20001-9-019

MIDWIFERY IN REVOLT

Judi Strid challenges the medical model of childbirth and the medical profession's determination to maintain control of normal reproduction.

Medicine, as practised in modern western societies, is androcentric and patriarchal and its values are those of the men who have power. Barbara Katz Rothman in her book *In Labour - Women and Power In The Birthplace* says,

> "Technological society dehumanizes people by encouraging a mechanical self image. To understand fully the way obstetrics conceptualizes the reproductive cycle, however, a second major ideological basis of the medical model must be considered. Medicine is based not only on the ideology of technological society, but also on the ideology of patriarchal society."

Medicine has treated, and in many instances defined, normal reproductive processes as diseases. The source of the pathology orientation of medicine towards women's health and reproduction is a body-as-machine model (the ideology of technology) in which the male body is taken as the norm (the ideology of patriarchy). From that viewpoint reproduction processes are stresses on the system and thus disease like.

Although physicians do not usually *speak* of normal reproductive processes as diseases (with the exception of menopause), they put ovulation, menstruation, pregnancy, childbirth, lactation and contraception into the context of medical management, care, supervision and treatment.

Reproduction is clearly a more complicated process for the female than the male, but the alternative to taking the female system as a complication of the "basic" or "simple" male system is (as midwives do) to take the female as the working norm. In this approach a pregnant woman is compared only to pregnant women, a lactating breast compared only to other lactating breasts. Pregnancy, lactation and so on are accepted not only as healthy, but as truly normal states. Women *are* pregnant, it is not something they "have" or "catch" or even contain.

Pregnancy involves physical changes. In the medical texts these changes are frequently called "symptoms". In the alternative, midwifery model pregnancy is not a disease and its changes are no more "symptoms" than the growth spurt or development of pubic hair are "symptomatic" of puberty. There may be diseases or complications of pregnancy, but the pregnancy itself is neither.

The medical model also sees the female as the passive receptacle for hosting the man's child. The patriarchal view sees women as the bearer of men's children, a view which is endorsed by our culture. The present health service structure is heavily integrated with the medical model. Although not all health professionals agree with this their lack of opposition to it in effect condones it. It is therefore left to consumers to challenge the power structure and its control by resisting a health care service that caters more to the needs of professionals than to the needs of those it is *meant* to serve.

Childbirth services in New Zealand are totally under the power and control of the medical profession. Control over where birth takes place, the procedures to be used, the conditions under which the birth occurs, who and how many supporters of the woman may be present, and even how the birth itself will take place, is ultimately in medical hands.

Although there is an increasing flexibility in some of these practices and some women are able to experience birth in a way more to their choosing, the responsibility lies with the *woman* to research what is available and to then present a "reasonable" case in order to be permitted to try an alternative. Even a home birth under the care of a highly skilled domiciliary midwife must also be under medical supervision and subject to the approval of a doctor. This process may actually be carried out in a friendly and amicable manner, but the woman is required to placate the medical profession, rather than have the doctors acknowledge her ability to determine her own needs and provide the appropriate support.

This is where the midwife comes into her own as the advocate of the pregnant and birthing woman. As Carol Flint, a member of the United Kingdom Association of Radical Midwives, says in her book *Sensitive Midwifery*,

> "To be a midwife is to be with women – sharing their travail and their suffering, their joys and their delights. To be a midwife is to engage in a close and intimate relationship which often lasts only as long as the pregnancy, birth and puerperium but the effect of which travels down through the centuries in the image women have of themselves and their abilities and worth. When midwives are strong, women are able to labour safely and without unnecessary interference. When midwives are weak women's bodies are taken over and the birth process is interfered with, often to their detriment."

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The role and perception of the midwife is clearly very different from that of the medical profession. Despite this clear distinction, the battle between midwives as traditional birth attendants and the medical profession dates back to very early times in western culture.

The medical profession's present preoccupation with high technology in childbirth is just a more sophisticated strategy to threaten and further undermine the existence of midwives. Throughout history and herstory midwives have shown great determination and tenacity to protect their position of supporting women in childbirth – a situation which persists today. As midwives are guardians of normal birth, the continued endangering of their position should be of concern to all women.

We can educate women to request midwifery care and emphasise the importance of consumer input into maternity services. Women's health priorities must be defined by *both* service providers and consumers who *together* assess the problems, resources and needs.

Having birth take place in hospitals further strengthens the power of the medical profession and their self-given role. The hospital is their territory, so they dictate the rules. The onus lies with women to organise resistance. Change will come only as the result of constant pressure, not because of any acknowledgement of the need to provide a service *for* birthing women. Birth in hospital is promoted as safer (and therefore more desirable) but there is no real evidence to support this. The role of the midwife in a hospital is reduced to nursing duties, assisting the doctor or battling on behalf of women to reduce the level of interference.

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Internationally, as resistance to high-tech birth increases, more midwives and some doctors (like Wendy Savage) have faced disciplinary action and dismissal for overturning hospital rules and regulations to allow women to have birth how they wanted, rather than the way a particular health authority has dictated.

It is essential for us as women to regain our power over childbirth and to develop the necessary strategies to do so. We need to more actively promote the midwife as a positive presence who focuses on the childbearing woman and the baby, with the knowledge and skill required, but also with a sensitivity and respect for the individuality and uniqueness of each woman and her choices for birthing. More midwives need to actively respond to this challenge.

I believe that women go through a grieving process if they have an unsatisfactory birth experience that leaves them feeling cheated, disappointed and with a feeling of loss. Because this grief is generally unrecognised it is usually left unresolved but it can be so profound that it continues to affect the quality of the woman's relationship with her partner and children.

We need to use our collective energies as women to oppose the continued pathological and high-tech approach to childbirth. We must mobilise our numerous networks and educate and empower women to be assertive enough to take back the control of their own birthing and to know they have the support of other women. Pregnancy and childbirth is a vulnerable time, so it can be difficult to focus on the patriarchal complexities of foetal politics.

I strongly endorse the plea of Carolyn Noble-Spruell from Australia who, in her paper to the recent International Congress of Midwives, in the Netherlands, urged feminists not to lose sight of the fact that all women are subjected to the powerlessness, control and degradation of present reproductive health practices that continue to use women's bodies as living laboratories. As she points out, the promotion of medical technology based on "professionalism" and patriarchal "knowedge" leads to women having very little control over its development, use and direction. Men are assuming control of the process from beginning to end, supported

by the prolific data of "value free" scientific research and technology, encased in the catch-cry that "women want it".

Women's power to procreate and man's attempt to colonise this power by medical intervention and the staking out of these functions as medical territory is the common theme linking fertile and infertile women. An important factor in this process is that continued medicalisation of female existence rests on the continued availability of female bodies to be analysed, quantified and integrated into the sphere of medical procedures that render these functions pathological.

The medical professions are totally dependent on women's bodies for providing the clinical material they need to maintain their high-income professional practices and also for the training of their successors. With the decline in birth rate we have witnessed a virtual squabble for women's bodies as there have been insufficient to go around.

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ILLUSTRATION MADELINE BEASLEY

It is no coincidence that midwives have been pushed aside in this highly competitive obstetric environment, their status completely undermined. Further attacks on the midwifery profession have been directed at their training and legal status. The 1971 Nurses Act prohibited domiciliary midwives from operating as independent practitioners as they were to commence working under the supervision of doctors and be accountable to them. Prior to this they could book cases, give antenatal supervision and attend deliveries on their own. The 1983 Nurses Amendment Bill excluded all future Direct Entry (DE, that is, without nursing training) midwives from registering as domiciliary midwives.

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By taking control of funds obstetric and gynaecologic (O and G) specialists have had considerable influence over the direction of midwifery training, along with input into the content of training and attitudes to birth. New Zealand's present midwife training is totally inadequate and inappropriate and is not recognised anywhere else in the world.

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The Save The Midwives Direct Entry Task Force is committed to the establishment of a three-year specialist midwifery training programme in New Zealand. Such a course will reinforce sensitivity to the needs of New Zealand women but will also meet international requirements.

The New Zealand midwifery profession has been pre-occupied with the problems of being subsumed by the New Zealand Nurses Association (NZNA), of which midwives as a group are merely a section. Due to the structure of midwifery training here most midwives are nurse-midwives and therefore appear to have divided loyalties about a break away from the NZNA. As long as the NZNA, which has conflicting interests to those of midwives, continues to make policy decisions for them their status as professionals in their own right continues to be undermined.

As Joan Donley states in her book *Save The Midwife* ,

> "Midwives and nurses have never been really compatible. Traditionally midwives have cared for healthy women performing a natural function in their own homes. Professional nursing is of comparatively recent origins. It grew up with the growth of hospitals and has always involved the care of patients suffering from illness or disease. Whereas midwives were independent practioners relying on consumer patronage, nurses cared for a captive clientele under orders from a doctor. They were trained to be submissive and respectful, and to care for the patient in the doctors' interests. Midwifery and nursing are two entirely different vocations involving different principles."

However, while New Zealand midwives agonise over the politics of their staus within the NZNA they have also responded to the crisis in midwifery education. Basic midwifery training, which was a year following general nursing training, was discontinued in 1979 and the midwive's section of NZNA is committed to reinstating this.

What presently remains of midwifery training has been placed within a post-graduate course of nursing – a midwifery option within the Advanced Diploma of Nursing that provides an obstetric component of only ten weeks. This has received considerable criticism during recent evaluations by the Education Department and nurse-midwives have also been critical of it. Many New Zealanders now prefer to train overseas.

As community attitudes move towards recognising the role of the midwife there is increasing demand for her care, both in home and hospital situations. So there is increasing community support for improved training to enable sufficient midwives to be trained to meet this demand. There is a simultaneous demand from a large group of women who wish to have this form of education/training made available to them in New Zealand, so considerable pressure is being directed to the ministers of both health and education.

For those of us who have a passion to practice midwifery but no interest in nursing, or who cannot afford the time or cost of six years' training, the options have looked extremely restrictive. However, we do have some choices:

- We can reject the present training outright for the farce that it is.
- We could reluctantly plough through full nursing training as a means to an end.
- We could disappear overseas to do someone else's midwifery training course.
- Or we can throw our energies into lobbying for changes within midwifery education and adopt strategies to ensure that New Zealand has a specialist midwifery training programme that is an asset to the profession *and* provides women with skilled and sensitive midwives.

Not only do I feel the latter to be the direction to take, I also feel that it is a realistic goal that we can achieve in the near future.

A DE course would require no nursing pre-requisite. A recognition and understanding of problems that could arise in pregnancy, childbirth and the post-natal period, with ways to deal with such situations are an essential part of DE training.

Establishment of *both* the Basic and DE midwifery courses would not put them in opposition to each other. Both are needed for the survival of midwifery in this country. The increasing national shortage of midwives, due to the restrictive training programmes now in place, is allowing an increase in O and G input into the birthing scene. This in turn results in an increase in the incidence of abnormal high-tech birthing, and contributes further strength to the O and G empire.

Basic midwifery training will target those with nursing training who wish to work in the midwifery field. DE training targets a completely different group – those who wish to practise as midwives only, and have no interest in nursing. Nursing should not be a pre-requisite for training as a midwife, but if nurses choose to work as midwives training should be available to them.

Provision of both courses will help to overcome the national shortage of midwives and increase the numbers, which will increase their strength as a group, and I hope, precipitate the much-needed split from the NZNA. Improving midwifery education will strengthen the midwife's position and equip her to work more effectively in areas like research.

Research by midwives is required to *redefine* childbirth and to *accurately* assess who is at risk, what a desirable outcome is, and what are acceptable and necesary procedures. Presently these issues are determined by male obstetricians, so individual choice often becomes overwhelmed by the control of the medical establishment.

The World Health Organisation commissioned an international study of routine medical procedures carried out during pregnancy and childbirth which showed that many procedures have never undergone scientific evaluation yet they have significant undesirable psychological and social effects. In most situations and in most countries women were not given a choice about procedures. To do so would acknowledge that women are capable of handling such knowledge and control, and the power base of the medical profession would collapse.

And so the suppression of the midwives' role and the medicalisation of childbirth have continued together. Although this development is historically recent it has become firmly entrenched in our culture and the return to "normality" will continue to be met with resistance, hostility and the inevitable prejudice against those who persist in disturbing the status quo.

There is a noticeable absence of Maori input into birthing and midwifery issues, as Maori women are having to deal with a multitude of other issues that take priority over this area. However, those of us in the DE Task Force are working to have a Maori perspective on the working party which is to compile a draft proposal and curriculum format.

As well as increasing the numbers of midwives and improving maternity care for women generally, we have a vision that a New Zealand DE course will provide appropriate training for Maori women wishing to practise as midwives (the present facility is stacked against them) and be sensitive to the needs of Maori women giving birth. As well as meeting the presently neglected needs of Maori women in this area the introduction of a Maori perspective will hopefully attract Maori students to midwifery. The incorporation of the Maori philosophy of health is very compatible with the DE philosophy. The Maori approach is also holistic, giving unity to spiritual, emotional, psychological, bodily, family and environmental dimensions. It rises above the divisions created by narrow professional roles and will further enrich the training of all student midwives experiencing the programme.

Positive action by all women can be taken individually or collectively by writing to the ministers of education and health demanding changes in midwifery training, the status of midwives and for realistic payment for domiciliary midwives. For changes to occur support from the community must be seen and heard. A correspondence campaign is an effective way of highlighting midwifery issues and keeping them visible.

We can encourage women to demand midwifery care and insist that women be acknowledged as a significant health resource. Women's health must be considered a major social investment and challenge. Although the appropriateness of consumer input into health care services is beginning to be acknowledged we have to demand to see this in action.

If we believe in ourselves we can change the system.

SAVE THE MIDWIVES is a non-profit voluntary organisation currently working -
- to encourage women to participate fully in their pregnancy, birth and motherhood;
- to share skills, information and ideas and explore alternative patterns of care;
- towards a direct entry specialist training course for midwives;
- for separation of midwifery training from the Advanced Diploma of Nursing;
- for improved payment for domiciliary midwives.

Save The Midwives has successfully -
- opposed parts of the Nurses Amendment Bill that were detrimental to midwives;
- formed "Maternity Action", a coalition of 16 major parent's and women's groups in Auckland;
- opposed the closure of Auckland's small maternity hospitals in 1985;
- made some changes to the quality of midwifery training in Auckland since the 1985 intake.

Anyone wishing to join Save the Midwives and receive the quarterly newsletter, send a sub of $10 or $6 (you choose) to 27 Taneera Cres, Wellington.

To become involved with the DE Task Force contact Judi Stid at P O Box 183, Ruakaka, Northland.