WOMAN-CENTERED CARE:
The Knowledge and Practice of Midwifery at the University of York

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ABSTRACT

This thesis explores the ideology of midwifery in a particular training program, that of the University of York. By analyzing the history which shaped the program, the legislation which regulates it, and the philosophical beliefs which influence it, in Great Britain, giving birth has evolved from a women-only event, attended by a midwife, which took place in the home to one which is now often attended by a variety of medical practitioners, both male and female, and most often takes place in a hospital. With childbirth, midwifery has undergone dramatic transition.

The study describes the ways in which York’s ideology revolves around the goal of “woman-centered care,” which seeks to provide pregnant women and new mothers with the power to make choices about their maternity care, to ensure that they have the greatest continuity of caregiver throughout their pregnancy, and that the care they receive is appropriate to their needs and desires. “Woman-centered care” is an ideal advocated by both the government and midwives themselves. The program trains its midwives to base their practice on knowledge, as opposed to habit or protocol; to be partners in care with women, rather than administrators of care; and to be safe, autonomous practitioners. The underlying philosophy is the idea that birth is a natural process, rather than a dangerous, disease-like state which requires medical intervention.

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This thesis would not have existed without the support and generosity of many, many people. I am immensely grateful to Michèle Oshima, who listened and helped at every turn, my mother, who told me to “just think of it as a big paper,” my sister and my father, who assured me that I could, Merideth Rising, who edited my thesis and never stopped believing in me, even when I doubted, Julie Park, who helped keep me sane, and Jean Jackson and Margery Resnick, my ever-patient and tireless thesis advisors. Many thanks to Evelyn Hammonds, and her work during my prethesis semester, Bette Davis for keeping me within regulation at all times and Noémi Giszpenc for her formatting guidance. Heartfelt gratitude to Joanna deGroot, my tutor at York, Pamela Milliken, my teacher and friend who showed me what a midwife was in the first place, and to the excellent staff of the MIT library system.

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The work that follows is both a brief history of British midwifery and an analysis of its ideology. During the fall of 1998, I spent three months in York, England, studying at the University of York and learning about its midwifery program. My interest in this topic stems from my desire to become a childbirth care provider. I feel that women should have as much choice as possible in their childbirth care, and be treated with respect and consideration. This analysis is both an academic study, and my own inquiry into a form of childbirth care and the ways it may or may not satisfy women. It is an exploration of midwives’ role in maternity care, their beliefs about birth, and the limitations of their practice, whether methodological or ideological in nature.

I chose to study midwifery because the “midwifery model” of birth appeals to me. As Mandy Robotham, a student of midwifery put it, "Having babies is not about healing or sickness. It is natural and normal." The model, briefly, is that birth is a natural event, not a disease. It was interesting to learn that the British healthcare system as a whole embraces this ideology (at least officially) as a basis for childbirth care. In concurrence with the belief that normal pregnancy and birth should not be treated as disease, there is a sort of division of labor in terms of maternity care: Midwives in the United Kingdom are responsible for the care of women with normal, uncomplicated pregnancies, while obstetricians care for women whose pregnancies are medically complicated.

I was attracted to midwifery because it has intrigued me for a long time as a traditional profession in which women, ideally, help and empower each other, but analyzing it also allows for a better understanding of the care most pregnant women receive in Britain. By studying Britain’s system, then, I believe that a better understanding of health care in the United States may be achieved. A comparison of the two countries illuminates the differences and strengths of each system.

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This study is a brief history and analysis of the ideology of midwifery in Great Britain, and the history which shaped it. Philosophy and belief are highly individual matters, resulting from the interaction of many factors, including training, professional and personal experience, religious beliefs, and social conventions. Because it would be impossible to quantify or generalize these beliefs for all midwives, I wanted to examine one factor which influences the formation of a midwife’s beliefs about birth and her practice: her training. More specifically, I investigated the philosophy of one particular program, the BA(Hons) Course in Midwifery at York University (which I refer to as the York program).

Although government, hospital, and profession establish certain guidelines and regulations governing her field, a midwife’s ideology is left up to her to define, understand, and incorporate into practice. Some questions which elucidate this concept are:

- How does a midwife choose to relate to a woman, her partner, a pregnancy, and birth in general? Is she authoritative? Deferential? Friendly? Brusque?
- During labor, does she actively manage the delivery, or does she only intervene under specific circumstances (for instance, pain, complication, the woman’s request)?
- Does she view birth as a risky time, requiring constant monitoring and medical attention, or as a natural event requiring little, if any, active intervention on her part?
- Is the midwife more likely to consult the woman as to her desires for treatment, or to act on the basis of her own professional expertise?

In this analysis, I examine many of the factors which contribute to the formation of the York program’s philosophy, from the legal doctrines established by the government to personal experiences of the program’s instructors. My aim is to understand the goals of and motivations behind this program.

In order to achieve this end, I conducted research consisting both of published materials (professional journals, government documents, oral histories and critiques of the profession), as well as

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2When referring to British midwives who practice after 1975, the female pronoun will be used to denote male and female midwives. The Sex Discrimination Act of 1975 allowed men to become midwives.
primary source material. I spent approximately three months in York during the fall of 1998. During this time, I formally interviewed three of the four midwifery lecturers in the program, and spoke informally with midwives, academicians, and people who had in some way been involved with maternity care provided by midwives.

This thesis is divided into four chapters. Chapter 1 explores the shared history of American and British midwifery, and the differences in the profession as it exists in the two countries today. Chapter 2 discusses the laws which govern midwifery in Great Britain today, and which provide a basis for the York program. Chapter 3 explicates some of the major debates which shape midwifery and which help to define the program's goals and challenges. The final chapter is an exploration of the York program itself: its methodology, goals and ideology.

The main goal and challenge of midwifery, and British maternity care in general, is to provide woman-centered care. Changing Childbirth, a major governmental publication in 1993 outlined a set of actions which would help the National Health service to realize the goal of universal woman-centered care. This had a great impact on midwives, and specified that they were to hold a primary role in normal maternity care. Since then, the ideas put forth by this document have been embraced by midwives and other maternity caregivers, but many midwives are frustrated with the disparities between the reality of health care and a woman-centered ideal. The York program seeks to educate midwives who will provide such care, both as clinicians and as activists who are willing to seek change and improvement in situations where they feel that maternity services and their governance are lacking.
Midwifery as a profession differs greatly between the United States and Britain. There are not only dramatic institutional differences in midwifery in the two countries, but more subtle, esoteric ones as well. A major purpose of this work is to explore these, and, most importantly, to better understand the ideology of midwifery in a society where it is so widely practiced that it is taken for granted.³

Midwifery and the governmental policies regulating it in the US can be traced to Britain. In both countries, the profession saw a decline as men began to attend births. So-called ‘male midwifery’ paralleled a growing prosperity among general practitioners, who sought to stabilize their progress by attracting new patients and expanding activities that fit with general family attendance."⁴ Despite a common past, however, midwifery underwent a very dissimilar evolution in the two countries: It was almost eradicated in the United States in the early 20th century, while it received legislative protection and regulation in the UK.

Historically, many factors, such as class and ethnicity, contributed to midwifery’s dissimilar paths in these two countries. In the United States, for instance, doctors had higher status than most midwives, especially midwives who were immigrants, or of non-Anglo-Saxon ethnicities. In Britain, on the other hand, midwives and doctors were usually of the same culture and ethnicity, and even the same class.

1.1 Development of British Midwifery

Midwifery in Great Britain has a long and well-established heritage. Women were able to practice midwifery without hindrance until the 13th century, when the Universities of Oxford and Cambridge created medical licenses. At this point, men created the surgeons’ guilds, which would eventually ban the midwife’s use of instruments like the forceps. Through the next several centuries, men began to attend

³Many Britons with whom I spoke were shocked to learn that midwives were not a typical part of a hospital’s staff in the United States!

births with the use of instruments, but midwives continued to give maternity care to the majority of parturient women.\textsuperscript{5}

As medicine became more available as an alternative to traditional treatments, many people began to see it as a means to circumvent pain and death. At the same time, trials for witchcraft became more common. As healers, and as guardians of the female space that was childbirth, midwives were often common suspects in these trials.\textsuperscript{5}

One crucial area in which women were subject to accusations of witchcraft was sexuality. The elevation by the Church and society at large of the 'male' virtues of rationality and intellect took place partly to isolate the rational man from the power of the flesh - a power which was greatly feared. By projecting this fear on to women, the object of that fear could be isolated and so dealt with. It was a fear of the unknown and the uncontrollable and this could easily be translated into witchcraft.\textsuperscript{7}

Why did midwifery survive the initial rise of physicians? Physicians' new treatment offered an apparent solace - many women desperately feared the dangers of childbirth - but according to Chamberlain women continued to use midwives for three main reasons. First, the intellectual climate of the time was based upon a rural economy and pattern of life. The midwife was a crucial part of rural society. Second, this economy had specifically defined roles established for women, especially with regard to health care. Finally, at this point, the medical profession was not strong or effective enough to offer any substantial challenge to traditional healing practices.\textsuperscript{8}

Much of this changed with the advent of the Industrial Revolution. During the 18\textsuperscript{th} century, a new middle class arose which wished to showcase its prosperity, in part, by requiring women to be idle and by

\textsuperscript{5}Jean Donnison, \textbf{Midwives and Medical Men} (London: Heinemann, 1977) 2.

\textsuperscript{6}This is but one of many analyses of the witchcraft epidemic. A wide range of explorations are possible on this topic.

\textsuperscript{7}Mary Chamberlain, \textbf{Old Wives' Tales: Their History, Remedies and Spells} (London: Virago, 1981) 65.

\textsuperscript{8}Chamberlain 67.
using the services of skilled, educated men (including physicians). As was also the case in the United States, the first women who were able to afford and use the new treatments offered by the physician were those of high social standing. Middle class women emulated this model, and the physician began to achieve a greater presence in the field of obstetrics. Physicians’ care became a status symbol, and their expertise was validated by both the church and the state – even when the care they provided offered no better results than traditional methods.

However, midwifery again survived. In the late 19th century, physicians were often less accessible than midwives, both financially (physicians served a primarily wealthy clientele) and in terms of locale (most practiced in urban areas). Midwives, then, were considered to be the most practical childbirth attendants to serve poor or rural women. British social and class structure was also an important factor: the poor were usually seen as undeserving of physicians’ “superior” service.

Women chose midwives’ services for a variety of reasons. Even in the rare cases when physicians were available, poor women often considered a midwife to be more trustworthy, as the physicians who were willing to serve them were often viewed as quacks. A midwife also offered a relatively high level of emotional security, empathy and comfort. Also, she filled a traditional role, which was still cherished – especially among rural women and women who immigrated to the cities. Often, the midwife intimately understood the community she served; as a woman attending other women, she did not threaten a mother’s

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Chamberlain 89.

Chamberlain 88.

Chamberlain 74.

Chamberlain 89.

Chamberlain 113.
modesty as a male physician might; and she offered a more thorough service than physicians. She stayed longer in a woman’s home than a doctor, and often performed household tasks during her stay. In addition, she was often willing to perform abortions and provide other forms of birth control, even when these methods were banned by the state.

Midwifery has continued to be an important part of British childbirth care. Today, midwifery has become professionalized and is the primary resource for normal maternity care. Not only are midwives regulated by Britain’s national government, but most are employed by the state under the National Health Service.

1.2 Development of American midwifery

In the United States, several major shifts marked the evolution of birth attendance. These shifts primarily involved the caregiver and the birthplace. In the middle of the 18th century, most American births were attended by midwives. Physicians only took part in some emergency births, and then only those of wealthy women. By approximately 1760, physicians had begun to attend the normal, routine births of upper- and middle-class Anglo-Saxon women. This change was the result of an intricate set of social and medical factors, including the development of new obstetric techniques in Europe, and women’s desires for a better birthing experience.

By the end of the 18th century, delivery in both countries continued to be dangerous, painful and traumatic. Many women wanted pain relief, but also feared death or serious injury in childbirth. Like the UK, American maternal mortality and disease rates were very high. As a consequence, women sought care which they felt would better their chances of emerging from the birthbed unscathed. Women’s efforts to

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14Chamberlain 111.
15Chamberlain 113.
achieve this goal resulted in three major transitions, involving both physicians and midwives. These transitions were greatly affected by factors such as class, race and geography. Each shift was seen first among middle- and upper-class women: "The acceptance of medical doctors as birth attendants by urban, well-to-do women during the early decades of the nineteenth century resulted in women no longer dominating an area of medicine which, for centuries, had been their domain." Poorer women also saw a change in the options available to them, but at a pace which lagged behind richer women.

The first period of transition occurred during the 18th and early 19th centuries, and was marked by physician attendance replacing midwife attendance in the home. During the second shift, physician attendance moving from the home to the hospital, which took place during the late 19th and early 20th centuries. Finally, the third transition took place during the 1960's and onward, when more birthing choices were made available. Today, most births are still attended by physicians in the hospital, but women may have other options in terms of childbirth care provider and location for their birth.

The first transition can be largely attributed to obstetric innovations in Europe. In the early years of the American republic and its medical practice, many physicians received their training in Great Britain or other European nations. Many women believed these physicians to be better trained than the midwives who had previously been their primary attendant choice. Physicians were able to utilize techniques or tools which midwives did not or could not employ, such as medication and forceps. Toward the end of the 19th century, many women who could afford to do so chose physicians to deliver their children, but still employed the tradition of a large circle of women in attendance at the birth. The physician's control was

18 Leavitt, Brought to Bed 73.


therefore tempered, as the mother retained the authority she held in her own home and was supported by the women who stayed with her.  

The shift of delivery from the home to the hospital was again the result of many factors. Some women enjoyed relinquishing their control in delivery, allowing physicians to guide the entire process of childbirth. Some found the hospital experience to be attractive because it was more comfortable, offered good food and a wide variety of options for pain relief (including ether and other anesthetics), and medical treatment should complications arise. The trend toward hospital birth was encouraged by the medical establishment, which sought greater control over women's births. During the 20th century, when most of this shift occurred, the "mystification of medical knowledge in the post-bacteriological era" became more common. Medicine had begun to embrace theories explaining that germs were the cause of most disease. As few lay people fully understood these theories, their trust in physicians was blind, and resulted in a loss of a patient's control over his or her treatment.

As physicians in the United States sought entry into the field of obstetrics, they competed against midwives for their clientele. As was the case in Britain, these doctors advanced the notion that midwives were unsafe. Even though a comparison of mortality rates between the two groups rarely supported this claim, the public perception of midwifery suffered greatly during this time. Midwives were often portrayed as being dirty or uneducated, as "typically old, ignorant and filthy . . . pestiferous . . . vicious—and not least, un-American."

Other factors also influenced women's decisions to give birth in hospitals. In the United States, the deterioration of women's ability to create traditional settings for childbirth seems to have motivated change.

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22 Litoff, American Midwife 59.
23 Litoff, American Midwife 171.
24 Litoff, American Midwife 174.
This deterioration stems from the fact that women were more geographically isolated from their families than before. Also, most communities were structured differently than they had been in the 18th century, when most births took place in the home.27

Despite this perception and the trend toward physician deliveries in general, some women continued to employ midwives during their confinement. These women were often poorer, usually immigrants or women of color. A midwife was often the only choice for these women because of racist social codes and financial limitations. "Immigrants sought out midwives because they spoke the same language and shared similar traditions and customs," for financial reasons, or because of cultural standards of modesty.28

In the 19th century, American midwives were also primarily immigrant and women of color. They did not enjoy the same position of social prominence as did English midwives, who were often of middle to upper class origins. This had many ramifications, one of which was that American midwives lacked the unity and the popular support felt by their British counterparts. In a study by Judy Barrett Litoff, American midwives of the late nineteenth century were mostly "poor, immigrant or black women who [were] empirically trained and enjoyed little occupational prestige or professional identity. Isolated from each other by poverty, geography, and language barriers, midwives lacked the resources to stand up to their critics."29

The vast majority of American women had their babies in hospitals. As more births occurred in the hospital, some women found that the conditions of their deliveries became increasingly more impersonal. These women often felt that they had been disempowered, either physically, emotionally, or mentally in terms of the options available to them in the birth room.30 "Women realized that in the earlier

27Loudon 175.
28Litoff, American Midwife 4.
29Litoff, "Midwives" 443.
30Litoff, American Midwife 190-194
period, with either midwife or physician attendants, they had been 'brought to bed' by their friends, while by the middle of the twentieth century they were ‘alone among strangers’ in an alien hospital environment.\(^3\)

With the emergence of second wave feminism, this dissatisfaction affected American women's birthing practices. Although “only a minuscule 0.05% of births were attended by midwives during the early 1970s . . . there was a small but significant shift away from physician managed hospital births.”\(^32\) Once again, women wished to change the conditions in which they gave birth: “In an effort to reassert control over childbirth, increasing numbers of women turned to midwives, and within a decade the number of midwife attended births had more than quadrupled.”\(^33\)

Today, there are still more options available to parturient women, at least to those who can afford health care. As has been the case all along, the poorest women have the fewest choices available to them. In rural areas, for instance, there may still only be one birth practitioner.

Throughout the evolution of childbirth in the United States, four key issues seem to have influenced women’s choices: concern over their own safety, the safety of their infant, increased comfort, and their ability to make decisions about their birth experience.

Women who have more than one option fall into three major categories. One group is comprised of those women who chose to give birth totally outside of the hospital. Some of these women are attended by midwives, some by physicians. Often, they seek a greater degree of control over their situation, whether it is in terms of being consulted on matters of the birth, or the desire to keep their child near them immediately following the birth.\(^34\) The second group chooses to give birth within the hospital system, but not necessarily

\(^{31}\)Leavitt, *Brought* 195.

\(^{32}\)Litoff, “Midwives” 448

\(^{33}\)Litoff, “Midwives” 448.

\(^{34}\)Leavitt, *Brought* 214.
under conventional obstetric supervision. These women, for instance, may choose a nurse-midwife to attend their birth. The third group includes women are satisfied with conventional obstetrics, and give birth in a hospital setting.

Although midwifery in this country has reemerged from near extinction as an accessible choice for childbirth care, midwives occupy a very different niche in the American health care system than in the British one. Midwives in the US are often considered to be a part of the world of 'alternative' medicine. The profession of midwifery is not uniform, but consists of three very different groups of practitioners. These groups differ in terms of both their training and their practice.

The first group consists of women who received their training as part of a long ethnic and/or familial heritage of healing practices. They are known as the grand midwives, and today they serve primarily impoverished, African-American and Latina communities. These midwives are decreasing in number, as many are becoming elderly and have fewer opportunities to pass on their practice to younger generations. One consequence of the prohibition of midwifery in the United States was that the system of apprenticeship crumbled.

The second type of midwifery practiced in the U.S. today is lay, or independent, midwifery. These midwives receive their training through a variety of means, often through newer apprenticeship systems or inheritance of traditional healing practices. Although these women may inherit some of the teachings of grand midwives, they are not considered to be of the same category, since lay midwives receive their training from a greater variety of sources. Schools which were created specifically for non-nurse midwives in the 1970's are one example. Lay midwifery came into existence in part as a continuation of the grand midwives' traditions, and in part as a result of women's desire to rejoin control over their births. As a

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35 Leavitt, Brought 214.
36 Leavitt, Brought 218.
group, these midwives are united by the location of their practice, usually in a birthing center or in a woman’s home. An organized body of these women has created criteria for their certification under the title of Certified Professional Midwife (CPM).

The last category of midwives includes women who were trained within an academic field. This group of midwives is called Certified Nurse-Midwives (CNM’s). They are regulated by the American College of Nurse Midwives, and by their respective states. These midwives are trained first as nurses, then as midwives. They work almost exclusively in hospitals with physicians. They now may practice on their own, but did not begin to do so until the women’s movement of the mid-1970’s, through which they were allowed to attend normal deliveries alone, and lay midwives won the right to practice in some states. CNM’s first existed as part of an effort to provide rural women with a greater degree of conventional medical care. The Frontier Nursing Service, created by Mary Breckenridge (an English-trained midwife), was intended to combine “midwifery with public health nursing.”

Midwives are not common in all parts of the United States. In 1994, only 5.5% of American births are attended by midwives. Nurse-midwifery is the only subset that is regulated nationwide; lay and traditional midwifery are illegal in some American states. The term “midwife” carries many different

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38 Chester 17.


40 This type of midwifery is not legal in every state. Even in states where lay midwifery is legal and licensed, the CPM certification may not apply. In Washington state, for instance, lay midwives may sit for the Licensed Midwife qualification.

41 Pincus et al. 451-452.

42 Chester 14-16.

connotations, some of which are negative. At worst, midwives can be considered less safe than doctors, averse to technology in health care, or even relics of the past. Midwifery can also carry with it connotations of feminism, representing a challenge to the United States’ paternalistic, woman-restrictive health care system. Another stereotype of a midwife, then, is a feminist who seeks to aid her sisters in their quest for a more satisfying birth experience, a crusader who strives to liberate childbirth from the control of a physician- and technology- dominated medical environment.

In contrast, “midwife” is a household word in the UK. In Britain, “midwife” implies a uniformed health care practitioner, an employee of the National Health Service, and the most likely person to attend one’s birth, as well as administer ante- and post-natal care. They are not “alternative” medical practitioners at all. Today, in fact, midwives are the senior attendant for approximately 75% of all births in the United Kingdom. Midwifery as a profession is protected and defined by law, and all midwives are registered and regulated by the same governmental body. Also, although there are definitely ties between midwifery and feminism, and although many midwives consider themselves to be radical or feminist, the relationship between feminism and maternity care is different in the United Kingdom than the United States. Midwifery holds a mainstream position in the NHS. A midwife does not, by definition, occupy a dissident role in the health care system, as she usually does in the US. Feminist initiatives are a part of maternity care politics in the UK, but the avenues through which they are pursued are part of a bureaucratic framework: British midwives can work within the system, while American midwives must often pursue change from without.

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Before examining York’s program specifically, it is important to understand the legislative framework which regulates the profession of midwifery, defines its scope of practice and determines what length of training is appropriate for midwives. The law provides a set of guidelines upon which the York program is built.

2.1 The Midwives' Act of 1902 and Regulatory Bodies of Midwifery

Midwifery is defined by law in a way that is unique among British professions. Unlike most professions, which establish codes of conduct and practice through professional bodies of their own, such guidelines for midwifery are set down by the government. This regulation began when, after nearly a century of effort to legislatively regulate midwifery, the 1902 Midwives' Act was passed. One of the major supporters of the 1902 legislation was the Midwives Institute (later the Royal College of Midwives), an organization comprised of a small number of university-educated women. At the same time, the profession was associated with the very negative image of Sairey Gamp, a midwife in Charles Dickens' *The Life and Adventures of Martin Chuzzlewit*. Sairey Gamp was dirty, uneducated, a carrier of disease, and a danger to women, children and society. At this time, some contemporary physicians were seeking control over maternity care, threatening midwifery's existence as a viable option in childbirth care. The Institute's goals in pursuing legislation were "to raise the standard of efficiency and status of midwives." This group felt that "education was essential" to improve both the efficacy and social image of midwives.

It can perhaps be speculated that this legislation was the crucial governmental action which prevented British midwifery from following the trajectory taken by American midwifery. There are many reasons for the differences in midwifery’s future in the two countries – for instance, American midwives were often immigrant women of lower classes, while British midwives belonged to poor and wealthy classes – but legislation was certainly a major factor in the profession’s evolution.


V.R. Bennett and L.K. Brown 693.
This first piece of legislation was passed after extensive lobbying from midwives and supporters. The law established bodies which would regulate midwifery and create a register of midwives. After the passage of that act, no unqualified persons could use the title of midwife:

From and after the first day of April one thousand nine hundred and five, any woman who not being certified under this Act shall take or use the name or title of midwife... or any name, title addition, or description implying that she is certified under this Act, or is a person specially qualified to practise midwifery, or is recognised by law as a midwife, shall be liable on summary conviction to a fine not exceeding five pounds.48

This law was the first to afford midwives (and birthing women) a special protection. The law also stipulated that "a person other than a registered midwife or a registered medical practitioner shall not attend a woman in childbirth."49

The 1902 Act established the first regulatory body for midwives. Today, after many metamorphoses, midwives are regulated by a national statutory body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. Two-thirds of the council’s members are elected, and one third are appointed by the Secretary of State. The UKCC is "responsible for setting the standards required of the practitioner through the formulation of rules and codes, and for the standard, type and content of training courses" as well as the maintenance of professional conduct.50,51

Each country in the UK has its own National Board, whose members are appointed by the professions (nursing, midwifery and health visitors). The boards’ primary responsibility is to accredit

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48Midwives Act 1902. Sec. 1. 31 July 1902.

49Section 17(1) of the Nurses, Midwives and Health Visitors Act 1979, as amended by the 1992 Act.


51The UKCC issues the rules and standards of practice governing midwives. These are published by the UKCC as a pamphlet called “The Midwives Rules,” with further elaboration in “The Midwife’s Code of Practice.”
training programs, and approve their courses. The English National Board (ENB) is the body which accredits York’s program.

An important function of the UKCC and the National Boards is to regulate not only midwifery, but nursing and health visitation as well. Although midwifery is very different from nursing in its practices, philosophies, and roles within the health care system, the professions of nursing and midwifery are regulated by the same body.

2.2 Codes of Practice

The midwifery profession also adheres to international codes and standards for practice, since the United Kingdom subscribes to the European Economic Community’s directives regarding midwifery. These include: a midwife must meet her country’s educational and standards of licensure; and be capable of providing antenatal, labor, and postpartum care, and of detecting abnormalities in the fetus or a woman’s pregnancy.

Perhaps the most important of the UKCC standards is rule 40, which "both enables the midwife’s autonomy and at the same time delineates its boundaries." Legal autonomy is guaranteed by the first and third parts of the rule in that "[a midwife] only needs to refer to a registered medical practitioner when an abnormal situation occurs. Otherwise she may practice midwifery by reason of her own

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52Jenkins 29-30, 32.

53This adherence allows a midwife who has qualified to practice in Britain to practice in the European Union.

54See Appendix A for a complete definition.

55Jenkins 41.

56See Appendix B for Rule 40 in its entirety.
qualification. Because the rule’s wording is not very specific, midwives are, in some ways, allowed a great deal of flexibility in their practice. They can, therefore, utilize certain procedures, such as ultrasound scanning, or ventouse extraction (a suction method used to assist the baby’s passage through the birth canal), in their practice. Because they are autonomous practitioners, midwives are, for the most part, able to decide what sort of care they will give. However, in practice, most midwives are not completely autonomous even in normal births. For instance, hospital policy or convention regulate a midwife’s practice. This flexibility also extends to training programs for midwives. Ideologically and structurally, programs can vary greatly.

Other important rules for midwives in the code of practice determine, for instance, which drugs a midwife may administer or carry, and the bureaucratic responsibilities of midwives (such as certification of a birth or a stillbirth). For example, while a physician may refuse to attend a woman who chooses to have her baby at home (rather in a hospital) a midwife may not, according to Carolyn Hollins, a midwifery lecturer at York.

2.3 Midwives’ Roles in the National Health Service

The 1902 Act was the first of several laws which regulate and govern midwifery. Many of these laws address educational requirements, gender equality, as well as the nature and venue of a midwife’s

\[\text{57Jenkins 41.}\]

\[\text{58Jenkins 41.}\]

\[\text{59According to the Midwives’ Code of Practice (17), certain drugs may be made available to a midwife given certain circumstances (she may work outside of hospital, for instance), and under arrangement with her supervisor and local medical authorities.}\]

\[\text{60Carolyn Hollins, personal interview, 25 November 1998.}\]

\[\text{61Legislation which stipulated the nature and duration of the course of study necessary to be called a midwife was enacted; The duration of training compulsory for midwifery practice was increased from three months to three years in the time since the 1902 Act.}\]
One such law established the National Health Service in 1948. The NHS provided that any British citizen could have access to medical care, including midwifery services. This dramatically changed the availability and location of the average person's medical care. Many more women began to deliver in hospitals (a move supported by the Ministry of Health), which resulted in a loss of power for midwives: "In the hospitals, the implementation of the NHS Act led to an increase in the number of junior hospital doctors and consultants which in turn resulted in considerable loss of autonomy for the hospital midwife."63

Women also began to turn to general practitioners (GP's) for their maternity care. "Suddenly any pregnant woman could have the free services of a general practitioner, a privilege for which she would formerly have to pay. Consequently, women began to book with a general practitioner who may not have been undertaking midwifery previously, and who all too often did not inform the community midwife until the woman went into labour."64 A GP's involvement did not always result in strained relationships between midwives and doctors, but the inclusion of GP's (and general medicine) into the realm of maternity care was a very important change. For the first time, all women could receive regular medical care, not just maternity care. Today, a woman often sees both her GP and a midwife during the course of her pregnancy. Even when all of her antenatal and delivery attendance is conducted by a midwife, the woman may still consult her GP for other health concerns.

In the United Kingdom today, midwives occupy a very central role in the National Health Service's maternal/natal care system. 75% of all babies are attended by midwives – the vast majority of medically uncomplicated births. Although there are some midwives who practice independently, most are

62 Governmental publications also addressed the scope of a midwife's practice, and how it related to that of other professions. Also, during this time maternity units and hospitals came into existence on a far larger scope than ever before. More and more British women began delivering their babies in hospital as opposed to in the home.


64 V.R. Bennett and L.K. Brown 699.
employed by the National Health Service. Of those who are employed by the NHS, most practice in hospital, although several work in midwife-staffed birthing clinics or attend birth in women’s homes. Independent midwives almost solely attend birth in women’s homes, although NHS-employed midwives do this as well.

As midwives may not attend (have primary responsibility for) complicated births, they are required to work with obstetricians (usually referred to as "consultant obstetricians"). A woman may request a physician to deliver her baby, but an obstetrician is primarily expected to be "the lead professional for women with complicated pregnancies" — rather than normal ones — "an adviser on actual and suspected abnormalities; the person responsible for the care of women who have obstetric emergencies; a provider of technical skills beyond the expertise of midwives/GPs; [and a practitioner of] fetal medicine." NHS policy requires that each mother be assigned a consultant obstetrician who would attend her birth should complications arise. However, the midwife has primary legal responsibility for any birth until it leaves her care.

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CHAPTER 3: NATIONAL DEBATES AND INFLUENCES

Because a midwife's scope of practice is not rigidly defined, many variations in practice and ideology occur throughout the profession and between training programs. The following are several trends and issues which affected the creation of York's midwifery curriculum, and continue to affect the program today.

3.1 Governmental Issues and Involvement

In addition to legislation and rules, many governmental statements which concern the philosophy of the profession have been issued. Since before the first Midwives' Act received royal assent in 1902, the role of midwives as medical practitioners has been discussed at length by physicians, legislators, and midwives themselves. As with any other profession, midwifery has seen many philosophical shifts in its existence. During the 20th century, the progression of midwifery in Britain followed a trajectory of increased medical intervention, a path not unlike that of American childbirth care. However, there are marked differences between the two countries.

During the 20th century, childbirth practitioners of all kinds came to rely heavily upon new developments in medical technology. Both midwives and doctors were likely to turn to instruments, monitors and laboratory testing to improve their practice, and insure the safety of mother and baby during birth. However, many women, midwives, and other interest groups argued that an increasingly "medicalised" approach served to disempower the mother. Health care practitioners acted upon her, depriving her of choices, and setting in motion a "cascade of medical intervention" that could perhaps cause her discomfort or dissatisfaction.

The height of medicalization came in 1984, when the Department of Health's Maternity Services Advisory Committee issued a report entitled "Maternity Care in Action." In it, the Committee advised

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*Hollins.*
health authorities that "As unforeseen complications can occur in any birth, every mother should be encouraged to have her baby in a maternity unit where emergency facilities are available."\textsuperscript{67}

This trend toward medicalization resulted in vociferous statements of dissatisfaction from both childbirth caregivers and recipients. In 1992 the House of Commons Select Committee released "Maternity Services," (also known as "The Winterton Report") in response to "Maternity Care in Action." It stated that "The policy of encouraging all women to give birth in hospitals cannot be justified on the grounds of safety," and that a "medical model of care" should no longer be the basis upon which all childbirth services are based.\textsuperscript{68}

The Winterton report laid the ground for the \textbf{Changing Childbirth} document, published in 1993 by the Expert Maternity Group. The group was headed by Baroness Cumberledge, Parliamentary Undersecretary of Health, and was comprised of "women who use NHS maternity services and . . . those professionals who provide them."\textsuperscript{69} Its purpose was "to review policy on NHS maternity care, particularly during childbirth, and to make recommendations."\textsuperscript{70} The problems which the expert committee evaluated, according to Baroness Cumberledge, were "the place of women in society, the importance of women taking charge of their own pregnancy and how services should be arranged to meet their needs, ensuring the safe delivery of the child and the health of the mother."\textsuperscript{71} The committee based its report on hearings, interviews, presentations and written evidence from women who used the service,

\textsuperscript{67}Cumberledge 1.

\textsuperscript{68}Cumberledge 1.

\textsuperscript{69}Cumberledge 2.

\textsuperscript{70}Cumberledge 1.

childbirth care providers, professional and advocacy groups, and visits to maternity units of varying sizes and midwifery scheme. It also held a conference in March of 1993 to gather more information.\textsuperscript{72}

The main conclusion of the report was that "We believe that women and their families should be at the centre of maternity services which should be planned and provided with their interests and those of their babies in mind."\textsuperscript{73} The goal of creating woman-centered care could be achieved by improving three major areas of a woman's childbirth experience. These were care, choice, and continuity, also known as "the three C's."

The committee chose appropriate care as the first principle of maternity service, and defined it as care that "was designed around the needs of the individual woman and the choices she may wish to make."\textsuperscript{74} Continuity refers to the goal of cohesive care during a woman's pregnancy by reducing the number of caregivers who attend her, "with continuity of carer (care by one individual) being recognised as the gold standard."\textsuperscript{75} The third goal is to provide women with the power to make decisions about their maternity experience and the care they receive.

The Winterton report was a defining document because it provided governmental validation of the widely held belief that birth is a natural process, and that status quo maternity care was not optimally fulfilling women's expectations and needs. Changing Childbirth also recommended ways by which these ideals might be achieved. Since it is a report rather than legislation, many of the changes it recommended have not come to fruition. Often, programs or schemes\textsuperscript{76} recommended by Changing Childbirth

\textsuperscript{72}Cumberledge 2.

\textsuperscript{73}Cumberledge 3.

\textsuperscript{74}Cumberledge 9.


\textsuperscript{76}One such recommendation calls for an increased number of midwife-led maternity units.
Childbirth did not receive the funding necessary to sustain them for long periods of time. According to Linda Allen, the York program's coordinator, even when the fledgling programs were successful, units often reverted back to their previous state when the funding was exhausted. The implementation of Changing Childbirth's recommendations varies widely from one region in Great Britain to another.

3.2 Non-Governmental Organizations

In addition to governmental statements and initiatives regarding childbirth care, several advocacy groups raise and address various issues in midwifery. Support for a renewed commitment to woman-centered care may be found in the wide community of midwives and childbirth care practitioners. The Association of Radical Midwives (ARM) is an advocacy group for both the profession and the rights of pregnant women to achieve the most fulfilling birth experience possible.

Changing Childbirth states that a woman should feel "confident that... any tests and investigations have a clearly defined and valid objective, relevant to her particular circumstances... The woman's care should be planned on an individual basis, and all procedures and interventions discussed and agreed with her." During labor, "the woman should feel that her psychological and physical needs are understood, her privacy is being maintained and her autonomy respected."77

This latter concern not only speaks of a belief that too much intervention was taking place, but that treatment was given to mothers without their consent – an act which is assault under British law. Ishbel Kargar, a midwife and longtime administrative secretary of ARM noted that "Too often the action accompanies the words, and lack of prior discussion assumes consent to the intervention."79

Another group which has long been an advocate for change in maternity services is the National Childbirth Trust (NCT). Like ARM, NCT campaigns for a greater degree of woman-centered maternity

77Linda Allen, personal interview, 30 November 1998.
78Cumberledge 6.
care. Both organizations were among the interest groups which contributed to the Changing Childbirth document.

One of NCT’s primary concerns involves a woman’s choice to deliver her baby in her own homes providing that it is safe. A recent NCT survey found that "many GPs were striking off pregnant women from their lists when they asked for a home birth."\(^{10}\)

NCT is also concerned with the medicalization of childbirth care. Specifically, it is currently lobbying for a reevaluation of current practices involving caesarian sections: "The current caesarean birth rate in the UK is the highest since records began (15.3% in England and Wales and 18.2% in Scotland). NCT is concerned that one of the factors driving this rate upwards is consultants' fear of litigation. NCT is campaigning for research-based practice so that women are given the information they need in order to make informed decisions."\(^{11}\)

### 3.3 Types of Training Programs

As education is regulated by the government, midwifery training is, to a large extent, standardized across Great Britain. However, variations exist among training programs as a result of the ideological differences seen in national debates.

Two major routes are available for midwifery training. The principal distinction between them is that one incorporates nurses' training and one does not. The former case entails a three-year course of study, achieving licensure as a nurse, and being listed on the UKCC's Professional Register. The register is a record of all those who have completed the necessary training to practice as a midwife, nurse, or health visitor in the United Kingdom. If one is already listed on the Register as one who has met the requirements and completed the necessary training in general or adult nursing, and wishes to study midwifery, an 18 month course must be completed. Such a course is referred to as a 'short programme.'

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\(^{10}\)National Childbirth Trust, (Glasgow, Scotland: National Childbirth Trust, 1998), online, NCT web page, 20 April 1999.

\(^{11}\)National Childbirth Trust.
On the other hand, a 'long programme' does not require nurse's training, but consists of a comprehensive three or four year degree course. This route of training predates nurse-entry training; indeed, nurse-entry training did not exist until the 20th century with the passage of the Midwives' Act of 1902. However, with the growth of the medical establishment's power, nursing became more prominent, and midwifery became a formalized part of the health care system. Consequently, it became more common for aspiring midwives to first train as nurses. 'Direct entry' midwifery training seemed to be moving toward extinction. The short program was by far the more popular of the two courses during the latter half of this century, and by the end of the 1980's, there was only one direct entry program available in the United Kingdom. However, there are now approximately twenty of these programs, with more being planned. The decline and subsequent resurgence of the long program mirrors the ideological shift in midwifery marked by the publication of the Winterton report and the Changing Childbirth document.

The benefits of the long versus the short program are the subject of much debate. Many medical practitioners feel that a nurse's training is necessary to become a successful, effective and safe midwife. However, others believe that a satisfactory, and perhaps even superior, training can be gained by training midwives independently of a nursing philosophy.

Besides the two major types of entry into the midwifery profession, practicing midwives may possess different certifications: a certificate, a diploma and a degree. These certifications vary according to the expected analytical capabilities of the program's graduates. According to Tony Fuell, York midwifery lecturer,

The difference is not a professional one. It doesn’t matter whether you're a diploma or a degree midwife -- you still must have safety in practice and meet a certain standard of practice. The difference is in the ability to use evidence and knowledge, and synthesize knowledge. A certificate-level midwife is expected to understand the principles of midwifery. At the diploma level, one must be able to understand the literature being produced, and to analyze it somewhat. At the degree level, a midwife must not only understand safety, but must be able to read and
analyze research to find the underpinning message, and use this to adopt modes of practice to meet the needs of women.82

As such, courses of study in the United Kingdom are accredited at each of the different levels, although the certificate level is gradually being eliminated, while degree level midwives see a rise in their numbers. In concurrence with governmental regulation, by the year 2000, all midwifery students will graduating with at minimum a diploma certification. Fuell said that this change is in large part a result of the migration of midwifery programs from polytechnic institutions and hospital schools to universities over the last thirty years. As training programs’ venues changed, so did their requirements.83

The University of York’s BA(Honours) program in Midwifery is, as its name describes, a bachelor’s degree program. It has been a degree program since 1997, after the program underwent dramatic revisions, and was upgraded from a diploma program.

York’s training program is a short program – therefore, one of its statutory requirements is that one must be a nurse, registered on Parts 1 or 12 of the UKCC’s Professional Register, to gain entry into the program. Training involves both clinical and academic study. Over the program’s 78 week duration, a student must spend half of her time in pursuit of each. The academic portion of York’s program is taught by four full-time midwifery instructors. The clinical segment takes place in hospitals local to York University, situated throughout Northern and Eastern Yorkshire. Although the clinical aspects of the training are very important, here I will focus on the program’s ideology as taught during the academic portion of the training.

In addition to these several structural and academic distinctions, the philosophies which are embraced by midwifery programs can vary greatly from one to another. A publication by the English

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82 Tony Fuell, personal interview, 7 December 1998.
83 Fuell, 7 December 1998.
National Board notes that "Each university develops its own midwifery educational program reflecting local services and resources within parameters laid down by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, and the National Boards for Nursing, Midwifery, and Health Visiting." However, just as Rule 40 allows for variation in midwifery practice, compliance with these directives allows for a great deal of flexibility. Programs may vary greatly in their beliefs about midwives' specific interactions with women, their partners and children, their reliance upon obstetric research, their beliefs about birth, or their attitudes toward their interactional role during labor.

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CHAPTER 4: THE YORK PROGRAM’S IDEOLOGY AND CONCLUSIONS

4.1 Philosophy

The academic segment of York's program consists of nine modules, the last of which is a dissertation on some researched aspect of midwifery. The program is reviewed annually by a committee of local midwives, faculty, and community members with an interest in midwifery.

A new curriculum was written when the York program's certification status was changed. Its three authors, Linda Allen, Cathryn Britton, and Tony Fuell, still teach in the University's midwifery program. The ideas of Changing Childbirth the new curriculum. When the Changing Childbirth document was written, its authors sought to address problems facing the National Health Service's maternity care by asking what would best meet women’s needs, and what would make women’s maternity experiences more satisfying to them. The answers to these questions vary dramatically depending upon the circumstances and the woman involved. A midwife must therefore be flexible. One book, prepared for expectant mothers, describes a midwife's role in a way that evokes the goals of Changing Childbirth:

A woman in labour needs the help of a midwife who will be able to empathize with her, provide her with assurance and inspiration and encourage her to let herself go without disturbing or distracting her. Being a midwife – the word means ‘one who is with the mother’ – is an intuitive art, and the presence of a skilled one is essential to the birth. An experienced midwife will understand your needs and help you to feel relaxed and secure, will be aware of your need for privacy and will also know when you need guidance, firmness or help. She will check your well-being throughout labour and also that of your baby.

Allen describes the program’s goal this way:

The main thing is that midwives must keep accurate records of care (and labour) up to 25 years after the birth of the baby. Records are vital. A midwife must also provide support for women.

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85Cumberledge 5.

This entails being caring, having good communication skills, being empathetic, strong, and an advocate for women. Being on the same wavelength psychologically, [and] helping her this way is important. A midwife should enable the woman to believe in her own powers, and trust her own body.  

The York program's goal is to train a practitioner who meets these objectives — who can provide compassionate care, clinical skill, and who respects individual women's needs. In order to accomplish this, York's curriculum was written with several different ideological objectives in mind.

4.11 Safe Practice

The first of these goals, to train safe practitioners, is not as clear as it may seem. Safety is a complex issue. Sometimes safety is used as an excuse to justify behavior which research findings do not support. Although safety is a somewhat subjective concept, there are certain practices, such as the use of sterile instruments, which are universally recognized as safe. Allen defines unsafe behavior as "not maintaining accurate records, [or] inappropriate behavior," such as a student's use of techniques without first having adequate instruction in the use of that technique, or by making decisions which the student cannot justify.  

4.12 Research-Based Practice

One of the major changes from York's diploma program is that the degree course requires "that students demonstrate from the outset an ability to evaluate the validity of knowledge and evidence used to justify the management and delivery of care and effectiveness of their own practice." This concept, known as "research-based practice," has two main components. One is that there are different "ways of knowing," or different forms of knowledge, which come from many different sources. The second is that

\[87\) Allen.

\[88\) Allen.

this knowledge must be the basis for all decisions a midwife makes about her practice. A midwife must constantly evaluate her beliefs about the care she gives and the information which informs her decisions. She should not blindly rely upon habit, methodology which does not have sound justification, or even upon hospital protocol, to make her choice for her.\footnote{For instance, shaving every laboring woman’s pubic hair was a routine practice for many years. The practice did not bear up under scientific scrutiny and was viewed as degrading by many women, but was very common until the later part of this century.}

In order to achieve this goal, students are taught to evaluate and understand different types of knowledge.

We expose students to different theories: What makes knowledge? Where does it come from? They do their clinical training, and from that, they pick an incident, and reflect on the practice . . . [In that situation, the mother’s labour] might have been induced, and she might have ended up with a Caesarian section. What was the evidence that favored induction? What influenced the management of this case? What does the research say? Were there other options?\footnote{Even though a midwife is subject to the regulations of the hospital in which she works, if hospital protocol mandates a procedure which conflicts with the mother’s wishes, for instance, or is injurious to the mother, the midwife can be brought up on criminal charges.}

Knowledge is not simply gained by scientific examination or academic study. The intuition of the mother and the midwife, for instance, is considered to be very important. Such knowledge manifests itself in the “hunches” described by Ina May Gaskin as integral to her practice as an independent midwife in the United States.\footnote{Ina May Gaskin, “Intuition and the emergence of midwifery as authoritative knowledge,” \textit{Medical Anthropology Quarterly}, (10.2, 1996): 295-298.} “Midwifery is about a lot of inbuilt intuition, and reliance on one’s own sense. If you have a gut feeling that you’re not happy about, you always need to bear in mind and act on that. [Midwives] need to listen to women all the time.”\footnote{Allen.}
The idea that there are many kinds of knowledge is not unique to York. It is found in nearly all cultures and many kinds of medical practices. Knowledge may come from clinical tests or symptomology, or from hunches. York's program teaches its students to value all of these.

In terms of academic knowledge, students are taught to keep abreast of current midwifery studies. They are encouraged to use this knowledge to make their own decisions about their practice. "We don't want them to be clones of us," said Fuell. "They are asked to tell us why [they make their decisions]: How is this demonstrating woman-centered practice? We try never to say 'you're wrong' or 'you're right.'"95 Also, as Allen said "If we're dictating to students, they'll do the same to mothers."96 The goal of this approach extends into several areas: students who must analyze their decisions are perhaps less likely to act on blind, unexamined habit. Furthermore, when it is justified by analysis and study, safety becomes a reality. It is no longer an empty word used to justify action resulting from superstition or unsubstantiated belief.

4.13 Skilled Companion

Knowledge, and the clinical skills which must accompany it, are a crucial framework for good midwifery practice, but they must be applied in context:

"Technical skills, scientific knowledge, practical abilities, and good clinical judgement are all necessary for effective midwifery, but they are not in themselves sufficient. To be effective, knowledge and skill must be employed in the context of a relationship with the woman and her family. The midwife must be more than a clinician, she must also be a companion, a skilled companion (Campbell, 1984), to the woman on this journey into parenthood. If the woman and her partner are to accomplish the goals of this journey, they should begin parenting with high self esteem and confidence." (Page, 1995)97

95Fuell, personal interview, 4 December 1998.

96Allen.

97University of York iii.
The idea of the “skilled companion” midwife is concurrent with the ideas and goals of Changing Childbirth, specifically the “care” objective: “Each woman has unique needs. In addition to those arising from her medical history these will derive from her particular ethnic, cultural, social and family background. The services provided should recognize the special characteristics of the population they are designed to serve.” A skilled companion is a midwife who is responsive to each woman’s needs.

An example of this is that midwives ought to respect and consider women’s cultural, intellectual, and spiritual beliefs. This is a special concern when the mother is of a non-British cultural tradition: “Indian women scream to release pain. They are socialized to know [that noise releases pain]. English women, on the other hand, are more reluctant to make noise. You bring your culture with you,” and all cultures must be respected,” said Carolyn Hollins, one of York’s midwifery lecturers. The treatment chosen as a result of this dialogue should be the product of the midwife’s expertise and the woman’s desires.

Partnership implies an equal relationship between mother and midwife, rather than an authoritarian one. As such, student midwives in the program are also encouraged to question their own assumptions of authority. They do not wear uniforms during their training, which manifests the idea that a midwife’s control should result from her knowledge, rather than the authority of her office. Power must be shared between the woman receiving care and the midwife providing it.

When we got students out of uniform, we did it because we didn’t want that trapping getting in the way by having them affect a power over their relationship [with women]. Because of that, they had to ask “Do you mind if I touch you?” rather than just doing it because they could. It forced them to adopt good practice.

In addition to hearing and respecting the woman’s desires and needs, the program also teaches that

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98 Cumberledge 5.
99 Hollins.
100 Fuell 4 December 1998.
one of the midwife's responsibilities is to act as the woman's advocate. A midwife should support the woman's desires/needs within boundaries of a research-established definition of safety, including occasions when those needs come into conflict with hospital protocol or other practitioner's opinions. Allen said that "It is difficult for students to be with women, to be women's advocates, etc. They will probably have to face midwives who will say "Well, 'Mr. So-and-So' does it like this.' We try to prepare students for conflict, to get them to question the philosophy of knowledge."  

An ideology of partnership between midwife and mother serves also addresses Changing Childbirth's goal of providing choice in maternity service: "The woman and, if she wishes, her partner, should be encouraged to be closely involved in the planning of her care. It should be clear to her that her views and wishes, including her desire for a safe outcome, are important and respected." In order to achieve this, childbirth care practitioners allow and encourage women to create a birth plan. "Birth plans are very women-centred. A woman has choices she wants to make. The midwife's role is to advise her – are her choices dangerous? When she makes a birth plan, it's very gratifying."  

A birth plan allows the woman to express her concerns and desires regarding her birthing experience. It gives her more control over her own care, before and during delivery. If any deviations were to occur in the birth plan, (for instance, if a Caesarian section or an episiotomy were necessary) they should be approved by the mother if she is conscious and able to respond coherently. Childbirth caregivers'  

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101 In Great Britain, physicians are addressed with the title "Mister" rather than "Doctor."

102 Allen.

103 "Partner" in this case refers to a woman's companion, spouse, significant other, or any person she chooses to take part in her maternity experience.

104 Cumberledge 5.

105 Hollins.
actions should be preceded by a discussion, or at the very least, a request to proceed, whenever possible.

By training midwives to become companions to a woman, a broad range of the woman’s needs are met. She is better able to express and honor her cultural traditions and personal beliefs; her desires are supported; and she is empowered to be a participant in the care being given her, rather than a recipient. Considerable evidence supports the idea that a woman’s childbirth experience is greatly enhanced when she is empowered. Changing Childbirth reinforces the idea: When a woman is empowered, she often feels more confident, and in the end, happier with her birth experience – even if the choices she makes are to allow others to make her decisions for her.

4.14 Autonomous Practitioners

Even though midwives are able to practice by virtue of their own education (rather than relying upon a doctor, for instance, to validate their practices and decisions), and even though their academic degrees are the same as doctors’ in the British system of higher education, the actual practice of autonomy is a major stumbling block for midwives. Because of this, emphasis is placed not only on research-based practice for a midwife, but on using this evidence to defend and support her professional decisions.

Learning to practice autonomously is one of the major transitions students must make when they are coming from a nursing background. “It takes about a year to train the nurse out of the student midwife,” said Allen, “Nursing philosophy is more concurrent with the medical model – nurses’ training is more about doing for than being with.”

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106 Midwives’ degrees and physicians’ degrees are considered to be of the same educational level, just as an American PhD in literature and one in physics are both considered to be of the same level.

107 Allen.
However, there is a paradox between the goals of autonomy and skilled companionship. As Allen noted, sharing power with the woman in her care results in decreased autonomy for the midwife. Fuell said that “when the locus of control rests with the woman, it devalues [midwives] in the eyes of other professional groups.” In order to rectify this, midwives must have a sense of their own power as a partner in care. “For midwives to be autonomous, they must be strong, assertive, knowledgeable and have self-confidence.” 108

Autonomy is important for another reason: Midwives are legally accountable for their own practice. They are subject to the regulations of the hospital or centre in which they practice, but they are also subject to the law and responsible to the woman under their care. At times, these legal responsibilities may come into conflict with hospital policy or convention. To reconcile this conflict, it is necessary for a midwife to defend her decision.

4.15 Nonintervention

The final principle for midwifery practice is nonintervention. One of the program’s basic tenets is that students must make their own decisions about effective and appropriate practice. However, the principles expressed in Changing Childbirth, and the ideas espoused by many midwifery and birthing choice advocacy groups (such as the ARM and the NCT) support nonintervention as crucial to effective maternity care.

Nonintervention does not mean that a midwife will not actively participate during a birth, perform diagnostic tests, ask for help, administer medication, recommend a Caesarian section, perform an episiotomy or vacuum extraction. What it does mean is that these things are not compulsory in all situations. Midwives tend to disagree with “medicalised” maternity care is because intervention takes place

108 Allen.
too frequently. British (and American) midwives often speak of the rate of Caesarian sections in the United States (where childbirth is almost totally controlled by doctors) as being incredibly high – 23.5%\(^{109}\) – in comparison to England's 15.3%.\(^{110}\)

It seems strange that two industrialized nations should have such a disparate rate of Caesarian section until one considers the differing representation of midwives and physicians who attend normal births in the two countries. Changing Childbirth itself promotes a model of birth and care consistent with a noninterventionist ideology: "Pregnancy is not a pathological process or a disease. It is a physiological event which occurs in a very high proportion of women during their lifetimes. The majority of pregnancies end normally and without complication."\(^{111}\)

A common rebuttal to the argument that intervention is overused is the obstetricians' adage “All births are normal in retrospect.” During the stressful time of birth, intervention may seem necessary, or even lifesaving, even if hindsight may later prove this sentiment wrong. Although medical intervention is often chosen due to safety concerns, midwives have almost identical rates of maternal and infant mortality to physicians.

The largest concern about intervention as a part of maternity care in Great Britain is often undertaken because of habit, rather than necessity. "The induction of labor, enemas, shaving of pubic hair and episiotomy were very common practices until recently. A midwife who used these by habit was not

\(^{109}\)ICEA, "Increasing Cesarian Rates: Concerns, Reasons, and Recommendations," The Pregnancy Place, online, Family Internet web service, 18 May 1999.

\(^{110}\)Without entering into a lengthy discussion of the various factors which influence the management of maternity services in the US, some of these are: HMO's and insurance regulations which require "efficient" management of health care practitioners' time (quotas, time limits, etc.); fear of litigation; financial prioritization; and patient demand for speedy, "safe" care.

\(^{111}\)Cumberledge II.
really being a partner in care. [These practices] were very medically oriented, [but were later proven to unnecessary in every case]. Midwives were dictatorial to women, and not crediting them with any sense." However, there are also many instances when medical care (given by an obstetrician) is appropriate and necessary – for example, if the mother has high blood pressure, or is ill during pregnancy or labor.

Another major concern with intervention is that one intervention will necessitate subsequent ones, resulting in a “cascade of intervention.” For instance, “if a woman is in pain, and you give an epidural anaesthetic, the labour will not progress so strongly. Her contractions might slow, and then she’ll need a forceps delivery to get the baby out. She will probably have a large tear, and then need an episiotomy,” said Hollins. Many midwives, including the York faculty, feel that taking a different approach will achieve the goal (in this case, pain relief), and will obviate this cascade. Allen provides another example: “Medical augmentation of labor when it slows down is often used. Rather than just give the mother tea and toast, they’ll rupture the membranes, give medication, etc. You could have gone through a normal process. Rupturing the membranes can cause fetal distress, which would require another intervention.”

Pain relief is an excellent example of how woman-centered care does not always mean nonintervention. Alternatives to treating pain through medication exist – midwives use techniques ranging from shiatsu massage to movement to “tea and toast.” The most important factor here is that the woman be satisfied with the treatment she is receiving. Nonintervention does not need to be the exclusive approach to childbirth care, but the York midwives do feel that other options besides medication should be available.

112 Allen.
113 Hollins.
114 Allen.
Midwives in the UK do have anaesthesia available to them, as they practice in hospitals.\textsuperscript{115}

In terms of alternatives in practice, however, another argument for a noninterventionist approach is that if a woman’s body is capable of giving birth by her own means, it can be empowering for her if she is allowed to do so.

If, for instance, the placenta separated, the product – the baby – is safe if you artificially stop the bleeding. It is a successful outcome, but from the place of the woman, her body has failed her. She may feel that she has failed. From one perspective, you have a live woman, and a live baby. But, every time you disturb a woman and you intervene, you may decrease her self-esteem.\textsuperscript{116}

Fuell, who worked as an independent midwife previous to his time at York, attended many births in women’s homes. After having watched women who were comfortable in their birthing space, and who were not afraid to satisfy their needs (move about as they pleased, eat if they wanted to), he came to see the role of a midwife as a very responsive one: “If we’ve succeeded [in training], they’ll keep their mouths shut, and their hands in their pockets [unless they are needed], and have an inherent belief in the woman’s ability to bear children.”\textsuperscript{117} At the root of all this is choice: a woman can still choose to have an anaesthetic, for instance, or a Caesarian section, but the choice is hers.

\textsuperscript{115}Midwives may not prescribe or administer certain types of anaesthetic, but these drugs are accessible to them through doctors’ prescriptions.

\textsuperscript{116}Fuell 4 December 1998.

\textsuperscript{117}Fuell, 4 December 1998.
4.2 Conclusions

The York faculty shares a commitment to radicalism and reform of their profession. Each midwife cited an experience in his or her professional career or education which resulted in a reexamination of belief and practice. Their individual conclusions differed slightly, but Fuell, Allen, and Hollins had come to believe that it was essential for midwives to reject ideological stagnation and the didactic protocols which often guided care. Fuell and Allen both found their ideas about midwifery challenged when they sought their advanced certification.\(^{118}\) Allen said that her experience "made me question – it disrupted everything I had been taught in basic midwifery. In basic training, I was not encouraged to question [my practice or habits]."\(^{119}\)

In many ways, the *Changing Childbirth* document is an echo of the change of heart that Allen, Fuell and other midwives felt. Fuell said that, it was "official recognition that these ideas had been accepted at the governmental level."\(^{120}\)

These ideas – woman-centered care, research-justified practice, and the 3 C’s – are the voice of radical midwifery breaking through as governmental recommendation. The notion of childbirth care as "woman-centered" is an old one. Every major transition in childbirth care has been accompanied by a great deal of dialogue about the ways in which it will serve women. However, *Changing Childbirth*, and the ideas put forward by the York program actively advocate placing power in the hands of the woman receiving care, even if this means taking some power away from the care provider. It is this transferral of

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\(^{118}\) Advanced certification is akin to a graduate level degree, and is required for midwives who wish to become lecturers.

\(^{119}\) Allen.

\(^{120}\) Fuell, 7 December 1998.
power which seems to be truly radical – and truly feminist.

A midwife’s authority as a care giver therefore derives from her knowledge and abilities, but does not give her superiority over the woman in her care. A midwife, according to York’s ideology, is a practitioner who is a partner to the woman to whom she provides care, not an authority figure. She will have her own beliefs about birth and appropriate care, but will be willing to discuss and make decisions about care with each individual woman, rather than utilizing the same set of behaviors to each case. She is, therefore, mindful of her legal responsibilities and her responsibilities to the woman.

At the foundation of this ideology is the belief in woman-centered care. This creates a sort of conundrum; at the same time midwifery is seeking to become a profession of partners to women, it is trying to establish itself more firmly as autonomous and secure among the other medical professions. By sharing power with the woman receiving care – who is typically at the bottom of the medical power structure – a midwife places herself at some professional risk. This paradox of seeking and relinquishing power is sometimes troubling. It is at the heart of midwifery’s evolving self-definition. The York program recognizes this, and acknowledges it in a very practical way. By training students to support their decisions through research, and to defend themselves against criticism by other professionals, the York program defends its ideology with action. The program’s beliefs are not merely theory: they are allowed to become reality.

In keeping with the concept of shared power, a paramount feature of the training is that the lecturers’ own ideologies are not gospel, but act only as another point of educational reference. Fuell said that in the classroom, he presents his opinions, and acknowledges them as his own. However, other options
are also explored. The role of these midwives is not to indoctrinate, but to facilitate. This is very much in keeping with the model of midwife as skilled companion. Like midwives in a clinical situation, the York faculty shares its expertise pedagogically, but ultimately to allow their student partners to come to their own conclusions. Students are equipped with the skills and knowledge necessary to define 'woman-centered care' for themselves, and to determine how best to provide it. Teaching knowledge is an important aspect of the program, but it is secondary to imparting the ability to acquire knowledge on one's own. The program, therefore, trains midwives with the aim of creating a dynamic profession: one which is able to evolve with technology while remaining responsive to the needs of the women it serves.

In order to cultivate their own knowledge, students are trained to be "politically aware and able to participate in changing and improving the delivery of midwifery care, at the point of qualifying and in the future." The York program was designed with an implicit acknowledgment that there are aspects of the midwifery profession which need to be changed. York's curriculum provides a very effective means of achieving the goal of improving women's care and midwifery as a whole. In concert with other groups' efforts to change the practices of current care givers and the health care system they occupy, this program seeks to improve the profession by enabling new midwives to analyze problems and effect change.

The philosophy of widespread improvement through education is a timeless and adaptive one. It relies upon technological innovation, but also upon the needs of the group which midwives serve. York's research-based ideology allows midwives to explore these needs by enabling them to make informed decisions. That the knowledge utilized in this case is not simply gained through clinical tests, formal research, or academic studies is a radical step. The knowledge a woman possesses about her own body,

121 Fuell, 7 December 1998.

122 University of York iii.
hunches (both the midwife's and the woman's), and emotional knowledge are all important. This program is a synthesis of scientific reasoning (support of practice by research) with the "organic" knowledge an individual possesses. Midwifery as it is taught at York is an integrated, holistic discipline. It is a synthesis of modern medicine with an ancient healing practice, bound together by a deep commitment better maternity care to continually exploring the bases of knowledge.

After having completed my research for this thesis, I am very impressed with the York program. It seems to be truly committed not only to improving the ideological foundation of midwifery, but to bringing this ideology to fruition. The synthesis which York's program seeks to achieve – between tradition with modern technology, emotion with reason, and power with partnership – is the golden mean of British midwifery.
Bibliography


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Appendix A: Definition and Activities of Midwifery

Definition of a midwife

3 The formal definition of a midwife was first adopted by the International Confederation of Midwives (ICM) and the International Federation of Gynecologists and Obstetricians (FIGO) in 1972 and 1973 respectively. It was later adopted by the World Health Organisation (WHO). The definition was amended by the ICM in 1990 and this amendment was then ratified by the FIGO and the WHO in 1991 and 1992 respectively. It now reads as follows:

"A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised 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 practise midwifery.

"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 new born 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. She has an important task in health counselling 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 gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service."

Activities of a midwife

4 The activities of a midwife are defined in the European Union Midwives Directive 80/155/EEC Article 4 as follows:
"Member States shall ensure that midwives are at least entitled to take up and pursue the following activities:
• to provide sound family planning information and advice
• to diagnose pregnancies and monitor normal pregnancies; to carry out examinations necessary for the monitoring of the development of normal pregnancies
• to prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk
• to provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition

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- to care for and assist the mother during labour and to monitor the condition of the foetus in utero by the appropriate clinical and technical means
- to conduct spontaneous deliveries including where required an episiotomy and in urgent cases a breech delivery
- to recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor's absence, in particular the manual removal of the placenta, possibly followed by a manual examination of the uterus
- to examine and care for the new-born infant; to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation
- to care for and monitor the progress of the mother in the post-natal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new-born infant
- to carry out the treatment prescribed by a doctor
- to maintain all necessary records."
Appendix B: Rule 40, Midwife’s Code of Practice

40 Responsibility and sphere of practice
1 A practising midwife is responsible for providing midwifery care to a mother and baby during the antenatal, intranatal and postnatal periods.
2 Except in an emergency, a practising midwife shall not provide any midwifery care, or undertake any treatment which she has not, either before or after registration as a midwife, been trained to give or which is outside her current sphere of practice.
3 In an emergency, or where a deviation from the norm which is outside her current sphere of practice becomes apparent in the mother or baby during the antenatal, intranatal or postnatal periods, a practising midwife shall call a registered medical practitioner or such other qualified health professional who may reasonably be expected to have the requisite skills and experience to assist her.

124United Kingdom, Midwives Rules 9.