

A History of Midwifery in the Western World

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Introduction

She ought not to be too fat or gross, but especially not to have thick or fleshy hands and arms, or large-bon'd wrists; which (of necessity) must occasion racking pains to the tender labouring woman...

She ought to be grave and considerate, endued with resolution and presence of mind, in order to foresee and prevent accidents; sagacious and prudent in difficult cases so as not to take all upon her own shoulders and judgment, but to have immediate recourse to the ablest practiser of the art, and freely submit her thoughts to the faculty of the more learned and skilful...

She ought to be patient and pleasant; soft, meek, and mild in her temper, in order to encourage and comfort the labouring woman. She should pass by and forgive her (the woman's) small failings, and peevish faults, instructing her gently when she does or says amiss: But if she will not follow advice, and necessity require, the midwife ought to reprimand and put her smartly in mind of her duty; yet always in such a manner, however, as to encourage her with the hopes of a happy and speedy delivery.

[Description of the qualifications of the female midwife by John Maubray in *The Female Physician* (1724) in Cutter & Viets 1964:12]

Midwifery is an occupation based on helping women through the childbirth process that has played a significant role through history. "It is generally recognised that the midwife has been with us since biblical times and that midwifery is the oldest female occupation and without doubt one of the most important" (Marland 1993). The very early description of the midwife above identified a number of key concepts that remain as significant to the role today as they were when John Maubray wrote this. The characteristics of being soft, patient, considerate and pleasant are significant to the part of the midwife's role in relating effectively to the woman. Those of sagaciousness and prudence relate to the importance of judgment and decision making in safe practice. The ability to 'submit her thoughts to the faculty of the more learned and skilful' identifies the issue that the midwife is part of a team of supporters in childbirth and needs to refer to the appropriate other team member when complications arise.

The development of midwifery over the past number of centuries has positioned it, as an occupation, with relatively limited status and authority as compared to medicine. This paper highlights the reasons why this has taken place moving to a discussion of issues relating to the 'profession' of midwifery and its power base as part of the team providing services to childbearing women. The hierarchical nature of the National Health Service as a bureaucracy and the power relations within the service are also discussed to set contemporary practice in context.

Historical Context for Contemporary Practice

Throughout most of history, women having babies were attended by women (Arney 1982). Kirkham (1996:167) highlights that the midwife was 'part of a closely knit community' in pre-industrial European

society and that 'for many centuries midwives cared for childbearing neighbours when required as part of the fabric of their domestic life'. This situation would have been similar in most parts of the world but developments in Europe from the 16th century led to significant changes which impact on the way midwives practice in the Western World today.

Midwifery in Britain - Pre Twentieth Century

Pre-Industrial Midwifery

It has been suggested, in pre-industrial society, there were three main hierarchies, that of men over women, Church over laity and landlord over peasant (Oakley 1976). The majority of midwives were women before the seventeenth century (Kirkham 1996) and so, on a gender basis alone, it could be anticipated that their status in society may have been limited. However, Hobby (1999), in introducing a manual written in 1671 by a practising midwife (Jane Sharp's 'The Midwives Book or the Whole Art of Midwifery Discovered') creates a somewhat different impression. She identifies that the midwife may have been in a unique position as, at a time when a woman was "supposedly absorbed into her husband's identity", the midwife "could earn enough to make a comfortable living in a line of work still largely closed to men" (Hobby 1999:xi). Midwives may have had a status, which most women were denied, by virtue of their employment in an all-female sphere where men posed no threat to their authority. Wilson (1995:26) supports this and suggests that "power, then, was a defining feature of the midwife's office" as she took charge in labour and stayed there until the birth was over, being paid in some way for her efforts. It cannot be expected that all midwives operated under the same conditions; Hobby (1999) points out that midwives in the 1600 and 1700's were as varying as other medical practitioners of the time. Some will have provided care extending from the early antenatal period until well after the baby was born and received a handsome fee for the effort (Hobby 1999), whereas probably the majority would have had a more limited sphere and income. Regardless, at this point in history, midwives seem likely to have had autonomy in their practice and some status in society.

In respect of the second hierarchy (Church and laity), Hobby (1999:xi) points out that midwives "played a crucial role in the male-run church"... "participating in baptism and churching ceremonies". However, in order for the Church to exert authority over midwifery, in 1512 in England, Parliament had placed the licensure of midwives under the control of the Church (Arney 1982). Hobby (1999) confirms that it was illegal to practice midwifery without a licence granted by the Bishop (sometimes at relatively great expense). Midwives had to produce either clients who would testify to their skills before they were licensed (Donnison 1977) or testimonials from other medical practitioners or church ministers (Hobby 1999). So midwives were controlled by the Church but also contributed to its work in a way that seems likely to have afforded them some status in pre-industrial communities.

The third hierarchy (landowners and peasants) is not likely to have been one that midwives challenged, as women were generally not landowners nor were midwives part of the gentry. Although property ownership would not have afforded the midwife status, Oakley (1976) claims that midwives were trusted parts of the community. In pre industrial European society, the female healer, including the midwife, was probably more trusted than her male counterpart. She was respected for her knowledge and ability to treat conditions, she was able to earn a living at a time when women were rarely in gainful employment outside of the home and she was an active participant in important ceremonies in the Church. Therefore, in Oakley's analysis, it would seem likely that midwives did challenge the hierarchies of the time and have autonomy (which has rarely been the case since).

A fourth hierarchy that became more evident as the pre-industrial period progressed was that of medicine over midwifery. The increased interest in knowledge and scientific approaches, which became prevalent during the Renaissance period, had a significant impact on the status of midwives and midwifery. The next sections of this paper will explore the impact of the hierarchies of medicine over midwifery and men over women which altered the authority and autonomy of midwives through subsequent centuries.

Medicine in Childbirth

One key way to identify the increasing interest in childbirth by the medical community is in considering the publication of texts or manuals about the subject through history. Hobby (1999) describes the scenario in early modern Britain; childbirth was almost entirely in the hands of women but the midwifery writing was almost entirely produced by men. She points out that the British books of the time were largely exploited from translations from the Continent, which themselves were based on ancient authors (and not attributed to the sources as was the norm at the time), primarily from the writings of Aristotle, Hippocrates and Galen (Hobby 1999). These manuals focussed largely on the qualities of a 'good' midwife, similar to that described in the introduction to this paper and were mainly written by non-midwives. One notable exception is the book referred to earlier, Jane Sharp's 'The Midwives Book of the Whole Art of Midwifery Discovered' which was written in 1671 by a midwife with thirty years experience of midwifery practice (Sharp 1671 in Hobby 1999). Sharp's contemporaries (Culpeper, Sermon, Wolveridge) were medical men, often never having had any experience of childbirth. However their gender and status, by virtue of being doctors, established their authority in the field despite having little or no practical experience. Sharp did believe that women had considerable anatomical and medical knowledge but recognised that this was not learned at university but from "long and diligent practice" and was "communicated to others of our own sex" (Sharp 1671 in Hobby 1999:xxiii). This was largely unrecognised by her contemporaries of the day, who dismissed female midwives as largely ignorant.

It is difficult to know how many midwives would have been able to access any of these writings as literacy in working class women, from which the majority of practising midwives emanated (Heagerty 1997), may have been limited. Wilson (1995) claims that the majority of midwives could in fact read in the 1600s in Britain (but that writing was a much less commonly held skill generally in society). Opportunities to acquire these medical or midwifery writings, however, may have made it difficult for midwives to use them to inform their practice. Traditionally, practising midwives' knowledge would have been communicated verbally and experientially, through being apprenticed for long periods, in order to learn their trade (Evenden 1993). This knowledge has been attributed less status than that of the written word; the erosion of the authority of midwives in childbirth was starting as medical men took command of the authoritative knowledge of the day.

The first textbooks written by the French (who were fairly prolific writers in that period) for midwives and about midwifery were largely inaccessible to females, as women were not able to participate in formal education at the time (Arney 1982). It was largely men, who were training to be doctors, who would be influenced by these writings and would form an understanding of childbirth that was not based on practical knowledge. Medical men had significant control over the writings about childbirth and would shape the development and spreading of midwifery knowledge from a limited experiential

base. "They were medical practitioners acquainted with medical books" (Hobby 1999:xviii); midwifery was being presented formally by individuals who may never have seen labour or birth to fit the academic convention at the time.

As the ecclesiastically sanctioned control of midwifery was taking place in England, developments in Europe were leading to an increased interest by doctors in childbirth. Public hospitals appeared in the sixteenth century in France leading to an increase in the percentage of births that took place outside of the home and affording the opportunity for doctors to become more actively involved in what had been primarily a domestic affair previously. Donnison (1977) suggests that other important developments were also taking place in France that would have far-reaching consequences for the future of both childbirth and midwifery.

The spirit of enquiry which the Renaissance had brought to other branches of medicine was now being directed to the processes of childbirth, as part of the new scientific study of anatomy.

Donnison 1977:23

This scientific interest and investigation began to strip away the perception of birth as natural, applying a rational approach that undermined the symbolic basis of traditional midwifery (Arney 1982). Progress, in relation to an increased understanding of anatomy which could inform care for childbearing women, did not come about as a result of the work of midwives however, as women generally did not have access to the new academic or anatomical studies (Donnison 1977), as discussed earlier. The "outstanding scientific achievement of the Renaissance was the rise of anatomy as the subject basic to the practice of medicine, surgery and midwifery" (Rhodes 1995:16). The knowledge that became formalised during that period led to birth being reframed, largely without midwifery input.

Science as Authority

The word 'science' is rooted in the Latin 'scientia' meaning knowledge. In its pure sense therefore, science does not assume the nature of reality, only that it is knowable.

Rose 1997:37

The making 'knowable' of the 'reality' of childbirth escalated from the early 1500's. The well known drawing by Leonardo da Vinci of the 'fetus in utero' was followed by Vesalius' book on anatomy in 1543 which depicted human organs as a result of dissection and recording by artists (Rhodes 1995). Fallopio, a student of Vesalius, identified and defined many female anatomical features in his 'Observations on Anatomy' published in Venice in 1561; these included the Fallopian tubes, ovaries, uterus, vagina, clitoris and hymen (Rhodes 1995). An understanding of the effect of the size and shape of the pelvis on labour was first described by Aranzi in 1564. Pare described the technique of turning the fetus in the uterus (internal podalic version) to assist poor progress in labour in the mid 1500s, using the knowledge of anatomy to intervene in the birth process (Rhodes 1995).

These examples of developments through that period identify an emerging priority for knowledge of the human body. The exposure of the 'inner' workings of the female body, which would have been poorly understood previously, led to a new understanding of 'reality'. The reality for those early anatomists was considered to be 'science' or, by their definition, truth.

The scientific paradigm was born in the sixteenth and seventeenth centuries when Newtonian physics and Cartesian reality replaced the softer and more organic logic of a world view based on religion and an Aristotelian respect for nature. A desire to predict and control events gradually replaced a less intrusive quest for meaning and significance. This displacement of one paradigm by the other has been associated with a drive towards complex technologies, rather than ecological solutions to human needs.

Oakley 1986:144

This move from religious and 'softer, more organic' explanations of the body, and therefore birth, set a scene for science as the eminent source of knowledge. Science can be defined as "observation, identification, description, experimentation, investigation and theoretical explanation of natural phenomena" (Marriner-Tomey 1989:3). Shiva (1996) points out that the rise of the 'science of nature' which took place between the fifteenth and seventeenth centuries in Europe, was a revolution led by males of western origin and which set in place a gendered hierarchy for modes of thinking. She continues by suggesting that science is projected as being objective or a universal, value-free system of knowledge that has displaced virtually all other beliefs and knowledge. The movement that started some five centuries ago has been an effective means of making science the authoritative knowledge in the western world. As midwives were largely excluded from building that knowledge base, unlike doctors who were educated and involved in the investigative and experimental scientific methods, they did not either impact on the knowledge development or maintain an equivalent status to that of doctors.

Science and Medicine

It is worthy of recognition, however, that knowledge and truth change all the time. In Hobby's descriptions of the pre-industrial writings on childbirth, she points out that there were many beliefs at that time which we now find somewhat amusing, assuming that we now know the 'real' truth (Hobby 1999). These include the thought that conception only took place if each partner had an orgasm during intercourse, that labour pains were caused by the baby's struggling to be born rather than by uterine contraction, and that the womb and breasts were attached by special vessels which allowed the postnatal blood to travel from the womb to the breasts where it was transformed into milk. New 'scientific' breakthroughs are now daily occurrences, for example genetic sequencing or cloning, yet it is impossible to know if scientists of the future will consider the knowledge we currently believe to be true as amusing, in the light of findings we cannot even consider at this point in history. Science is thought of as 'true' and 'real', but it is bound by contemporary understandings and capabilities, and these change all of the time.

There appears to be an implicit belief, from the writings in these early times to the current notion of evidence based practice that medicine is science-in-action. As science became increasingly revered as truth, medicine sought to find 'scientific' answers to the challenges posed by childbirth. The impact of this will be further explored later.

Men in Midwifery

As scientific interest in birth increased, so did the part that men played in the process. "In England, the existence of this new order of practitioners had been recognised by the early 1600s with the addition

of the word 'Man-Midwife' to the English language" (Donnison 1977:23). The development of the obstetric forceps by Chamberlen, from as early as 1634 (Rhodes 1995), gave male midwives (or accoucheurs as they preferred to be known) a more positive role than that of their predecessors, the barber surgeon (Towler & Bramall 1986). "No technology will gain widespread acceptance and be the basis for reform of culture unless it is introduced into an ideologically social field" (Arney 1982:27). The forceps, then, became a symbol of socially accepted change; men were increasingly accepted as having a part to play at birth. Hobby (1999:xii) identifies that the Chamberlens' "secret midwifery forceps are seen as a proper scientific intervention into birth" and that they kept the design of these secret in order to protect both their profits and their control.

This use of the word 'scientific' equates it to technological development. Although some of the developments of the day would have been based on the increased knowledge of anatomy, this in itself did not make them 'scientific'. Using Marriner-Tomey's definition above, science is explanation rather than intervention. However, under the name of science, many of the developments taking place in and around childbirth were interventions intended to expedite birth to the benefit of mother and baby. Male midwives or accoucheurs were those using this technology; they would have been seen as the 'rescuers' when the attempts of the midwife were unsuccessful in supporting normal birth, in cases of complication.

The midwives' role, which would rarely have been questioned before the 17th and 18th centuries, now started to be both challenged and influenced by medical men. Bourdillon (1988) identifies that, by the mid eighteenth century, accoucheurs were the most highly paid practitioners employed by the upper classes. Therefore the male midwives had moved into the influential sphere of society and were seen as more prestigious than their female counterparts. The working classes continued to be served by the lay midwife or local handywoman (Kirkham 1996). These lay midwives practised in their local communities with little or no communication between them and, therefore, were not organised in any way to challenge the increasing control over birth which the medical men were exerting. These women did not receive any formal educational preparation for their work but, as discussed earlier, were apprenticed, often for lengthy periods (Marland 1993), into learning the skills necessary to support women through the birth process. But the value of this learning was becoming less recognised as important and considered by some as inferior to the new 'scientific' knowledge.

The Dickensian image of the gin-swilling, unkempt 'Sairey Gamp' type midwife devalued any knowledge base on which practice was established. It gave the impression that these women were unscientific and therefore unsafe, despite there now being available evidence of 'unofficial' systems of training from at least the seventeenth century in London (Evenden 1993). Even though this training existed, it would not have been based on a formal understanding of human anatomy / physiology or the potential value of 'scientific' intervention. The midwives who cared for women giving birth could have been considered as ill prepared or even dangerous by those in the developing scientific community despite the fact that, both historically and internationally, birth was normally successfully accomplished under these conditions.

The early 19th century saw significant change; no longer was just birth of interest to accoucheurs but pregnancy began to be framed as a pathological possibility and, as such, not safe in the hands of midwives. In Britain, there were moves to try to organise lay midwives through regulation; the

Obstetrical Society (an organisation of male practitioners) from 1826 tried to make a case for this with some success (Arney 1982). But possibly the most significant development was in mid century, when the Royal Colleges in Britain established examinations for male practitioners in midwifery. Donnison (1977) claims that this put the final seal on the exclusion of women from controlling midwifery as women were unable to attend university and, therefore, take these exams.

Towler & Bramall (1986) point out that Elizabeth Nihell had tried to attack the male midwife in her 'Treatise on the Art of Midwifery' as early as 1760, claiming that they used forceps unnecessarily. Nihell decried the pay differential between male and female midwives and appealed to midwives to maintain the 'naturalness' of birth. However the lack of organisation and education of lay midwives would have made this plea one which few midwives heard. Donnison (1977:177) points out that the poor and sometimes illiterate working class midwife was not "the stuff of which a successful pressure group is made".

A number of groups tried to take control of the organisation and education of midwifery in Britain through the nineteenth century; for example, Florence Nightingale set up a training school and the Female Medical Society organised a Ladies' Medical College. Both of these allowed midwives the opportunity to be formally trained in a way largely inaccessible to them previously. The Matron's Aid or Trained Midwives' Registration Society (to become known as the Midwives' Institute) was formed as a key player in the move to gaining recognition for midwifery as a respectable means of employment (Arney 1982). This group was to be instrumental in both the survival of midwifery as an occupational group and its ultimate control by medical men.

The Midwives' Institute was a group of middle- and upper class nurses and trained midwives who sought to provide respectable employment for middle-class women (Heagerty 1997). It was instrumental in bringing about the Midwives Act of 1902, which made the training of midwives compulsory to stop the perpetuation of the attendance at birth by lay (and largely working-class) women. The social standing of this group was crucial to the outcome of their energies. They aligned themselves to the prestigious medical community and had little in common with either the midwives or women from the working-class and were, therefore, unlikely to take into account the needs and desires of these groups.

Midwifery in the United States (U.S.)

Several developments were taking place in the U.S. alongside the evolution of midwifery in Britain; these would lead to a very different outcome for midwives and women. It is important to consider the developments in the U.S. as doctors there have taken the lead in childbirth over the past century across all spheres, virtually eliminating midwives and midwifery for a substantial period. This would have been one possible outcome for midwifery in this country had the Midwives' Institute, or some similar group, not taken an active role in ensuring its preservation. Also the relative power of the U.S. as an international trendsetter means that approaches to birth there have impacted on the norms throughout the Western world.

Several factors impacted on the possibility of maintaining a distinct occupational group in the U.S. These included the economic importance of midwifery to medical men, the lack of upper class patronage of midwives, increased emphasis on science (or technology) in medicine and the lack of any

organisation of midwives in a large and decentralised country (Arney 1982). Indeed the word 'midwifery' was largely dropped after the American Medical Association was started in 1847 as the scientific division of 'obstetrics' was considered preferable (Arney 1982). By the time midwifery was being enshrined in statute in Britain, there was a substantial move in the U.S. to remove midwives from the system of health care altogether.

Dr. Henry Garrigues published a book in 1902 (Oakley 1989:214) which dismissed any sound basis of midwifery practice suggesting that "midwives do harm not only through their lack of obstetric knowledge, their neglect of antiseptic precautions, and their tendency to conceal undesirable features, but most of them are inveterate quacks". Barker (1998) points out that the publication of 'Prenatal Care' was a systematic attempt to introduce women to a medical interpretation of pregnancy in 1913 in the U.S. This document was distributed to well over twenty two million women by the mid-thirties and effectively led to the reconceptualising of pregnancy as medically problematic rather than as an 'experientially and organically demanding' social transition (Barker 1998).

This widespread dissemination of medical propaganda in the early twentieth century was an important and explicit means of leading American women to the belief that they need hospitals and technology to give birth and obstetricians to safely control that process. Davis-Floyd (1998) confirms that this belief colours women's perceptions of their own bodies and their ability to give birth normally and remains prevalent today. Rothman (1996) supports the idea that American women have been systematically stripped of power and control through the routine management of childbirth. The campaign from the early twentieth century appears to have been very effective in redressing much of American society's expectations of birth and in setting up obstetricians with ultimate authority in its control.

It is not surprising that midwifery was all but eradicated in the U.S. (Mander 2002) until a resurgence of interest by women in the past few decades led to the creation a relatively new practitioner, the 'nurse-midwife'. The 'nurse-midwife' appears to be a being more socially acceptable to the medical community. It is likely this acceptance is based on two factors: nurses have limited autonomy or authority in practice (i.e. they provide the treatment prescribed by doctors) and their training/ education is based in the biomedical approach to health and health care and they are, therefore, likely to accept intervention as routine. These nurse-midwives practice primarily in hospitals with only a few supporting women outside of the mainstream obstetric system (Davis-Floyd & Sargent 1997).

However through the twentieth century, lay midwives did remain prevalent in the U.S. in very specific areas, those of deprivation, remote access or minority ethnic cultures (that is, those areas least likely to provide lucrative employment for obstetricians). There are some notable examples of innovative midwife led care initiatives led by organisations like the Maternity Center Association (Lubic 1979). In addition, lay midwives have continued to practice in specific areas like the commune in Tennessee, called 'The Farm' from which Ina May Gaskin has become very well known internationally. These examples are far from the norm, however, and are based in areas of little prestige or limited potential financial gain. There has been an increased number of midwives who have not come from a nursing background in the past twenty years (known as the MANA -Midwives of North America, an organisation created in 1982- midwives) but there is still widespread scepticism about their legitimacy. They largely practice primarily in free standing birth centres or in supporting home births.

Therefore, in the U.S., midwifery has developed in a very different direction than in Europe. The intentional devaluing of traditional midwifery, through the systematic dissemination of propaganda that claims obstetrics as the only safe option of care for childbearing women, has relegated midwives into relatively powerless pockets of practice. Despite the resurgence of some interest and support for midwifery practice, it remains marginal in a medically dominated health system. Technology is considered as an essential part of safe childbirth and that technology is largely the domain of medicine. Midwives, although growing in number as a result of interest by women, are generally still considered as fringe despite their efforts to meet the requirements for in depth knowledge of the 'science of obstetrics'. This adversarial approach to birth, with midwifery opposed to obstetrics as the legitimate authority on childbirth, is less explicit in Britain but the developments in the twentieth century have meant that it exists nonetheless (Taylor 1999).

Midwifery in Britain in the Twentieth Century

Midwifery became legally recognised in Britain in 1902 with the first Midwives Act. Despite this, there continued to be a large proportion of women who were supported by midwives who had not been formally trained. "Before the First World War and, in some areas, until the mid-1930's, the majority of working-class women in Britain were attended in childbirth not by a professional but by a local woman" (Leap and Hunter 1993:1). The Midwives Act allowed for lay midwives to continue practising, as there were so few trained midwives at the time (Heagerty 1997). However, there was a time scale attached to this; by 1905, all midwives had to register as 'bona fide' or they could not call themselves midwives (Heagerty 1997). After 1910, bona fide midwives could no longer legally attend births without being under the supervision of a certified midwife or physician.

The Central Midwives Board and Legislation

The Central Midwives Board (CMB) was established as part of the Midwives Act. Its function was to approve training programmes, define 'Rules of Practice' (which clearly identified the sphere of the midwife as normal pregnancy, birth and puerperium) and set an expectation of moral good character, which was to be demonstrated in written proof submitted by individuals considered acceptable to the Board (Heagerty 1997). It also set up Local Supervising Authorities that provided routine supervision of midwives by non-midwife, middle-class lady inspectors (Duerden 2002). The CMB initially had no midwife members, as this was not considered acceptable until 1920 and even then it was statutorily forbidden that midwives form a majority (Drury & Staples 2000), with an obstetrician as its Chair. Midwifery was legitimated through the Midwives Act but the control of midwifery practice remained largely in the hands of other groups.

The developments in midwifery within the twentieth century are a reflection of the continued battle for recognised status. There was a series of additional Midwives Acts- in 1918, 1926 and 1936- which provided stricter guidance in assuring that only qualified midwives were able to attend births; many women continued to seek unqualified midwives as they were less expensive. One of the outcomes of the fourth Act in 1936 was to lay a foundation for a significant change to the working lives of midwives. The Local Supervising Authorities in England and Wales became responsible for providing a salaried domiciliary midwifery service (Towler & Bramall 1986). For the first time, midwives supporting women in their homes received a regular income, planned off duty, annual leave and financial security (although the norm was only one day off per month at the time and the salary relatively low).

The National Health Service (NHS) Act in 1946 provided free access for all women to doctors as well as midwives; it was at this point that general practitioners began to regularly see women through pregnancy in order to get the fee available to them from the NHS. As they were not required to attend the birth in order to be paid, this role was frequently left to the midwife who may not have had the opportunity to meet the woman through the pregnancy. Continuity of support suffered as a result of these changes (Towler & Bramall 1986); total responsibility by the midwife for the pregnancy, birth and postnatal period was also affected.

Changes took place in the CMB through the century; the numbers of members increased but the proportion of midwives continued to be in the minority. The most significant change took place in 1973 when, for the first time, the Chair of the CMB was a midwife. This was short lived, however, as the Nurses, Midwives and Health Visitors Act (1979) ended the CMB, moving the locus of control of midwifery from doctors to nurses. A Statutory Midwifery Committee within the UKCC was established, with some effect, following pressure from midwives (Thomas 2002) to ensure midwifery regulatory issues were not subsumed within the broader nursing agenda. This remained a vexatious point for midwives throughout the life of the UKCC as the Midwifery Committee was not autonomous and the work was controlled by Council with its majority of nurses. There has been little change in this since the Nursing and Midwifery Council was established in 2002.

Supervision

Supervision of midwives altered through the century as well. Following the initial introduction of supervision by non-midwives (the middle-class lady inspectors), in 1936, two types of supervisors were recognised- medical and non-medical. The non-medical supervisors were expected to be senior, experienced domiciliary midwives but they were responsible to the medical supervisors, maintaining legitimate control by the medical establishment. In 1974, with the reorganisation of the NHS, the Regional Health Authorities became responsible for midwives, delegating the Local Supervising Authority (LSA) function to District Health Authorities. In 1977, it was agreed for the first time that supervisors must be midwives (Towler & Bramall 1986) and the words 'non-medical' were removed from the title of 'supervisor of midwives' (Drury & Staples 2000). It was very unlikely, however, that these midwife supervisors would be responsible to midwives in the District Health Authority; therefore ultimate control of midwifery practice was still not in the hands of midwives.

There has been a tension within the role of Supervisor since the early days of the twentieth century when they were known as Inspectors and their function was to investigate cases of misconduct, negligence and malpractice. Despite the 'Ministry of Health Letter' in 1937 stating that the newly titled 'supervisor' should be 'regarded as a counsellor and friend to midwives rather than as a relentless critic' (Drury & Staples 2000:160), the role remained largely a 'policing' one (Halksworth, Bale & James 2000), with little evidence of close support for the midwives being supervised. Possibly the most significant change in the quality of supervision was brought about in 1993 when it became a requirement that new supervisors undertake an educational programme of preparation for the role (Mayes 2000). Following this development, from 1996, for the first time all Local Supervising Authority Responsible Officer posts were taken by midwives (Duerden 2000). These two developments ensured that supervision was in the hands of midwives and that there was a consistent understanding of the remit of and positive potential of the role.

The effectiveness of the supervision function as a support to midwives, rather than as a policing role, was explored in a study reported in 1998 (Stapleton, Duerden & Kirkham 1998). The key results of this study demonstrated variable quality of supervision, some supervisors being perceived as helpful and supportive and others as intimidating and undermining. Power was an important theme in this study; the supervisor was perceived as relatively powerful especially if the supervision role was alongside a management one. The vast majority of midwives supported supervision, however, and wanted to see the model of support continue as they felt it had a direct impact on their professional wellbeing and the service they were able to give to clients. Therefore, it would seem that supervision did offer support for many midwives but, in cases, it can be controlling and disempowering. Some midwives appeared to be constrained rather than enabled through this mechanism of professional support.

Despite supervision having been a function unique to midwifery practice (it is not replicated in any other health professional group), changes planned for midwifery supervision in 2017 may significantly change or remove this important and distinctive feature of professional midwifery support and regulation.

Patterns of Care

The changing patterns of maternity care over the twentieth century have provided another challenge for midwives. Increasing rates of hospital births supported by successive government reports (Cranbrook Report 1956 recommended 70% hospital birth, Peel Report 1970 recommended 100% hospital birth), the technologies and interventions which became much more common place in the late 1960's and early 1970's (induction, use of Syntocinon for augmentation, electronic fetal heart rate monitoring, episiotomies) and the increased proportion of obstetricians employed within maternity services, all impacted on the autonomy of the midwives' role (Towler & Bramall 1986). The increasingly technological approach to birth has largely followed the pattern of change in the U.S. where intervention in birth became the norm in advance of it happening in Britain.

In the 1980's there was a continued emphasis on hospital birth supported by the Short Report in 1980 but, as a result of criticism by women of the impersonal service this provided, there was a move to make hospitals a nicer place in which to give birth. The change in the 1990's instigated by Changing Childbirth (DOH 1993) was potentially the most significant in the last century in terms of the midwives role in the UK. It promoted midwives as the ideal supporter in cases of normal childbirth and identified the importance of women being able to have choice, continuity and control of their childbirth experience. However, despite this report being an ideal tool for midwives to use in increasing their autonomy, there has been little significant progress in consistently adopting the principles of Changing Childbirth across Britain since that time, as Sandall (2014) highlighted in her research report for the Royal College of Midwives. Resourcing teams of midwives undertaking caseload practice in order to provide continuity of care may be seen as resource intensive by NHS maternity services, despite many projects having demonstrated positive outcomes (for example Page et al 1999, Benjamin et al 2001). Being able to deliver high quality, safe and compassionate care continues to be an NHS priority but the cost of socialised healthcare since the inception of the NHS escalates as technologies and treatments become increasingly expensive over time. The introduction and acceptance of maternity support workers as an important part of the maternity services (RCM 2010) has offered one solution in respect

of resourcing demands and has increased the role of the midwife as one of overseer of care rather than delivering it directly throughout pregnancy, labour and the postnatal period.

There is considerable evidence of the positive impact of midwifery care on outcomes for women having babies (Cochrane Review, Sandall 2015). However the future of midwifery practice will need to continue to change as resources, expectations and opportunities do, as it has throughout history.

Conclusion

Midwifery has survived and thrived in Britain and has been revived in the U.S. It would seem that it is still recognised as an important occupation, highly valued by women. However its history has been one of conflict; despite pre-industrial midwives being in positions of relative authority, changes over subsequent centuries eroded this authority. The rise of science as authoritative knowledge, the involvement of men and the influence of medicine on childbirth have all had impact on the status of midwifery and the control of midwives. In the past two centuries, other occupational groups have been vying for control over the midwifery sphere of practice in the UK. Changes in relation to skill mix in maternity services and in supervision set the scene for the potential of professional control remaining an important issue in the future of midwifery practice.

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