AUSTRALIAN MIDWIFERY – PAST, PRESENT AND FUTURE

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'Long before the butter churn and camp fire oven signalled the arrival of Western housewifery in Australia and while Europe was still guessing what lands lay below the equator, the dark thin-shanked aboriginal women lived and mated here, raised children, fed the fires, prepared food, performed family and tribal duties' Pownall in Australian Pioneer Women in N.S.W. Midwives Association (RANF) 1984; for as was the tribal custom of the day around 1710, when a birth was imminent, a 'nurse' would be chosen to 'help' the labouring woman – perhaps some could argue, this was the true origin of Australian Midwifery. However, as the above quotation states, 'Western Midwifery' would have its roots founded in the traditions of Florence Nightingale.

1770 saw the discovery of Australia by captain James Cook – an English navigator.

1788 saw the arrival of the so called 'First Fleet' into the harbour of N.S.W. The cargo it carried included naval officers, sailors, convicts (both men and women) and doctors. The women numbered about 15% of the total. A ratio of about 6 male to 1 female existed, the conclusion was inevitable – prostitution and illegitimacy and many women arrived pregnant. Women looked after women and as the new colony established so to did 'Midwifery'. Some have described this 'convict era' as producing the 'Accidental Midwife'.

As the settlement expanded and the economy grew, opportunities presented for more midwives and by 1806 the records listed 2-3 employed midwives.

1820 saw the establishment of the first 'Female Factory' which housed women convicts for employment, punishment and obstetric confinement – this was the first lying-in maternity hospital. With the arrival of 'free' settlers, the convict era ended in 1884, the Female Factories were closed and midwifery moved into the homes.

Colonial expansion continued and by 1859 there were 9 midwives listed. 1860 saw the 'Ladies Monthly Nurse' begin – the fore-runner of the Australian midwife. This person was employed on a monthly basis, arriving 1 week prior to birth and remaining for 3 weeks after.

The next few decades saw the development of maternity hospitals and an improvement in the teaching of midwives. 1862 saw the first attempts at training midwives. In 1893 the Diploma of midwifery became available but could only be undertaken after 'general' training. By 1899 employment in hospital midwifery departments would only be given to those who were midwifery and general trained. The training of Australian midwives was deeply influenced by the English system.

By the turn of the century many untrained midwives were replaced by hospital trained nurses. As midwifery hospitals grew eg. there were 4 recognised midwifery training hospitals by 1907, there was a decline in domicillary midwifery and a move into hospitals. By 1913, in some major towns, 37% of deliveries were attended solely by the midwife. Subsequent years saw the continual growth of population, and with this came an increased demand in the services of medicine, nursing and midwifery; in fact, midwifery became an integral part of general practice as was evidenced by the increase in the number of hospital deliveries by doctors.

With the arrival of the 'Golden Age' of medicine, the growing prestige and power of the medical profession, and the movement of midwifery into the 'hospital' environment, one can't help but wonder if this was the beginning of our autonomic downfall.

Since the early post war years, there has been an increase in medical technology and with this midwifery and obstetric practice. Large modern day 'maternal and infant care' hospitals have envolved which provide the latest state-of-the-art technologies in ante, intra and post-natal management.

Birthing in Australia has become very much a 'family affair' where father and siblings are encouraged to participate in the management and care of their wife/mother. As this father was heard sighing, after five boys, 'at last a girl!'

Interaction with sick neonates is encouraged by staff in most hospitals as is interaction with handicapped, dying or dead infants – in the past this was frowned upon.

As was custom years ago, the majority of women had their 'childbirth experience' in the hospital setting. Nowadays, women crave an alternative method of experiencing the birthing process. These needs have been partially met by the inception and erection of 'birthing centres'.

Educationally, Australian midwifery has come of age, with the advent of practitioners and specialists in the various areas and the potential of attaining qualifications at the Masters and Ph.D levels, Australian midwives now have the opportunity of achieving excellence in their midwifery training and practice. There is greater sharing of responsibility and authority with colleagues; due to this present increase in collegiality, level of education and the expansion of midwifery, midwives have been given greater autonomy in the decision-making process and so are held individually accountable for the decisions they make.

We have come a long way from the days of the 'first fleet', but let us not become too complacent, for we still have a long way to go. For as our social, educational and technological environments change, certain problems will be solved whilst others will be created.

The future for Australian midwifery is bright, changes are inevitable and indeed we live in a world of dynamic flux. I believe Australian midwifery will change for the better and certain trends will develop. These will include:

1. a decrease in hospital based births with a subsequent increase in home births ie. midwifery will move back into the community;
2. there will be an increase in community based and independent midwife practitioners;
3. the 'family unit' will be the focus of care and will have maximal input into the care and management of the birthing process;
4. midwives will become more academically qualified and function at the doctoral level;
5. midwives will become more science and research oriented, although not to the detriment to the 'art of caring';
6. midwifery practices and procedures will be research based;
7. there will be symbiotic relationship reflected in collaborative sharing in obstetrical management and research with the medical profession to attain optimal carte for families;
8. there will be greater autonomy for the midwife in the decision-making process relating to education, practice and research. Medical interference will become less, with midwives shaping their own future. Control will be from within the profession;
9. the Art and Science of midwifery will ultimately marry – and live happily ever after;
10. there will be a greater role expansion as 'primary care givers' for normal childbirth as well as community educators;
11. and lastly, I believe there will be synergistic union of theory, practice, education and research which will cystallize as the underpinnings of 'excellence in midwifery practice'. What more could one ask for?

To date, this paper has briefly looked at midwifery in Australia in general. I would now like to spend a few moments looking at an area which has become a sub-specialty of midwifery in it's own right – that of intensive neonatal nursing.

The field of perinatology has grown considerably in the management of the foetus and newborn infant have been enhanced by advances in technology. This has resulted in a decrease in perinatal mortality and an increase in the number of intact survivors.

Progress has been assisted by the advent of new technologies ranging from genetic mapping and intrauterine transfusions and surgery to extra-corporeal membrane oxygenation and high-frequency jet ventilation. The role of the midwife and neonatal nurse in the delivery of care to the family unit in relation to this 'high-tech' era has been a pivotal one.

Generally, health services of nations may be judged by the way they provide care to key elements of their populations, none of whom are more important than mothers and their newborn infants. Vital statistics reflect the quality of preventive and clinical care given to patients but of necessity they fail to describe the science and effort that has gone into the

provision of that care, and quite often, I fear, it is the midwives who are the forgotten ones.

The standard of care can be reflected in the related mortality and morbidity, and Australia continues to enjoy a decrease in its maternal and perinatal mortality rates which compare favourably with that of other countries.

It must be recognised that reproduction has never been safe for any species, including the human. Nature can be a benevolent midwife; nature can also be cruel and capricious, for us who are responsible for health delivery, we would do well to remember this.

Towards 2000 will continue to see a linear deceleration in maternal and perinatal mortality. For as technology advances, and it will, so to will the knowledge, devotion and courage of our midwives.

For its historical beginning, a midwives gift, in relative context, has been love, skill and knowledge; this has not changed, and at present a midwives gift is still love, skill and knowledge. In the future a midwives gift will continue to be love, skill and knowledge, but I believe in a greater capacity.

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