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Short Commentary

Doctor Versus Midwifery-led Care: A Commentary on a Task-shift, not Only Complex but Difficult to Accept

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Abstract

Task-shifting from doctors to midwives/nurse-midwives is not a novel human resources strategy but an evidence-based return to the origins of women's care in pregnancy, birth, and the postpartum period. Many countries still rely on medical-led care models to care for women at low risk of complications despite solid evidence that midwifery models result in better outcomes for women and babies. This commentary reflects on how historically women have been cared for by midwives and how a patriarchal and medicalized culture interfered negatively in a physiological life event.

Keywords: midwifery, obstetrics, models of care

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1 INTRODUCTION

Sustainable and resilient health care safeguards better quality of life for everyone now and for generations to come.

Today there is a robust body of evidence that establishes that midwife-led care (educated to international standards and when working in interprofessional teams fully integrated into the health system) results in more than 50 direct and indirect, short, medium and long-term advantages for women, babies but also communities[1,2].

Despite the overwhelming benefits of midwifery care, and despite availability of trained midwives, expected to lead care for healthy women and babies in pregnancy, birth, and the postnatal period[3], in many countries (in Europe, America, and many others), for various reasons, there are obstacles to midwives being able to achieve their full scope of practice[4].

Midwives are accountable and responsible professionals and in addition to the autonomous tasks referred to above, their care includes risk assessment, escalation of care, and

providing immediate care awaiting medical support when care is referred to a medical professional[3].

Whilst in many countries midwifery is normative and established practice, in others medical-led care is standard and though task-shifting from obstetricians/family doctor-led care to midwife-led care is seen as an innovative strategy[5] this shift seems not only complex but difficult to accept. But, was it always this way?

In this commentary, we briefly describe how historically women's care shifted from midwives to doctors and we argue that a midwife-led care approach, following the Quality Maternal and Newborn Care framework[2], is a simple evidence-based, cost-effective and sustainable return to the origins of women's care in pregnancy, birth, and the postpartum period. As a curious fact, the word obstetrics, which is derived from the Latin word obstētrīx, means midwife[6].

We also address the following question often posed in countries where midwife-led and collaborative care is not established:

1. Is the shift from doctor-led care back to midwife-led care an actual down-grade in care?

2. For centuries the midwives were the sole carers of women's health needs, but they were gradually displaced as being able to independently act in the birthing process[7]. How did this unfold?

2 COMMENTARY

In France, Germany, and Switzerland, as early as the 15th century, traditional midwifery started to take form as a profession where midwives actions were regulated and licenses to practice were created[8]. Historians theorise that this was prompted not to ensure the best care to women but to institutionalise the power of The Catholic Church and municipalities to control women's reproductive wishes[9]. They held midwives accomplice or accountable for their influence towards abortion, infanticide, birth control, and pregnancy outside of marriage[9]. Business, and activities predominantly controlled by women were considered a threat to the male-dominant society of that time.

The first midwifery schools were founded in Paris in the 16th century[10] and it is not until the 18th century that doctors/barber surgeons started to take their first footsteps in "obstructed labours of live babies" though then they attended these births in the "capacity" of "man-midwives"[11]. Man-midwifery thrived, both because of the success of the Chamberlen family in "difficult labours" with the use/invention of forceps but also fashion. For business purposes, and since the Chamberlens' were barber-surgeons, and not licensed physicians, they kept their instrument a secret for many years and only attended to wealthy families, gaining reputation as men of science with better skill than their female-midwife counterparts[12]. Although barber-surgeons were not medically trained, men in general were academically privileged compared to women and received formal education and training[13]. The indirect consequence of this was that soon patriarchy, paternalism, and a claim that men surpassed women in skill, even at managing normal births, began to infiltrate the birthing room[11].

Despite a period of growth in the medical field, obstetrics stagnated until almost the 20th century as it was not recognised as a medical speciality by its own medical community[14].

Some maternities "lying-in" wards opened in France and Britain between the 18-20th century, but they became an area of public concern since their maternal mortality rates were higher (puerperal fever) than in homebirths[15,16]. This difference in outcomes maintained until the middle of the 20th century when germ theory was confirmed, antibiotics discovered and sanitation conditions improved[17]. This part of history is conflicting with the widespread belief that the credit for the reduction of the maternal mortality rate is owed to the hospitalization of birth. In fact, we argue that such direct assertion cannot be made.

By birthing in maternity wards and with the introduction of "man-midwives" in birthing settings the concept of childbirth changed from a domestic, private, intimate, and feminine event and started to be lived in a public manner, as a pseudo-medical occurrence, with unlimited scope for intervention and the interference of other social actors[7,18].

By late 19th century, the formal education of midwives through training and competency-based certification intensified, especially in Europe. Simultaneously obstetrics was finally recognised as a medical sub-speciality of surgery with the introduction of successful cesarean sections and advances in anesthetics[14] which permitted the surgical birth of live babies.

In the 20th century there has been an uniformization of training, professional conduct and definition of both medical and midwifery practice competencies. Beginning in the early 1900s European countries created boards (British Central Midwives Boards (1902), l'Ordre national des sages-femmes français (1943), Spanish Colegios officales de matronas-Spain (1931), which aimed to secure better midwifery training and regulate their practice[19].

These institutions were however dominated by the medical profession for a long time, with the belief that their superior knowledge and skill was fundamental in

the development of midwifery practice though creating a superior hierarchical relationship and undermining the knowledge and skill passed on from experienced midwife to apprentice, and through the practice of "being with women"[19].

The 20th century sees births being completely shifted from home to hospitals and in many contexts (especially high income countries) obstetricians assumed total control of what became an entirely medicalized procedure[20]. Pregnancy and birth changed from a "natural event into a medical problem"[21].

As technology and access to drugs developed, women with straightforward pregnancies were subjected to routine interventions: intravenous infusions, oxytocin infusions, electronic fetal monitoring, lithotomy position (for better view of their health carers), routine episiotomies and so on. And as labour intervention became widespread, so have the practice of assisted delivery and caesarean sections[22].

But by the end of the 20th century events shifted, there was a new emphasis on health promotion and disease prevention and public health experts started highlighting the iatrogenic consequences of this medicalized pregnancy and birth culture[21]. At the same time influential historians and sociologists started questioning the evolution of maternity care and presented a scenery of societal childbirth control, medical authority into domains of everyday life, and an historic "power grab that had transformed obstetrics and gynecology into privileged and powerful professions at the expense of female midwives" and at the expense of women's control over their bodies and wishes[23]. This perspective gained public and political attention and patient consumer organisations started campaigning for choice in childbirth and redistribution of power between health specialists[23].

Important institutions such as the Department of Health (United Kingdom)[24] and the World Health Organisation[25] emphasized that safe and effective care to childbearing women had to be women-centred and that every pregnant woman should have a choice in her care and access to a midwife. The National Institute for Health and Care Excellence, internationally, recognised for their rigour, independence, and objectivity, wrote guidance stressing the above and recommending practices to promote and maintain the good health of women, not intervening in pregnancy and birth unless deviations of normality occur[26].

Late 20th century and the 21st century saw midwives re-surge as women's advocates in pregnancy and birth and childbirth re-entering private and home environments. Midwifery Units were created in several countries as optimal birth places for women with uncomplicated pregnancies and agendas to decrease the rate of intervention in pregnancy and birth were elaborated.

In some countries (e.g., United Kingdom) there was a shift from medical-led care back to midwife-led care as the latter were recognised as specialists in the physiology of pregnancy and birth, with family doctors and obstetricians taking their role as specialists in medical and obstetric complications[27].

Since then, as earlier mentioned, a series of research studies have demonstrated that midwives, educated and trained to internationally accepted standards and licensed to practice, are adequate practitioners to care for women experiencing uncomplicated pregnancies[2], presenting advantages over other models of care. Less episiotomies, less amniotomies, less regional analgesia use, less instrumental births, lower prematurity, higher rates of spontaneous vaginal births, higher breastfeeding uptake, higher satisfaction are amongst the benefits of midwifery-led care compared to other models[1]. Adding to this, midwifery care has also been credited as more sustainable, both due to less use of unnecessary intervention but also due to its cost-effectiveness[28-32].

3 CONCLUSION

It is unquestionable that Midwifery and modern Medicine/Obstetrics are intrinsically intertwined and that safe and optimal care rests on their relationships being collaborative and respectful rather than polarised. Yet medicalization of otherwise normal childbirth has been proven to do more harm than good and we hope that it does not take another century to reverse mistakes such as happened with tricotomy, routine episiotomy, precipitate cord-clamping, routine use of continuous cardiotocography monitoring, and promotion of formula feeding/undermining breastfeeding, amongst others. Historically the task shift was actually from midwives to doctors and if research is pointing us in the original direction again why are we blindfolded?

It is time that decision-makers accept research, acknowledge evidence, embrace and support physiology, empower women and their bodies, leave prejudice aside, and allow midwives to practice to their full capacity, with obstetricians as professional collaborators and colleagues, not superiors, and as specialists in pregnancy, birth and postpartum complications.

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Conflicts of Interest

The author declared that she has no financial interests or personal relationships that may have influenced the work reported in this paper.

Author Contribution

Goncalves AS conceptualized this commentary and wrote the original draft. McCourt C and Prata AP contributed, supervised, validated, reviewed and edited the draft version into its final version.

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