Midwifery: Women, History and Politics

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Midwifery: Women, History and Politics

Carolyn Hastie

Abstract: Much has been made of evidence-based practice in health care and in particular, in maternity care. Numerous studies have indicated that small maternity units plus midwifery, as a primary health care practice, is best for the physical and emotional health of the majority of childbearing women and their babies.[1,2,3] However, despite various state and federal government reports recommending midwifery led care[4,5,6,7] and a flurry of Alternative Birthing Services pilot programs in the early 1990s, Australian governments and health care organisations have not generally shifted from a medically dominated approach to a social health model for maternity care provision. History suggests that to do so conflicts with the professional and economic interests of medicine.[8,9] This paper explores the history, the politics and women's place in society within a midwifery context, so that midwives have a wider perspective on contemporary issues associated with midwifery practice. Such a broad view will enable newer members of the midwifery profession to recognise that the current negativity from some medical colleagues about moves to increase midwifery-led options for childbearing women and the associated midwifery autonomy have long standing historical and political roots. Such an understanding will help make sense of the current political and practice landscape.

Key Words: midwifery, history, midwifery education, politics
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The essence of midwifery is staying sensitively in the moment – in other words, being humble and paying attention. But this simple focus can easily be destroyed by the desire for control....the wise midwife...understands ebb and flow.
An American midwife quoted in "The Midwife Challenge" by Sheila Kitzinger, 1988.

and

Without the presence and acceptance of the midwife, obstetrics becomes aggressive, technological and inhuman.
Professor GJ Kloosterman, formerly of the Department of Obstetrics and Gynaecology, University of Amsterdam Hospital, The Netherlands.

Introduction

The current changes in Australian midwifery education and service provision are exciting. Consumer organisations, midwifery groups, some medical practitioners and government bodies are seeking to reduce intervention in birth by increasing women centred options for maternity care. Despite research indicating the safety and satisfaction associated with expanded roles for midwives and midwifery led care,[1,2,3] the voices of medically driven opposition to these changes are loud, negative and frightening.[10,11,12] For new recruits to the field of midwifery, it is essential that they understand the history and politics that have gone before. Without an understanding of our history, it is easy to take the current opportunities for granted. It is also easy for new midwives to be influenced by the rhetoric

of a vocal group of medical personnel and be frightened about birth and seek the comfort and perceived safety of 'high tech' tertiary level care.

For example, a new graduate asked me about the options available in midwifery. She had been offered a position in a tertiary level fetal maternal medicine unit as well as one in a midwifery-led low risk birth centre. She wondered if she needed the experience of working in the 'high tech' area to get 'skills' before she worked in the normal physiological birth field. I encouraged her to choose to work in the midwifery-led centre. Whilst midwives work across the continuum of women's experience of birth, they are specialists in normal physiological birth. Midwives also have a deep appreciation of the importance of mother/baby interaction during pregnancy, birth and the immediate postnatal period. The quality of that interaction sets the tone for the future life of the infant.[13-19] By working in a setting which promotes and supports the physiological process of birth, new midwives learn to recognise all aspects of normal physiology in the birthing process and factors and signs which can lead to deviations from normal. Working in such settings enables midwives to develop the skills and abilities necessary to support women in the normal process of birth and avoid unnecessary problems caused by over surveillance and/or unreasonable anxiety on the part of the health care practitioner. It is important for midwives to become thoroughly familiar with the normal process, so that women can be supported adequately and appropriate interventions can be suggested in the event of deviations from normal. For those midwives who start their career in the 'high tech' area, it can become more and more difficult to believe that birth can ever be 'normal' or natural, meaning physiologically healthy. In fact, in 'high tech' areas, what is 'normal' is medical intervention. Learning about birth from the 'high tech' end of the spectrum can skew one's perspective and lead one to believe that birth is only 'healthy and normal' in retrospect, if at all.

Midwifery History

Prior to industrialisation, midwifery and nursing were seen as 'women's work' and part of one of "a series of natural life events through which most women passed"(p2).[20] Midwifery was part of women's subculture and a lay craft. In the early days of the New South Wales (NSW) colony, women who had been transported as convicts had their babies at the Female Factory until it was closed in 1848. Other female convicts at the Female Factory attended these women in labour and birth as well as nursing each other when sick. Those women who practised midwifery were called 'a fingersmith', the colloquial word for midwife in the colony. In 1938, five nuns from the Sisters of Charity religious order with two nursing sisters arrived in the colony and started work at the Female Factory. They cared for sick women and children. Rich and poor free settlers had their babies at home with the help of a neighbour.[21]

Around the turn of the century 'granny midwives' ventured out on horseback, foot or sulky, regardless of 'weather, payment or terrain' to help women birth their babies.[21] Many stayed with the women for two weeks, helping out around the home. However, in the ensuing years, women were encouraged to have their babies in hospitals and gradually the call for domiciliary midwifery dwindled to 0.3% of the childbearing population.[21] Some midwives opened their homes as maternity homes to birthing women. One such home was "Nurse Dick's" at Belmont, NSW and another "Sister Edward's" at Windsor, NSW. These lying-in homes provided the basis for 'a private maternity hospital system in NSW'.[21] When Sister Edward retired in the 1950s, her lying-in home in Ross Street, Windsor became the Windsor Hospital's maternity unit. It remained so until the new hospital at Windsor opened in 1995 opposite the old site. The maternity unit was included on campus within the new buildings of the Hospital.

Whilst Industrialisation and Victorianism provided the background for modern day nursing and midwifery, patriarchy provided the framework. Victorian ideas dictated that women's role was to "serve men's needs and convenience"(p215).[22] Hospital and school systems emerged from the male dominated church and army medieval institutions. These church and army systems have a long history of ignorance and denial of women (p322).[22] Victorian social mores forbade women to challenge male authority. The Victorian social and cultural social system of domination, control and oppression was transferred into hospital culture and instituted into the hierarchical system.

In keeping with the prevailing cultural ideas of her time, English woman Florence Nightingale set standards for nursing with the decree that 'to be a good nurse, one needs to be a good woman first'(p32).[23] Florence Nightingale's work in the Crimean war made nursing respectable for middle class women, but the perspective of

midwifery was unflattering. Over the centuries, hostile rhetoric by medical men has painted ugly images of midwifery. Recorded instances include "denouncing midwives as 'cackling dames' who prescribed 'kitchen physics' "(p4).[24] Writing by physicians such as Thomas Sydenham claimed midwives 'infested the sacred of medicine'. Graphic depictions of dirty ignorant, drunken midwives like Sairey Gamp in Charles Dickens' *Martin Chuzzlewit* in 1844 discredited both births at home and midwives.[23,24] The figures of Florence Nightingale and Sairey Gamp could be seen as archetypal images, each representing exaggerated characteristics ascribed to the dualistic notion that women are either good (God's police) or bad (dammed whores).[25]

Sociologist, Deidre Wicks[26] argues that the emergence of medicine as a scientific profession and the takeover of midwifery can be related to industrialisation. According to Wicks,[26] the changing social, economic and political climate of the early eighteenth century created a substantial middle class of merchants who increasingly demanded medical services. As medical services expanded and medicine became 'professionalised', the barber surgeons, seeking new, lucrative fields, turned their attention to midwifery. It was difficult at first for man-midwives to be accepted by women as birth attendants.

Several successful strategies were adopted to change the power dynamics around birth and promote medicine's involvement in maternity care. One ploy was subjecting midwives to a smear campaign and actively refusing them admission to institutions of learning and other educational programs.[23] Lying in hospitals were established for the poor and working class women, providing the experience of normal birth for the education of doctors. With expertise gained from 'confining' poor women, man-midwives could ply their services with the rich. Taboos against male attendants were gradually eroded and female midwives were employed as subordinate assistants.[26] Obstetric forceps were developed by the Chamberlain brothers and kept secret for over a hundred years. As news of their life-saving possibility spread, women opted for the man-midwife and his technology.

As Wicks[26] outlines, the relationship of domination and subordination was the cause of a bitter and acrimonious struggle between midwives and medical doctors. The struggle, generated by medicine's opportunistic expansion during the economic, political and social upheaval caused by industrialisation, still has not been resolved. The unequal class structure between midwifery and medicine was enshrined in law in Australia in the Medical Registration Act 1862. Whilst this Act specifically excluded unqualified practitioners, meaning midwives, it allowed the registration of practising man-midwives with a 'grandfather clause'.[26] The subordinate position of midwifery in the hierarchy of health care was set in the same year with the establishment of midwifery training under medical supervision. The politically grounded 'ideology of professionalism' reinforced and promoted the idea that 'effective health care can only come from doctors' (p.36).[8]

Leap and Hunter[27] explored the history of midwifery in England. They explained that the term 'midwife' came from the old English *mid-wyf,* which meant 'with women'. During their research they were surprised to discover that midwifery history was full of authoritarian, rigid attitudes from the days of the handywoman to today's professional midwife. They found evidence of 'meddlesome activities', rather than the women-centred care they had been expecting to find. Initially judgemental and critical, the researchers' own attitudes softened when they became aware of the extraordinary achievements the midwives attained in the severely restrictive climate of the first half of the twentieth century within the politics of gender, class and poverty. In Australia, the push for control of midwifery was constant, some medical men seeking to control through legislation, others resisting, anxious that registration would lead to a second class of doctor. As Reiger notes, "From both quarters, though, the goal was the taken-for-granted hegemony of the medical profession in midwifery"(p91).[28]

Throughout history and to the present day, the issues confronting women and the issues confronting the nursing and midwifery professions are on a parallel course. Muff identified the connections between the attitudes, attributes, limitations and concerns of women and nurses.[22] As midwifery has been subsumed into nursing in Australia, this is relevant to midwifery as well as nursing. Both groups are seeking autonomy, respect and recognition. Yeaworth described the similarities in the role and status of nurses and therefore midwives, in the hospital culture with those of women in our patriarchal society.[29] Nursing for example, with its stereotypic image of "caring, nurturing and subservience, is a caricature of womanhood"[22] and has been viewed as the natural job for

women. Although these words were written in the 1980s, not much has changed.

Lawyer Jocelyn Scutt exposed the gender related inequities still active in our economic and political processes.[30] Inequities, explains Scutt, which leave women "in dead-end jobs, clustered below the glass ceiling or confines them under the concrete canopy"(p.iv).[30] Scutt contends that women are oppressed primarily because they are women. As Bell and Klein explain, each woman's experience of the systemic oppression of women is different, because class and culture creates difference amongst women. [31]

In both England and Australia, The Midwives' Act permitted the registration of experienced midwives who had not had any formal training[28] but as Leap and Hunter found in England, many of the 'handywomen' midwives had been taught by district medical doctors and were very skilled.[27] Medicine found an ally in nursing, already well established as a subordinate profession, in its campaign to remove autonomy from midwifery practice.[26] Around 1900, the expansion of nursing led to the release of campaign materials to encourage midwifery 'nursing' to be incorporated into general nursing.[26] In New South Wales, nursing subsumed midwifery in 1928. Interestingly, the new breed of trained midwives accepted the "superior status of doctors".(p92)[28] A formal Act was passed which incorporated midwifery as a specialised branch of nursing. The NSW Midwives' Board was abolished and control over midwifery was vested in the NSW Nurses' Registration Board.

According to Wicks,[26] the history of midwifery can be seen as a struggle over an occupational territory. An interesting example of the way that nursing has sought to subsume and control midwifery is evidenced by the secretive way midwifery lost its register in the 1991 review of the NSW Nurses' Act. The Nurses' Board decided to remove the midwifery register and all midwives and nurses would register as nurses. Under the review of the Act, midwives would only be endorsed to practise midwifery. The one and only midwife on the NSW Nurses' Board at the time, was told by the other members of the board, that the removal of midwifery as a separate register in the changes to the Act in 1991 was 'confidential'. Midwives did not know about the removal of their register from the Nurses' Act until the changes became enshrined in law in 1992.

When the NSW Nurses' Act of 1991 was to be reviewed, there were moves to re-establish midwifery as a discrete profession. Jan Robinson, a Sydney midwife in private practice, started the movement in July 1999, by submitting a lengthy and subsequently highly controversial document from the Australian Society of Independent Midwives (ASIM) to the NSW Health Minister, Craig Knowles and Judith Meppem, the Chief Nurse of NSW.[32] This document clearly articulated the differences between nursing and midwifery and identified the need for midwifery to be a discrete profession. The ASIM submission called for a Midwives' Act and a separate Midwives' Registration Board. The ASIM document galvanised the NSW Midwives' Association (NSWMA) into action. A sub-committee (of which I was a member), was convened and the decision was made to write a submission for a Nurses' and Midwives' Act and a separate register for midwives. The committee decided at the time, that asking for a Midwives' Act would be too radical. Even the submission for a Nurses' and Midwives' Act was considered too radical by many. The submission by The Australian College of Midwives and the NSWMA to change the NSW Nurses' Act to a NSW Nurses' and Midwives' Act resulted in controversy and hostility from the nursing sector. I observed a senior nurse angrily shout "midwifery is trying to claw its way to power on the back of nursing" at one of the state wide forums conducted by the New South Wales Midwives Association (NSWMA) in 2000 to promote the submission. Overt resistance continued until the revised Act was passed in late 2004 and the Nurses' and Midwives' Registration Board was legislated.

Increasing use of technology, education and regulation have shaped and changed many aspects of midwifery practice and women's experience of birth. Rising rates of intervention and caesarean section operations have caused alarm in many quarters. Health care costs are rising and fewer Australian women are giving birth normally. Murphy-Lawless[33] comments that obstetrics has firmly positioned itself in a dominant position and is 'self aggrandising' in its belief in its "capacity to deliver the hard, scientific facts" and its assertion that its "account of birth is the most definitive and its route the most certain way to avoid death"(p7) Murphy-Lawless[33] argues that obstetrics dismisses the emotional and spiritual realms and leaves the woman and her power out of the picture completely. The obstetrician's propensity to leave women 'out of the picture' is demonstrated in a study that investigated decision-making associated with

caesarean section births.[34] The researchers found that one third of the women studied who gave birth by caesarean felt they had no role in the decision-making process. The failure of modern obstetrics to incorporate the emotional and spiritual aspect into their perspective of practice is reflected in a recent study, which found women's chances of having a baby normally with private obstetric cover to be less than 18%.[35] As Ivan Illich observes "Diagnosis always intensifies stress, defines incapacity, imposes inactivity and focuses apprehension on non-recovery, on uncertainty, and on one's dependence on future medical findings, all of which amounts to a loss of autonomy or self-definition".[36]

Kitzinger[24] contends that obstetricians, seeing themselves as "saviours and defenders of the fetus" (p7), intervene in perfectly normal, healthy labours, causing iatrogenic problems. The evidence from a study involving 242 nulliparous pregnant women by Fisher, Smith and Astbury in 1995 supports Kitzinger's contention.[37] The study found the likelihood of women experiencing operative delivery and caesarean section was: "...increased further among those who in late pregnancy were thinking clearly, had high self-esteem, mature means of dealing with anxiety, were confident in their knowledge of childbirth procedures and in secure partnerships with highly educated men"...and..."that obstetric decision-making is significantly influenced by...the response of obstetricians to assured, well, pregnancy-educated pregnant women..." (p1)

The response of obstetricians to assured, well, educated pregnant women in that study has parallels to the findings from the investigation into gender and school education.[38] The researchers concluded that sex-based harassment seems to be part of a process of establishing relations based on dominance among males as well as putting girls as a group in their subordinate place in a gendered system. Is it possible that obstetrician's use of operative intervention in healthy, self-assured pregnant women is unconscious behaviour left over from the schoolyard?

Because of consumer pressure, various government investigations and initiatives have been undertaken to reduce interventions in childbirth. A sample of these initiatives include: The Shearman report;[4] Alternative Birthing Services Grants;[39] Having a baby in Victoria;[40] Options for effective care in childbirth;[5] Rocking the Cradle[6] and Rebirthing.[7] In each case, the recommendations include suggestions for the implementation of midwifery models of care for childbearing women. Some health services have responded positively to the reports and now provide midwifery-led care in antenatal clinics. Other health services, such as Northern Sydney Central Coast (NSW) and Hunter New England Health (NSW) have instigated comprehensive midwifery care at Ryde and Belmont respectively, as primary health care services for childbearing women. Sadly, initiatives to increase autonomy for nursing and midwifery roles still meet with opposition from medicine. The catch cry of 'untrained' and the corollary, 'dangerous' either stated or by innuendo, is still used as emotional rhetoric by doctors to denounce changes to maternity service provision.[10,11,12,41,42]

Changes in service delivery and scope of practice for midwives, have meant that education for midwives is also evolving. Midwifery education has moved away from hospital-based courses and all post-nursing midwifery education is via the tertiary pathway as either graduate diplomas or master degrees as post-nursing qualification. Some universities, such as UTS (University of Technology, Sydney) have instituted a Bachelor of Midwifery as a single degree. The last direct entry hospital based midwifery students graduated from Crown Street Hospital in Sydney in 1970.[21] After 35 years of nursing as a prerequisite pathway to midwifery, graduates from new 'direct entry' programs around Australia have been entering the workforce from 2005. It will be interesting to see the effect on maternity services of midwives who have entered midwifery with an educational background that did not include the nursing route.

Conclusion

It is known that childbearing women have fewer interventions and better outcomes where there is a strong and autonomous midwifery profession.[43] Current strategies towards autonomy and self-regulation through the increased numbers of midwifery-led units being established in NSW are a positive sign. We also know that politics and counter arguments from medically oriented colleagues will not go away. Only by recognising the long and deep history of struggle, resistance and re-emergence will midwives be able to continue to develop their scope of practice, recognising that medical and nursing hostility is cultural and historical, not personal. With a broad understanding of the political and historical threads in our current practice climate, midwives can continue to seek and establish a co-operative way of working with childbearing women and their families ***and*** medical colleagues. It is only by

understanding the background to the negativity that we can wholeheartedly, fearlessly and with good humour, encourage our medically oriented colleagues to join us in co-operative and sensible maternity care. There are medical practitioners who support women's choices. Mutual respect with intelligent communication between women, midwives and medical practitioners is the only way to ensure the best care for each particular woman and her individual circumstances. Understanding what has gone before will give us the strength, tenacity and courage needed to see our collective vision of women-centred maternity care realised.

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Author

Carolyn Hastie RN RM DipNursEd IBCLC
Midwife, Unit Manager, Belmont, Newcastle.
heartlogic@iprimus.com.au

Correction

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The implications of ingesting alcohol and caffeine when breastfeeding: What are the risks?

It has come to our attention that there is an error in our article. This paragraph from p45 should be deleted or ignored as it reports incorrectly on the research:

Merhav and colleagues[29] describe a higher incidence of microcytic anaemia among infants whose mothers are tea drinkers compared to non-tea drinkers. In this study, 122 infants underwent routine blood count counts at 6-12 months of age, demonstrating a high frequency of anaemia; 21.3% exhibited microcytosis and 19% microcytic anaemia. When a mother is lactating, the authors recommend abstinence from tea drinking where possible otherwise abstain from drinking tea for several hours around the breastfeeding schedule.[29]

The study by Merhav et al[1] actually reports on the relationship between tea consumption by infants and microcytic anaemia, not that there may be adverse consequence to the infant from the mother consuming tea. No articles related specifically to effects on infants of mothers ingesting tea when breastfeeding have been found in the literature, so no recommendations can be made. The authors apologise for the error.

Claudine Haber and Jane Allnutt
wombats66@hotmail.com

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