



The Essential Midwife

[AIMS Journal, 1998, Vol 10, No 2](#)

Companion article to [Active Management of Labour - The Irish Way of Birth](#)

The most fundamental aspect of active management of labour, largely ignored outside the National Maternity Hospital, is that of continuous midwifery care during labour. Professor O'Driscoll recognised that women in labour do not like to be left alone so a basic provision of his policy ensures that every woman is given the continuous companionship of a midwife. There are now a number of studies world-wide (referred to as the doula studies) which bear out what every mother and every midwife worth her salt has known since the dawn of time: if a mother is fully supported during labour in a companionable manner, she is less likely to grow fearful, she will labour more effectively and need less intervention like forceps and caesarean section as a result.¹

A doula (from the Greek) is a woman who is present and interacts with a woman before, during and after labour. She literally mothers the mother. Once anthropologists like Margaret Mead rediscovered her worth in so-called primitive societies, doctors like Klaus and Kennel worked hard to re-acquaint the medicalised system with her undramatic preventive abilities. In fact they have demonstrated that these abilities are not the sole province of the professional midwife. Their work is an example of how science has to validate very obvious human needs before they can be "officially" recognised.

Midwifery is probably the oldest profession. The word "midwife" means "with wyfe" or "with woman" and is therefore a basic job description of what midwives have always done and should still be doing. Curiously, the best effects and lowest intervention rates, are the result of ordinary lay women with a kind heart simply being there as a support during labour. Hospitals with less fixation on "professional abilities" in other parts of the world have instituted programmes of lay woman (doula) support.

Midwives working in such a clearly defined system as active management outlined above can only work "with woman" up to a point.

*"Conflict, when it occurs, is usually a no-win situation for the midwife if she is dealing with her superiors or doctors. But midwives also learn to implement changes in ways which do not attract censure. These changes are limited in the hospital setting to getting things as close to "normal" as possible, again without a clear definition of normality. But a midwife is not easily able to privilege the woman's wishes and desires over an obstetric decision. In fact, she must negotiate between the two, the burden of the work more often than not being to enable the woman to accept the obstetric norm."*¹

In implementing active management policies the midwife is not always replicated accurately outside the

NMH as a recent example of installing this policy in Harvard, Massachusetts demonstrates.² In fact the quality, necessity, and impact of her entire role may be overlooked.

Instead, those parts of the active management package that most appeal to medical authorities may be instituted, especially those quantifiable, economic- based, time-and labour-saving aspects. The results are a kind of a la carte active management, such as excessive membrane rupturing and oxytocin administration, without the continuous supportive presence of an authentic midwife. What is more the policy of active management is increasingly, and inappropriately, being implemented in women having second and subsequent babies.

References

1. Murphy-Lawless, J, *Piggy in the middle: the midwife's role in achieving woman-controlled childbirth*, Irish J Psychol, 1991; 12(2)
2. Frigoletto, F, *The Boston randomised control trial of active management of labour*, lecture given at the Centenary Scientific Meeting of the National Maternity Hospital, Dublin March 1994

Editor's Note: For a view on low-tech management in a hospital setting at the Semmelweis Clinic in Vienna see the AIMS Journal 1996; 8(1): 6-8 and 18-19.