery subject positions, a conservative one, inside the dominating medical discourse where being sure of knowing what to do and doing it reigns supreme. However, these midwives still employ the fractured discourses of being ‘with woman’ which sometimes means, often surprisingly for these midwives and others around them, they find themselves working with women in the (un)known.

A belief in midwifery as a truth leads midwives in the first group to their fight for access and celebration and for those in the second group makes available an (un)comfortable position inside the obstetric, technological and nursing discourses while still allowing a (sometimes tiny) space in which to function as a midwife. These midwifery subject positions are not in binary opposition to one another.
Midwives move in and out of these two discursive positions, taking up (neither and) both simultaneously and often ambivalently. Both create, and are created by, midwifery as a ‘truth’, not withstanding that they hold different truths in each group (natural/normal versus techno/medical).

Midwifery needs more (viable) options both within and outside the dominant and resistant discourses around childbirth where midwifery can disengage from itself as truth and engage in multiple possibilities. Poststructural theory is a way to help do that work. It suggests that there is no one truth. In its place we find a range of competing and overlapping historically specific discourses which make claims to the truth (Weedon 1997). These truth claims structure a hierarchy of truths, formed by the power relations discursively constructed within them. Some voices and versions are privileged over others, just as different voices and versions are privileged in different contexts, even by the same speaking subject. All then is not equal, which means that ‘[w]ho and what is privileged is an ongoing site of political struggle’ (Weedon 1999:108). However, we often act in the maternity health system including and especially in midwifery, obstetrics and midwifery education, as if we can hold/find ‘one truth’ about working with, and being, woman. However, as we have seen in earlier parts of this work becoming midwife includes not only taking up a ‘with woman’ discourse in all its complexity, but also taking up and being taken up by other competing and overlapping discourses and seemingly incongruent positions: positions of power, of selflessness, of surveillance, of judgement, of guardianship, of subservience, of responsibility. Midwives take up multiple positions simultaneously and yet we tend to understand subjectivity in midwifery (as in other places/times) as holding one subject position (at a time).

However, even trying to settle for one truth (even if it was desirable and I believe it is not) narrows our understandings and our possibilities. By accepting and embracing multiple truths, overlapping and competing discourses and that which is unknown to us, we gain more room to manoeuvre, to query, contest and change practices, which allows more and different possibilities for social justice (St Pierre 2000:493). This, I believe with Judith Butler, is a work of necessity:
Lastly, I would ask what place the thinking of the possible has within political theorising. [...] it has to do with the ability to live and breathe and move and would no doubt belong somewhere in what is called a philosophy of freedom. The thought of a possible life is only an indulgence for those who already know themselves to be possible. For those who are still looking to become possible, possibility is a necessity.

(Butler 2004b:219)

Poststructural possibilities, modernist moorings...

Postmodernism calls into question the belief (or hope) that there is some form of innocent knowledge to be had. This hope recurs throughout the history of Western philosophy (including much feminist theory). While many feminists have been critical of the content of such dreams, many have also been unable to abandon them.

(Flax 1992:447)

I see myself mirrored in Jane Flax’s words. I think I have given up the very tasty idea of innocent midwifery knowledge and yet I find myself caught out, again and again, saying, doing, writing and acting as if midwives own the high moral ground in health, especially as it relates to access to the public domain and celebration of womanhood. So I am strangely comforted by James Schurich’s (1997:175) suggestion that unhooking from our ‘deeply modernist moorings’ is a very difficult task, perhaps even an impossible one. In research (as in life), moving away from realism requires a huge shift in philosophy and is a complicated process because ‘[...] realism is so endemic to the way researchers ‘naturally’ think and especially to the way they think about research’ (Schurich 1997:176). We are steeped in realism and think it is normal. As Kathy Ferguson (1991:327) puts it, ‘We make up our claims to truth, Nietzsche states; then we forget we made them up; then we forget we forgot’.

As I (re)type this chapter I feel nervous and uncomfortable; treacherous almost, but exhilarated too. This entire doctoral work is about unhooking from my/our modernist (midwifery) moorings and I love the fact that feminist poststructuralism can help us do that. Why then does my heart rate increase in this section? I suspect because, at the risk of mixing my metaphors, a belief in ourselves as useful, as right, is midwifery’s Holy Grail, as it has been mine for twenty years. As I open this space
in which I seek, in Flax’s words, to (further) disrupt midwifery’s innocence and to (further) abandon midwifery dreams (which are clearly precious to me), I flash on to a memory of an adolescent holiday plan to swim our river from bridge to beach, a course of several miles:

The river is wide, known and loved: the Murrumbidgee of my childhood. We are good strong swimmers from a lifetime of 17 summers in the hot inland of a dry continent but the current out in the middle, downstream from the landmark bridge, is new, winding, strange, uncharted. The wide brown water surrounds me, envelops me, comforts and cools me. Calm, I float on, the sky blue and hot above. I hear the others around me, sometimes chatting, sometimes nervously giggling. We are together and alone, (ir)responsible.

But the river is both friend and foe and unfamiliarity causes panic. We are miles from the bridge, miles from our beach. We float with the current past river banks which are high and inhospitable. Suddenly, I reach out to catch on to the snags as I pass. They slow me down, help me stop, give me somewhere to rest but they are sharp and slimy. Even as I splash and grab, I wonder if the hurt caused by clasping the partly submerged branches is worth it. I wonder, what purpose trying to hold on when I want to be free, floating out here in the middle, as planned?

I am carried around the last bend and swim over to our sand, tired, relieved and nervously exhilarated.

I was scared in and of my river. We are no longer innocent, my river and I. I type with scratched hands and fast heart.

JB’s journal

Now, as then, I push myself further and further into the (post) river, out towards the doctoral adventure in the middle. Thirty two years after our Murrumbidgee escapade, I am both calm and panicked but in my already-hot-in-the-morning study at the beginning of a new inland summer, I remind myself that I want to go where the freedom of letting go will take me. Poststructuralism helps me see the world differently. I believe in multiple truths. I do. I do. And yet when I re-read Jane Flax’s (1992:445-463) denial that there is ‘some form of innocent knowledge to be had’, I see myself (floating with my sisters) down the midwifery river, not just heading for the realist snags, but rather, reaching out for them to save me, believing in them, acting like the cuts and bruises and slime are worth it, resting from the fast flowing (unk)nown of my own and others’ making. Can we swim/float on our midwifery way to the (un)thought? Can we not?
Davies and Gannon describe the usefulness of poststructural theory to the understanding of a ‘precious’ discourse:

Agency in poststructuralist writing is not understood, then, in terms of an individual standing outside or against social structures and processes. Agency becomes instead a recognition of the power of discourse, a recognition of one’s love of, immersion in and indebtedness to that discourse, and also a fascination with the capacity to create new life-forms, life-forms capable of disrupting old meanings of gender, even potentially overwriting or eclipsing them. Poetic and multilayered writing becomes a central tool in those attempts to both recognise and eclipse gendered discourses and regulatory practices through which we are constituted.

(Davies and Gannon 2005:319)

I love and am immersed in and indebted to midwifery discourse and I love the capacity poststructural writing has to disrupt old certainties and invite multiple speaking positions. In some ways I accept midwifery, readily and daily: the being with, the usefulness, the beauty, the connection, the generosity enfolded within the work. In other ways I reject midwifery: spending my midwifery/teaching/academic career spotlighting, undermining, what I see as strangeness, oddity, weirdness, the bizarre even, in order that it can be different, otherwise. I know that seeing ‘truth’ as ‘multiple, historical, contextual, political and bound up in power relations’ (St Pierre 2000b:26) does not mean that there are no truths or that one truth is as good as another. Indeed, multiple and contextual truths call for discerning engagement with particular problems which do not have ‘generalisable solutions’ (St Pierre 2000b:26) and which require thought which is ‘still in the making’ (Peters 1999:paragraph 7.4).

Midwives’ work with/in the realm of the profound/profane and ‘being with/being useful’ propels us into times/spaces of the (im)possible, the (un)thought. This propulsion into the (un)known creates/demands a more open subject. The demand to be open to the other often comes as a surprise to learners of midwifery and to those for whom midwifery is not new but who realise that demand at some moment(s) later in their careers. Midwives find themselves being taken/pushed/led further out by childbearing women’s embodied experiences of the (un)known. This is the space/time of surprise where women ‘go up the mountain’ and midwives go with them, spaces/times in which women and midwives find themselves challenged, where they are working in the yet-to-be-thought. This space/time too has been
discussed in earlier chapters. Here, midwifery subject positions which go beyond (or through) the first and second generations of feminism into and away from the third makes a more mobile, fractured space/time at the points of overlap in discursive practices: health and illness, mind and body, male and female, connection and aloneness, language and silence, the known and the unknown, and responsibility and freedom. In these spaces/times of less belief that we know what is right, less certainty of what is going on and more desire to just ‘be with’ and wait and see, truth becomes multiple, contested and just not so important. In a third generational time-space, truth becomes not something which one group owns, but something about which one may be curious and take or leave. The midwife enters Weedon’s (1997:32) realm of the ‘precarious, contradictory and in process’ subject, one who is ‘constantly being reconstituted in discourse each time we think or speak’.

Poststructuralism can help midwifery look at its belief in itself as a truth and at its end as an unquestioned good. Midwives, including me, (often) believe that midwifery can free all childbearing women (and in the process, midwives) from oppression. I know, as do many midwives, that the ‘freedom from oppression’ discourses have served us well, and we them, and they will probably always be part of our discourse but is it that we are now snagged on those truth-holding discourses? Do we speak midwifery (into existence), unhelpfully, as the truth, as an ‘unquestioned good’, the way that medicine speaks itself in as the truth, an ‘unquestioned good”? Often in midwifery’s (feminist) work for access to the public domain and in its beliefs about women as essentially ‘celebrate-able’, I believe we do see midwifery view itself as a truth. However, to view the world otherwise is (perhaps more) complex and uncomfortable, even while I see it might be life-changing and exhilarating. It may even be useful and responsible.

Gladly because of (feminist) poststructuralism I am at least in the (post) river, where I believe there is more room for affirmation and joy by unpacking our, my, precious midwifery. According to Gilles Deleuze, who said, using Spinoza and Nietzsche as examples:

*If you don’t admire something, if you don’t love it, you have no reason to write a word about it. Spinoza or Nietzsche are philosophers whose critical and destructive powers are without equal, but this power always springs from*
affirmation and joy, from the exigency of life against those who would mutilate and mortify it. For me, that is philosophy itself.

(Deleuze 2004:144)

Judith Butler (1998:2) agrees with Deleuze, writing that ‘(t)o deconstruct a category is not to eliminate it; it is precisely to make an inquiry into a category that we cannot do without’. Michel Foucault (1994:336) suggests that ‘Maybe the most certain of all philosophical problems is the problem of the present time, and of what we are, in this very moment. Maybe the target nowadays is not to discover what we are but to refuse what we are’. Refusing what we are carries risks, of course. The effects and the processes of poststructural theory can be read as anti-liberal and anti-feminist, and may well be read as ‘anti-midwifery’ but as Spivak writes:

This is the risk one must run in order to understand how much more complicated it is to realise the responsibility of playing with or working with fire than to pretend that what gives light and warmth does not also destroy.

(Spivak 1993:283)

So down the (precious) midwifery river I swim and float (and clutch and grab) with Jacques Derrida and Judith Butler and Julia Kristeva and Michel Foucault and Gilles Deleuze and Gayatri Chakravorty Spivak and Bronwyn and Alison and the other midwives I love for company. I am also alone.

Poststructural responsibilities in the (midwifery) everyday…

How then do we proceed forwards, backwards and sideways, to a less comfortable midwifery, a midwifery that tries to be accountable to complexity (Lather 2001), a midwifery under erasure (Spivak 1974)? How can we be ‘with woman’ and trouble being ‘with woman’? How can we upset the very category of midwife and yet remain useful and connected to women in our work? How can we both live in the House of Midwifery and in the same moment trawl its ruins (Lather 2000)? How can we keep a grasp on what and who made us ‘midwife’ while we hold on to a ‘desire for futurity’ (Probyn 1998:134)? What could come with being open to ‘the possibilities of the impossible’ (Derrida 2001:63)?
A re-focus on ethics in poststructuralism grew out of the work of Levinas, Derrida and Foucault, where responsibility emerged as a major issue and where ‘not knowing what to do became the grounds for rethinking the “ethico-political”’ (Lather 2004: no page number). Deleuze and Butler also call for ethical disruptions to the ‘ongoing repetitive citations of the known order, citations which offer some a viable life and at the same time deny it to others’ (Davies Forthcoming). This call to responsibility is both a political and an ethical movement. Increasing our ‘capacity to recognise multiple readings’ means that ‘no discursive practice, or positioning within it by powerful others, can capture and control one’s identity’ (Davies and Gannon 2005:318-319).

I believe we have a responsibility not to close ourselves and others off to possibilities, especially if we do so because we are uncomfortable. Dominating discourses in midwifery can fuel ignorance, fill us with debilitating fear, enforce a certain morality upon us, and close us to difference, all of which contribute to a nervousness towards the other and demand of us positions more closed to possibilities. If we are closed to possibilities, childbearing women’s possibilities are also affected. Therefore, midwives need to consider not only the positions we take up and are given inside dominant discourses but also how we ‘word the world’ (St Pierre 2000:484), because just as humanism is inevitably part of us in our society, so humanist/realist discourses become normal/natural, including those of our own construction, and it is hard to think and act outside them (St Pierre 2000).

‘Poststructuralism does not allow us to place the blame elsewhere, outside our own daily activities, but demands that we examine our own complicity in the maintenance of social injustice’, writes Elizabeth St Pierre (2000:484). Using Deleuze, she reminds us that we speak our world into existence, just as surely as we are spoken in (to) it. Poststructural theory burdens us with the responsibility of understanding how we construct ourselves and others, at the same time as they construct us and themselves. Davies (Forthcoming) calls for an urgent need in the context of schooling, a need which I believe has equal urgency in midwifery, ‘for a reflexive examination of how that which grants one pleasure and security and power may be harming others, withholding from them a viable life’. If we understand midwives’ work with childbearing women to be that of the time/space of the (un)known, the
(un)thought and (im)possible, then I believe midwifery’s responsibility to value and seek difference, in order to work in and out of the times/spaces of the (un)thought, urgently needs to be facilitated, encouraged, recognised, brought to the foreground and developed. Viable (childbearing and midwifery) lives, I believe, require opening up of possibilities, not a closing down of them. Butler (2004b:8) suggests that we need to stop ‘legislating for all lives what is livable only for some, and similarly, to refrain from proscribing for all lives what is unliveable for some’. Poststructural theory gives us our best ethical chance to be open to the other, to answer Derrida’s call ‘to proliferate and maximise difference’ (Grosz 2005:92). I believe, as those who use poststructural theories do, that we carry a responsibility to resist (local and specific) dominating discourses, including those we take up as our own. We also carry a responsibility to try to deconstruct both our resistances and whatever fluid, ever-changing products come from them. Working with women in the (un)known demands that we cast doubt upon our certainties. In this, midwives carry a particular ethic of responsibility. Laurel Richardson (2000a:7) writes about poststructural research that ‘[n]o method has a privileged status’. Likewise, by casting doubt on what we consider precious and true, midwifery opens itself up to ways of thinking and being which is less constrained by binary logic and ‘rules’ about what is normal and acceptable and ‘allows’ new possibilities for childbearing women (and midwives), new possibilities which in turn can be and must be critiqued (Richardson 2000a:7).

Foucault once stated that, as important as the fight for basic and legal rights for homosexual people was, the ‘real target was the general impoverishment of social relationships in contemporary society’ and with that in mind he urged people to ‘try and invent something else’ (Rabinow 1997:xxxvii). He explained:

*We live in a relational world that institutions have considerably impoverished. Society and the institutions which frame it have limited the possibility of relationships because a rich relational world would be very complex to manage. We should fight against the impoverishment of the relational fabric.*

(Foucault 1997:158)

Rabinow (1997:xxxvii) depicts the responsibility to work for a ‘rich relational world’, described by Foucault, as work which is ‘not only ethical, it is also political;
but it is politics without a program’. Elizabeth Grosz (cited in Parkins 1999:378) argues that ethics ‘is not opposed to politics but a continuation of it within the domain of relations between the self and other’. Wendy Parkins (1999:378,384) calls for a feminist ethic in which ‘claims to autonomy are considered alongside the claims of the other’, one which is ‘lived in the midst of living people […] where the primacy of the other’s right to exist summons us to pay attention and to act’. Julia Kristeva, too, is clear about our ethical responsibility:

Consequently the time has perhaps come for each and every woman, in whatever way we can, to confront the controversial values once held to be universal truths by our culture, and to subject them to an interminable analysis. In this sense this may be a theoretical task; it is above all a matter of ethics.  

(Kristeva 1987:116-7)

I believe we have an ethical responsibility to undertake this task in midwifery.

Possibilities for viable (midwifery) lives…

While in some sense midwifery can be viewed as being snagged on the first and second feminist generations of access and celebration, in other times and spaces midwives’ work calls them every day towards a responsibility for openness, for otherness. Midwifery discourses and practices at work with childbearing women go beyond (or, in front of) the first and second generations of feminist understandings into the third generation, poststructuralism. In the minutiae of their body work with childbearing women, midwives embrace the work of helping make viable lives. They embody the belief that a viable life includes everything, in the sense of Cixous’s (1991:347) claim, that ‘living means wanting everything that is, everything that lives, and wanting it alive’.

Childbearing women in their work of bearing the next generations ask midwives to undertake ethical work which Parkins (1999:378) describes as a demand for us to ‘pay attention and act’. Because of this, midwives navigate the complexities of major philosophical and practice standpoints every day. In doing or attempting to pay attention and act, midwives open the spaces between binaries male/female,
risk/safety, illness/wellness, abnormal/normal, working with/caring for, intervening/waiting, choice/need, fast/slow, outside/inside, practice/theory and many others which function simultaneously in the practice arena. Opening momentary spaces in which to do connected embodied work is the work of midwifery, work which is simple and complex, often hidden, sometimes not attainable, or even desired. Midwifery’s ability to see and value difference often comes by surprise, out of its positions of resistance. It is our refusal of what we are (Foucault 1994) which opens and closes possibilities. Butler (1992:7) says our task is to ‘interrogate what the theoretical move that establishes foundations authorises, and what precisely it excludes or forecloses’. In some sense, obstetrics, with its robust beliefs in its own truths and the societal and personal power to achieve its own agenda, makes midwifery what it is. Midwifery and obstetric discourses are oppositional and dependent on one another. Deconstruction entails disrupting, overturning and allowing some play between these discourses, enough play to become uncomfortable enough to look at what it and we authorise, exclude or foreclose. In the dailyness of midwifery work, midwives are often called by women’s needs and experiences and desires (and our own) to a responsibility to do just that. We are called to fluidity as Kristeva writes:

> In order to bring out – along with the singularity of each person and, even more, along with the multiplicity of every person’s possible identifications (with atoms, eg. stretching from the family to the stars) – the relativity of his/her symbolic as well as biological existence, according to the variation in his/her specific symbolic capacities. And in order to emphasise the responsibility which all will immediately face of putting this fluidity into play against the threats of death which are unavoidable whenever an inside and outside, a self and an other, one group and another, are constituted.

(Kristeva 1981:35)

Midwifery, every day, demands that midwives work with childbearing women and babies and newly (re)formed families in the spaces/times of ‘fluid and free subjectivity’ (Kristeva 1981:33). Most midwives would not use those words to explain their practice because midwifery has not (yet) really embraced a poststructural discourse. However, midwives do discursively construct multiple and fluid possibilities in their work. The following stories from midwifery practice and teaching spotlight some of these moments.
In the following story Megan speaks of a fluid identity in her previous work as a home birth midwife. Megan works to (re)call her relationship with/in the discourse of fear, a common discourse in the neoliberal times of our maternity care system (Murphy-Lawless 2000; Morris 2005) and in doing so speaks herself (into existence) as an (extra)ordinary practitioner:

"I didn’t think it was scary, Jenny. I just didn’t think it was. I just did it. I was careful and thoughtful but it seemed so normal to me. I didn’t feel overburdened with responsibility. I just did it, really, without thinking too much. Women would just ring me up and ask if I would be their midwife and I would say yes, basically, if that was what they wanted. I had a great mentor and we had a wonderful support group of other home birth midwives. We supported each other. We did peer review, in a supportive way, around someone’s kitchen table or lounge room, before it was fashionable. We used to put our practice on the table for us all to see. Sometimes they would have great insights but often they would just listen, with love. But I was not scared, Jenny. I hear midwives talking about risk and fear now... it’s like another world to me. I sometimes wonder now if I missed something but I don’t think so. I have never done anything where I work from a basis of fear.

Megan, JB's Journal

Here Megan makes a move to refuse the fear/trust binary of the dominant discourses and in doing so positions herself, as she is most likely positioned by her home birth clients, in the unknown, in the midwifery ruins. Megan views birth as a social event, not a medical one. She speaks of birth as being inside the family, outside what Marsden Wagner (1994) calls The Birth Machine. In positioning birth so, Megan is able to refuse (most of) the constraints of the dominant half of this powerful fear/trust binary. She meets the request for midwifing at home from women ‘if that is what they wanted’ without much fuss. To her this is not a burdensome chore. Here we can read Megan as seeing herself carrying a responsibility to maximise ‘the possibilities for a viable life’ (Butler 2004b:8). Megan constitutes birthing and therefore midwifing at home as normal/natural ‘[…] it seems so normal to me’ and in so doing, creates a space in which to do her midwifery work. Megan now has moved from midwifery to the work of midwifing the dying and while she talks of risk and fear as if they are new concepts, they are not. They certainly were in evidence in the years when Megan practised at home, although it is true to say the discourses of fear and risk have become more strident in our neoliberal times. We know that once a discourse becomes ordinary, including those of our own construction, it is hard to think and act outside it (St Pierre 2000). Here Megan
seems to manage that. She seems to undertake a (poststructural) doubling back on risk, both doing ‘birth as normal’ and troubling it. The discourse of fear and risk hold much sway in our society (Morris 2005) and as she hears other midwives talk of fear, we see her wonder if she ‘missed something’. We see, too, that she takes up (self) regulating and controlling practices which can be viewed as neoliberal ones (Davies and Bansel 2005). She undertakes risk managing strategies: peer review, collective learning, mentoring and interpersonal support. Yet even though she describes her peer review process she does not seem to hold it solely responsible for her safe practice. Nor is it related only to Megan’s own internalised form of surveillance (Foucault 1977): ‘I was careful and thoughtful’. Megan refuses to be fully subjugated in the place/time where ‘[p]ower disciplines and produces subjects – subjects caught in the web of the minutiae of endless self-regulation’ (Henriques et al. 2002:464). For Megan, safe practice is also related to a lack of fear. While she constitutes herself as open to both the possibilities of non-institutionalised birth and midwifery, and to some not-yet-fashionable risk management strategies, we are left with the impression that Megan reads herself as not fearing birth or women: ‘I was not scared, Jenny’. A life (too) privileging of the dominant side of the binary, fear, and too dismissive of (one of) its binary opposite, trust, is ‘like another world’ to her. Megan does not seek or seemingly require the order imposed (Flax 1992) by fear. Megan’s refusal of being fearful of birth (and women) means that she can let the concept of fear ‘float freely’ (Flax 1992:457). For Megan in reading herself (into existence) as never working from a basis of fear, lives a midwifery life of hope. She is prepared to work in spaces/times of possibilities with/for childbearing women as she positions herself in the (responsible) unknown.

Alison, too, refuses to be caught (up) in the binary logic of the dominant discourses. When I ask her if she thinks midwifery and obstetrics are binary opposites, Alison invokes something quite different. In talking here about obstetrics she describes a process where she tries to achieve for women what they and/or she sees they need by making new possibilities:

Well, [obstetrics] has kind of made us what we are, hasn’t it? (Laughs) That’s the trouble. I don’t know if you would say it is opposite or not... It’s not opposite - I mean we try and work alongside to a point (laughs). [...] We try and do the sliding. It’s kind of more than sliding... it’s weaving really, isn’t it?
Sometimes it is weaving and it’s like a hint of mesh or net… but it has like a hint of… I can’t think of the word… duplicity about it, or what’s another word? Because you are doing it for your own ends… Really [I mean] devious, I suppose.

Alison, interview

In refusing to be constrained and constructed by this binary split of her midwifery world, Alison also refuses the very categories which constitute that binary: midwifery and obstetrics. She understands that midwives’ subjectivity, like that of birthing women and obstetricians and others in the health system, not only speaks itself into existence but, as Davies (2000:85) writes, is spoken into existence, in every utterance, ‘inside the male/female dualism, socially, psychically, physically’. Alison speaks obstetrics (into existence) not simply (complicatedly) in opposition to midwifery but as something which has ‘kind of made us what we are’. Alison identifies a [midwifery] subject which is ‘[…] precarious, contradictory and in process, constantly being reconstituted in discourse each time we think or speak’ (Weedon 1997:32). Alison’s mesh has connotations of being all-covering or all-connecting and yet of allowing, perhaps even fostering, breath and movement. She doesn’t call it a blanket, it is a mesh – open and mobile yet constraining and containing and connected. She laughs somewhat cynically as she says midwives try to work alongside the discursive field of obstetrics, because she and I both know how hard it is to do that, and not be swallowed up by this powerful discourse. Yet she continues on, trying to explain how midwives and obstetricians are connected in a non-hierarchical way. Yet this ground is not firm underneath her. She speaks of a slippery slope, a slippery slope on which (only) midwives ‘do the sliding’. In using multiple metaphors, Alison proposes not a binary opposite - she denies that - but a messy coupling of mixed, woven, interdependent subjectivities. She clearly has an agenda to be ‘with woman’ and yet she has no need to position obstetrics in binary opposition, as other, as ‘without woman’. She circumvents the powerful/powerless position in this way and in doing so creates a new/old time/space, albeit with some irony, for midwifery, a time/space in which to live (un)comfortably with obstetrics, in a land of mesh. It is a slippery space/time of unknowns and impossibilities. We hear this in Alison’s laugh and in the movement of her net.

Foucault (cited in Butler 2004b:215) suggests that one of the first parts of critique is to distinguish the relationship ‘between mechanisms of coercion and elements of
knowledge’. After struggling for an appropriate label, Alison suggests what goes on in midwifery is ‘devious’. There is a sense in which she calls up the ubiquitous nurse-doctor relationship, where nurses/midwives get what they want for ‘their patients’ by devious means, playing gender ‘games’, ‘suggesting’ treatments and plans of management couched so that the doctor thinks he (advisedly) thought of it himself (Gordon 2005:63). In another sense, Alison attempts to distinguish between coercion and knowledge. She begins by suggesting midwifery slips and slides between the two but this explanation doesn’t suffice in surfacing the complexities of the ongoing relationship between the two disciplines. She then doubles back and accuses herself of sliding and weaving to try to achieve what she knows to be useful to women. Yet she refuses a powerless position on the non-dominant side of the medicine/midwifery binary. In her refusal to name midwifery and obstetrics as binary opposites, Alison ‘words the world’ in such a way as to spotlight the complexities of midwifery’s both knowing and coercing. Even as she refuses to separate midwifery and obstetrics into opposites, so she also acknowledges the relationship between the mechanisms of coercion and elements of knowledge in the practice arena. She sees both in her story and she reads them as messy. Instead (or as well as) she takes up the responsibility of lives as they are lived in/under/above/through the mesh of practice, in the House of Midwifery and in the ruins, where ‘[k]nowledge and power are not finally separable but work together in a set of subtle and explicit criteria for thinking the world’ (Butler 2004b:215). Alison constructs a space/time of possibilities and in doing so makes room for women, midwives and obstetricians.

Maureen finds another way towards a more fluid identity for birthing woman and their midwives in the following words:

[...] I think the other thing is it felt like we were doing something really old, something really noble, something old and for me the best thing was how mysterious it was and how precious that mysteriousness was from quick-fix, globalisation, packaged, sanitised world that we live in. That we couldn’t tell somebody how long a labour was, we couldn’t tell them what their baby would look like - gradually it was becoming that people want to know the sex of the baby now but the mystery - and how much I used to enjoy when people would say how "long would it be until...?" - and I would say "If I knew that...!" And how acceptable it was for me not to know that, and how proud I was not to know, and that helped me through lots of hard times because it’s not ours to know
Maureen’s interview

We see work in the space of the third generation here as Maureen tries to be accountable to complexity (Lather 2001). We can read Maureen as refusing the knowledge/ignorance binary by privileging ‘not knowing’ and by elevating midwifery above those who seek to know. In her opening up of another space/time, Maureen creates ‘an ongoing site of political struggle’ (Weedon 1999:108) a potential space between the midwifery/science or midwifery/obstetrics binary. Maureen constructs science and obstetrics as needing to know and midwifery as having different knowledge, knowledge of not knowing. Midwifery, in her construction, is content, privileged even, to not know. We see work of all three generations at play in Maureen’s words. Her fight for access to the naming rights of legitimate knowledge is informed by the work of the first generation. We hear a celebratory tone too about Maureen’s words. ‘It’s OK not to know everything about being a woman in that mystery’ suggests an immersion in the essence of womanhood, a discourse which calls up the identity struggles of the second generation. At the same time, and in the moment, Maureen constitutes herself (as she is also constituted) as seeking more fluid/fractured possibilities towards more viable lives (Butler 2004b) for all. She commits to (trying at least) the ‘full elaboration of difference and its uncontrollable and uncontainable movements of differentiation or becoming’ (Grosz 2005:92). She constructs a pleasurable midwifery time/space, a space of not knowing and discomfort, a space that lives difference. She speaks this time/space in as being (becoming) midwifery, a space made by cracking open the knowledge/ignorance binary of medical dominance.

Maureen reads herself as not having to be in control and this grows a freedom which becomes part of her midwifery (ir)responsibility. Maureen seems content that she cannot answer the big questions. Indeed, she seems happy that there are no answers. She feels no obligation to make up a time the baby might be born, no need for small talk about who the baby might look like. We see her constituting herself as midwife-connected-to-past-midwives and in so doing she joyfully releases herself and the labouring women and their partners and families into the ‘old’, ‘noble’, ‘precious’ and ‘mysterious’ (un)known. In connecting with the midwifery past, she also
unravels the fast/slow binary of modern midwifery practice. She dissipates the need to hasten labour with drugs or by breaking waters. By aligning with past wisdoms, with an earthier, connected midwifery position she becomes less concerned with timing and counting; and more concerned with the woman’s body work (Murphy-Lawless 2000; Kitzinger 2003). Maureen also takes up a sense of the future in the dailyness of her midwifery, in her third generation work towards a more fluid subjectivity for both birthing women, herself and midwives. She builds a time in which women can do their body work in peace separated from the constraints of our fast, manufactured modern world (Simonds 2002). In so doing she constructs a calm, slow, previously occupied space for herself as a midwife. She constructs a responsible not-knowing time full of (im)possibilities for both herself and the women with whom she works. It is a past-present-future space/time of which she is proud. Out of, and in, the dailyness of ‘being with’ but not knowing Maureen accepts the responsibility of thinking/making possibilities of difference, in a Derridean sense:

_There is a deep, profound, and scary sense in which the future and our responsibility for the future cannot be in any other hands [...] To be faithful to the future, then, is to open ourselves to the address, “what are you doing today?”_

(Cornell 2005:71,74)

There is an embodied sense of the now in midwifery work, an immediacy in the dailyness of women managing new and very complicated work, which calls up a responsibility to be open to difference, otherness. Shannon tells a story from practice in her reflective journal of a time as a student midwife:

_One of the women I’m working with today is in tears. She is [first time mother] with a 9½-pound son who is jaundiced. She hasn’t actually noticed that he is yellow but she is very frustrated that when he wakes he can’t seem to keep himself awake to latch and feed. She has got herself into this kind of spaced out mode, staring at the wall, crying, boob out, baby somewhere near it and she looks at me and says “I didn’t think it would be this hard.”_

“Oh god, I think,” but that is not what I say. I let her cry, I acknowledge that it is hard work and I tell her that it is worth it. I get her to just comfort her baby for a while, hold him and love him, she feels him nuzzle into her neck and she can feel his warm breath and soft hair. I get her to take a deep breath, drop her shoulders and breathe out all the tension. Then we talk for a bit about
how she thought it would be, how it really is, and how things will change and get
different, and new, and challenging, and easier. I tell her again that both she
and her baby are on a steep learning curve, they are in a whole new world - but
at least they are together and they will learn together and become an efficient
team. When the tears have stopped and the smile is flickering, I get her to try
feeding again (by this time a midwife has come to check on me, and baby and
boob get brought together by her well meaning hand - I think I will go mad!).

Three hours later, before I head home, I knock and stick my head in the door.
There she is, sitting up in a straight-backed chair, baby at the breast and ready
to go. He latches, her shoulders drop and she looks at me and grins. They did it
all by themselves. And I felt so proud - of her, for her. So I told her, gave her
the thumbs up, and left.

Shannon’s Journal March

Here Shannon refuses the idea of midwifery as an ‘unquestioned good’ (Spivak
1993:47). She does not accept the midwife’s actions and, in so refusing, Shannon
makes a space to reject both the theory/practice and knowledge/ignorance binaries.
This creates a Foucaudian (1997) situation of a more shared power relation where
the woman and Shannon are not trapped. In resisting the midwife’s way of
‘helping’, Shannon opens up possibilities for changing the situation. Together they
are, in a way, free to do something different (Foucault 1997). It becomes a situation
where ‘[…] resistance comes first, and resistance remains superior to the forces of
the process; power relations are obliged to change with the resistance’ (Foucault
1997:167). Shannon’s knowledge/ignorance of breastfeeding carries less weight
now. However, this is a messy situation. Shannon is embroiled in the poststructural
question of ‘what are you doing today?’ (Cornell 2005:74). In the dailyness of
Shannon’s work we see a woman in distress. I suspect anyone who has ever
mothered, or perhaps fathered, or done anything big ‘without a manual’, could relate
to this childbearing woman’s pain and stress in the very early days of mothering for
the first time (Maushart 1997; Wolf 2002). Then along comes Shannon. Here is a
classic story of the ‘theory-practice’ binary where midwifery students are taught one
way to help women breastfeed using a hands off technique (Fletcher and Harris
2000), a technique Shannon is trying to follow. In comes the midwife and ‘puts the
baby on’, as it is called in the midwifery vernacular, by clutching the baby’s head
and the woman’s breast and bringing them (not always gently) together. ‘Putting the
baby on’ means that the baby latches and feeds and of course, the woman, and the
baby, often feel better in the short term, but not always, as it can be a very
disempowering thing to have happen to a new mother. In the medium and long term the woman does not learn the skills she needs to be independent in her lactation or in her mothering. In the short term, too, it means that the woman still cannot latch the baby to her own breast, a skill which can take some time to learn, which in turn undermines the woman’s confidence in her ability to breastfeed and mother. But this story constructs something else, too. The woman constitutes her relationship with her body as ‘hard’ in relation to breastfeeding. This is a common discursive position in our society for a multitude of reasons. We live in a society where breasts are sexual organs first and means of feeding next (or last). We also see very little role modelling for lactating which affects women’s success in breastfeeding (Henderson and Scobbie 2006). We have a complex relationship with our body as biological nutrition-providers because often our mothers and mothers-in-law bottle fed their own babies. Little is known about the physiology of breastfeeding and its basis of supply and demand in the community at large. Our rates of vaginal birth are dropping and so women are often needing to breastfeed when they are just back from major surgery. Many first births are traumatic vaginally, even if women do not give birth surgically. Women often tell each other only the awful breastfeeding stories. Finally, this woman, like most others, is alone in a hospital room in an unfamiliar setting, among strangers. It is not surprising that she looks catatonic. (I have always thought it amazing that women manage to successfully breastfeed ever, under such circumstances). The woman tells Shannon she did not think it would be this hard. A first-time mother’s experience often comes quite by surprise, even though she has probably attended antenatal classes (or because she has) and learned some breastfeeding facts.

Shannon constitutes herself as having a responsibility to be with the woman in the (im)possible. Writing that the woman is almost catatonic, Shannon reads her as having ‘gone up the mountain’, the place where women go when everything is not doable. Shannon, too, seems to want to go up the same (or different) mountain: “Oh god, I think,” but that is not what I say.’ Shannon, relatively new to midwifery, is daunted just as is the new mother-woman; Shannon is clearly uncomfortable. But by the end of the story something has taken place and the woman, against the odds, now constitutes herself (in this moment) as mother and lactator. In that same moment, the woman also constitutes Shannon as midwife which Shannon herself does by writing
this story in her reflective journal. Jacques Derrida (2001:63) said that we inherit ‘through a thick stratification of layers’ what we can think of as possible and impossible. Because neither Shannon nor the woman know what to do, they begin with the not-doable, the unthought, the impossible, a space/place Derrida (2001:63) describes as ‘not simply the opposite of the possible’. We can see the beginning of the possible in this story. Both Shannon and the woman are initially catatonic, steeped in the impossible. The woman is there and not there, (dis)embodied. Her breast is exposed, left out and alone as if it belongs to someone else, not to her or her baby. She and the baby are both crying. She is facing the wall. Shannon doesn’t have the skills yet to ‘get the baby on’ without touching him or his mother, skills she has been taught theoretically and which she will acquire in time. For now she owns only the theory and it is not working. So Shannon begins here from the time/space of the unthought, the unthinkable, too. Uncomfortably she breaks open the theory/practice binary and uses her relationship skills, kindness and her ability to be ‘with woman’ but she and the woman are both swimming out in the unknown. Then something happens. She thinks about what she has inherited to think ‘impossible’ (Derrida 2001:63) and she rejects it: ‘I think I will go mad!’.

Shannon tries to help the woman to rethink what the possible might look like, what it might mean. She builds a space in which the woman can do her own (im)possible work. Shannon knows that she cannot make this (mother-baby feeding) possible – she has tried and failed in the moment to do that - but she can refuse its impossibility. In refusing confines of the theory/practice gap by making a (new) way to act responsibility, Shannon helps the woman come to a new time/space, her own different (im)possibility and at the very end of this story we see its (momentary) results. She, mother-lactator, looks at Shannon and grins.

A few years into my midwifery teaching career the value of poststructural theory started to become obvious to me:

She had to run the afternoon tutorial in the hospital and she was tired and a bit grumpy and had nothing concrete prepared. Her little girl was waking up a lot at night and she was drained. The students came into the room from their various wards in dribs and drabs. She could see they were weary too and quite despondent. They were whingeing about work and how what they were seeing wasn’t good enough and why wasn’t it different - on and on they went, moan, moan, moan.
She picked up a whiteboard marker and stood up and started writing some of the words they were saying on the board. It was as much as she could be bothered to do. Really, she only did it to show them she was listening.

More students came in, also grumpy. She wrote more words as they talked. Then she started circling things, matching up a few words with other words. Suddenly, one of the students said: "Look, this is about patterns. We just have to sort out the patterns to help it make sense." They kept talking and I kept writing until the board was totally filled with words. Two or three of the students stood up and one said - tell us what to join together. The students got really excited and started yelling, all calling out instructions and joining words and concepts.

Then it went really quiet. I sat down and we all looked at the board - covered in words and lines and circles. It looked a total mess. One of the students said "Now I understand what is going on in this unit." Everyone laughed but the others said yes - look at that - there is a pattern here - the same pattern repeated over and over - in different places and it comes out in different ways but it is the same pattern.

The group used to talk about that tutorial as the best one they ever had.

Jenny's Memory Story ‘Patterns’.

This story can be read as being about a teaching technique spontaneously employed by a tired woman-teacher in desperation! It is a story about (tired) bodies struggling in a ‘positivist’ system (Lane 2006:49), a system, like others, ‘that often brutalise[s] women’ (St Pierre 2000:481). It can also be viewed as a class where the students and teacher know each other very well, are used to process-style teaching, where it is safe for adult students to complain and be ‘grumpy’ because they want their world to be different and where the teacher pushes the students towards greater understanding of what is happening to them. It can also be read as a story of an ethic of responsibility. Here the students use their own bodies, standing up, yelling, writing, to deconstruct their ‘reality’ and found (new) meaningful patterns in and through the spontaneous whiteboard text. They went from being tired and bodily and spiritually dis-stressed, to being energised by a different way of viewing their work and the workplace. They and I saw issues of power/‘truth’/gender/identity/agency/bodies and resistance. They made links which grew into patterns which brought clarity, wonder and energy and, in particular, a recognition of (im)possibilities, and somewhere in the process we dissipated our pain and fatigue. ‘That Tutorial’, as it became known inside that student group, meant something special to all of us. For the students, the whiteboard’s web-like structure of multiple and overlapping discourses gained more and more meaning over the later months of their midwifery program, as the
recognition of their investment in the same system which was undermining them, grew. They came to see that their (un)comfortable positions in their midwifery world, positions which they had thought were individual ones, could be understood differently, as collectively, contextually, culturally inscribed (Haug and Others 1987; Scheurich 1997). By realising our own complicity in ‘the system’ we came to see ways that our ‘deconstructive gaze becomes a vision of liberation and justice’ (Rocco 2004:140). That tutorial board has undermined binary thought and practices every day since.

For me, that whiteboard became a metaphor for my academic work, including this doctoral labour. Examining discourses to recognise contradictory possibilities, seeing complexity entwined with incredible simplicity, noticing resistance, hearing metaphor, ‘outing’ power, disrupting truths and recognising the intersections of gender, history and women’s bodies all became steps towards a different set of possibles, or at least, not-impossibles. That teaching session taught me many things including that my poststructural reading and theorising could be translated into the practical to find ways to make connections, to translate what I could see and experience into broader ways of understanding for me and my students. When I think back on that time in my teaching career, just over ten years ago, I see the seeds of poststructural possibilities which I have incorporated into my teaching ever since. I still do not know where those possibilities or the refusal of impossibilities will lead the students or me. That is its joy.

In an act of theoretical courage, everything went up on that whiteboard, the precious and the not precious and we unpacked it all, in the spirit of Foucault:

My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. [...] I think the ethico-political choice we have to make every day is to determine which is the main danger.

(Foucault 1984b:343)

The responsibility to keep that whiteboard as a ‘work in progress’, as a collective venture into the birthing and midwifery (un)known, was felt very keenly on that afternoon, and I suspect, is still by all of us.
Like Megan’s refusal to be frightened of the (im)possible/(un)known, Maureen’s embracing of the (im)possible/(un)known and Shannon’s utilisation of the (im)possible/(un)known, this group of students was equally open to possibilities. In filling that board with (im)possibilities we opened up new desirable time/spaces for new moments of midwifery work and learning. Maybe we even increase chances of a viable life for the women (and their partners/families/friends) with whom we work. Certainly we increased our own. The following memory story of my teaching constructs another kind of midwifery responsibility which also increases the hope of more viable lives:

When a few groups had graduated through the course which was based on a women-centred midwifery model, she began to see the changes she had always wanted in students. They were questioning, connected, knowledgeable and very brave: all the things she believed they could be and were.

After a while they started doing things in practice - good things that women wanted - but things that no one else much would really do - certainly not ‘junior’ or not-experienced midwives. They were braver than she was herself. It was like a ball rolling down the hill, faster and faster. They would come to her with a story and she would always say - “You know you were right - you kept the woman right in your focus and called it the way you saw it”. When they left she would be scared. What if it didn’t work? What if she wasn’t right? What if the stuff she said made them bad, not good? She tried so hard to find ‘evidence’ for what she said and to encourage good midwifery and when they went way beyond what she sometimes meant it was scary! She felt responsible.

After a while she realised that was crap. They were adults and they were responsible for themselves and their work. And anyway they did call it right and their work was beautiful work but either way, it wasn’t about her at all. It was about midwifery and women and midwives. She could keep doing her stuff and she could let what happens, happen.

Jenny, memory story

New discursive constructions changed the conditions under which students could, and did, move into and out of the maternity system and in (some) ways this changed the discourses, desire and practices of the students and new (and old) midwives and their lecturer. In both a political and an ethical movement these students increased their ‘capacity to recognise multiple readings such that no discursive practice, or positioning within it by powerful others, can capture and control one’s identity’ (Davies and Gannon 2005:318-319). Here, the experienced/new binary (as well as the theory/practice binary) is shaken open as the students become the teachers and the teacher the learner. The students in this group, taught by a relatively radical
academic (me), are further out in the (un)known than I, led/pushed there by placing women in the centre of their work and opening up what came next. I had a vision for the future when writing the curriculum which came, not to pass, but to be surpassed. This group taught me that what I needed to do was to discursively construct a possible time/space and childbearing women and midwives would find ways do their work of the (im)possible. In opening childbearing/midwifery up into fractured/multiple positions we allowed/created a space/time for new (im)possibilities, which (further) increased all our possibilities for more viable [midwifery] lives (Butler 2004b). The responsibility towards and desire for the other, towards the (im)possible grew and grew, far beyond my imaginings and well beyond my (initial) comfort. This poststructural play doubled back and made me ask myself more hard questions. What was my desire and what was in it for me, to have the students ‘women-centred’ but only perhaps to my point of comfort? The students put me well beyond what Lohse (Browne and Lohse 1996) calls the ‘comfort zone of rage’. The three generations of midwifery, like the three generations of feminism, are in play here. The third, poststructuralism, is uncomfortably, (im)possibly so.

Midwifery: intact, and in ruins

Our midwifery house is intact, and in ruins. It has two forms at the same time. In one dimension stands the House of Midwifery: sturdy, stubborn, determined to withhold attacks from both within and without, from the left and right and from above and below. Here midwifery’s walls are tall and wide and made of stone, a (closed) space with many rooms and inhabitants. Inside the House, midwifery lives, grows, thrives, (sometimes) fights for access and (sometimes) celebrates the essence of womanhood. Here, midwifery still likes order, stability and uncontested meanings. It is closed to other possibilities. On the inside, childbearing women are permitted only certain discursive positions, as are midwives, women’s partners and medical officers. Men’s position is of dominance, or of support. Taking up ‘values, norms and desires’ (Davies and Gannon 2005: 318) of midwifery, the midwife becomes midwife. She becomes ‘a recognisable, legitimate member’ (Davies and Gannon 2005:318) of midwifery. The House of Midwifery in its humanistic structures and discourses tends to ‘[…] reward identity and punish difference’ (St
Pierre 2000:484). This has been discussed more fully in the previous chapter. In another dimension, but not in binary opposition, midwifery crawls/trawls around with childbearing women in the ruins (Lather 2000) of itself. Midwifery ruins hold the (open) secrets of the past, the joy and pain of the present and a hope and vision for the future. In the deeper layers of the ruins are the collapsed structures of birth-at-home, of a time when birthing belonged to the community, not to medicine: tea cups and pots, bowls, jugs, herbs and berries, sheets, and prayer beads of every kind. The next layers closer to the surface are the remnants of our earlier entry into the public domain: enema kits, baby bottles, antiseptic lotions, stainless steel instruments, trolleys for every imaginable purpose, nurses’ fob watches, uniforms and white caps, baby baths, rubber rings for sore bottoms, sleeping pills and miles of green fabric designed to keep the birth area ‘sterile’. The closest layer of rubble contains our most recent artefacts, machines that go ping, test results, epidural drugs, birth balls, operating theatres, clocks, calculators and computers and miles of budget spreadsheets. In the ruins, midwives not only (try to) hold a space for difference, they move actively toward the other, often unknowingly. Working with/in the rubble, a midwife ‘can act to disrupt the signifying processes through which she [and the childbearing woman] is constituted’ (Davies and Gannon 2005:318). In this palimpsest, difference is rewarded. This has been under discussion in this chapter.

Just as a house made of ruins is (im)possible - once ruins are used to build a house, they become the house – so, too, metaphorically speaking, midwives attempt, succeed and fail, with the (im)possible. Midwifery both trawls its ruins and builds its house with them. I believe midwifery both shuns and embraces the responsibility of being open to difference and to the (un)known, to the (im)possible, both at the same time. Midwifery is still trying to reveal its place in a Kristevaian sense:

No longer wishing to be excluded or no longer content with the function which has always been demanded of us (to maintain, arrange, and perpetuate this sociosymbolic contract as mothers, wives, nurses, doctors, teachers...), how can we reveal our place, first as it is bequeathed to us by tradition, and then as we want to transform it?

(Kristeva 1981:23-24)

I believe midwifery finds itself in an ambivalent position in relation to its own practices. Midwifery can be seen (as in the previous chapter) to be working in the
stages equivalent to radical and liberal feminism: seizing back control after centuries of medical dominance and celebrating the essence of womanhood. In that sense, inside the House of Midwifery, midwives are caught (up) in these discourses, fixed in (combat with) the dominating medical and nursing/management discourses of the maternity health system. These discourses make us who we are.

So, from inside the time/space of the House of Midwifery the idea of, and desire for, a further deconstructive step, Kristeva’s (1981) third generation, is still utopian. Sometimes there seems to be a linear relationship for midwifery to Kristeva’s third generation, even though she did not suggest a linear relationship between ‘generations’ herself. In our society, while the ontology of childbearing is such that it takes place in female bodies (although even those boundaries are blurring with medical and technological ‘advances’ like invitro fertilisation and cloning), men have already encroached so far into the sphere of childbearing that it can no longer be considered solely the domain of women. Thus, from some perspectives midwifery could move on/move forward from the work of the first and second generations to take up a more poststructural stance, to admit that childbearing and midwifery are not the domain solely of women, and start acting like it.

However, in this work I have suggested that in some times/spaces (but not in others), midwives are already, as they have always been, enmeshed in Kristeva’s third generation, in poststructural practices, even though they would mostly not name them thus. I have spotlighted ways in which we undertake that work: breaking open binaries, making spaces inside and outside discourses and creating new possibilities. This is part of what poststructural theory offers midwifery. Midwifery, seeking the other, moving toward the other, is made possible in/by trawling the ruins of the House of Midwifery. Working the [midwifery] ruins (Lather 2000; Lather 2001), women and midwives together call up the time/space of the (un)known, the (un)thought. Midwifery is found/formed in the ruins, just as surely as is its House.

So how can we, must we, manage our midwifery house that is (must be) intact and in ruins? We have worked so hard to build the structures of our House of Midwifery and there would be no useful ruins without them but it is in the ruins where the work of the unknown might be unleashed, here that we can be ‘with woman’ in a
multitude of ways, here where childbearing women may speak and think themselves into the unthought. If midwifery has a responsibility to difference (Derrida 1978) and I believe it does, ‘how does one act knowing what one does?’ (Vivweswaran in Lather 2000:285). The tension between the House and its ruins is worked out in the practice arena every day in midwifery. What better place from which to undertake a poststructural account, as Judith Butler suggests:

The critique of gender norms must be situated within the context of lives as they are lived and must be guided by the question of what maximises the possibilities for a livable life, what minimises the possibility of unbearable life or, indeed, social or literal death.

(Butler 2004b:8)

‘Use your words, Louisa’
says David.
23 years old to 13. Stirring, but nice.
What manner of wind, that which
‘works its words of love around us’?
Loving and being.

‘Be nice
And don’t drop the baby’.
Un/selfish love
Women, women, women.
Loving and giving.

The gift. Another ploy?
More guilt, more shame?
More to worry about.
Worry is the work of midwifery
Loving and taking.

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1 Adapted from O’Donohue (1997:12)
2 Thomas (2000)
Hear the angels' voices
from Granny to us.
Past, present, future perfect.
Products of our generations
Loving and moving (on).

Carry our histories
in/on your bodies
Women and midwives alone,
Together.
Loving and minding

You never get a grace until you need it
The gift?
In particular circumstances\(^5\)
Too scared to write it but take it, with both hands, rush it.
Loving and needing.

'Write yourself. Your body must be heard'\(^6\)
The women know; you know.
Inside/outside your body and theirs,
Holy, responsible work.
Loving and writing.

The next and concluding chapter summarises my writings in this thesis and in so
doing brings together many possible threads which make up the House of Midwifery
and its ruins.

\(^5\) Probyn (2003:298)
\(^6\) Cixous quoted in Weedon (1997:65)
Possibilities work: being with, becoming

Individuals of all sorts need to sustain their power to affect and be affected. This requires maintaining patterns of self-regulation. But in addition to creating a space that allows one to sustain the comforting rhythms of familiar places, one must also be able to confront the new: “one opens the circle a crack ... One launches forth, hazards an improvisation. But to improvise is to join with the World, or meld with it. One ventures from home on the thread of a tune”.


Writing the midwife’s present

Even the conclusion hurts. At the end to my work it is (still) hard for me to speak outside the passionate rhetoric of midwifery. It is (still) hard not to be the teacher and say how we can fix things to make birthing better for women. I think I am ‘being poststructural’ by saying midwives need to ‘unlock our old discourses’, yet in the very act of saying/writing that (way) I construct myself as midwifery and academic authority. Out of my passion for women and midwives and teaching and
researching I become (again and again) unreflexively authoritarian. I have to think and think again. I have to write and then write again. I have to create and create again so I can write what this long difficult doctoral journey has been about. It takes many attempts to write something other than truth statements, something other than bold assertions about how midwifery and childbirth could be, should be, something other than right/wrong and (un)happy endings.

As I sit at my computer, with Granny looking down from the wall above, summer becomes autumn. It rains beautiful wet water for the first time in many, many months and violent storms light up the darkness, bringing white hail the size of stone fruit. The long hot days go, leaving just a promise of winter in the air. ‘Tempus fugit’ our sundial says. I don’t like the thought of the cold. I’m a summer girl. Yet there is something wonderful about four distinct seasons, about the ebb and flow of life, about recognising future signs even when we do not know what will happen next. The changing seasons and the near-end of my thesis work make me think of the last summer of my ‘childhood’, driving out to the river with my friends every day, swimming together every day, before we went our different ways, all scared and excited about leaving. In a leaving-home panic, I tried to take in everything: the colour of the water, the shape of the trees, the feeling of the sand, the shimmer of the sky in the heat of the day and the long shadowed times of early morning and late evening, etched on/in my mind. I wanted to leave but I was frightened that I would not remember the river properly, that the river would not remember me properly; scared and excited by the (un)known.

For the last swim of my doctoral work (I hope), I resist the comfort of our known midwifery beach and go back into the river. I turn, purposefully, upstream. I swim, but not alone, against the sometimes fast, sometimes slow current of medicalisation. I swim past, into, towards and away from the slimy and sharp partly submerged snags which are labelled risk, indemnity insurance, money, Medicare funding, hospitalisation, discipline, power, punishment, conformity, professionalism, technology, science, nature, choice, neoliberalism, consumerism. I head further up the river, swimming from the beach labelled ‘access’ towards the beach upstream labelled ‘celebration’. I know the river well, its landmarks on the banks, how the snags move, change, submerge and reappear. I swim from snag to snag, holding on
to what is available to support me. Tired, I reach the beach near the bridge. Rested, I turn and float back downstream.

When I began my doctoral swim, I thought that floating down the (poststructural) river from bridge to beach would be fun and wonderful and scary and life changing. It was. What I did not know then, what I do know now, is that the destination is not a beautiful beach of coarse yellow river sand. There is little sense, not only in this doctoral work but also in and for midwifery, of having arrived safely, of having made it. As I float and swim both up and down my poststructural river, starting my journey at our comfortable known beaches, on into the waters in a way still (and always) uncharted for midwifery, I come to see that midwifery may never own its own beach, its own resting points. We will not, certainly in my career or lifetime, be in control of our own waters. We cannot colonise the beach at either end of our swim. More importantly than understanding that, I see that it doesn’t matter. We do not have to own territory. We can, but if we do we need to be careful, superstitious and uncomfortable, or we will not be able to do our fluid, fractured work with women. Our work is in the river, swimming upstream against the current, floating downstream with it, hitting, grabbing at, holding on to snags, waving happily as we pass them by, unassisted. Perhaps this is the (un)comfortable, fractured, fluid work of midwifery.

I swim past and with and into the women and midwives and men who people this thesis. I hear the known punctured by questions like Elle’s ‘That noise is mine, then?’ I re-feel the dots going purple and I think of Cixous’s ‘Am I dreaming? Am I misrepresenting?’ I hear Kate’s ‘We must ask all about power’ and Millie’s stressed ‘Did I say I was more scared of breastfeeding than birth?’ and Patrick’s ‘Shame they have their heads too far up their own arses to see the great side of midwifery’. I swim towards and away from the being with/being useful discourses of my (dis)comfort, feeling again Shannon’s pain when she asks but expects no answer: ‘Life is never the same is it?’ I hear Alison ask ‘why can’t everyone labour, birth and ‘postnate’ like that?????’ and Maureen decide that knowing is beyond us because ‘it’s outside life as I know it’. I remember Cathy’s cards full of thanks. I see a small bustling Granny on the bank of her river, my river, smiling and waving to us in recognition and shaking her head at the ‘young things today…’ I think of Derrida’s
impossible ‘...we cannot conceive of this...as a possibility. It is impossible, it’s inconceivable, but that is exactly where one starts thinking’ (Derrida 2001:65).

A space/time to start thinking

Writing made this thesis (possible). Of course it did, but for me the process has been (extra)ordinary. Before I started to write I (arrogantly) thought I knew what I would write. ‘It’s all in my head’, I would say/think/act, ‘I just have to write it down’. Nothing could have been further from my experience of and in this doctoral river. I do sleep and eat midwifery and midwifery teaching and midwifery academe. I have also read widely in the poststructural literature and have been using poststructural theory and practices in my midwifery and teaching and research work for ten years. That part was accurate, that is all in my head, and in my body and my life and my friends and my family. However, until the pain/pleasure of actually writing happened, in a sense nothing had happened. When something did happen it was surprising and wonderful for me. As Richardson (2001:34) says: ‘writing is a feminist practice, and like other feminist practices its effects are surprising, complex, rich and rhizomatic, having unexpected consequences for the writer and the reader’.

There have been profound moments of discovery and understanding during my genealogical writing process. Writing the play, presented here as the second chapter, became a watershed for me, a defining moment where I realised I needed, and need, other voices across times and spaces to help me think, write and do the complexity of midwifery work. Other moments of insight and excitement came from realising that I could theorise the profound and the profane together, not separately and not in opposition to one another. Embodied moments where women recognised or left what they previously ‘knew’, helped to write about my own and others’ moments of movement, of possibility and of ambivalence inside and outside our complicated maternity health care system. Writing the access and celebration chapter, which was, surprisingly to me, the most difficult chapter to ‘get right’, also offered me profound (and profane) understandings. As I struggled to put into context the hard work midwives have done, often successfully and often not, in order to change the health system for women, I noticed (again) the wonders liberal and radical feminisms had
helped create and I saw (again) that they will beach us, again and again, at particular places. In some senses I had already realised the limitations of access and celebration. In another way, every time I realise it, it is both shocking and freeing. I loved writing about the ethics of responsibility, which brought other defining moments when I realised just how poststructural and how structural midwifery is at the same moment. Little wonder midwifery is complicated to write and do and learn and teach and no wonder it is also easy and rewarding and addictive.

How then do we as academics and educators bring our students with us to and into the (poststructural) midwifery river? How do we help new learners of midwifery, and old ones, to trawl midwifery’s ruins and build our house with them? I know what I want. I want student and midwives (and ourselves) to be open to the other, to be open to ourselves, to be open to possibilities. But how do I/we make room, to not just allow (for) other discourses, but to encourage, expect, even demand, other voices? How can we become open to and capable of saying yes to everything?

The position I have come to trust from this doctoral work comes especially from thinking and re-thinking and feeling and re-feeling and understanding and misunderstanding Derrida’s impossible: ‘…we cannot conceive of this…as a possibility. It is impossible, it’s inconceivable, but that is exactly where one starts thinking’ (Derrida 2001:65). What midwives can perhaps do best is understand what we learn and know as a beginning, not as an ending. My journey has brought me to the point where I believe in working with students for where we start thinking, for a beginning, not for an ending. I do not mean here ‘beginning’ as in beginning practitioners, or in ‘beginning knowledge’ which will be increased with experience. Those beginnings do and will and need to happen for students. What I mean is a recognition that midwives and academics might know the beginning, but we do not know or own the end or even the next part of a childbearing woman’s story. More importantly, it is not ours to make up (and yet practitioners very often do act to make it up). Finding spaces/times to hold openness and ethics and action together is hard for students, very hard. It is very hard for us all but, I believe, worth striving for, every day. If we can find ways to be ‘with woman’ where what we can learn and know helps us see (what) we don’t know, then what we don’t know becomes the beginning of a possibility, not something to fix or an end in itself. The inconceivable
as a beginning of a possibility can then be recognised, talked about in classrooms and in practice areas, brought to the foreground and valued as our work.

**Teaching (ir)responsibility**

Some years ago I set an inquiry-based question in an assignment about a woman whose baby was posterior (facing the front, a fetal position which is considered both in the text books and in midwifery practice to be more difficult for the labouring woman and her baby). Included in the question was an actual comment from a friend of mine, Emma Baldock, an independent midwife, who says posterior positions are just a construct, that *that* particular fetal position does not matter. In their assignment I expected the students, experienced nurses who were becoming midwives, to look at the ways in which finding a full term baby in this position just before birth changed the ways we talked and acted as midwives. I wanted them to see and think about what happens to a woman with a posterior baby both in the woman’s own mind and what happens to them in the health system. I gave the students lots of readings about poststructural theory. We talked a lot in class about how we construct our own reality and the reality of others by our language, at the same time as reality is creating us and others. Then they answered the question on the assignment. When I gave the marked assignments back we talked about it some more. This is the feedback I received from one of the students, on behalf of her friends, some weeks later:

> Well, thank you very much, Jenny. You have totally messed us up. We were happy thinking what everyone else does. We were happy with straight answers or better still no need for answers because we had not thought of the questions. You have ruined us now. We cannot go back to thinking the way we did. We are questioning the basis of everything. Yeah, thanks a lot.
> Carrie, JB’s journal

Carrie and her group became uncomfortable by noticing what was going on around them and by making themselves think (and act) in different ways. They started to see when practitioners say ‘posterior’ we often mean ‘difficult’. We also think and act ‘long’, ‘painful’, ‘exhausted’, ‘epidural’ and ‘assisted birth’, even though every midwife and medical officer is taught, correctly, that 90% of women’s posterior
babies turn, in a well labour, to face the right, easier way before birth. None of those things we think about posterior babies and their mothers is wrong. In fact they often are very accurate but my issue is this: if we spoke differently and acted differently about not just posterior babies but all babies, would having a posterior baby be different for women? What if every time midwives felt a baby in this position we said ‘Oh, this baby must be so clever – she is facing out into the world already!’ or ‘Oh, posterior babies are always pretty!’ or ‘Oh, your baby is posterior – he will always sleep well’ or ‘have beautiful teeth’ or ‘be kind’ Would that make her labour harder or easier? Or what if we wrote a policy which said that women with a posterior baby laboured somewhere more familiar, perhaps their homes, would that make labour kinder to them? What if they all knew and loved their midwife? What if they all knew and loved themselves? Would that make a difference? We don’t know the answers to all those questions but I think there is the possibility of yes.

I think Carrie and her group forgave me after this assignment but I am not totally sure. What I do know is that this new knowledge and new discomfort changed their thinking and their practice, in that moment, as it had changed and is still changing both my midwifery and my teaching and research practice, in some moments. They began to notice what happened when someone said a baby was posterior, or a woman only four centimetres, or a husband creepy. They also began to notice what happened when they said particular things and then began to say them differently. They saw that they had a responsibility because their words, like those of us all, are not just describing words. Their midwifery responsibility, like mine, is to notice both possibilities and to notice when we close possibilities off for others: ‘[…] when we place responsibility on some centred presence, some foundational principles outside the realm of human activity, we may in fact be acting irresponsibility' (St Pierre 2000:484). But students are not always happy to receive new knowledge and skills which make their lives more complex, especially initially, but then they often come to see the joy in noticing, in difference, in (ir)responsibility. Complexity is difficult for students, just as it is difficult for their teachers.

(Feminist) poststructuralism helped me see that dailyness matters not only in practice but also in theory. We need theories which remind us that midwifery does not have to be the way it is, that we do not have to be locked into our (current) gendered
normative patterns. Midwifery, like every other social practice, has been formed by a series of accidents, a set of circumstances, a mishmash of beliefs and events which cement(ed) what we are and separate us from what we might (have) become. A woman does not have to think and act in a particular way to grow and birth and raise a baby. A midwife does not have to think and act in a particular way to be a midwife. To be childbearing woman, mother and midwife, is not fixed. How childbearing and midwifery are now are not how they have to be. ‘Present social and moral orders are not inevitable’ (Davies 2006:189).

Understanding the processes of our subjectification can be scary and complex, like navigating a (known) river, but it is also potentially freeing, and responsible. While (gendered) normative patterns offer some people a set of viable options for living life to the full, other people are only constrained by the same set of social norms. Under a system in which social and moral rules govern who we are and who we can become, possibilities for a doable life are not evenly distributed. Set societal conditions do not offer everyone a viable life. On the contrary, the very action of setting rules excludes some modes of behaviour and thus some people, unless they conform to those particular set modes of behaviour. Patterns which lock us into old and tired ways of being and thinking also lock people, real walking, talking, sleeping, loving, fighting, reproducing people, into old and tired ways of living. When the patterns themselves become normal and ordinary, the patterns disappear into the everydayness of life and often become set, unchangeable and inevitable. As Ferguson (1991:327) puts it so succinctly, ‘[w]e make up our claims to truth, Nietzsche states; then we forget we made them up, then we forget we forgot’. What was and is a made up pattern becomes who we are and who we can become. This is not just the case for childbearing women. It applies to us all, students, midwives and academics.

Preset social and moral orders (sometimes, often) do not work when humans go or are pushed out to the edges of their previously known and accepted and acceptable world. ‘Under particular circumstances’ (Probyn 2003:298), sets of human patterns and conditions become surprisingly reviewable and imminently changeable. ‘Normal’ modes of action and thought can become (instantly, momentarily) obsolete. When a revolutionary change happens, or begins to happen, accepting or even
embracing or demanding other major changes becomes possible, even desirable. When something big (or perhaps rather, someone little) dislodges the familiar, the known, the understandable, humans become vulnerable, open to the possibilities of altered ways of being and doing.

Childbearing is one such series of events which, often unexpectedly I think, opens women’s (and men’s) lives up to new and different ways of thinking and being. Women in pregnancy, labour and birth and the early parenting time find (and/or lose) themselves in the time/space of mother-in-progress, meaning-in-progress, subject-in-progress. With those who accompany them on their ‘with child’ journey, a woman can enter, and leave, previously (un)imagined spaces/times where the unknown and the unthought meet in moments of past, present and future. This (un)familiar, previously (un)imagined space and time calls up the unthought of Deleuze, the Kriste van subject-in-progress, Derrida’s (im)possibilities. It is a time/space somewhere out on the edge of human; a moment of human (im)possibility.

Midwifery is another series of events which can open up lives to new possibilities. Because of our work with childbearing women, students and midwives have our (im)possibilities broadened and we can then help to broaden others’ possibilities. In shared moments of becoming, midwifery mobilises the discourses of ‘being with woman’ and ‘being useful’ to (re)invent spaces and times in which to do midwifery work. These discourses create, and are created by, working inside and outside the women’s discursive times and spaces of the profound/profane, times/spaces ‘outside life as we know it’, where the (extra)ordinary happens. Inside this special time/space of women’s work together, the sister works of childbearing and midwifery open up possibilities, not only for childbearing women, but for midwives too. In the dailyness of midwifery work and teaching we can both ‘hold a space’ to nurture women’s work in the (un)known and we can move towards our own (un)knowns. The midwifery discourse of being with/being useful holds all of these possibilities. Because of childbearing women, inside midwifery the (im)possible awaits.

Midwifery, like birthing, is thus possibilities work. (Increased) recognition of it as such may bring with it more chances of creating viable lives for those with whom we deal, and for ourselves. Opening ourselves up to the realisation that it doesn’t have
to be this way and to the awareness that our (childbearing/midwifery) world can be otherwise, may bring new life to old work. In the bringing of new life, in the bringing in of new lives, other lives are changed, new norms created, examined, used and discarded. New possibilities are given…

**Discourses at work and play in midwifery**

Midwives work with women in their embodied and discursive times/spaces of growing, birthing, feeding and raising others. While each woman’s experience is hers alone, in a collective sense, childbearing twists and turns and wanders back through generations of women in the growing of babies and forward into the next generations of reproductive work. Childbearing and midwifery are embodied, social practices involving gendered subject positions which are constituted through a host of discourses.

Childbearing and midwifery are caught (up) in the discursive struggles in our society about the ‘nature’ of the feminine, the ‘nature’ of knowledge and the ‘natural’ rights to name and control human processes. The public domain of maternity care changed progressively over the past hundred years to become a model dominated by scientific, obstetric and technological discourses. The dominance of these discourses, especially obstetrics, lets them proceed relatively unchecked, sometimes seemingly unopposed and out of control. Midwifery work of ‘being with’ also moved in Australia from the community into hospitals, and thus midwifery has always had a presence, although sometimes or often silenced or hidden, in the maternity care system in this country. Overall, though, with obstetrics’ continuing ownership of the authoritative knowledge in childbirth, knowledge that views the body as fragmented, its processes as mechanistic and ‘nature as a bad midwife’, comes also obstetrics’ ability to capture and hold the high discursive ground of maternity care.

Many inroads into a more woman-friendly system have been made in the past thirty years. Yet, discursive regimes that disadvantage women, some in evidence since the system’s inception, some more recent, are still endemic in our health care system.
These discourses often remain difficult to confront and successfully challenge. Modes of action and discourses which demean women and women-as-midwives are evident even in institutions where people actively work towards a woman-friendly environment and in spite of the major changes implemented in the health system in recent years. The extent of women’s gendered disadvantage in the health system is shocking.

Two available feminist discourses, liberal access and radical celebration, are often employed in midwifery in response to loud male obstetric discourses. These feminist discourses produce the complex and (sometimes competing) midwifery positions of demanding childbearing women’s and midwives’ rights to and in the public domain as equal with men, and demanding acknowledgement of childbearing women and midwives as special and contributory. In taking up a ‘with woman’ position and in employing liberal and radical feminist discourses, midwifery worked hard to make changes to childbearing and midwifery, with some rather spectacular successes. New laws, new curricula and a heightened awareness of and respect for childbearing women and midwives are important effects of liberal and radical feminist work. However, while these discourses worked for us as we worked for them, it is becoming increasing clear that they alone will not suffice to complete work towards a system which offers all childbearing women viable lives. Seemingly, more and different modes of theorising and action are required to make meaningful changes for all childbearing women and midwives and in the process, men and others in the maternity health care system.

The discourses in childbearing are (in part) formed in the embodied moments of movement, of change, of human (mis)understanding. Childbearing discourses construct and are constructed by women’s body work and human connection in times/spaces which are complicated, evolving and often (un)expected. They (dis)appear in times and spaces of human frailty and strength. Childbearing work inhabits the spaces and times in between binary notions. It is broad and narrow, general and specific, big and small, easy and hard, profound and profane. It is all of these and more, and less. It grows in the small spaces in cracks and in the largesse of the universe. Discourses move, twist, tangle (in) the muddy waters of childbearing. Some discourses in childbearing, or discourses sometimes, are lasting, loud,
powerful, strident and obvious. Others, or at other times, are obscure/d, seemingly less powerful, less credible, silenced and ignored. Ways of speaking prescribe and proscribe patterns of behaviour which over- and under-lie the timeless connection between women as they give birth and midwives as they give help. In the maternity health system, as in society, citational practices make available subject positions within gendered normative patterns. Childbearing women and midwives have a timeless (dis)connection which follows us into the present through our heritages of child bearer and helper. Women’s embodied childbearing work and midwives’ embodied work of helping is now carried out, not only as work in the social, but as work in the medical and technological. Inside and outside the complex discursive times and spaces of our maternity health system, women and midwives constitute themselves in ways that are (un)recognisable. Midwifery work ‘with woman’ is important and insignificant; it is noticeable and hidden; it is helpful and it hinders; it is connected and separate; it is big and small; it is useful and futile. It is all this and more, and less.

Putting midwifery sous rature spotlights ways midwives and students of midwifery constitute themselves and are constituted by discourses and modes of action. It shows ways midwives move in and out of discourses, discourses which push and pull us towards and away from childbearing women, and towards and away from ourselves as women and midwives. Inside and outside the (shared) discursive and embodied times/spaces of childbearing, times/spaces which can be (un)expected, (un)intentional and (un)remarkable, midwives work (hard) to constitute themselves as midwife, as recognisable members of the midwifery profession/discipline. As they undertake the minute-by-minute work of becoming midwife, midwives and students are buffeted, seduced, negated and/or opposed to competing and overlapping discourses inside midwifery. In the same moments as midwives and students themselves work to become midwife, they are worked on and over and through, being constituted as midwife by the (dominating) discourses outside midwifery: obstetrics, nursing and management.

Using genealogy and writing as methods of inquiry, I read and wrote the discourses (un)available in midwifery in the particular circumstances of the opening years of the 21st century in Australia’s capital city as mobile, overlaid and intricate.
Midwifery’s powerful (and powerless) ‘being with/being useful’ discourse leads to, and from, a complicated intersection and overlapping of other discourses. In previously unknown childbearing moments, spaces/times open up for different discourses, for new possibilities; for different possibilities of being. Aligned with these discursive moments of the profound/profane of pregnancy, birth and early mothering, midwifery’s ‘being with/being useful’ becomes a work-in-progress. These discourses wrap themselves around each other in practice and in theory and then together and separately they tangle with other powerful societal discourses.

A poststructural dare for midwifery: possibilities work

As I tack (unwillingly) back and forth towards and away from the modernist snags, a part of me wants to say in this concluding chapter that I found this and this and this… However, I cannot say I do not believe in grand theories and then present a new one to finish this work of mine; that is not the way of the midwife’s present. What I can say is this:

If midwives let them, birthing women and their babies push midwives into the (un)known, just as childbearing pushes women into their (un)known. If we are open to (im)possibilities, midwives’ lives might be different, broader and more encompassing of what-we-do-not-yet-know because of childbearing women, because of our work with childbearing women. Even more importantly, if midwives are open to (im)possibilities, childbearing women’s lives may also be enhanced, their possibilities for growth extended, their understandings broadened, their embodied experiences, thoughts and feelings enlarged, their selves opened up, their lives made more livable, more doable, more viable.

My readings of the midwives and childbearing women in this thesis suggest that there may be much to be gained by being open to oneself, and to the other. Being open to difference, or perhaps better still, embracing difference rather than rules and order, may change the ways in which we are constituted and constitute our selves as women, childbearers and midwives. As midwives are led/pushed/dragged, scraping into the (un)known by placing women at the centre of their work, midwives themselves can also be opened up to the (im)possibilities that come with/in those
times-spaces. Midwives and childbearing women together and apart can construct, discursively and embodiedly, times/spaces of difference, previously unimagined. Women can come to the birthing (un)thought and in those unthought times and spaces, midwifery work can be done, surprising and meaningful work. Momentary work can be done, together, ‘appropriately and well’ (Morrison 1987:85).

Midwives, midwife-academics and students are ethically bound to notice complexity and to value difference; to embrace both complexity and difference, to speak them and to not deny them. Childbearing women need midwives to understand how complicated ‘who we are’ is, and how formative we are in our own and others’ subjectification. Because ‘who we can become’ is not set, not pre-ordained, not unchangeable, midwives and childbearing woman can actively and reflexively (dis)engage in the processes which make us who we are and can therefore disrupt what looks and seems inevitable and/or desirable. Midwives can help childbearing women by being ‘with woman’, that is, with the other, in an open vulnerable way, in order to acknowledge, value and create difference.

Vulnerable (yet strong) openness to the other does not come ‘naturally’ for most of us. Thus we need discursive (de)constructions to help us learn, teach and research how to pay attention in each moment when childbearing women are undertaking their embodied works. Inside (and outside) those discursive (de)constructions we may also learn, teach and research how to pay attention in each moment to ourselves so that we may undertake possibility-work with women. Likewise, we may learn, teach and research how to pay attention in each moment when working with students of midwifery. This is the possibilities-work a midwife, a student-midwife and a midwife-academic can do.

Working with women in the space/time of the (un)known has constructed (some) midwives as feminist and political and respectful of, and celebratory towards, women’s processes. However, in the early years of the 21st century we begin to see that this has not been enough to facilitate the systemic, collective and individual political and ethical changes required such that women, and thus their partners and families, and midwives and others who populate the maternity health system, do not
have their options for viable personhood curtailed. I believe midwifery would be enhanced by going (further) towards the midwifery unthought, as some midwives already do, without abandoning liberal and radical feminist discourses and practices, to (further) recognise and (further) take up, in the dailyness of midwifery work, the possibilities held within (feminist) poststructural theory and practices. These are possibilities which do not shrink, but rather grow, humans’ potential; possibilities that allow/demand/create times and spaces for the embodied sister works of childbearing and midwifery to flourish; possibilities which act to foster opportunities for difference inside and outside childbearing and midwifery. Herein lies the possibilities-work a midwife and a midwife-academic can do.

(Some) midwives create and hold discursive, embodied spaces/times in our complicated birthing system for valuing difference. (Some) midwives intervene in our medicalised society’s determined march towards order and sameness. (Some) midwives maintain the embodied watch for women so that women have the spaces/times they need in which to do their precious body work. Being able to hold the space/time for the (un)known, often in the face of opposition or disbelief from those inside the dominant discourses, means being strong and vulnerable at the same time. It means being open to the (un)known and sure of ourselves as practitioners in that process at the same time. It means looking in and out from practice, at the same time, through lenses of multiple understandings. Because midwifery can make/open possibilities for more viable/livable childbearing lives, midwives have a responsibility to watch the way we work (in) and word (in) the world: making new possibilities in practice, by doing and not doing, by writing and talking, naming what we know by using our words, asking hard questions, refusing binaries, and creating embodied times/spaces for women to do their work with help. From a position of vulnerable strength we can take up what I think of as the poststructural dare, a dare based on the works of Derrida, Kristeva, Foucault, Butler Deleuze and others. Poststructuralism dares us all towards an (ir)responsibility of resistance, of learning, of the (im)possible, of difference and of the future.
**Poststructuralism’s present**

Feminist poststructuralism, the third ‘generation’ of feminism, continues and surpasses the political struggles of liberal and radical feminisms. (Feminist) poststructuralism moves us towards a concern for ethics, a position continuous with political struggle. For midwifery, a practice discipline embodied in and with women’s childbearing processes, poststructuralism breathes life into our understandings of the past and present ways of being ‘with woman’ and helps us open ourselves and childbearing women to (un)imagined futures. Pregnancy, labour and childbirth and early parenting offer women the chance to be (more) (im)possible. These embodied and precious processes offer women (and men) the chance to be other, to be different, to be beyond themselves in ways previously (un)thought. Those who midwife for women during these life-giving, life-affirming (and life-taking) processes are greatly affected as well. Midwives, too, are offered possibilities for being, for the previously (un)thought. Yet, only sometimes do we notice or take up those challenges, as birthing women and as midwives. Often, we accept (un)comfortable futures in which current ways of thinking and being constrain us as women and midwives. We become only who we have been, who we are. We do not become who we might become.

Midwifery holds a responsibility and the possibility of noticing and acting on difference. In order to actively seek ways to cause and make a radical break, midwives, midwifery students and midwife-academics can refuse (à la Foucault) what we are, to be different (to) ourselves. Becoming more honest, certainly becoming more noticeable, and operating less inside the system and more outside it are (im)possibilities for us. We do not need in patronising ways to ‘lead them to water’ but, working together in a connected spirit of generosity and freedom, midwives can smooth women’s paths towards difference, opening up their access to their unknown, refuse to close their access to possibilities, in embodied and discursive ways. Because midwives know the maternity health system arguably better than any other group, and we know, too, about childbearing physiology, anatomy, relationships and spirituality and we have seen and heard some (im)possibilities and (un)knowns, we can be useful during women’s body work. We carry with us a responsibility to notice difference in order to break open the binaries
and we must break open the binaries in order to notice difference so we are not closed to possibilities for women, their partners, their families, their babies or for ourselves. Childbearing demands a midwifery reflexivity which allows/enables/fosters us to work in and from our own bodies and embodied processes, a midwifery reflexivity which allows/enables/fosters others in their own precious embodied processes, whatever they may be, supported, if they desire/require, by us.

In the present, as in the past, midwifery both takes up and refuses its ethical position of being with women and open to the (un)known. But this is midwifery’s work, work which midwives do and do not do in the current maternity space/time. Foregrounding an ethics of recognising and valuing and creating difference may help us (continue) to try to read the complexities of midwifery’s working space/time. Making our work with women in the (birthing) (un)thought visible may help break open our own binaries, listen to our own silences and critique our fondest attachments and teach for radical and liberating change.

The educator’s present

Educationally speaking, discursively (de)constructed learning may make/foster times/spaces where childbearing women and midwives find ways to do their work of the (im)possible. We, the teachers of the new (and the not-so-new), carry a responsibility to double back on ourselves, to ask hard questions, to regularly check our teachings, learnings and motives, to ask ourselves my favourite poststructuralist question: ‘If not this, then what else?’ As midwifery-academics we can take up the three ‘generations’ of midwifery, which are akin to the three ‘generations’ of feminism, and play them to childbearing women’s advantage and to students’ advantage. Taking up the poststructural dare, a dare which contests our modernist teaching and learning beliefs and strategies and unhooks us, if temporarily, from our modernist moorings, allows us to swim towards the other, towards positions of educative (ir)responsibility, resistance and difference, to increase our own and others’ options for a viable life.
So, in order to break out of the dominations of others, in order to be different, in order to make a difference, in order to live and value difference, and be freed by that, we can be open to the possibilities that closed binary thinking and acting cut off. Being open might give us and our students a freedom to learn anew, and if we are brave enough to be (ir)responsible, to teach anew. What happens next can and could be very surprising. We do not know what will happen as Davies (1990:514) writes ‘The fact of the matter is we do not know what we can speak/write into existence until we’ve done it […]’ and that is the joy of this (possibilities) work.

There is a sense in which midwifery begins when and where other things run out, similar to St Pierre’s (2005:972) suggestion that ethics begin where the rules do not apply. Teaching for that (im)possible space/time requires in itself an openness, a sense of the (un)imagined. Midwifery is a teaching/learning space of great and little structure, of opinions and the suspension of judgement, of few precedents and of multiple genealogies, of physiology and philosophy, of being with and being without, of working with/in the self and working with/in the other. It is a precious and tender space (over) filled with bodies, babies, breasts, blood, words, love, laughter, learning, books, tears, fear, panic, people, places, pain, fun, silences, violence, journals, art, poetry and joy, all of which demand some belief in, and some understandings of, the (un)thought.

In the dailyness of our work, midwifery academics and educators can teach for openness, not for ‘closedness’, a position we ourselves need to model. We can teach to value and recognise difference, not sameness. We can teach for possibilities not for recipes, no matter how tempting it is to construct our world in such a way as to ‘manage’ it. We can teach for beginnings, not endings. We can talk to birthing women about the (un)known, the (im)possible and how they might embrace it/cope with it/manage it/love it when it gets to them, and they get to it. We can help students and midwives (and women) not to be scared by the (un)known but to be energised by it, to move towards, not away from it. We can seek ways to teach for midwifery work that begins, not ends with the (un)thought, the unthinkable.
The researcher’s (future) present

There is much yet to do in finding out more about the precious spaces/times of the (un)known, the (im)possible, the (un)thought for childbearing women and midwives. There is more work to do in working out ways we can open ourselves and childbearing women and their families and other health disciplines and the maternity health system as a whole to the (im)possibilities of the (un)known in childbearing and midwifery. There is more work, too, in working out ways of resisting who and what we are. There is more work to do in appreciating beginnings rather than endings, openings rather than closings. In researching ways to teach, learn, do, trust, honour, recognise, value and live possibilities work with women, midwife-researchers can seek out the spaces/times of the (un)known and learn from them. We could ask childbearing women and women about their times/places of the (un)known, the (im)possible. We could videotape midwives in their work in the spaces of the (un)known. We could facilitate writing projects for childbearing women and midwives to see what they create by their writing and what that creation does to their doing. We could delve further into the responsibilities of the (un)known, the (un)thought by asking midwives to take special care of how they work and word the world, then see what happens. We could ask medical officers and managers to do the same and see what happens for childbearing women and midwives and maternity care as a result.

It is simple and complex work childbearing women and midwives do together and alone. Further researching for understanding the experience of not understanding, for understanding in the sense of both insight and tolerance, may open up our chances of protecting and creating precious times/spaces of the birthing (un)thought. Like a woman in childbirth who has many years of parenting in front of her, there is a sense in which, for me at this (thesis) birth, this project has just begun.

Towards a past future: women and midwives, together, working in the present

My aim in this thesis has been to write the ways midwives, and others, word the world and act in it, in order to understand how we can embrace opening our midwife-
selves to possibilities and difference, in order that childbearing women will not have their possibilities for viable personhood *closed*. I wished to (begin to) theorise the ways in which midwives become practitioners who are open to the (un)known, to the (un)thought, to (im)possibilities, practitioners who embrace difference, the other.

Together, midwives and childbearing women, with their and our partners, families and friends, societies and the universe, can be otherwise. Once we begin to see that things do not have to be this way, we can then start to ask, and perhaps answer, the hard questions:

*Whose life is counted as a life? Whose prerogative is it to live? How do we decide when life begins and ends, and how do we think life against life? Under what conditions should life come into being, and through what means? Who cares for life as it emerges? Who tends for the life or the child? Who cares for life as it wanes? Who cares for the life of the mother, and what value is it ultimately? And to what extent does gender, coherent gender, secure life as livable? What threat of death is delivered to those who do not live gender according to its accepted norms?*

(Butler 2004b:205)

Childbearing does not have to be the way it is. Midwifery does not have to be the way it is. Learning does not have to be the way it is. They can be, or they need not be. We can continue to use what we have learned from liberal and radical feminist positions and from poststructural theory and practices to invent new questions and bring back old (un)answered ones. We can make up new answers and bring back old ones. We can grow new ways of being inside and outside the profound/profane and we can nurture different ways of being with/being useful. And when we have made up the new ways, we can subject them to new and old ways of scrutiny. We can ask of them, new and old questions. We can try and guard against loving the new ways too much, as seeing them as inevitable and wanting them to be complete, ordered and just how it is. Elizabeth Grosz suggests:

*The task is not so much to plan for the future, organise our resources towards it, to envision it before it comes about, for this reduces the future to the present. It is to make the future, to invent it. And this space, and time, for invention, for the creation of the new, can come about only through a dislocation of and a dissociation with the present rather that simply its critique. Only if the present presents itself as fractured, cracked by the*
interventions of the past and the promise of the future, can the new be invented, welcomed, and affirmed.

(Grosz 2004:261)

Women in pregnancy, during labour, giving birth and in the early parenting time inhabit a world of very particular circumstances. In this space/time the discourse of the profound/profane opens up a space/time for birthing women (and holds them in that space/time). It also opens up a space/time for midwives and midwifery students of being ‘with woman’ (and holds midwives and students in that space/time). Together, and alone, women and midwives, if they are open, (re)invent moments of possibility, moments previously unknown and unknowable.

In this timeless and (un) timely space, body work can begin and be supported. Giving and receiving, working in the thought and the unthought, women and midwives puncture the known and the unknown. (Together) childbearing women and midwives speak themselves and they are spoken into the (ir)responsible spaces/times of woman-in-process, mother-in-process, midwife-in-process, meaning-in-process, subject-in-process. In moments where past, present and future meet, in the new waters of an old country, childbearing women and midwives undertake precious, momentary work together. They undertake possibilities work.
The (Not) Final Act:

Many months after the midwives had been at Granny’s place, they are gathered in the Delivery Suite tea room, all except Reggie who is ‘admitting’ a woman in labour. A farewell party for one of the midwives is in full swing. Granny and Jenny arrive. Granny places their presents with the others. Jenny quietly puts her finished thesis on a table at the side.

Kate (yelling): Wow, can we finally read it?

(Maureen goes over and picks it up, turns pages and reads a few bits out aloud).

Alison: We’ll need to wet the baby’s head!

Shannon: Hey, JB, that reminds me. Reggie said he wants to know what your thesis is about in one word, so he can understand it!

Jenny (after a short pause): Tell him it’s about the (un)known.

Shannon: He’ll have a fit! He’ll say you have done years of work and written thousands of words to tell us midwifery is about the (un)known… didn’t we tell you that?

Jenny: I hope so…

They all laugh, Jenny included.

Jenny: …and from your unknown I have been out into their, your, our, my (new) unknown…

Reg comes to the tea room door.

Reggie: Would it be possible that anyone is coming out here? To work out what is going on with this woman? So I can go home?

The laughter begins again...

Alison: Yes!

Reg (grumpily): Yes to what?

Alison (smiling): Yes to coming out!

The other midwives in chorus (laughing): Yes to everything!

Midwifery Aside: Just as Derrida hoped…
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