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The Swallowed Mother: C - Sections, Metaforms and Male Cuts

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But Athene's own priests tell the following story of her birth. Zeus lusted after Metis the Titaness, who turned into many shapes to escape him until she was caught at last and got with child. An oracle of Mother Earth then declared that this would be a girl-child and that, if Metis conceived again, she would bear a son who was fated to depose Zeus... Therefore, having coaxed Metis to a couch with honeyed words, Zeus suddenly opened his mouth and swallowed her...

In due process of time, he was seized by a raging headache as he walked by the shores of Lake Triton, so that his skull seemed to burst, and he howled for rage until the whole firmament opened up. He persuaded Hephaestus, or some say Prometheus, to fetch his wedge and beetle and make a breach in Zeus's skull, from which Athene sprang, fully armed, with a shout.

Robert Graves, from Hesiod: *Theogony* 886-900; Pindar: *Olympian Odes* vii. 34 ff.; Apollodorus: i. 3. 6., *The Greek Myths*: 1, 46.

All blood is menstrual blood.

Judy Grahn, *Blood, Bread and Roses* xvii.

Athene, the mythical Greek goddess of war, was born from her father, a god who gave birth by swallowing her mother whole. How might this ancient story pose significance for a study of the modern act of giving birth? Such a study would incorporate the seeming absurdity of swallowed mothers, fathers giving birth, and

daughters leaping to war. Yet myth, a story beyond story, acts as a psychic and temporal map – a way into both past and present. For a male to give birth in this and other stories, a human male who has neither womb nor vagina mediating inside to out, a cut is surely the only route through which life could hypothetically exit his body. And though males are not giving birth through actual cuts in their heads, medical practitioners are cutting into female flesh and womb in order to *produce* the act of birth. New life is thus brought forth through the surgical procedure known as: *cesarean section*.

It is this moment of birth, a baby's emergence from her/his mother's womb into the world, with which the surgeon plays. Thus rendered, cutting becomes the moment of giving birth. The mother is inert, passive below the surgeon's knife. Due to anesthesia and the surgical procedure she will not pick up or hold her child to her breast in this moment. The surgeon and her/his attendants are the first to touch, hold, and claim this baby. The baby is swaddled and set in a tray, or passed to someone else (perhaps the father) until her/his mother's recovery. The baby cannot yet feel, see, hear, or smell her/his mother, a small mouth searching for suck. It is done and cannot be re-made. The intense, feeling-full moment of ecstatic mother and child re-union is literally severed. The mother is *swallowed* - is her child born to the battle cry?

How can we *think* about cesarean section?

I want to reconsider and destabilize the meaning of this act of cutting beyond its current medically hypnotic grasp. The use of cesarean section is increasing worldwide beyond its statistical medical necessity. I posit the need for social and cultural perspectives from which to understand forces at play within this procedure – perspectives related to feminist readings of gender and practices of subjectification. *Metaformic theory* as articulated by poet and cultural theorist Judy Grahn in *Blood Bread, and Roses: How Menstruation Created the World* affords such a view. Through the radical lens - radical meaning going to the root - of metaformic theory, I hope to loosen the grip of cesarean section from medical mystique and protocol, from the realm of the 'expert' and *author-ity* where the *author* of birth becomes the surgeon, the male, *the cut*.

As gestation to this essay on metaformic theory and cesarean section, I have for years been an apprentice, practitioner and now re-searcher of the arts of the midwife and women giving birth - at home. I offer the perspective of midwifery and home birth, where the qualitative experience of giving birth is acknowledged as a primary instance of meaning within women's lives. Medicine, with all of its potential to assist and save, is currently eclipsing birth out of women's life-course, out of the everyday intense, feeling-full, momentous ecstasy of having a baby consciously and sensate, and being supported and loved through it.

My passion for birth arose from attending a home birth as a teenager in Toronto, Ontario in the 1980's with then unregulated lay midwives. This visceral gift awoke an ancient calling within me. It also put me in the position of standing at the crux of two world-views, or stories, where I had an embodied experience of knowing birth worked

safely at home, yet adamantly hearing from many voices around me that birth is only 'safe' in the context of the hospital.

Broadly speaking, through the re-emergence of modern North American midwifery, woman as active agent with the baby in birth-giving is understood as a 'normal' and not a medically pathological event (Chester). The mother is considered inherently capable, strong, and passionately able to receive her child through the incredible transformation of giving birth. The notion of 'risk' in home birth is mediated by the experience of midwives in knowing the limits of 'normal' birth. Home birth in North America is found to be as safe as hospital birth, with radically reduced statistics of medical intervention (Davis & Johnson). The presence of midwives as attuned care-givers especially negotiates the often overwhelming liminal and consciousness-shifting experience of giving birth, mediating also its social and medical reinforcement as pain- and fear- full.

Through my early experiences of attending births, I became aware of, and in-love with, the awesome-ness of women's birth-giving capabilities – the profound simple joy of a wide-eyed, conscious (un-medicated) baby's arrival into the arms of her fully conscious (un-medicated) mother. I also observed over and over again the qualitative experience of women giving birth at home - the testimonies of satisfaction in birth-giving through such hard work of surrendering to its processes. I later studied midwifery, attended home births, and worked as a lay midwife and post-partum doula, ever re-envisioning the 'cultural capital' of birth in what I saw as a most intense and sacred of human experiences.

Throughout my community practice, I was developing my own theoretical perspective: that birth practices are related to, and symbolic embodiments of, larger cultural values and 'norms.' I was, and still am, specifically interested in how North American birth practices are symbiotic to environmental / economic relationships and practices: how a "symbolic ritual order is played out this way" (Jordan 51). For my Master's level thesis in Women's Spirituality, I listened to, collected and wrote women's birth stories, inquiring into just what was it about 'natural' birth and woman to woman support that makes this work of giving birth satisfying and integrating for women. I wanted these stories of empowerment told within a research framework, told because medicalized stories of birth so often ended in pain, frustration, or fear.

Birth and birth-giving can be a lens into the complex social/cultural/spiritual situated-ness and dynamics of the generative, life-giving female, in partnership with the human male. Transforming birth practices has the radical reverberation of transforming an ethic of relationship within the dominant culture at large. Metaformic theory, because it situates culture within blood rituals, offers a way to read further this fabric of relationship as played out in material gender signification – and the generative quality and power of blood, both physically and metaphorically, or *metaform*-ically.

The gestation of cesarean birth

Cutting is rampant in birth. The current U.S. cesarean rate of 26% (Odent, *Caesarean* 6) belies its statistical necessity of as low as 7% (Wagner, "*Choosing*"), a rate reflecting its life-saving capacity for mother and baby. Cesarean section, once a last resort operation to save a mother (or baby) from imminent death in the birth process, has become a safe surgical technique since the 1950's. Post-war advances in antibiotics, anesthesia and blood transfusions contributed to this development. The 26% U.S. cesarean rate is topped by countries such as Brazil. Brazil's national rate of 47.7% reaches 100 % in some hospitals (Wagner, "*Choosing*" 1679). French obstetrician Michel Odent predicts that if the present trend continues, cesarean rates will soon reach the 50% mark in many cities and countries around the world (*Caesarean* 5).

Reasons for escalating cesarean rates in medical literature include the notion that cesarean section is virtually 'risk free' compared to the 'hazards' of vaginal birth that could include urinary and fecal incontinence (Klein). Is *tokophobia*, the fear of childbirth, psychically allayed through this surgical procedure? Given the well-documented culture of fear surrounding birth-giving, especially within North America, and the norm of frightening, overly technologized, disengaged hospital birth stories, this option makes 'sense' – it has a kind of logic running through it. Add to this the notion of risk and 'safety', that a cesarean is 'safer' or is as safe as vaginal birth, include the rise of obstetrical litigation issues, and cesarean becomes a normalized method of *birth-giving*. This practice runs contrary to significant evidence indicating its actual *harm* as major abdominal surgery in: placenta problems especially in later pregnancies, infertility, increased newborn breathing difficulty and stillbirth, cutting into the baby, and increase in maternal mortality in countries where cesarean rates are higher (Sakala; Feinman).

What is not well documented, or studied within medical literature, but is well known to midwives, doulas and traditional birth attendants working with birthing women, is how the 'cascade of interventions', or routines of hospital birth, can lead to the final act of a cesarean section. I would contend that induction of labour, fetal monitoring, and the use of anesthetics such as Demerol and epidurals, increase the likelihood of cesarean section (see Klein on epidural). How many hospital births, in which the mother is too exhausted and distraught to go any further, her birth process 'delayed' or slowed, a cascade of interventions already enacted, have I heard of ending in cesarean? In a bizarre twist, one might say that the experience is (un)consciously orchestrated for this end. Most doctors and nurses are not 'trained' for normal physiologic birth, nor have the time, energy and skills to spend with an un-medicated birthing woman dilating from 0 to 10 centimeters (the full range of 'cervical dilation').

Many women enter their hospital birth experience with no intention of having a cesarean and end up as a 30% c-section statistic within British Columbia, Canada (Government of British Columbia). Once the initial process of birth is technologically interfered with, the mother is less and less likely to be able to use her own physiological, mental, emotional, and spiritual resources to give birth and relies more and more on the experts surrounding her. Michel Odent makes the case to leave mothers "undisturbed" through research that examines how birthing physiology reacts to behavioral cues and stimulus (*Farmer*). Women need to feel safe, secure, even 'loved' as they give birth,

leading to the altered consciousness and intensity of birth giving and the emergence of their babies. Why not direct more scientific study to the intricate birth dance of female/infant physiology, a dance seemingly wired for ecstasy in the release of the hormone *oxytocin* (Davis)? This “love” hormone reaches its greatest human climax during the process of vaginal birth and infant release.

Metaformic theory: blood and bleeding now and then

If birth is (un)consciously feared and is currently consciously over-managed and controlled, it is also situated within a more ancient genealogy of female blood and bleeding. The cyclic bloody and bleeding female, along with her rites, passages and practices finds modern passage mostly through shame and public unspeakability. The more recent taboo of female blood and its transformation from sacred to filth means it is now caught upon disposable products and rendered as garbage. Bleeding North American females are thus expected to give up seclusion time and to participate (work) in day after day life and its ‘ordinary’ consciousness through our disposable blood.

Metaformic theory interjects new suppositions into this play of blood. It is “a new myth of origin” (Grahn, *Blood* 7), a menstrual origin story, a *grande theory*. Drawing from cross-cultural anthropology, archaeology, and etymology, as well as the poetic and social imaginary of modern experiences of menstruation, metaformic theory posits the social and cultural evolution of human beings through the *entrainment* of the female blood cycle with the cycle of the moon.

In her book, *Blood, Bread, and Roses* Judy Grahn considers how ancient human females recognized their menstrual cycles as timed with the lunar cycle, which itself moves through visible, timed phases of light to dark. Females secluded themselves at their time of bleeding for safety from predators whose keen scent would pick up shedding blood. As this seclusion coincided with the dark moon, a merged identification began between the female social group and the distant non-human moon. “The synchrony between the lunar and menstrual cycles mirrored and “named” both moon and human, and timed seclusion rites kept that naming intact” (Grahn, *Goddesses* 10). This consciousness of identification is what Grahn calls: *metaformic*. This “unique tool of internal-external measurement” led to the development of notions of ‘time’ and ‘measurement’, tracing current articulations of these in modern science itself to the menstrual ‘mind’ and its development over millennia (Grahn, *Blood* 7).

Grahn proposes that primal, ancestral, bleeding females developed systems of marking themselves with blood to keep males and non-menstruating females away from the predatory dangers of blood-smell. Blood became a substance of *communication* - a “linguistic paint” (Ibid. 11). Thus, female blood was (is) a highly charged substance, not only literally but symbolically in a signaling language that had the power to direct social interaction. The power of this blood is more than metaphoric – it is *metaformic* – drawing out from within the body the material and social expressions of what we industrialized moderns now identify as culture, writ large.

Grahn identifies the word 'taboo' as appearing over and over in stories of menstrual ritual. She points to its origin in the Polynesian *tapua*, which means both 'sacred' and 'menstruation,' and also, "the woman's friend" (Ibid. 5). Taboos surrounding menstruation often consisted of severe restrictions. Grahn notes the etymology of the English word 'regulation' in its link to other European languages as the word for 'menstruation': in German, *regel* and in Spanish *las reglas*. Thus 'rules,' 'measure,' and 'menstruate' "are cognate with the terms regulate, regal, regalia, and *rex* (king)" (Ibid. 5). Menstruation is linguistically embedded in the ordering, ceremony, and leadership of human affairs.

Further, Grahn decodes the word 'ritual' in its blood origins, from Sanskrit *r'tu* meaning menstrual. *Rita* means a proper course. *Ri* means birth and is also the root of 'red,' "suggesting that ritual began as menstrual acts" (Ibid. 6). Birth rites are themselves blood rites, blood being a highly visible fluid in a mother's expulsion of her baby. Ritualization, through the control and management of women giving birth, has interesting links to this 'ruling' of the bleeding menstrual women. In my work as a postpartum doula, I saw that both medically and cross-culturally, postpartum lochial bleeding is central to measured restrictions of movement, location and diet of the new mother and her baby. Thus birth is itself situated within *blood taboo*.

Women's birth rituals, midwifery and me, and the problem of c-section

Much has been written on the medicalization, pathologizing and male appropriation of birth (Arms; Rich; Koehler). The history/her-story of the lay midwifery and home birth renaissance in North America since at least the 1970's was founded by many women's desires to experience birth outside of hospitals and away from paternalistic medical intervention and protocol. My midwifery apprenticeship developed in this political and cultural climate of reclaiming birth from medical practices through an unregulated midwifery renaissance.

As a young woman entering formal university studies in visual arts in the late 1980's, I began an extra 'side-line' education. There being no formal midwifery training programs in Canada at the time, I sought out local midwives with whom to study. As I was an avid and attentive ally, pregnant friends called me to their birth chambers. I attended many hospital and home births that transformed my life and expanded my community in this time, deepening my understanding of women's unique and awe-inspiring ability to bring forth life. I undertook a midwifery study group with other women in the home of a lay midwife. The skills of the midwife in being 'with women' were taught to me through text, story and practical experience. Understanding 'normal' birth, *being with* the physiology and behavior of the un-medicated, home birthing woman was the love and task of women in this group.

During this time I became aware of the extent to which cesarean section was used as a medical intervention on women giving birth, not just in British Columbia, but across North America. A 25% rate was often quoted at the time such that one in four women heading to the hospital to give birth to their babies could expect a cesarean section. Our

study group often considered the ill effects of the overuse of this surgical procedure on women and babies. Cesarean sections potentially led to infection, breast feeding complications, the difficulties of recovering from major surgery and caring for a new baby, loss of self-esteem and emotional trauma in the loss of the birth experience, depression, body scarification, and the issue of repeat cesareans.

Though cesareans were low in number for the women we served, we lamented, even cried, as individuals and as a group every time one of our clients/mothers ended up with a cesarean section. In a recent study on outcomes of midwifery-attended home births in North America, the cesarean rate was noted to be as low as 1.6 % in multiparous women and 8.3% for first time moms (Johnson & Davis 2). This low percentage is indicative of the skills and work of the midwife and woman giving birth to enter into whatever intensity, bliss, pain, moaning, rocking, moving, stillness, grief or joy that birth-giving requires of the mother. Understanding female birth physiology, midwives often display a high level of holistic (mental, physical, emotional, spiritual) commitment to support each woman's birth-giving process. I contend that this holistic care can be understood as 're-feminizing' the rituals of birth in a modern North American context, a ritual context in which 'safety' is subverted from hospital back to home. Fear and pain are understood as symptoms of surrendering to non-ordinary, overwhelming states of body sensation and consciousness in giving birth. It is not necessarily 'safe' in a hospital situation to enter into such altered states of consciousness and birth experience, when ritual facilitators are not trained, nor have the time, for these paradoxically immanent and transcendent female *openings*. Their training is geared towards maintaining linear, rationally focused, 'ordinary' reality - a masculinized reality.

In this context of providing holistic care, if one of our mothers ended up having a cesarean, we would go over the birth, the story, together looking for the missing link in the picture that ended in surgery. What was happening for this woman, this baby, this birth? What could we have done more of, less of, differently? What were we powerless to do? It was as if cesarean was the most extreme act of opposition, and even oppression, to the women we served and our own burgeoning lives as midwives. We were midwives who served un-medicated, freely birthing mothers. A woman having her baby cut out of her was the final act of paternalistic medical intervention - the final act of a woman having *her* birth taken away from her. We understood as women and mothers ourselves the physical, emotional, mental and spiritual costs of cesarean. Overuse of cesarean was and is a pivotal issue of two world-views, stories, and ritual sets of practices at work in the (post)-modern industrialization of birth.

I report all of this while acknowledging a low statistical necessity for cesarean sections as a potentially life-saving operation for mother and baby (Sakala). What is less considered in medical scientific literature is women's, babies', men's and whole families' social, mental, emotional and spiritual well-being after giving birth at home as compared to birthing in a hospital through medical procedures. Frederick Leboyer pioneered these considerations for the newborn within his own arena of obstetrics in *Birth Without Violence*. Obstetrician Michel Odent operates a [Primal Health Research](#) data bank through which he links studies of long term effects of medical interventions at birth,

including cesarean sections on mother and child. Organizations like the [International Caesarian Awareness Network](#) (ICAN) mark the social, psychological and spiritual costs of unnecessary cesarean sections, working to prevent unnecessary cesareans through “education, providing support for cesarean recovery, and promoting Vaginal Birth After Cesarean (VBAC).”

This kind of study significantly emerges in the grassroots storytelling of women – hence my need to give voice to these birth stories within my Master's of Arts research (Jordan). Midwifery and mothering magazines and websites hold voluminous accounts of women's birth experiences and stories [1]. This is woman to woman talk – as mothers recount the highs and lows, the intensity, beauty, pain, ecstasy, laughing, crying, rocking, moaning, bonding gift of giving birth.

I critique cesarean sections from a *metaformic* perspective in order to investigate the overuse of cesarean as a debilitating cultural phenomenon - at large. I draw from metaformic ideas of *male cutting*, *thievery*, and *necroforms* as articulated by Grahn (*Blood; Goddesses*). By thinking through this new/old story of menstrual origins, I reference a transfer of *blood power* from female to male through the ritual act of cesarean section.

I run the risk, or maybe *I am the risk*, of ethical imperative because my overt bias is that the rate of cesarean section *must come down, that women must be able to give birth vaginally and be holistically supported to do this*. I know the power of this procedure as practiced by the medical profession and its complex physical and emotional embodiment in women's lives and storytelling, the paradox of its experience. I would acknowledge the millions of women worldwide, who have experienced cesarean section,

those who mourn their experience, those who embrace it, those who walk away and move on, those who were saved, those who were not, those who feel too much, those who feel not at all, those who loved it, those who hated it, those who chose it, those who did not choose, those left with complications, those who dwell long in what it means, those who dwell just a little, and those who dwell not at all.....

And all left with a line across the belly, the womb - a mark, a line, a sign.

Metaformia and male cutting: parallel menstruation

*....cutting or piercing to draw blood was **(is)** the primary method by which males entered **(enter)** the metaformic mind, and therefore something they came **(come)** to imagine as theirs.*

Grahn, *Blood, Bread and Roses* 49 (words in bold are mine)

In relation to cesarean section, my interest in metaformic theory stems especially from Grahn's analysis of “parallel menstruation” in men's rites of cutting and bleeding (Grahn, *Goddesses* 19). Anthropologists recognize these rites in indigenous Australian

aboriginal and North American groups in boys' seclusion and initiation rites of cutting and marking of body parts or even the penis itself (Ibid). Metaformic theory subverts the usual significance given to male initiation rites in anthropological texts. Through positing female bleeding as the primary social ritual, Grahn identifies how primal, ancestral males had to induce bleeding upon themselves in order to participate in the human family and its metaformic evolution. Because female blood shedding led to the "gender solidarity" of female seclusion rites, parallel blood rites entrained the males within a social group to the blood and lunar cycles of the females (Knight). Male rituals that cut, pierce, or tear the flesh, result in blood that references the first blood of girl's physiologic puberty rites (Grahn, *Goddesses* 19). Thus begins a complex mirroring of blood practices between the genders. In Grahn's pre-historical analysis, parallel rites were an important step in pulling human consciousness into an "externalized language of cultural containers, artifacts and gestural acts...." (Ibid. 16). These acts and artifacts constitute what Grahn names *metaforms*.

In drawing this work to cesarean section, I also note that the discipline of anthropology, speaking from the vantage of the dominant Western historical trajectory, fails to turn its lens upon itself - to notice the appearance of *cutting* as a rite, or ritual, within our own place and times. In relation to birth practices, cultural anthropologist Robbie Davis-Floyd notes the medical profession's biased perspective of the transfer of birth from home to hospital as constituting a "deritualization" of birth from the realm of the so-called "primitive" (Davis-Floyd 2). David-Floyd suggests that this transfer to hospital has actually resulted in a "proliferation of rituals...even more elaborate than any heretofore known in the 'primitive' world..." (Ibid). Her thesis contends that routine medical procedures – as in epidural, episiotomy, and fetal monitoring - used on women during birth are "rituals" that enforce and inscribe a "technocratic" patriarchal culture on mother, baby, family and medical attendants. She demonstrates how often unscientifically proven and therefore 'irrational' medical acts continue to be used as "rational ritual responses...to extreme fear of...natural processes..." (Ibid).

Cesarean section understood within, yet beyond, Davis-Floyd's thesis to Grahn's metaformic theory, is immediately apparent as an act of *male cutting*. Like menstrual rituals, birth-giving and birth blood are charged with a power from which the male is traditionally excluded. The lying-in period found worldwide for women immediately following giving birth not only provides necessary rest, but secludes women from others until their lochia (post-partum bleeding) has completely subsided. Lochial blood and the placenta are often carefully handled and buried or disposed of ritually only by other women (Kapoor).

The history of obstetrics in Western culture is one of greater and greater inclusion of males in what was a female-only attended event. Cesarean section is actually the newest chapter in the Western trajectory of male inclusion at births. It makes necessary the male at birth – *entraining* the male to the generative female cycle of gestation and birth. If the move to give birth in hospitals constituted the proliferation of technocratic and paternalistic rituals as never before seen, cesarean section is surely the 'holy of holies' of such practices.

By applying metaformic theory to the practice of cesarean section, I contend that the cesarean cut subverts traditional male initiation rites of self-inflicted bleeding by crossing genders and applying a cut to the female body itself (as had been done with previous cross-over rituals). Let me say this again: *the cesarean cut subverts traditional male initiation rites of self-inflicted bleeding by crossing genders and applying a cut to the female body itself*. The cut is applied at the precise moment of the female giving birth. During this complex interplay of crossed meanings, genders, and metaforms the male ‘masters’ birth. *Both male and female become initiates to a process of male birth-giving through cutting*.

Lost in this cut is the original memory of entrainment to female cycles and blood power. I say “lost” because female birth capability is highly *pathologized* within the culture of medical authority that surrounds this cut – so lost that women themselves might choose cesarean over vaginal birth (Wagner, "Choosing"). Female authority and creativity is effectively transferred to the ‘expert’ at hand. Grahn titles this total shift of powers, “crossing the abyss to male blood power” (*Blood* 248) or a “crossover move”^[2]. The female traditions are lost, forgotten, or devalued in a discourse of pain, fear, and litigation within medical ‘risk’ and its management.

Though women are entering the profession of obstetrics, this has done little to lower the cesarean rate. In fact in one study of female obstetricians, practitioners were noted to choose cesarean as a preferred method of giving birth (Wagner, "Choosing"). Despite the proliferation of scientific and social literature that counters such practices, Davis-Floyd interprets this kind of response as indicating the degree to which women are “embedded in the hegemonic cultural model of reality that most of us to some degree embrace” (Davis-Floyd 5). Female obstetricians, as women, may have the most to lose by not conducting the rites to which their professional body adheres. Though this complicates the issue of male cutting, the cesarean itself inculcates the surgeon, mother and child into a culture of ritual cutting, tokophobia (fear of giving birth) and the separation of mother from child at birth.

So here we are with Athene again, as the woman who cuts, having been born from a male cut. In one sense the ancient Greek myth tells us of women becoming ritually male.

Male thievery: ritual acknowledgement or simple theft

...the male is always one step removed from actual physical correspondence with the lunar cycle, and from other metaphoric tools of the menstrual and birth huts, he has developed an ingenious tradition of ritualized, ceremonially acknowledged “thievery” to acquire cultural paraphernalia.....to explain his own creativity in the context of “new” metaforms.

Cesarean section is a new *metaform*. The male psychically and physically acquires the “cultural paraphernalia” of the “birth hut”(Ibid). This acquisition is achieved through what Grahn names the “male tradition of thievery” (Ibid., 249). Male thievery is an indigenous concept, an explanation of rituals crossing from female into male domains. Ritually described male thievery both transfers female menstrual and birth blood knowledge and power to males. It also acknowledges the female source and that men must steal these forms for their own uses because, as Aboriginal Australian men have openly acknowledged ethnographically, “the women have everything, the blood, the baby, everything....” (Ibid., 250).

When this crossover does not acknowledge the female source, it is simply theft. Simple male theft is an essential feature in the historical decline of European midwifery. The decline of midwifery was instrumental to the development of the medical profession in Europe in the 17th and 18th centuries. Understood through feminist critiques, medical control of the ‘business’ of birth transferred the art of healing from a domestic female sphere to a male public one (Cahill 6). This emerging professional body of doctors financially benefited from the growing monopoly on birth. An interplay of medicine and religion systematically excluded women from power through negative focus on women’s reproductive capabilities, devaluing these while working to control and subvert their expression (Merchant). Interventionist tools such as metal forceps are indicative of this change in birth practices towards a model of male physician rescue, towards the inclusion of, and necessity for, men at birth.

The threat of death or disfigurement looms at the edge of every birth. Birth occupies a liminal, intermediary ground between life and death. The birthing mother and baby submit to a process that could cost them their lives. Though healthy, well-fed and housed women and babies can expect to survive the process, this is the ‘risk’ within which medicine and midwifery play themselves out. What male thievery accomplishes is control of this liminal space at the cost of the mother’s and baby’s experience of negotiating its terrain - mind, body, heart and soul.

Necroforms and re-member-ing Metis

.....necroforms – metaforms that have not only grown out of sync with the greater knowledge of science and religion alike, but that actively work against the survival of the ecosystem.....They are illogical separations that shred the social fabric of nations and the web of life on earth.

Grahn, *Blood, Bread and Roses* 266

My critique of the cesarean section comes to this – I identify the cesarean section in its overuse with what Grahn calls “necroforms.” *Necro* denotes death. In revisiting the birth myth of Athene, Greek Goddess of war, I would heed her paternal emergence from this cut. She is born battle-ready, for whom does she fight?

I call back to my understanding of birth and its practices as a lens to female/male duality, and as symbiotic to larger cultural norms and practices. If cesarean is a *metaform* of male birth, its overuse has come “out of sync” with the science and knowledge that made it possible. It is an “illogical separation” of mother from child at the moment of birth release and union - the mother and child’s very own. It is an unnecessary use of technology. As a necroformic event, it is symbiotic to the current thrust of war, mass human dislocation, and industrial and economic trajectories of destruction of ecosystems we inhabit and depend upon.

As a sign, a scarred line, an ever-increasing number of women are written over on their wombs, life’s source, with this life-long mark of *the cut* as the Western medical model of birth is exported world-wide. Does trauma beget trauma? The transformation of giving birth has become over-played as an anesthetized, surgical procedure in domination of feeling-based, sensation-al, potentially ecstatic physiology of ‘labour’ and birth.

In the myth of patriarchal Zeus, Metis, the lover and mother Zeus swallows, is a *Titaness*. Her mythical origins lie within a tribe of giants who once walked this Earth. This *swallowed mother* holds the key to her own return. She is immortal, presiding over all wisdom and knowledge (Graves). And so we have the knowledge, but how to use it *wisely*? In a time of the marginal proliferation and political diminishment of home birth practices and midwives (Wagner, *Global*; Jordan) how might the swallowed mother fully return? Her return is significant to blood practices as mirrored between genders, without exclusion of one from another. How might the genders signal each other and deepen a capacity for love through birth practices, such that the parallel blood rites of the male with ‘his’ *cut* and knowledge of *cutting* are used only when necessary during the grand rituals of giving birth?

How to re-ritualize this dialectic of blood.....

Poem by Judy Grahn: “[like a woman in childbirth wailing](#)”

[1] See the magazines *The Compleat Mother: The Magazine of Pregnancy, Birth and Breastfeeding*; *Mothering: Natural Family Living*.

[2] From a discussion with Judy Grahn on February 19, 2007.

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