The Rebirth of Midwifery
A Political Spirituality

by Louise Mangan Harding

L'auteure nous fait part d'une expérience spirituelle de partage entre participantes d'une équipe de planification composées de femmes enceintes et de dispensatrices de soins. Cette expérience a redonné vie au mouvement des sages-femmes de la Colombie-britannique de même qu'aux autres provinces canadiennes tout en revitalisant le mouvement mondial des sages-femmes.

> *I call the bond which made it possible a spirituality because it opened our hearts.*

In ministry with groups which are grappling with differences, I realize how much we have yet to learn about autonomy, interdependence, and well-being. How can we help diverse communities nurture personal spirituality and also build authentic community? Does community require us to "blend" our integrities in order to achieve a common view? Or can we be faithful to our own distinctive callings and become a community of integrities? What will bind us together? Can community emerge through commitment to relationship with otherness?

I recall an experience of community and spiritual growth in the early 1980s in British Columbia, which affirmed the creativity of separate integrities joined in relationship. Team visioning by childbearing women and care providers launched the rebirth of midwifery in British Columbia, contributed to similar efforts across the country, and helped re-vitalize midwifery around the world. At the time I was awed that a shared spirituality could guide groups and individuals with very different vested interests into a plan for the future. This collaborative effort by women and childbirth experts felt like a miracle and changed us all. I call the bond a spirituality because it opened our hearts, let the Spirit flow among us, and disciplined and changed our ways of being.

The will to change birthing practices originated with childbearing women. My daughter as a toddler played duplo through more childbirth meetings than I could count, while my infant son passed from lap to lap. For years, women's groups had consulted with hospitals, gathered for conferences, and circulated news and petitions. Consumers realized that countries with more humane childbirth outcomes have midwives to provide preventive care.

With staunch support from "lay midwives" (without formal training), midwives trained in other countries, doctors, nurses, epidemiologists, and statisticians, they dreamed of access to licensed midwives within the health plan. Parents were convinced that midwifery could prevent birth complications, improving physical and emotional well-being. And they believed that midwifery would give birthing back to women by enhancing their competence and role.

At that time here in Canada, only medical care was legal for birthing families. Cynics said disputing the medical monopoly would be futile. But the midwife who had attended the birth of my son spoke out for the power of love itself. She said: "Love is the strongest power in the universe. We just have to have the faith to persist." Those involved with birthing politics shared no single faith stance. But they did share a reverence for the creative power at work in human birthing. In a spirit of confidence in that life-giving power, caregivers and women (with little ones in tow) put together an international convention on midwifery in 1980. They called it "A Labour of Love."

It fell to women to build bridges between groups of professionals who were estranged from one another on this issue. Sensing that people don't let go of their biases until they feel safe with alternatives, mothers talked about the human costs of medicalized childbirth and then described the world experience with midwifery. They wanted to give people room to move and change by offering support instead of blame. So, focussing on existing strengths and points of agreement they proposed a balanced system to provide for both acute care and prevention. To assure all concerned of a place in this future, parents said, "Let's plan it together."

Soon after the "Labour of Love" consultation, the Interdisciplinary Midwifery Task Force (MTF) came together as a representative planning team. Participants included mothers, as well as lay and licensed midwives, general practitioners, obstetricians, and nurses. The MTF gathered monthly from various parts of the province to envision how services could support birthing families, and how that future could unfold. It sought wisdom and insights from varied bodies of knowledge and from women's experience around the world. The commitment which wove all these points of view together was "wellness" for women and their babies.

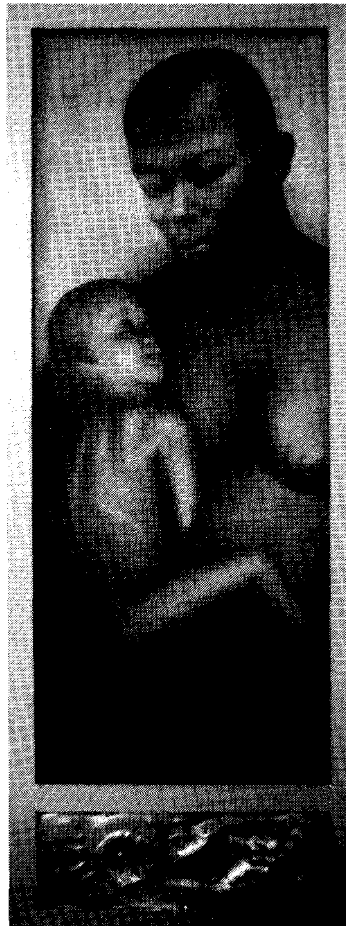
The language of "wellness" was starting to be used to mean more than had been meant by "health." Wellness is not exactly the absence of disease (since we all produce cancer cells daily.) Wellness is wholeness of body, mind, and spirit. Wellness is a goal, and a process, and way of being that enables us to deal well with challenges. For MTF participants, the wellness goal was safe, humane birthing. The process was collaboration through which change would unfold. And the way of being involved qualities of caring.

Despite historic conflicts among the parties present—or maybe because of that past—the MTF saw collaboration as the relational expression of wellness. As a way of relating, collaboration anticipates a wholeness greater than the sum of its parts. It weaves separate autonomies into a pattern of relationship. Each perspective is seen as a distinctive strand of colour which, though it may in itself be a blend of different shades, has its own integrity and worth. In the process of collaboration, different colours are interwoven. What makes the weaving transcend the composite of its colours is ultimately the creativity of the "weaver." The spirit of the working relationship among collaborators—their relation to one another and to the Source of creativity—inspires the artistry of the work.

The premise of wellness is "abundance." If the Source of creativity is both within us and beyond us, then power is abundant and can be shared without fear of depletion. If different views expand the pattern, no one needs to compete to keep their place within the bigger picture. In that hope, Task Force participants brought diverse views to the table, and worked together as both teachers and learners. Perhaps no group more mixed or potentially conflicted ever sat around one table, met each other eye to eye, and called one another by first names.

Giving voice to mothers who usually had no part in planning was itself a "preventive" approach to wellness. Most health care services still focussed on sickness and relationships were strictly hierarchical. The MTF said that the dominance of professionals in these relationships encouraged passivity, not health. They agreed that support for parents' active role in childbirth would require not only a different kind of professional, but a relationship with a different flow of power. A relationship that supported women's primary role in wellness would honour their primary power to make decisions.

In the collaborative role relationship envisioned by the MTF, women and their midwives share power and make decisions together. Women confer professional authority on midwives, for their breadth and depth of insight and expertise. Midwives use this authority to encourage and strengthen the women's contributions to birthing. Midwives help to frame questions mothers might not know to ask, on the basis of experience beyond what the mothers might have. A midwife provides resources and support that women need to participate actively in making choices. Her opinion is one of the women's resources. But it's the mother who has ultimate say. The midwife's authority is not matriarchal. She supplements the mother's primary power.



A. M. Matejko, "Gaia," mixed media, 21" x 54", 1993.

Sharing power can be complicated. For instance, both midwives and mothers use personal power to decide which risks they're willing to bear. The midwife articulates her professional discernment and her personal ethic during planning. Should differences emerge, at that stage either mother or midwife could choose to have the midwife replaced. But once labour has begun, it would not be a legitimate use of personal power for a midwife to decide to abandon care. Her professional concern to safeguard well-being—without coercion—would govern her personal preferences. In the final analysis, the primary power in childbirth is the mother's. She's the one who gives birth to her baby. Her relationship to her midwife is marked by sharing and also by boundaries. The collaborative relationship promotes wellness in persons and in their relationships by making boundaries and the flow of power clear.

Unlike most consensus models, collaboration does not depend on blending diverse perspectives or eliminating tensions between them. Collaboration values differences and the tensions that come with them as contributions to community well-being. Collaborators don't rush to solutions. They place high priority on both listening and self-revelation. They are willing to change or not, as the integrity of their calling directs. Their intention is faithfulness to both self and others, until the picture expands, and some new pattern can "make things work for everyone." Over time broad agreements build inclusive community, within which boundaries can be honoured and diversity can be seen as gift and blessing. This kind of community does not require sameness or agreement. Cohesion rests on commitment to relationship—on the loving inspiration of the "weaver."

The benefit of collaboration, with its respect for clear boundaries, was evident to midwives from the start. The unique gift of doctors is their acute-care expertise whereas midwives are "the guardians of the normal." Each discipline contributes richly to wellness. Creative tensions between the two enrich them both. Internationally, where distinctions between them have been honoured, medicine is reserved for acute-care situations and healthy births are preserved from intervention. But where the tensions

between the two perspectives have been "resolved," the preventive role of midwives has been eroded. Either midwives are medicalized at the expense of preventive skills, or those without midwifery training preempt their roles. Either way, the normality of healthy births is lost.

This has been our situation in Canada. Allopathic medicine has suppressed other gifts. Health care systems are like religions; they tend to regress to ideologies of dominance, since stakes are high and human beings are prone to fear. Where diversity is not intentionally preserved, the most powerful tend to replicate themselves. The MTF decided that committing to wellness meant consciously validating differences.

Relationships committed to preserving diversity and sharing power require much trust, acceptance, and respect. These qualities build an intimacy that helps people work together through the challenges and stress of transitions. Attitudes, skills, and disciplines which deepen qualities of caring are intrinsic to encouraging wellness. It is the midwife's role to acquire these, model and teach them through the childbearing period.

The MTF was convinced that qualities of caring affect birthing outcomes, and would inspire their own work for change. As the team moved through all the normal phases of maturation, relationships were strengthened by mutual accountabilities to qualities of caring, set down as "Guidelines for Group Process." These guidelines established norms for direct communication and for dealing with negative feelings. They translated qualities like trust, respect, and acceptance into specific behaviours. They endorsed ways to safeguard the team and its project—by presuming "good faith" in others and avoiding all uncharitable conversations. They helped everyone work openly and creatively with differences, without letting shadows fall between them. And they reminded participants that the "Spirit" of their relatedness was essential to the goal they all shared. They set the wellness pattern for group relationship.

Commitment to wellness was imbedded in the MTF process, task, and way of being. In this unusual environment inner wellness expanded, too, as personal growth and spiritual illumination. Participants grew conscious of communicating in helpful ways. We learned to check perceptions, acknowledge subjectivities, and distinguish our opinions from facts. Sometimes we managed to let go of fear and say what might help—without blame. We found strength in vulnerability, and prayed in whatever form we knew. It was as if our shared passion for women and their babies helped us to love one another. And our respect for that power which is within and beyond us helped us respect each other's views. At our best, we embraced the power of our calling to go where the Spirit was trying to lead.

Well, this is also a story about dragging a toddler, a baby, and lots of toys to childbirth meetings, and ending up in pastoral ministry. When the legalization of midwifery was announced in British Columbia in 1993, I was present as chaplain to the International Congress of Midwives. It was a long-awaited moment, and many of the original Task Force participants were there with their almost-grown children. My daughter—the one who had played through all those meetings—was beside me. In that sea of familiar faces, she said, "My childhood comes together here today." I said, "Amen." Working with the Midwifery Task Force had shown me most of what I know about what's possible in the world, and taught me the power of love. By love's power, many lives had been changed.

The Midwifery Task Force project was primary theology—the lived experience of the people with the power and presence of the Spirit. It was spirituality rooted in transcendent benevolence. It was participation and companionship in sacred abundance. It was meaning and purpose in the unfolding of right relationship. And right relationship is wellness. The Midwifery Task Force was also the ambiguity and paradox of spiritual formation. It was spontaneous flexibility and disciplined commitment. It was both self-assurance and humility. It was the fullness of offering and emptiness to receive. It was simple human virtues, and the wonder of the Spirit in our midst.

So what can this tell us about autonomy and interdependence, about personal spirituality and community? Perhaps, first of all, that we can dare to believe that the power of love is at the heart of our relatedness, and the divine view is broader than our own. We are created for both relationship and selfhood, so we can learn to be comfortable and skilled in the presence of otherness. We can learn to collaborate, embrace divine abundance, and find joy being part of God's energies. We need not relinquish the fullness of autonomy to participate in interdependence. In the tensions of diversity, the fullness of each being expands the abundance of community.

We can also take seriously the power we are given, to let the Spirit work through us for good. We can recover a sense of wellness in human community, wherein parts are unique and functions are distinctive, and every contribution is respected. We can acknowledge the particularities of designated leaders and clarify the boundaries and flow of power. And we can pattern wellness in human community with helpful norms for ways of being together, and with disciplined qualities of caring. We won't do any of this perfectly, but we don't need to be perfect—we need to be who we're meant to be. Being ourselves in authentic community is part of God's self unfolding in the world.

As a childbearing woman and consumer advocate, Louise Mangan Harding chaired the Midwifery Task Force through its first two years, and is now an ordained minister of The United Church of Canada.