Chapter 1
What Is Midwifery?

This book has two subjects—childbirth and midwifery. Neither subject is understood well by most Americans, even by many professionals working in maternity care. It was written for midwives and midwifery students; for medical students and physicians, especially obstetrician–gynecologists and family physicians; for everyone who needs to have a solid understanding of midwifery and the problems and circumstances affecting the health and health care of pregnant women in the United States; and for anyone interested in learning more about the roles, lives, and health of women and the social and historical development of medicine and midwifery.

Early in this century American obstetrics became committed to a path that has led to a highly medicalized approach to the care of women during pregnancy, especially during childbirth. Prenatal care focuses on detection of pathology; labor is intensely monitored and controlled. This form of care involves the use of many unnecessary procedures and other interventions during labor and delivery. It is expensive, causes complications, results in increased use of cesarean sections, and changes the nature of the act of giving birth, robbing many women and their loved ones of a powerful, potentially life-enhancing experience. Highly medicalized pregnancy care is based on a view of pregnancy that focuses on its potential for pathology. The alternative model is midwifery; though it is a minority model in this country, it is the standard in most other developed countries. Those countries provide care that is less sophisticated technologically; they spend far less money in the process, and their results are better than ours. Virtually every year the U.S. Public Health Service announces that our infant mortality rate has decreased. The announcements fail to mention that, although lower than before, our infant mortality rate is higher than rates in almost all countries whose level of wealth, development, and medical sophistication is similar to that of the United States. The gap between our infant mortality rate and the rates in most of those countries is getting wider, and our rate

would be much worse except that we lead the world in the ability to save the lives—though not always the full health and potential—of babies who are born so premature, small, or damaged that they would not survive without the most sophisticated, expensive neonatal intensive care.

This book explains the difference between midwifery and medical obstetrics—conceptual and philosophical differences and differences in history, practices, and the effects and outcomes of care. It also explains the problems that underlie the relatively high rate of infant mortality in this country—long-standing problems related to poverty, social distress, and high-risk behaviors among a large proportion of pregnant women; and persistent problems related to lack of access to maternity care for highest risk women, poor quality of maternity care for highest risk women, and care that fails to address the most serious problems.

The greatest gains in the safety of childbearing came from medical discoveries and inventions made during the first half of this century—blood transfusions, antibiotics, and medicine to treat pregnancy-induced hypertension. The ability to perform rapid, relatively safe cesarean sections was also important. These treatments arose from medicine doing what it does best—focusing on the diagnosis and treatment of disease, looking for knowledge and solutions by studying the structure and function of the human body at the level of the cells, organs, and organ systems. Medicine deserves high praise for developing these essential treatments and making them widely available. All further efforts to improve pregnancy outcomes rely on this basic level of safety. Nevertheless, much of the recent progress has come from other disciplines, including midwifery, which deal with problems and solutions that affect pregnant women and newborns at a different level. Unplanned, unwanted pregnancies; social and psychological stress; smoking, illegal drug use, domestic violence, poor nutrition, sexually transmitted infections, and poor hygiene; depression; newborn infections; inadequate nourishment and care of the infant, even physical abuse—these are the problems that need to be addressed to reduce infant morbidity and mortality further and to give American children a better start in life.

Whereas medicine focuses on the pathologic potential of pregnancy and birth, midwifery focuses on its normalcy and potential for health. Pregnancy, childbirth, and breast-feeding are normal bodily and family functions. That they are susceptible to pathology does not negate their essential normalcy and the importance of the nonmedical aspects of these critical processes and events in people's lives. Midwives know about the medical risks, identify complications early, and collaborate with physicians to ensure medical care for serious problems. But attention to the medical aspects of these complex processes, although essential, is not sufficient. Midwives focus on each woman as a unique person, in the context of her family and her life. The midwife strives to support the woman in ways that empower her to achieve her own goals and hopes for her pregnancy, birth and baby, and for her role as mother. Midwives believe that women's bodies are well designed for birth and try to protect, support, and avoid interfering with the normal processes of labor, delivery, and the reuniting of the mother and newborn after their separation at birth. This is a far cry from prenatal care that focuses primarily on the uterus and fetus, the possibility of pathology, and a sequence of tests and procedures; and on childbirth care that interferes with the normal processes to such an extent that 30 percent of women cannot give birth on their own but must be assisted by cesarean sections, forceps, or vacuum equipment to pull the infant out of its mother.

The care provided by midwives reflects a deeper understanding of the needs of pregnant women and newborns and the intricacy of the natural processes of labor, birth, and breast-feeding. It also provides opportuni-

ties to address some of the problems that result in poor pregnancy outcomes. Midwifery brings benefits to all women, especially those who are most in need of support and a positive entrance into motherhood.

Medicine and midwifery are distinct professions, based on overlapping but distinct bodies of knowledge. They are inherently complementary. The competitive nature of the American health care system has accentuated the competitive aspect of the medical/midwifery relationship.

Virtually all industrialized countries experienced increasing medicalization of childbirth during the 1970s and 1980s. Dissatisfaction with that kind of care led to reforms in some countries. Studies conducted in the United Kingdom and Australia during the 1980s and early 1990s found that women wanted an opportunity to develop a relationship with an individual midwife and wanted midwives to be free to practice midwifery, not the pathology-oriented care prescribed by doctors.

The United States is unique in having two distinct kinds of midwives—certified nurse-midwives and a broad group of other midwives. At the beginning of the 1980s, most midwives who were not certified nurse-midwives were referred to as "lay midwives." As time progressed, many of the women who had become lay midwives during the 1970s became committed to developing their form of midwifery (based primarily on home births and much more independence from medicine) into a separate "direct-entry" (i.e., non-nursing) arm of the midwifery profession in this country. Although considerable efforts have been made to unify the midwifery profession, the history and position in society of certified nurse-midwives and direct-entry midwives are so different that they remain separate despite growing experience, friendships, and respect between members of the two groups and a great deal of common ground.

The proportion of births attended by midwives increased steadily during the 1980s and the first half of the 1990s. Midwives now attend the births of nearly 6 percent of the babies born in the United States. Nurse-midwives attended 90 to 95 percent of all births attended by midwives in 1994.

Etymology

The English word *midwife* is derived from *mid*, which means "with," and *wif*, which means "wife," that is, a woman. The term was used as early as 1303 (Helman et al., 1971). The literal meaning—to be "with woman" during childbirth—is the *sine qua non* of midwifery. The simplest definition of a midwife is a woman who assists other women while they are giving birth. Midwifery in that sense has existed throughout the history of mankind. Until the eighteenth century, *midwifery* referred to the care provided to women during childbirth regardless of the type of practitioner. Because most midwives were women, the term implied a female birth attendant. Male doctors who became involved in childbirth were referred to as *man-midwives*. *Sage-femme*, the French term, means "wise" or "good" woman, reflecting the larger role many midwives have played as sources of knowledge on herbal medicine, health and illness, child care, and death, as well as pregnancy and birth (Rothman, 1983). The Danish term is *jordmoder*, or "earth-mother." The focus of midwifery has been normal, that is, medically uncomplicated, pregnancies. The word *obstetrics* is derived from obstetrix, which is the Latin term for "midwife" (Cunningham et al., 1993).

The Care of Pregnant Women: Separation into Two Different Professions

As part of the normal female reproductive function and life cycle, pregnancy and childbirth across cultures have, until very recent times, been within the domain of women. Childbirth was—and is, to varying degrees—

an extreme experience, involving pain, hard labor, and the possibility of dying or losing the child; however, women had many pregnancies and childbirth was a common experience, part of everyday life. Women supported one another and shared knowledge about pregnancy and birth, as they did in other aspects of their roles as wives, homemakers, and mothers. In most communities, certain women were drawn to this special work. Women who were particularly effective at comforting and encouraging other women during childbirth and who seemed able to wrest good outcomes from frightening circumstances were esteemed among women, and their assistance was sought frequently. In this way, certain women developed skills and empirical knowledge of pregnancy and childbirth, which they passed on to younger women when additional midwives were needed. Although many midwives performed this work simply to assist the women of their extended families and communities, it became a paid occupation for some. For the most part, it was part-time work that women did from their homes.

Men were excluded from childbirth due to religion and sexual propriety and because they had no relevant expertise. Midwives in most Western societies were expected to summon a priest or other male religious authority when death of the child and/or mother seemed imminent, and midwives sometimes called a surgeon to extract and, if necessary, destroy an impacted fetus in an effort to save the woman's life. As medicine progressed, physicians' interest in pregnancy remained focused on pathology; they had little interest in pregnancies that did not involve a complication or disease. The invention of forceps in the early seventeenth century gave doctors their first technical advantage over midwives; a physician or surgeon skilled in the use of forceps could sometimes save both mother and baby in situations that previously would have resulted in the death of at least one or the other.

Medicine eventually became a learned profession, the training for which was based in universities. Medical education was available primarily to men from the wealthy and educated social elite. Most midwives, like the majority of all people, were relatively poor. When physicians began to demonstrate an advantage over midwives, first by use of forceps and later through anesthesia, wealthy women and women of the newly expanding middle class preferred to use physicians.

The history of midwifery and, to a lesser degree, obstetrics is described more thoroughly in later chapters of this book. The brief synopsis given here explains the different origins and purposes of obstetrics and midwifery and factors that led to the development of two distinct professions: One focuses on pathology and has continuously expanded the proportion of pregnancies considered pathologic. The other focuses on the healthful potential of each woman's pregnancy and tries to protect normalcy and expand the proportion of women remaining normal.

As a specialty of medicine, the main focus of obstetrics was and remains the diagnosis and treatment of pathology: complications of pregnancy and management of diseases affecting pregnant women and the fetuses they carry. Physicians became involved and increasingly dominant in maternity care through utilization of a technical innovation (forceps) that enabled greater success in overcoming a life-threatening complication. Other medical innovations—antibiotics, blood transfusions, drugs to treat pregnancy-induced hypertension, and cesarean sections—each a medical triumph over potentially lethal pathology, dramatically reduced both infant and maternal deaths. Through use of general anesthesia, systemic analgesia, "twilight sleep," and, now, epidural anesthesia, physicians have held out the promise of pain-free birth. These methods, however, cause complications and interrupt the normal powers and processes of labor, requiring use of interventions such as oxytocin and forceps. Anesthetized women are more

likely to experience pathology and are, in fact, no longer having normal births. Medicine strengthened its role in maternity care by expanding the concept of obstetric pathology, using hypersensitive monitoring devices, creating constrained definitions of normal, defining variation from those definitions as pathologic, and routinizing and eventually "normalizing" childbirth characterized by a sequence of preemptive interventions. In recent years, the development of "risk assessment" (women with characteristics associated with a higher-than-average rate of poor pregnancy outcomes are defined as "high-risk") has further expanded the proportion of women considered to be in need of pathology-oriented maternity care. As in the past, many contemporary obstetricians have never witnessed a completely natural birth.

In contrast, normal pregnancy and childbearing are the primary focus of midwifery. Midwives look for early signs of pathology or other deviations from normal and involve a physician in the care of women with serious complications or diseases. But midwives' particular interest and special expertise and skills are related to the care of women with uncomplicated pregnancies. Midwives try to avoid the need for pathology-oriented interventions by giving women the information and help they need to maximize their health and prevent complications. They are critical of physicians' efforts to control labor and delivery, in part by restricting the environment and behavior of women during childbirth, and of physicians' frequent or routine use of invasive, uncomfortable procedures that limit freedom of movement and interfere with the social, emotional, and spiritual experience of giving birth. Midwives have developed and are assessing less invasive *midwifery* methods to manage some abnormal conditions successfully or to return them to normal. Whereas their primary goal is normal births, the midwife's focus is wide in time and scope. Pregnancy and labor are not the limits of her concerns, which include the sexuality from which pregnancy results, the baby with its needs, and the effects the birth and baby have on the mother and father and other children. Breast-feeding, mothercraft, and the emotional, social, cultural, spiritual, and ceremonial aspects of pregnancy and childbirth are within the scope of midwifery, in addition to the physical and biological aspects of conception, pregnancy, labor, delivery, lactation, the mother's return to a nonpregnant state, and the newborn's adaptation to extrauterine life.

Differences in the history, socialization, education and experience of physicians and midwives have led to differences in philosophy, which have led to differences in practices, and thus differences in outcomes. These are described in the following chapters. It is important to understand at the outset, however, that midwifery and obstetrics are two distinct professions—with different philosophies and overlapping but distinct bodies of knowledge.

The differences between midwifery and medicine are better understood in the British Isles and Europe than in the United States. In the United States the issues have become confounded by the development of two new kinds of health-care providers—physicians' assistants and nurse practitioners—as means to remedy a shortage and maldistribution of physicians during the 1960s. The physician assistant (PA) concept was based on the U.S. military's successful experience with paramedics. The nurse practitioner (NP) role adds specific delegated medical tasks and functions to the role of the registered nurse. Both were based on recognition that a significant proportion of health care needs arise from a limited number of common problems that can be effectively diagnosed and treated or managed by persons with less preparation than a physician. Nurse anesthetists are also part of this category. The special knowledge and functions of physician assistants and nurse anesthetists are drawn from medicine and are within its realm; their tasks are delegated to them by physicians, who supervise and re-

tain authority over these practitioners. Physicians are also responsible for the *medical* functions of nurse practitioners. All three practice from a portion of the body of knowledge of medicine—the "midlevel" of the medical field—the entirety of which is the province of physicians.

Ever since the beginning of the development of the PA and NP concept in the mid-1960s, programs to prepare, evaluate, or support PAs and NPs have tended to group them with nurse-midwives as a category variously referred to as "physician extenders" or "midlevel" health-care providers. Although there are similarities among these categories (in amount of training and how they fit into the health-care system), they are dissimilar in their relationship to medicine. The role, functions, and body of knowledge of midwives and physicians overlap to some degree, but each profession has its own body of knowledge. Midwives are not practicing from the middle realm of obstetrics. They are practicing midwifery.

Varying Definitions and Kinds of Midwives

There are several different kinds of midwives. The word *midwife* has many overlapping but different definitions, especially in the United States, where one group of midwives is undergoing important changes.

The International Definition of a Midwife

An international definition of a midwife was developed by the World Health Organization (WHO) in 1965. A revised version was adopted by the International Confederation of Midwives (ICM) in 1972. The International Federation of Gynaecologists and Obstetricians approved and adopted ICM's definition in 1973. It was further revised by the ICM in 1990:

> A midwife is a person who, having been regularly admitted to a midwifery educational program duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.
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> She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.
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> She has an important task in health counseling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.

How Does a Midwife Differ from a Traditional Birth Attendant?

The World Health Organization defines a traditional birth attendant (TBA) as "a person who assists the mother at childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants." Although reflecting common usage, the dictionary definition of a midwife as a woman who assists other women during childbirth* does not distinguish between midwives and TBAs, a term that is used primarily in developing countries. Although TBAs are often referred to as traditional or "indigenous" midwives, WHO tries to maintain a clear distinction between a midwife and a TBA. WHO defines a trained TBA as one who has received a short course, usually not longer than one month, through the

*Although most midwives are women, a small percentage of American midwives are men. However, this book uses only feminine pronouns in reference to midwives.