Should midwifery really be a speciality or extension of nursing?

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Introduction

In South Africa, once upon a long time ago, midwifery *was* a separate discipline. Even today, there are many older midwives and nurses who remember the 'green epaulette' brigade. When these midwives are spoken about, it is mostly with respect and even a modicum of reverence. I should know, because my own grandmother was such a midwife in the Eastern Cape, fondly known as Nurse Dominy by the many families she assisted as they started or grew their brood.

The road to lumping nursing and midwifery into one profession under one Council is on the one hand an interesting slice of health sector history, and on the other a difficult narrative to follow for those less enamoured of policies, politics and professional posturing. However, that is not the main emphasis of this article; instead, it is to look at how nursing and midwifery differ, and to postulate the potentially positive implications of ensuring the independence of this vocation.

A case of mistaken identity?

Not only did the lines between midwives and nurses become blurred along the way, but so did those between maternity homes and hospitals. Most South Africans of 55 years and older would have been born in their own home, or in a dedicated maternity home, with the primary help of a midwife (often a catholic nun) or the general family doctor. Today, the burgeoning urban and peri-urban communities hardly know of any other way than slotting into the clinic or hospital system to monitor their pregnancies in antenatal clinics or obstetric practices, and have their babies in labour wards or C-section theatres.*

While the upsurge of modern medicine and medical professionalism changed (sometimes correctly known as 'developed') at a great rate of knots in South Africa, maternity care, midwifery training and birthplace did what has now become the common model of modern western medicine – they followed suit! Maternity care sashayed, apparently unchallenged by mothers or midwives, into the domain of the doctor and in time the specialist, or obstetrician. Midwifery devolved into a relatively small section of overall basic nursing training, to be followed by more in-depth training to enable registration with the 'Nursing' Council as a 'midwife'! This model has undergone, and continues to undergo, a number of adaptations and further specialisations over the years, mostly as a response to the unacceptably high maternal and infant mortality rates of our developing country – for instance, the advent of Advanced Midwifery and Neonatology Nursing. Maternity homes were re-deployed, bought over or integrated into multi-focus hospitals, one by one until almost none were left in the whole of the country. The changing face of politics and religion (as Catholicism and the number of maternity nuns diminished) also had some bearing on the demise of midwifery as an independent profession.

Midwifery vs Nursing

Most nurses and midwives in South Africa believe the status quo should be maintained. They gasp when one suggests that there is indeed room for direct-entry midwifery training. They protest vehemently when one suggests a midwifery-only trained midwife could know enough to be a reliable and knowledgeable health professional.

It would seem that the basis of the argument against independent midwifery training, from those in academia and the hospital world is two-fold:

1. The training would never be comprehensive enough if midwifery were the sole focus; apparently there is concern that these midwives wouldn't know how to treat 'patients' with systemic conditions, or be able to take into account overall anatomical and physiological implications of the pregnant, birthing and recovering woman.
2. Historically, most hospital midwives haven't felt equipped after their basic and 'one additional year' of midwifery training to deal with all possible pregnancy and labour complications. Somehow, this has led to the fear that direct entry midwives wouldn't know what to do when there truly are complications; nor would they be full members of the multidisciplinary team and be able to refer women when necessary. Is this possibly because we know, from hard experience and gut feel, that midwives often are and would be shunned by obstetricians and even their nurse-midwife colleagues?

Precisely these concerns highlight the core of the problem, and of the solution! Some of the considerations that need to be borne in mind are:

- Direct-entry midwifery training would not encompass just one or two years as in the green epaulette era; in other countries, a minimum of four years and far greater practical exposure than in historical South African midwifery training is the norm. While the content of the curriculum might focus on midwifery, pregnancy and birth affect the whole body-mind, and as such midwives would be truly holistically trained.
- Much of the concern is rooted in pregnancy and birth being seen as primarily medical conditions, not a life experience. Avoiding, diagnosing and managing complications seems to be the prevailing approach, despite evidence clearly demonstrating that the medical model often leads to a knock-on series of complications and interventions which could have been avoided with a midwifery model of care. The two previous articles submitted to this publication speak more about this model of midwifery, and should be read in conjunction with this article.
- Hospital midwives, especially in the private health sector, are truly not midwives, but rather, obstetric nurse professionals. Admittedly, most don't like this connotation, and vehemently protest that they *are* midwives! However, if you almost never help a woman to birth her baby, and you are under the authority not only of hospital management, but the presiding obstetrician, how can that be called midwifery? Having met the criteria for a green bar, and working in a labour unit, does not automatically make one a midwife!
- The demigod of western medicine is the multidisciplinary approach. While supposedly aiming to ensure that the 'patient' is evaluated and treated holistically, it so often leads to fragmented care and neglects to take into account that every 'patient' is more than the sum of their parts, systems or disease components. This is never truer than when working with pregnant and birthing women, and new mothers and babies – who in any event, are very seldom truly 'patients', unless we as the health professions turn them iatrogenically into patients. It is unethical to gloss over this failing of obstetric care!
- Midwifery staff is often summoned to work in other hospital units experiencing shortages. Certainly, that is a concern needing to be addressed, but should it be midwifery's concern? Would one ask an obstetrician to work as an orthopaedic surgeon? Let's not allow hospital and Health Department management to pull the wool of nursing challenges over the eyes of the midwifery profession!

Most importantly of all, nurses are primarily trained to assist with the care of diseased, ill, operated and dying patients – all extremely important, but that is of course not in question in this article or in a midwifery mindset. Yes, prevention and patient education are part of the scope of nurse practice too but, in all honesty, how many of her or his daily duties are devoted to this? Midwifery, on the other hand, is focused on the well-being of mother and child throughout pregnancy, birth and the postnatal period. None other than the WHO has said that 85–90% of pregnancies and births could and should be 'normal' deliveries, no matter the setting in the world. These are the women who should be receiving midwifery care from midwives focused only on midwifery. Midwifery is a profession with an overwhelmingly positive holistic health focus – complication monitoring and resultant action is a given, but midwives are the experts in helping make natural birth with excellent outcomes the right and norm for the vast majority of women and infants. They pose the solution to many of the problems in maternal and child outcomes faced by the Department of Health today. The crux is that they must practice real midwifery, not obstetric nursing!

Pondering the significance of birthplaces

There are three telling examples of alternatives to the hospital as the automatic birthplace in South Africa today. The oldest is home birthing; in the green epaulette days midwives delivered most women at home, and the slow resurgence of independent midwives since the 1980s continues that tradition. Traditional midwives (also called Traditional Birth Attendants or lay midwives) have always gone about their business in the homes of the women they assist and pose a huge challenge to the health authorities – not because they are bad at what they do (because many are excellent, even if some aren't), but because many women prefer their care because they fear the clinical, often-frenzied hospital environment.

Secondly, there are the Western Cape MOUs – sometimes said to be Midwife Outlying Units, more often Midwifery Obstetric Units. These world-renowned units mostly fall under the auspices of that venerable midwifery institution, the only state midwifery hospital, Mowbray Maternity Hospital. The midwives working in the MOUs are certainly practicing midwifery and doing sterling work, but the birthplace itself and the close alliance to the medical model pose significant challenges to the full potential of midwifery care from midwives hailing from an independently trained profession. Under such midwives, these units could be taken to a whole new level and become the norm for most pregnant and birthing women in South Africa. The best of the non-medical approach would be what elevates these units and the name 'Maternity Home' should preferably be revived.

Thirdly, there are the private birthing units, houses and active birth centres, ranging from state-of-the-art hotel-like facilities to homely converted premises to special units within hospitals. Here, independent midwives (or a dedicated complement of employed midwives in the case of active birth units within hospitals) ply their trade, often in conjunction with doulas, midwife-friendly obstetricians and allied mothering supporters like hypnotherapists, nutritionists and breastfeeding counsellors. While most are doing a sterling job, some need to take care not to lose sight of the primal life experience that birth in fact is, because that too can divorce a woman from her powerful birthing instincts and result in higher-than-necessary medical intervention rates.

Conclusion

Considering that direct entry midwifery would provide more in-depth theoretical and practical training than currently the case, and that midwifery-birthing has shown improved mortality and morbidity outcomes, not to mention better subsequent breastfeeding and emotional wellness of women, how can we justify not moving to separate midwifery education and professional regulation?

*This is very different in outlying and rural areas, of course, and that warrants an article of its own, so it won't be explored further here.