Skills for the Modern Midwife

The More Things Change, The More What's Important Stays The Same

Christine Cornwell PSM RN RM BHA
Life Member of ACM and Secretary ACM (SA Branch)

Much has changed for both women and midwives over the last few centuries. These indisputable facts, however, have remained unchanged: that women need to be cared for and valued through their childbirth experience and midwives need to be 'with woman'.

As western society changed and evolved, so has the role and status of women and so has the profession of midwifery.

Traditional midwives were women selected by their community. They learnt by training as apprentices to local midwives, working with them and hearing their stories, and their learnings were passed from one generation to the next. These wise and respected women knew the importance of caring for the woman throughout her journey to motherhood, during her pregnancy, labour, birthing experience and for some time afterwards. The midwife's role was to help, to support and to prepare the space for the baby's birth. She also protected that woman's space, to enable her to focus on her task of birthing and feeding her baby.

It was a normal event in a woman's life, and these traditional midwives trusted in the woman's natural ability to experience labour and birth, with minimal intervention from them. If things didn't go as expected, they were there to deal with it.

Midwives used their voice to support and advocate. They observed, and applied knowledge, experience, skills, and intuition, as well as their hands and gentle touch in caring for each woman and her baby.

At the time of white settlement of Australia, midwives attended the vast majority of births in Britain and Europe, and this continued in the colonies. According to Cahill, Arnup and Wertz and Wertz, midwives were respected members of the community and central figures within social childbirth practices.

The midwife attended the woman during labor and birth in her home and either stayed after the birth to provide household support or visited the new mother over the following days. Midwives upheld the local female traditions and rituals of support and care.

The midwife also had another role in the social childbirth setting: ensuring the health of the baby and the protection of the mother/baby partnership. This role has been largely overlooked in the literature, making the breadth of her socially designated responsibilities largely invisible.

Childbearing and lactation were seen as a continuum. As the midwife attended women through both the birth and the time following birth, she was responsible for the wellbeing of the mother and the baby. While breastfeeding was considered a necessary and natural function, the midwife's expertise would be used, particularly in difficult cases.

Within the social childbirth setting, the "lying-in" described the time that begins with labour and ends with the woman returning to her household responsibilities and social activities. Ulrich observed in "The Midwife's Tale: The Life of Martha Bullard - Based on her Diary 1785-1812", that "parturition ended when the mother returned to her kitchen". The labouring woman had female relatives and friends to assist her through her labour and birth, as well as the doctor or midwife, if available. But even when male doctors were present, it was the women who oversaw the labour and birth and who exercised control over the physical aspects of the environment. When the new mother 'returned to her kitchen', she would thank the women and midwife who had helped her, with the sharing of food and stories.'

Social childbirth practices of the 'lying-in' protected the new mother. They allowed her to rest and delineated the expectation of her role to feed and nurture her baby. She also had a clear understanding of the support she would receive from other women, her community, her partner and the midwife.

How different it is for a new mother today! She has to negotiate periods of rest within a full and busy day, undertaking her housework and other social duties, including caring for other children. The support from the 'community of women' is more commonly just not there.

What led to this dramatic shift in caring for the new mother?

Although childbirth practices had been firmly established in the domestic sphere for thousands of years, this shift happened over the relatively short period of a few centuries.

Evolving social, political and medical reforms over the last three centuries altered the focus and control of childbirth and contributed to the medicalisation of childbirth and the lessening of social childbirth.

Much of this social aspect of childbirth was featured in the stories of the women and their experiences. These stories and the social integration of childbirth cannot be separated from the physiological processes. Both are interwoven and equally integral in the woman's experience.

We all have many stories of women where the social and emotional aspects of their journey were more important to her ongoing wellbeing than the physical experience.

In the 18th century, medical practice, generally, remained unregulated in British Law. There were three orthodox medical groups, physicians, surgeons and apothecaries, all educated in the sciences of biology and anatomy. Although there was little evidence to support their therapeutic superiority over other practitioners, these medical men, self-identified as professionals and began to organise to gain control of the medical marketplace. These practitioners were the same gender, class and race of the men in power within the ruling Government and served the wealthy classes who could afford their services. These alliances undoubtedly assisted them in the process of professionalisation.

There was also a hierarchy within these three groups of medical men. The physicians had the highest status and provided services to the wealthy upper class. The apothecaries had the lowest status and were the original general practitioners (GPs) who provided services to the bulk of the community at a low cost. The apothecaries

gained power by aligning themselves with the physicians. During the 19th century, GPs found it difficult to establish a practice and earn a living, as they had no real competitive advantage over other health care providers, including midwives.

From the ranks of these self-named medical men, a new class arose, who attended women in childbirth. They had exclusive access to the use of forceps, a technology inaccessible to midwives. According to Cahill, these medical men destabilised public support for other healing professions by discrediting them. In particular, they disputed and devalued the 'unscientific' knowledge of midwives.

After decades of intensive, internal organising, these practitioners formed one occupational group called 'doctors' and successfully lobbied to have the profession enshrined in the 1858 British Medical Registration Act.

As Fahy states in her paper - "An Australian History of the Subordination of Midwifery", "This Act gave medicine autonomy, that is the right to define and control medical practice and limit other workers from practising medicine"

Obstetric practices eventually came to the colonies, where middle and upper-class women had physicians in attendance at their birth. However, the vast majority of women who were poor, working-class or living in rural areas were attended by midwives.

These medical men offered similar treatments as midwives to childbearing women. Their reputation and their professional status were built by producing medical journals, establishing medical associations, and fostering disdain for midwives.

Despite the presence of doctors at the births of the wealthier, urban women in the 19th century, birth still took place in women's homes and was seen very much as a social event. Women continued to retain authority over the social context and network of birth.

In her book, Leavitt says "The psychologically vital presence of trusted women friends, despite the influence of male medicine, continued to shape much of the childbirth experience for individual women. Men could be asked to do things, restrained from doing others, they could be argued with and agreed with, but rarely were they allowed to make decisions on their own. Medicine changed the birth experience, but only within the limits set by women's birthing-room culture."

Also, according to Wertz and Wertz, "Births attended by midwives, with female friends, female neighbours and female family members present, continued to be an occasion of the expression of care and love among women."

As recently as the 19th century, women were seen as the experts in domiciliary affairs, including childbirth and child-rearing. This expertise was conferred on them through their essential female nature. There was a notion of the sacredness of motherhood. This was clearly stated in William Cook's book 'Woman's Handbook of Health' where he states "The reproduction of the species, their nurture in the womb and their support and culture during infancy and childhood is the grand prerogative of women."

Women were entrusted with nurturing and maintaining their families and with managing the domestic affairs of the household. This social construction of motherhood placed a woman at the centre of decision making regarding her care and that of her family.

With the increase of physician attendance at birth, women came to depend on them and forsake their own knowledge of birth. The woman called the doctor for the expertise and science that he was expected to bring to her birth and yet more often than not, he simply relied on the woman's natural ability to give birth and then took the credit for the outcome. This representative of science was thanked for the safe delivery, reinforcing a relationship of paternalism and power that only served the physician.

Women were losing their belief in their innate strength and natural ability to give birth, which, along with the notion of Victorian modesty and female frailty, served to undermine women's confidence in these matters further. Middle and upper-class women had invited these medical men into their homes to attend them in childbirth, more and more undermining their own confidence and allowing them to abdicate their role and knowledge on childbirth.

Then, with the social reform movement, medical men who attended the wealthier women in their homes began to care for the poor during childbirth within public hospitals.

In Britain and many of its colonies, the maternity or lying-in hospital emerged initially as a charity that served the poorer women giving birth. From the public's point of view, the early lying-in hospitals were associated with charity cases, poverty and death. Women often died in childbirth due largely to puerperal infections, spread by bacteria passed to them by the hands of their caregivers. These were not places of medical healing, but places of social reform.

In the latter part of the 19th century, the length of stay in many lying-in hospitals was up to 30 days. The lying-in time was referred to as a period of weakness and susceptibility, which served to reinforce the Victorian values of the frailty of women. Women were barred from participating in activities which may offend their notion of privacy, essential frailty or sense of modesty. This removed other women from being with and supporting the birthing woman.

The social nature of childbirth was all but lost with this medicalisation, the creation of the lying-in hospital and the changing attitudes of women.

Many GPs migrated to Australia and initially in urban areas found less medical competition. As more GPs arrived and competition grew, they moved into rural areas, where the competition didn't come from other GPs, but from unregulated health workers, including midwives.

As the number of GPs grew, midwives became an impediment. As Fahy stated in her paper "Doctors writing in the Australian Medical Journal, informed each other that the fastest way to build up a general practice was to establish a relationship with the woman during pregnancy to build up her trust and then become the doctor to the whole family." Therefore, the midwife stood in the way of medical income and status. GPs had to find a way to justify their involvement in all labours and births. They used the same

strategies that were used in Britain and Europe, claiming midwives were dangerous and the cause of maternal death due to sepsis.

Given doctors were not taught about hand washing, it was plausible that it was doctors that carried the sepsis from one woman to another. Ideas of cleanliness and dirtiness were also class-based, and midwives were vulnerable to this stigmatisation, being working-class with no formal education. However, that lack of education was related to being female as much as being working class. In spite of these obstacles, midwives provided strong competition to doctors in the care of childbearing women, particularly in the country. Midwives were generally held in high regard by the community, and their fees were lower.

Medicine needed to counter this competition, and they turned to nursing. Nursing had emerged with the work of Florence Nightingale, who established nursing to work under the direction of medicine.

At the time, nursing wanted to claim the occupational territory of the whole of the life cycle. And so, medicine and nursing formed an alliance that served both their interests.

In Australia, in the early 20th century, the Australian Trained Nurses Association was formed professionalising nursing, using the medical model of establishing an association, a nursing journal and advocating for standards.

According to Summers in her paper "The Lost Voice of Midwifery", membership of the Australian Trained Nurses Association was open to other eminent members of society, including doctors, whose influence cannot be understated. Whereas the nursing members of the Association were trained nurses or nurses who had also undertaken midwifery training, community or vocational midwives were excluded.

Over time, and through the membership and structures of the Australian Trained Nurses Association, nursing successfully achieved superiority over midwifery.

In 1920, South Australia became the first state to implement legislation which included nursing, midwifery and psychiatric nursing under a single Nurses Registration Act, each on a separate register. Through this Act, the Nurses Registration Board had complete control of nursing education, standards and training hospitals.

Anyone not registered under the Act could not practice legally. The demand for this registration in South Australia came not only from medicine and nursing but also from the South Australian Hospital Association. This assisted in overcoming staffing shortages, by making hospitals, particularly country hospitals, training institutions, and thereby accessing the cheaper workforce of students.

The members of the Nurses Registration Board were mainly doctors or members of the South Australian Hospitals Association. The implementation of the regulations of the Act, supported the role of the obstetric nurse to work in hospitals under medical direction, rather than the role of the midwife working across the childbirth continuum and in the community with women.

The Australian Trained Nurses Association had subordinated midwifery within the Association, but with the Nurses Registration Act and the establishment of the Nurses Board, the Australian Trained Nurses Association lost control of nursing. So, as Summers states in her paper with the implementation of the Nurses Registration Act, "Nurses lost their self determination, but Midwives lost their profession."

During this time, there was community and Government pressure to improve birth outcomes for mothers and babies. Education of community or vocational midwives was seen as one possible solution. However, separate midwifery education was opposed by both nursing and medicine, who joined together to ensure that midwifery education could not be undertaken unless nursing training had been completed first.

In 1912 the Australian Federal Government was concerned by the low population numbers and introduced a baby bonus of 5 pounds. As time passed, women could only access this baby bonus if they had a medically supervised birth.

Some states supported the need for midwives, mainly because of the unmet need in rural areas and the Midwives Registration Bill was passed in Victoria in 1915. Both vocational midwives and nurses with midwifery qualification were entered onto the register, but vocational midwives needed a doctor's endorsement as to their safety and fitness to practice.

All of these power games happened in the context of a shortage of midwives and medical practitioners. Both medicine and nursing's refusal to support separate midwifery education and to educate vocational midwives indicates it was not about community needs or wellbeing, but about power and control and midwives being eliminated as a source of competition.

By the late 1920s, medical dominance in the care of women during childbirth was firmly established in Australia. Despite medicine being 'in charge' of births across the country, there was no decrease in infant or maternal mortality. The death rate from puerperal sepsis didn't decrease until antibiotics became available in the late 1930s and 1940s, and the use of an anaesthetic and forceps resulted in a proliferation of birth injuries to mothers and babies.

The medicalisation of childbirth, starting in Britain and Europe which came to Australia with white settlement, forever changed the social context of childbirth. The social and psycho-social aspects of childbirth which were, and are, so important to women, were largely forgotten.

Breastfeeding was crucial to the survival of the baby and was a central activity within the 'lying-in' time. If the woman couldn't breastfeed, the baby was sent to a wet nurse. The process of breastfeeding is an intimate and mutually adaptive experience, for both mother and baby. However, the biomedical goal was to produce a healthy baby in the ways and means of science. By the end of the 19th century, and well into the 20th century, breastfeeding was seen through a scientific, medical and industrial lens. As such, the first profound relationship of the newborn's life was replaced by a focus on the product. Women's lives were also changing. Women were campaigning about their suffrage, were achieving higher levels of education, joining

professions and working outside the home. They were enjoying newfound freedom and were seeking ways to safely control their fertility.

Both the private and social constructs of motherhood were directly affected by these events. The mother and baby were literally and symbolically separated by the advent of the obstetricians, pediatricians, infant formula, lying in hospitals and women's newfound freedoms. These notions disrupted both public and social confidence, as well as women's belief that they could birth their babies and feed them without medical guidance.

The postnatal period was redefined through a biomedical lens, as a time of physiological recovery for the new mother and where the mother and baby were separated. With hospitalisation they were seen as separate patients in separate beds, each requiring so-called expert medical care.

Governments and administrators accepted this biomedical definition and supported this medicalisation. Women themselves supported the process, in the interests of being modern and good citizens and with the belief that this medicalisation would save their lives and that of their babies.

Reducing maternal and infant mortality has become a never-ending focus of power in obstetrics and paediatric care, where the interests of institutions, specialists and politicians' controlled women and their infants at the time of birth. In biomedical terms, the mother has been reduced to a carrier of a fetus and a potential care provider for the baby. As either pregnant woman or mother, the woman became ultimately dependent on expert supervision.

Under the biomedical gaze, there has been a profound shift in symbolism, to the notion that the woman's body is potentially a harmful host. The symbolic notion of mother was disappearing. Yet, the human experience is that we all have mothers and that the mother-child relationship is significant in every individual's life.

The current times bring the era of safety and quality, risk management and risk minimisation, measuring everything we can. Usually, we measure time, numbers, compliance and dollars as indicators of quality and efficiency. We measure one institution against another and produce evidence that supports our compliance and improvements. It is an industry in itself, with the expressed intent of improving care and outcomes for patients. These processes perpetuate and support the medicalisation of childbirth, all but ignoring the social context of childbirth.

Within this climate of safety and quality, obstetrics has experienced the erosion of its control over women and childbirth. Obstetric practice is increasingly influenced by neonatology, advances in ultrasound and other diagnostic testing, as well as the practices of obstetric anesthesia and obstetric medicine, and now by the sub-specialty of maternal-fetal medicine. Women now have to negotiate their care with, not only obstetricians but often, with many medical specialists.

In spite of the campaign against them, the subordination of their profession, and the medicalisation of childbirth - midwives have survived. Independent midwives, throughout this period, continued to work to support women across the childbirth continuum. While independent midwives were all but eradicated in Australia in the early part of the 20th century, some re-emerged a few decades later. Midwives, who had been educated as nurses first, within the framework originally set by medicine and nursing, emerged from this education with the belief and commitment to the social context of childbirth. They contracted their services directly to women, just as midwives had done centuries ago. The number of women using their services was small and the number of midwives was small, but these midwives worked with women and provided care in the community or the woman's home. These midwives often received significant criticism from medicine, nursing, politicians and other midwives.

Today the majority of midwives work in hospitals, where work practices are organised by and for the convenience of the institution and medicine. Nursing industrial arrangements are also applied to the midwifery workforce. The midwives in hospitals provide high-quality care with the intent of supporting and caring for the woman and her baby. However, that care is provided by multiple midwives, especially in the larger hospitals, because of the organisation of wards and departments, which in turn determines how midwives work is structured and organised. Women often have to negotiate their care with a number of medical specialists, as well as tell their story repeatedly and negotiate with numerous midwives during their childbirth experience. With the reduction of postnatal hospital length of stay, the postnatal period is again essentially in the women's home. Whilst this is an opportunity for women to regain some of the social context of childbirth, the critical aspect of the support and care of the new mother and her baby by a 'community of women' as in centuries past, is just not there.

The last few decades have seen an increasing movement of women and midwives working together to reclaim women's control over their own normal human process and experience. To reclaim social aspects of childbirth, across the whole childbearing experience and within the agreed clinical guidelines. This has seen the introduction of birthing centres, team midwifery models and midwifery group practices or caseload models and most recently, publicly-funded homebirth.

The development of these models has been within existing clinical guidelines, and they demonstrate reduced interventions and improved clinical outcomes at reduced costs. However, a woman's access to them depends on whether that particular woman meets the set criteria for that particular service and/or the geographical area that each specific service covers. The majority of birthing women in Australia are still unable to access continuity of care from their known midwife. These models enable midwives to regain their full role and scope of practice

In the 1920s, only midwives who were first educated as nurses could register as midwives with the Nurses Board and only those who were registered could practice legally. Less than a hundred years on, in 2002 commencing in South Australia and Victoria, midwifery education leading to registration as a midwife became available as an undergraduate degree. Students could now access midwifery education without prior registration as a nurse.

We continue to experience dramatically increasing costs of health care with reduced resources, and one of the most common reasons for admission to an Australian hospital is for maternity care. Interventions such as induction of labour, epidural, instrumental birth, and caesarean section are rising, with no improved health outcome and at increasing cost. At the same time, we have increasing incidences of postnatal depression, other mental health disorders, recreational drug-taking and addiction, alcohol consumption, domestic violence and other social disruptions.

The emerging midwifery models are supporting the social context of birth. They work within the same agreed medical clinical guidelines and are producing outcomes that reduce these interventions with no compromise to mother or baby and at a reduced cost.

Midwives working in these models develop a mutually trusting relationship with each woman across the perinatal period and provide some social support, as well as clinical expertise. The woman remains central to the process, exercising choice and control over her own normal human experience.

Women deserve to regain confidence in their natural ability to bear and birth their babies. They deserve to regain the social context of childbirth and where and if necessary, to integrate it with medical aspects of childbirth. They deserve to have the space in which they labour protected, so they can focus on birthing their babies. They deserve to be tended to, nurtured and cared for following their birth. Women deserve respect for their childbearing and mothering role.

Just as regaining the social context of birth, will improve and change the lives of women, supporting women changes midwives lives. Like midwives of years past, midwives own lives will have to become more interwoven with their practice of midwifery.

For midwives, much has changed. However, being 'with woman' and using our voice in support and advocacy, our knowledge, experience, skills, intuition and our hands and gentle touch to care for each woman and her baby has not changed.

For women too, much has changed, but there is absolutely no doubt that childbirth is a profound experience in every woman's life. In the history of humankind, a woman's need to be cared for, respected, valued, nurtured and loved through her childbirth experience to motherhood has not changed.

Acknowledgements

Bridget Lynch, is a respected and influential Canadian midwife, and a Past President of ICM, having been elected in 2009. Her presentation at the ACM National Conference in Darwin in 2003, left an indelible impression on me. We spoke after that presentation and she told me of her writings for her Masters Research Paper, "Cultural Values and Post Partum Practices: The Loss of the Lying in Time" which she subsequently kindly shared with me. Her presentation, our discussion and her research paper, will stay with me forever and influenced and informed much of this article.

References

Arnup, Katherine, Andree Levesque and Ruth Roach Pearson, eds. *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries*. London: Routledge, 1990

Cahill, Heather. "Male appropriation and medicalization of Childbirth: An Historical Analysis" *Journal of Advanced Nursing*. 33(3) 2000.

Cook, William H. "*Woman's Handbook of Health*" 1871

Fahy, K. "An Australian History of the Subordination of Midwifery", *Women and Birth*. Vol 20. Elsevier 2007

Leavitt, Judith Walzer. *Brought to Bed: Childbearing in America, 1750 – 1950*. New York; Oxford UP, 1986

Summers, A. "The lost voice of Midwifery". *Collegian*. Vol 5, Issue 3. 1998

Wertz, Richard W. and Dorothy C. *Lying-In: A History of Childbirth in America*. New Haven: Yale UP, 1989 ■