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Chapter 1

# The History of Postnatal Care, National and International Perspectives

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*Sally Marchant*

The Princess was composed after her delivery, and, though of course much exhausted, every hope was entertained of her doing well. A little after twelve a change was observed in Her Royal Highness. Her quiet left her – she was restless and uneasy, and the medical attendants felt alarmed. From half-past twelve restlessness and convulsions increased, till nature and life were quite exhausted, and Her Royal Highness expired at half-past two this morning.

(Jones 1885)

## Introduction

The history behind the role of midwives and their sphere of practice has already been comprehensively described in a number of publications (Schnorrenberg 1981; Donnison 1988; van Teijlingen 2004). These texts describe how the attendance of the midwife, particularly to a woman in labour, has often been undertaken within a framework of conflict, tension and disharmony by a whole range of key figures in society. These include representatives of the main religions as well as most male medical practitioners. The impact of these influences on the work of midwives was very mixed, with some midwives gaining considerable skills and knowledge from working with doctors (van Teijlingen 2004) while others had less formal training and, where they often used a range of traditional remedies, they were viewed with suspicion and, to some extent, disdain (Donnison 1988; Southern 1998). It was only comparatively recently, considering the longevity of the work of midwives in society, that there was a more objective recognition of

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their role leading to professional recognition and registration (Cowell & Wainwright 1981; Donnison 1988).

While there is quite extensive literature on the work of the midwife when attending women in labour, there is less detailed information about what was expected of the midwife with regard to the care of the mother and the new baby after the birth had taken place. This lack of information hampers the interested researcher trying to tease out the more specific role of the midwife in relation to post-birth care and overall maternal and infant health. However, based on the contemporary textbooks and other literature available, this chapter will explore the status of the midwife and the role given to post-partum care and how it has evolved over the centuries but mainly within the context of care provision in the United Kingdom at the time the Midwives Act was passed in 1902. The main focus for the text will be on the relationship of the health and well-being of the mother and the care provided to her after birth. This will be addressed in terms of management of care for the most serious aspects of ill health post-partum, rather than in relation to the entire range of possible post-partum health problems. Care of the newborn is not included in this chapter.

### **Historical references to midwifery and post-birth care**

There is evidence that midwifery as a female occupation was recognised in ancient Egypt between the period 1900 and 1550 BC as it is included in some of the text identified from the *Ebers papyrus Encyclopaedia Britannica* (2008). In ancient Egypt, midwifery was a recognised female occupation as verified in another text, the Westcar papyrus, and it would appear that midwifery was a well-recognised aspect in this culture (Chamberlain 1981; Towler & Bramall 1986). Midwives are also evident in Greek and Roman times, although their professional status is not entirely clear (De Costa 2002). Some texts suggest that midwives could be quite well educated, to the extent that they were then seen as medical physicians (French 1986). They used a wide range of herbal and other remedies in their practice and received payment for their work. However, where families could not afford the fees of these more educated midwives they appear to have been attended by other unskilled women who used a more dubious range of practices (Flemming 2000). Some midwives may have originally been slaves but it would appear where they could receive some payment for their work, it is possible that they were then able to buy their freedom, thereby achieving a more respected status in Roman Society (Flemming 2000).

On the demise of the Roman Empire and the emergence of Christianity, the work of midwives came to the attention of the Church (De Costa 2002) There are similarities between several of the main religions with

regard to events after childbirth for both the mother and the new infant. In particular, the period of recovery after the birth appears in most cultures and is linked to religious rituals, although the duration of this period varies. A wide range of customs and rituals have been adopted but many appear to be underpinned by concerns over the woman's spiritual integrity and the need for her to undertake some form of cleansing as well as a period of recovery after the birth (Kitzinger 2000; Cartwright Jones 2002).

Focusing on mainland Europe, the Catholic Church appears to have had concerns about the need to have control over a woman's fertility and her influence on men (Biggar 1972; Ehrenreich & English 1973; Derbyshire 1985). It was generally considered that the pains of labour were entirely justified since all women were descendents of Eve and that they should 'pay' the consequences of Eve having led Adam astray. The work of midwives was therefore regarded with some suspicion where they had access to women for a range of conditions linked to sex often in preference to care from physicians or male healers. Where they then used a range of herbal remedies to relieve the pain of labour, this, in effect, was going against the will of God (Southern 1998; van Teijlingen 2004). This was in an era when good and evil were strong paradigms used to explain the causes of disease and death by attributing the outcomes to either salvation by God or damnation by the Devil. In order to exert some control over these 'women's affairs' the Church became involved in deciding who was fit to be a midwife by introducing a form of licensing. This was undertaken by a bishop and the midwife was required to swear an oath not to use magic when assisting women through labour (Field 1993; Wiesner 2004).

The emergence of male midwives and of the involvement of doctors in midwifery, as opposed to obstetrics, is not discussed here as the care of the lying in woman and her infant was almost entirely the province of women, unless complications required the assistance of a medical practitioner, where this could be afforded (Schnorrenberg 1981; Donnison 1988).

### **Historical aspects of care and support post-birth and its relevance to current health provision**

However far back history takes us with regard to care after childbirth, it would appear that the main reason for maternal death then, as it is today in many parts of the world, was infection and haemorrhage and the interrelationship between the two. The post-partum period or puerperium describes the time after the birth where recovery takes place in the major organs and the body systems return to their pre-pregnant state, apart from the hormonal cycle, where the influence

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of prolactin for breastfeeding affects the production of oestrogen and progesterone, reducing the woman's level of fertility. The time frame for these occurrences has traditionally been around 6 weeks, or 40 days and as such, as noted previously, also appears to have been incorporated into many religious and social frameworks for motherhood and care of the new mother and her child (Southern 1998). The process of birth, especially where the mother continued to have vaginal bleeding or fluid loss, was treated with great suspicion and anxiety. In many religions, the woman was considered unclean until the vaginal loss had ceased. This time frame was linked to the sex of the baby and would have an effect on the length of time the woman was excluded from social and religious events, until such time as she could be 'cleansed' (Southern 1998).

This also meant that in some social settings, men were discouraged or even forbidden from being in contact with their wives and newly delivered babies for several days or weeks after the birth. This in turn also fuelled suspicion around the activities of the women, the new mother, and those who attended her, where there was doubt over the viability of the child as well as the health of the mother (Cartwright Jones 2002).

It is not possible in this chapter to explore these issues in great detail, but it is important to note that many of the customs undertaken today that have their origins from many centuries ago remain significant to the members of those cultures.

#### **Good practice point: reflection exercise: historical aspects of post-partum care and current practice**

It may be helpful to consider how well you know the social circumstances of the woman you are attending post-natally. Where some cultures have preferences for foods and rituals, how well does the care you are providing account for these? An example is where there is a naming ceremony for the baby – did you know about this? If not, you might have kept on asking the baby's name before this has been given to him, you might also have arranged a visit on the day of the ceremony.

Where there was perhaps an overemphasis on rest – particularly, that of enforced bed rest, the situation is not very different and arguably, new mothers do not seem to think they need much 'daytime' rest, but then they are deprived of sleep overnight. How do you help a new mother manage her rest periods, how do you explain about rest and time for herself where she is breastfeeding? There are only the two of them and they are anxious about the care of their baby. What resources could you offer them to improve the situation?

## **Life and death – midwives as helpers of God or the Devil**

Infection poses one of the greatest threats to women's health after the birth. References to 'childbed fever' have been found in old Hindu texts and in the writings of Hippocrates and these identify the extreme concern attached to this where there was such a high risk of death (De Costa 2002). There was also some understanding of the basic nature of infection and that this disease could be passed on to other women, although the mechanism and identification of bacteria was not recognised until many centuries later. There appears to be very scant literature regarding the work of midwives attending women at the birth or afterwards throughout the early times of Christianity and into the Middle Ages. This might reflect that many midwives would not have had access to writing materials, or been able to read or write, and even if they did write this down, it is not clear who would have read it. The impression from one of the earliest English texts is that the work of the midwife was one that was passed down and that the midwife was expected to rely on experience and possibly, trial and error (Fraser 1984).

The frequency of maternal death from infection 'childbed fever' and the lack of knowledge about what caused it may have contributed to an overtly polarised religious framework of the work of God versus the work of the Devil. This led to great suspicion of the activities of women and the work of midwifery and threatened the control that could be achieved by the established Church. Midwives fitted both aspects of a spectrum by being called 'wise women' undertaking the work of God by assisting the safe birth of new life, to being 'witches' involved in the work of the Devil (Ehrenreich & English 1973). As witches, midwives were also seen as being responsible for a wide range of social ills related to sex, conception and abortion as can be seen from a text listing the main 'crimes' of witches that underpins the great suspicion about the powers of which many midwives were then accused of:

Now there are, as it is said in the Papal Bull, seven methods by which they infect with witchcraft the venereal act and the conception of the womb: First, by inclining the minds of men to inordinate passion; second, by obstructing their generative force; third, by removing the members accommodated to that act; fourth, by changing men into beasts by their magic act; fifth, by destroying the generative force in women; sixth, by procuring abortion; seventh, by offering children to the devils, besides other animals and fruits of the earth with which they work much charm . . .

(Malleus Maleficarum in Kramer & Sprenger 1928)

## Post-partum treatments and rituals in the Middle Ages

Where midwives used a range of herbs and plant extracts as healing agents, these were called *witches brews* despite their ability, in some cases, to heal rather than harm the women (Biggar 1972; Ehrenreich & English 1979). There was also use of incantations and talismans, all of which raised suspicion during this period of religious fervour where there was a need to find someone on earth to blame for the actions of God or of the Devil and where death was such a frequent visitor to so many households. From the fourteenth to the seventeenth century in the main cities of Europe, this suspicion led to many midwives being branded as witches and being put to death, although this was less common in England (van Teijlingen 2004; Wiesner 2004). Historical writers reflecting on this time suggest that it was incumbent upon the key figures of society, both religious leaders and medical men, to try to make sense of these events although the Church and medicine were at some conflict themselves (Ehrenreich & English 1973). Therefore, to some extent, midwives were the perfect solution to fill that need where they had almost sole access to childbearing women and where, of course, they were women.

Where the midwife was seen as the 'wise woman', she was usually a local woman of more mature years, was usually married and had given birth herself (Wiesner 2004). These women offered their skills in attending women in childbirth and often received no overt payment for this. Prior to the extreme suspicion and witch hunts of midwives, the established Catholic Church had already required midwives to be involved in law enforcement where this concerned conception, pregnancy and childbirth. Midwives were used as 'expert witnesses' for a number of situations, examples including confirming a pregnancy to mitigate the death penalty where a woman had committed a crime as well as to ascertain virginity or impotence in a prospective bride or husband or evidence of a pregnancy where abortion was suspected (Wiesner 2004). The Church also involved midwives in post-birth rituals where it was the midwife who presented the infant for baptism at the christening and who was also part of the female group that gossips at the ceremonial churching of the post-partum mother. Churching was a ceremony undertaken to purify the woman's defilement of carrying the unconsecrated fetus and was performed around 6 weeks after the birth when the woman was also considered to be free from the pollution of uterine blood (Donnison 1988; Newell 2007). Baptism of the infant was an essential part of mediaeval Catholicism. If there was insufficient time to get a dying child baptised by a priest, it was considered appropriate that the midwife should do so to ensure that the infant would not be consigned to remain forever in purgatory (Wiesner 2004). The midwife would be instructed not only on the correct words to use, according to the religious laws at the time but also to ensure that no subversive or

satanic incantations were used instead. If there was any suspicion of this, the midwife would be removed from practice. Various artefacts from the birth including the placenta, membranes and umbilical cord, were all considered to have mystical (benevolent and malevolent) as well as healing powers and the midwife was involved in either the protection of these or in their appropriate disposal. This again placed the midwife in a position apart from the medical men or church leaders of the time, fuelling the concern for being linked with the work of the Devil.

From some contemporary notebooks, it can be seen that the midwives and physicians used a range of resources to ward against haemorrhage and sickness after the birth. In her detailed account of midwifery during this time, Jane Sharp gives detailed accounts of what action should be taken to assist the haemorrhaging woman (Hobby 1999). While it is of perhaps rather morbid interest to note what was used, these 'remedies' included a range of substances. For example, to reduce the risk of haemorrhage it was advised to use poultices and suppositories of hogs dung and ashes of toad, as well as laying a newly flayed sheep skin over the abdomen to assist in the delivery of the 'after burden' (Hobby 1999). Donnison (1988) in her seminal publication on midwifery history comments that Jane Sharp's adherence to such practices noted above were founded on superstition and poor knowledge, and were no longer in use by other contemporary midwives. However, the list of remedies recounted by Jane Sharp and the observations of physical disorder (uterine prolapse, oedema, infection) demonstrate how much concern and diligence was held about the services a midwife could offer to relieve women's pain and distress associated with pregnancy, childbirth and the puerperium (Hobby 1999). Therefore, in some instances, treatments are noted that are still in common use today – an example being fennel to ease gastric pain in the infant.

#### Good practice point

There is a wide choice of conventional and alternative medicines available to help women feel more comfortable with their own health and that of their baby after they have given birth. Examples of proprietary products include paracetamol, lactulose, Lansinoh and Co-relief, as well as a huge range of skin lotions and creams, and, of course, formula milk. What framework would you use in deciding what advice you can give a new mother who is considering using these products, with regard to benefits for her health and that of her new baby? What safeguards are in place to reduce the risk of harm from any of these products and why is it important to know about them?

At the same time there were practices that clearly encouraged infection and poor health where, for example, there was great adherence

to 'sealing up' the birthing room and where women remained in bed in what could be very overheated rooms for up to 9 days after the birth. Charms or talismans were given to the women in the form of necklets and girdles made of blue thread and worn by the new mother as they were thought to ward away sickness and ensure a good milk supply (Biggar 1972; Hobby 1999). The health of the infant was directly dependent on a healthy mother who could breastfeed; however, where this was not possible, there were alternatives and a range of substances were given to babies who were in need of supplementation (Hobby 1999). Alternatively, there were the services of a wet nurse that was available to some, not always on a payment basis, as women in the community would be likely to offer their services when this was needed (Tait 2003).

### **Education, enlightenment and the involvement of medical men**

Although a more enlightened age evolved after the Middle Ages, the prevalence of childbed fever continued unabated. As a result of the reformation and greater use of written records, albeit usually in Latin, more information could be shared between physicians across Europe and beyond and a more overt scientific community began to be established (Ehrenreich & English 1973; Donnison 1988; van Teijlingen 2004). The first epidemic of puerperal fever was recorded as having occurred in Paris in 1646, where one woman in four died following childbirth. Such high levels of mortality appear to have led to the setting up of 'lying in' hospitals around the seventeenth century where labouring women could be attended by midwives and obstetricians and where the aim was to give greater care for women in labour and for a designated time afterwards (Mackenzie 1872). However, far from improving the care women received in labour, the 'lying in' hospitals were often grossly overcrowded, instruments were reused unwashed, blood-soaked and contaminated linen was also reused and the high frequency of internal examinations led to increased infection rates, making these institutions places more of death than of life. In addition, there was still poor understanding of the physiology of the puerperium and some confusion over what was termed *mental disarray* alongside physical disorders, which hindered appropriate treatment. 'Mental disarray' of course could have presented where very high temperatures from puerperal infection led to disorientation, as well as from the known hormonal factors associated with the immediate post-partum period.

The term *lying in* then seems to have been adopted to describe the time of labour itself and then for a designated time afterwards where women could 'recover' and nurse their newborn. This will be referred



to later in the chapter when discussing instructions for the attendance of midwives at the beginning of the twentieth century.

While Semellweiss is usually given the accolade for having been the first to link contamination between care attendants and women as the source of puerperal infection, it appears a Dr Oliver Wendall Holmes had actually proposed this connection a few years earlier in America in 1843 (De Costa 2002). His initial theories were ridiculed by his peers; however, his work and of course, the work of Semmelweiss became a turning point in the recognition of contamination and the onset of disease, although it took almost 40 years before there was general acceptance of this from the scientific and medical fraternities (De Costa 2002).

Other medical discoveries also contributed to better understanding of puerperal sepsis where the need for a clean environment and how to obtain this were identified by Lister in the mid-nineteenth century (Illingsworth 1964) followed by the identification of bacteria by Pasteur in 1879. Therefore, while doctors were now more conversant with the aetiology of infection, they were not, on the whole, the people who had the most contact with childbearing women, most of whom continued to be attended by midwives.

### **Life-threatening blood loss**

Haemorrhage, either immediately after the birth or within the post-natal period, is still one of the main causes of maternal death and contributes to longer term morbidity in the puerperium. Where women approach childbirth in poor physical health, especially where they are anaemic, undernourished or with a pre-existing infection, then even small amounts of blood loss at the birth can seriously affect their health. Where catastrophic haemorrhage occurs, the management for this, to some extent, still remains outside the management or control of carers in the twenty-first century, let alone at the time preceding blood transfusions or the current methods available to maintain circulatory support. There is less information in the literature about treatment for excessive or prolonged blood loss, which is surprising considering the emphasis placed on lochia in the rituals surrounding the puerperium.

In this chapter, I will concentrate on secondary post-partum haemorrhage, which lies more in the remit of postnatal care within the community setting than primary haemorrhage (largely covered in Chapter 6).

### **The effect on postnatal care of formalising midwifery as a profession**

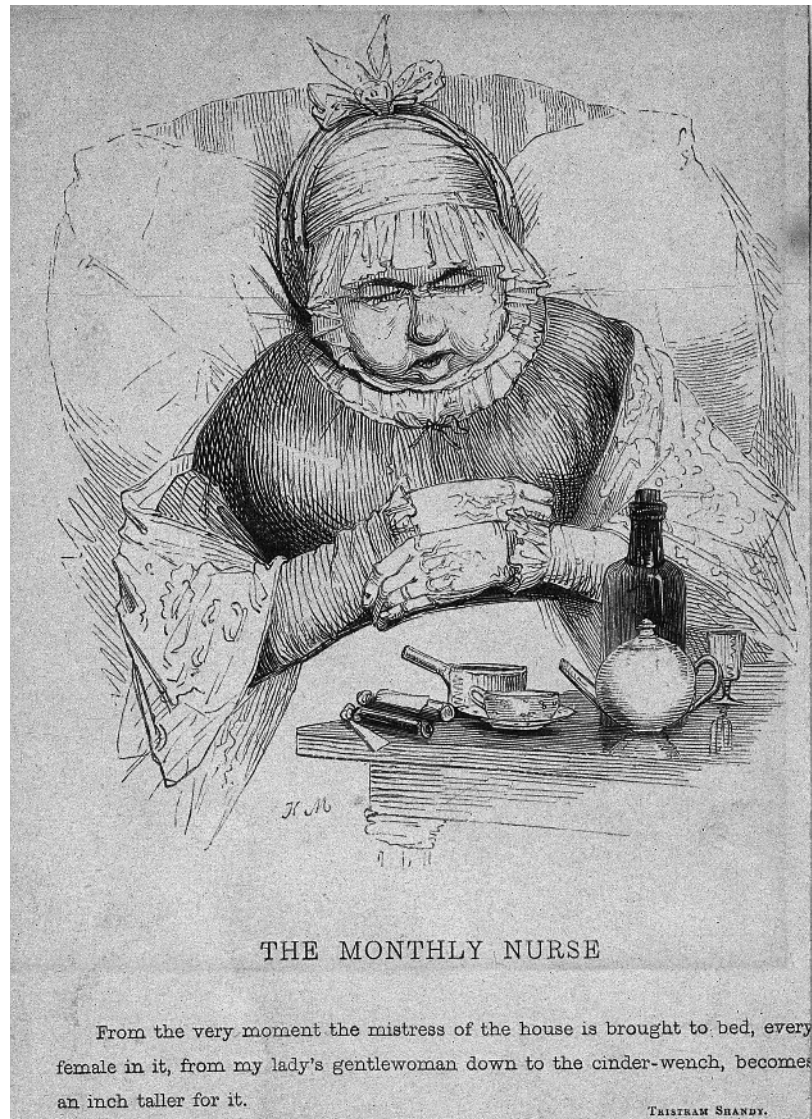
It was around the mid-nineteenth century when the Victorian era of enlightenment was at its peak, that more women began to emerge

as campaigners for the status of women in society as a whole. It also needs to be acknowledged that there were many influential men also working for the improvement of social welfare. These included such diverse people as Dr John Snow who identified the cause of cholera from the appalling state of London's sewers (Frerichs 2009) as well as Charles Dickens, whose writings brought the social inequalities into the public eye.

Care of women following childbirth, where there was no formal recognition of the midwife, led to a wide range in those who offered their services to the post-partum woman and her family – from the appearance of the frankly drunken midwife, Sarey Gamp, as portrayed by Dickens (1844) in his book *Martin Chuzzlewit* and supported by other publications of the era (Haslem 1996), to the slightly less malevolent references made to what was called the 'handywomen'. There was also the more official employment of the 'monthly nurse', and of course, there was still the midwife (Leap 1993). Whether these women had midwifery skills or were unskilled women who were willing to take care of a new mother and her baby for payment, is unclear, although from various contemporary texts, it would appear that the monthly nurse (who could be a midwife as well as a nurse or also be untrained) would move into the family home for the 4 weeks after the birth and help with household duties as well as caring for the mother (Donnison 1988; Leap 1993).

This lackadaisical state of affairs was not in keeping with the still high rates of maternal and infant deaths in the first few weeks after childbirth and the emerging recognition of the need for better social welfare. This was a time of great social introspection and as a result of this, small advances were made on behalf of women, where, for example, it was recognised that the work of caring for the sick required some instruction above just kindness or necessity. This led to the instigation of a formal nursing education and with regards to midwifery, the attainment of a diploma from the London Obstetrical Society (Cowell & Wainwright 1981). In the United Kingdom, following her own nurse training, Florence Nightingale, while being best known for her work in the Crimea, also had a huge influence on improving public health services (Nightingale 1871; Dunn 1996; Baly 1997). Her work with government officials influenced the organisation of services that aimed to reduce the high levels of poor health caused by poverty and ignorance. She was also supportive of the actions of Zepherine Veitch and others in their campaign to establish some form of regulation and training for midwives (Cowell & Wainwright 1981).

From the perspective of midwifery, Zepherina Veitch was one of the most influential women to promote the education of midwives and her collaboration with Louisa Hubbard, a journalist, led to the setting up of the Trained Midwives Registration Society as the forerunner to the Midwives Institute and ultimately, The Royal College of Midwives



The monthly nurse. Taken from the Wellcome Library, London, by kind permission of the Wellcome Trust.

(Cowell & Wainwright 1981). Such leadership motivated other women who were well placed in society to make a difference (Heagerty 1997). Women with common aims to improve women's status in society met through a range of societies, one such being the Co-operative Guild (Llewellyn Davies 1990). These societies advised and supported women from a range of social backgrounds to cope with a life often of great poverty, but also giving them vision for a better future (see Box 1.1).

**Box 1.1 Memoirs of Mrs Layton, bonafide midwife**

Mrs Layton recalls her life and how she became a bonafide midwife, from initially being asked to help at several births because the women could not afford a midwife. She considered training to be a midwife but could not afford the £30 needed to fund her training. She was very experienced and as part of her practice, worked alongside several doctors who appeared to recognise her skills, lent her textbooks and even instructed her on the use of forceps. She did eventually attempt to train as a midwife but sadly failed the exam and was instead admitted to the roll as a bonafide midwife when the Midwives Act was passed in 1902 ('Memories of seventy years' by Mrs Layton in Llewellyn Davies (1990), p. 35–55).

The focus on education and the need to regularise the work of midwives became an important goal for many women at that time although the pathway to achieving such registration was long and arduous, and was met with considerable opposition from both medical and nursing contemporaries (Donnison 1988). It is perhaps a throw back from these days that there is still a degree of antagonism rather than collaboration between midwives and obstetricians; where there was such opposition to something that should have meant better standards of care for women overall.

**Good practice point**

This point relates to the role of all health-care professionals and possibly other health-care workers in what care is available to women after they have given birth. You might want to think through the different aspects of post-partum care; these might include the need for direct care to relieve pain, the need for nursing care to reduce the risk of ill health from infection or complications following surgery, of information needs about child care, and psychological support following birth trauma or the death of a baby. At some point, it is possible that a woman will need care and support from a number of health workers, professional and non-professional. What aspects of direct and indirect care would you consider to be common to everyone involved? What would improve or reduce the effectiveness and satisfaction for the woman?

The eventual passing of the Midwives Act in 1902 in England set the future framework not only for the education and standards to be attained by midwives but also for a recognised framework of care

provision for pregnancy, labour and birth, and afterwards (Donnison 1988; van Teijlingen 2004). The setting up of the Central Midwives Board allowed for the provision of regulations that set out the required standards and tasks that were to be undertaken by midwives. In comparison with the broad base of our current rules and standards (NMC 2004), these are highly detailed and specific with regard to what was expected from the certified midwife (Calder 1912; Central Midwives' Board 1919; Berkeley 1924). A number of contemporary textbooks set out the rationale for some of these activities and it would appear that these were, and to some extent still are, led by the concern over the risk of illness and death following childbirth, as opposed to recovery and restoration to normal health (Longridge 1906; Calder 1912; Berkeley 1924).

### **International aspects of midwifery regulation and registration**

Midwives in Europe were also keen to collaborate and there are records of a conference held in Berlin and attended by 1000 midwives from Europe (ICM 2008). The origins of what is now the International Confederation of Midwives are said to have begun in Antwerp in 1919 when midwives from several European countries met on a regular basis. There are very few records for the period before and during the World War II, but in 1954, another meeting was convened in London and this was the point when the name of the International Confederation of Midwives was decided and the framework for the triennial Congresses established (Towler & Bramall 1986).

In the United States, while there had always been 'lay' or untrained midwives (Humphrey 1891) the Frontier Nursing Service, led by Mary Breckenridge introduced a training for nurse-midwives in 1925 (Centre for Nursing Advocacy 2008). This was broadly based on the UK midwifery model of both nursing and midwifery instruction. From these beginnings, a more established national service was promoted and the Frontier Graduate School of Midwifery started the first nurse-midwifery education programme in 1939 to produce 'certified' nurse-midwives (Centre for Nursing Advocacy 2008).

Certified nurse-midwives were educated in both nursing and midwifery to provide gynaecological and midwifery care in recognised institutions as well as in women's homes. There continued to be lay midwives, uncertified or unlicensed midwives who obtained their skills through more informal routes such as self-study or apprenticeship rather than through a formal programme. However, as with the health services in the United Kingdom, the increasing involvement of medicine and doctors in matters associated with normal childbirth alongside the establishment of formal certification of midwives meant

that very few untrained midwives continued to practise, and there was increasing inequality in the provision of care to non-white women in America (Bair & Caylett 1993).

This picture of the midwife with skills but no formal qualifications is replicated throughout the world as the recognition of education and formal training, and its beneficial impact on mortality and morbidity was recognised (Field 1993). Where, over recent years, there have been considerable efforts to reclaim the origins and identity for midwifery as a separate and discrete profession from nursing, it is difficult to fully understand the background that meant so much to those campaigners for registration and reformers of the health services, such as they were, over 100 years ago.

Once the regulation and registration of midwives was achieved in any country, this set the pathway for midwifery registration up to the present day. While there have been considerable changes in presentation of the role and scope of practice for midwives, there remains a statutory obligation in the United Kingdom to attend the mother and child for a set period after the birth. The next section will address the content of care expected of midwives from the late nineteenth to early twentieth century. It is by understanding some aspects of this framework for care that the current challenges and dilemmas facing contemporary postnatal care can be assessed (see Chapter 2).

### **Historical aspects of post-partum care and clinical observations**

As noted earlier, puerperal infection and haemorrhage were lethal conditions for the post-partum mother (Loudon 1987) and the role of the midwife was to observe for signs that might indicate the mother was either at increased risk of developing this major morbidity or was already affected. There was a strong adherence to the need for the new mother to rest and to remain in bed, lying down, for a set number of days before they could even sit up, and then stay in bed for a further few days before being allowed to sit in a chair and eventually to walk about. This, of course, was only possible for those who were not required to work or provide for their family's needs, and who could afford the attendance of the midwife and/or the monthly nurse (Donnison 1988). The work of the midwife varied from being a professional attendee to also undertaking basic household chores and activities in order to allow the women to stay in bed. The monthly nurse was seen more as an attendant for the mother and carer of the new infant (see Box 1.2).

**Box 1.2 Qualifications of a monthly nurse**

1. A good nurse ought not only to be a woman of irreproachable moral character, but she ought to also have a deep sense of religion. This will lead her to regard her office as a high vocation, the duties of which are to be conscientiously performed for His sake, who entrusted them to her; it will support her under fatigue, and in the midst of scenes of difficulty, distress, and sorrow, will lead her to the only source of strength, and comfort and wisdom. An irreligious nurse will generally be more or less inefficient.
2. She ought to possess a tender sympathy for the sufferings of others; far from interfering with her usefulness, this will render her efforts more diligent and untiring, at the same time that the gentleness and feeling she manifests will soothe the patient and acquire her confidence.
3. A habit of quick yet careful observation is essential, lest she should overlook some important symptom, or undervalue some unusual occurrence, and so lose the earliest opportunity of affording relief, or of sending for advice and assistance.
4. She should possess a certain amount of education. A nurse who cannot read cannot be trusted with the administration of medicines without great risk; but a degree of cultivation ensures greater intelligence, and, as they have abundant leisure, they have time for improvement. I can also say, from experience, that a nurse who can read pleasantly has it in her power to beguile many a weary hour for her patient.
5. Neatness and cleanliness should characterise not only her person and dress, but the entire sphere of her duties. The arrangements of the sick chamber, of the bed, of the patient and of the infant, should all be marked by order, cleanliness and neatness. A slatternly nurse is generally something worse. She should have 'a place for everything, and everything in its place'. (Churchill 1872)

From the midwife's viewpoint, the spectre of death from disease and excessive blood loss was ever present, and a number of observations were undertaken on a regular and consistent basis to alert the midwife to the possibility of complications and make referral to a medical practitioner where this was appropriate. The observations included palpation of the uterus to assess the rate of involution and recording maternal temperature and pulse and on occasions, the respiration rate. The state of the breasts and the activities around breastfeeding and bladder and bowel function would also be noted. The woman's psychological well-being was also observed, although it has been argued

that the assessment of this was often dubious and critically flawed (Marland 2004). The next part of this chapter explores the advice given to midwives on post-partum care, based on the information presented in textbooks written for midwives early in the last century. The textbooks offer quite detailed descriptions of aspects of post-partum care, including how to perform abdominal palpation of the post-partum uterus and advice that such observations should be carried out at the same time of day and by the same attendee (Longridge 1906; Calder 1912; Berkeley 1924). The authors of the textbooks were medical practitioners who not only made up the majority of members of the newly created Central Midwives Board who issued the instructions that regulated midwifery care, but were also largely responsible for presenting the lectures that led to certification.

#### Good practice point

'A silly ritual of measuring the height of the fundus of the uterus above the symphysis pubis carried on. It was charted daily as if it gave an indication of the rate of involution. The measurement is only in one dimension, whereas, involution is three-dimensional. It wasted a lot of time to no purpose'. (Rhodes 1995, p. 170–171)

What do you think about the above statement? Do you generally agree or disagree with it? Whatever your decision, give at least two reasons to support your view and how this is reflected in current practice in the United Kingdom.

The examination of the post-partum uterus can offer valuable information about the progress of involution and the return of the uterus as a pelvic organ. However, there is a need to accommodate the information gained from your palpation with a range of other clinical observations in order to make an overall assessment of normality. What would you consider to be the most important information to help you make your decision?

## Care of the post-partum woman

### *Attendance of a midwife*

When the first Midwives Act was passed in 1902, a framework was set for the duties and obligations of the midwife, during a woman's pregnancy, labour and puerperium. The 'lying in' period was defined as the period of labour and the 10 days following this and the midwife was responsible for 'the cleanliness and give all necessary directions for securing the comfort and proper dieting of the mother and child'



(Calder 1912). Most births took place in the home, and the midwife would visit within 12 hours of labour, once daily for first 3 days, thereafter every other day until a woman got up. Generally women were very much 'confined; to bed where their social circumstances could support this' (Baker 1985). Instructions about the length of time women should remain in bed are quite specific although a link is made to the physical recovery of the woman where they may mobilise earlier if involution is complete and the lochia have ceased. Generally though the following extract is typical of the advice regarding bedrest:

Rest in the horizontal position is essential to the lying in if the double results of involution are to be accomplished. The rest should continue at least a month, the first two weeks in bed, then one week out of bed lying on the sofa, and the fourth in the bedroom, lying down at intervals.

(Calder 1912, p. 130)

The usual practice is to keep the patient in bed during the nine days subsequent to labour. Some authorities advocate fourteen days on the assumption that this additional rest tends to reduce uterine displacements and sub-involution, complications more particularly found in women of the poorer classes.

(Berkeley 1924, p. 380)

It is fascinating to read some of these texts where the authors almost debate with themselves about the wisdom of certain actions. With regard to the involuting uterus and the freedom of drainage of the lochia, one author questions the wisdom of such prolonged periods of bedrest as this would only promote the retention of fluid rather than assist its discharge, but then seems to dissuade himself of this notion, considering it only for women of the 'lower classes'. Having recommended the framework of rest over the first month Calder (1912) then debates these new practices and their safety for women overall as this extract shows:

Many patients it is true, leave their beds long before this, and apparently without harm, making it difficult to convince them of the risk they run; but bad results must frequently follow as is shown in any outpatient department for women's diseases. Attempts have been made in some quarters to get the civilised woman to do as the uncivilised does, and not to lie up for the usual time, but so far the results have not proved that this is a safe plan to follow.

(Calder 1912, p. 130)

Reading these textbooks written at the cusp of the nineteenth and into the early twentieth century, and on which the early education

of future midwives was based, there are also references made to the overall health of the woman according to her social status. Reference is also made to the different social status of the women midwives would attend; therefore women who were in domestic service, or in extreme poverty were recognised as having quite separate health needs from women in situations of greater affluence (Calder 1912; Loudon 1986; Donnison 1988). As can be seen from the following extract, this meant that they would be offered different foods and different advice on the duration of bed rest after childbirth. It is interesting that this advice showed considerable sympathy for the plight of women of lower social class alongside almost a degree of disdain for the pampered, 'well off' woman in her comfortable home.

In poor circumstances she should be kept in bed for twelve to fourteen days only as this is an opportunity of real rest . . . for directly they get up, they have to return to their household duties . . . . The more comfortably a woman is off, the less time she need spend in bed after her confinement . . . she may profitably be allowed to get up a little after the first week.

(Berkeley 1924, p. 381)

In addition to their midwifery duties, midwives were also expected to adhere to the Central Midwives Board guidance, which included a section called *The Principles of Food, Hygiene and Sanitation*. This covered aspects of the woman's social environment where advice from a midwife should include the promotion of health (Calder 1912; Berkeley 1924). A section on sanitation and hygiene is included in both Calder (1912) and Berkeley (1924) although Calder (1912) appears less didactic in giving the following advice:

It is possible to make a fad of cleanliness without making a fuss of it . . . a little tact is required, for it would be unfortunate if the avoidance of dirt meant the avoidance of patients, but with care it is surely possible to keep both cleanliness and a clientele.

(Calder 1912, p. 167)

In Berkeley's (1924) favour is a very relevant instruction that the midwife had an opportunity to work on the woman's behalf where, for example, lodgings were unsuitable and the midwife could notify the local housing authority to improve the living conditions (Berkeley 1924).

As part of the visiting schedule, midwives were clearly expected to be involved in the physical care of the newly delivered woman, by attending to her hygiene needs in the form of a bedbath, of irrigation of the genital area and of seeing to her diet, in some cases, providing and cooking food (Central Midwives' Board 1919; Garcia & Marchant 1996).



Where there existed two 'levels' of midwives in the early part of the twentieth century, it is likely that those who were 'certified' would be more involved with undertaking clinical observations leaving the more direct care and social support in the form of providing food, seeing to some basic household chores and generally offering support to the uncertified midwife or monthly nurse, as described previously (Garcia & Marchant 1996).

## **Instructions on undertaking specific observations**

### *Uterine involution*

Midwives were instructed in the palpation of the uterus to assess the progress of involution; this is clearly described in one extract presented here:

This is best done by sinking the hand, palm to pubis, into the abdomen above the naval, and bringing it down till it is checked by the fundus.

(Calder 1912, p. 126)

All the text books make reference to the description of a regular descent of the fundus over a period of days post-partum until it is no longer palpable. The text books mostly agree the time period for this as being 10–12 days (Calder 1912; Berkeley 1924). They also offer guidance on when palpation should be undertaken and the action that should be taken when involution was not following the normal pattern. Where recent research has demonstrated such a range of variance with this observation (Cluett *et al.* 1997), it is interesting to note the context within which these observations would have been made at that time. In practice, it probably would have been the same midwife who would visit at a very similar time each day and this would therefore offer greater consistency with the daily palpations, possibly making them of more value clinically. At one time it was fashionable to bind the uterus, applying a wide strip of cloth around the body and detailed descriptions of how this should be done can be found in the guidance about the role and work of the monthly nurse (Churchill 1872; Berkeley 1924) but this practice was later discarded.

### *Blood loss*

Before blood transfusions were available, the risk of death from haemorrhage was a serious factor in maternal mortality (Loudon 1987). Giving



attention to blood loss, with respect to the amount, colour and duration of loss – all feature in the midwifery textbooks alongside information about the midwife's role with regard to cleanliness and disposal of soiled linen. It is advocated that the position of the woman should be lying down in order that 'the lochia drain freely and do not become slightly decomposed, offensive and green' (Calder 1912). Calder's book, *Lectures on Midwifery* (1912), as one of the earliest textbooks gives an account of the make up of the pads used to contain the lochia. These, it is advised, must be 'absolutely aseptic' and this was achieved by putting several of them in a clean bag and placing them in the oven to be 'scorched'. There is also advice on how to make the pads using cheap grey hospital wool encased in cheap muslin, the wool is then discarded and the muslin washed and re-used, with the note that 40 pads could be made for a shilling (Calder 1912). The duration of lochia is noted as being variable, and only tenuous links are made to the amount of lochia, colour and the relationship of this to post-partum haemorrhage where there is the presence of blood clots several or few days after the birth. The most significant factor noted in most of the textbooks is a cessation of lochia in the first few days post-partum as a portent of impending uterine infection. Post-partum haemorrhage (both primary and secondary) was treated with what are described as hot douches said to 'stimulate the uterus to contract'. These were of temperatures of at least 115°F up to 120°F and Calder gives the following advice:

The patient may complain of the heat but if you are certain, by use of a thermometer, it is not greater than 120°F you are not to desist; for a douche cooler than 115°F is lukewarm and of little service, and under 120°F it will not scald. If you do not have a thermometer, water so hot that you cannot keep your hands in it will answer.

(Calder 1912, p. 204)

As well as using the hot douche, it was recommended to knead the uterus to induce a contraction; this was also recommended where there was a possibility of retained products of conception leading to a secondary post-partum haemorrhage (Berkeley 1924). Such measures in contemporary times seem extreme but presumably, where there was little recourse to any other treatment, it was better than watching the woman bleed to death. Although ergot was in use at this time, the midwife was instructed to take all other measures before administering this as it needed time to be effective and was only for use by a midwife in emergency situations. At the time Calder was writing in 1912, the use of saline – a 'teaspoon of common salt in a pint of boiling water' had just been introduced as a method of restoring fluid volume. This was either administered intravenously or rectally by a medical practitioner.

### *Observations of temperature and pulse*

There are quite specific instructions about observing maternal temperature and pulse rate and the relationship of these observations to the development of infection. Calder (1912) notes that the temperature and pulse rate should be taken in the first visit to the post-partum mother in order to establish a baseline for future observations. He also notes that while the pulse rate has been stated to be between 60–70 beats per minute, he suggests it is slightly raised to 75–80 in the days immediately after the birth. The temperature and pulse rate were to be observed night and morning and recorded on a chart. While a small increase in the normal range was acceptable, where this exceeded a degree in Fahrenheit in temperature or a pulse over 90 bpm, then the observations should be repeated in 6 hours, and then repeated over the same time interval until the midwife was certain the temperature was stable and not rising. Where the temperature or pulse rate continued to rise, it was stated that medical assistance must be sought as required by the Central Midwives Rules. Calder (1912) summarises the circumstances where the midwife should seek medical aid:

- Rigour
- Rise of temperature above 100.4°F in 24 hours
- Offensive lochia
- Raised swelling or tenderness in the abdomen, breasts or legs
- Bleeding
- Fits
- Dying or dead

(Calder 1912, p. 248)

All the textbooks included such information although there is also the appreciation that there might be an alternative cause for an increase in temperature other than the development of infection.

The midwife must however, be very careful not to ascribe to some trifling and temporary condition any rise in temperature, since a persistent rise, even though very slight, is nearly always an indication that the patient is septic.

(Berkeley 1924, p. 373)

However, most advice underpins the need for alertness to the presence of infection being the likely cause and that midwives should therefore adhere to the most serious possibility and not dismiss it without due consideration.

## Other aspects of care

The textbooks all give quite detailed advice about care of the bladder and bowels, on assistance with breastfeeding as well as management of engorgement, poor lactation and mastitis. There was also great concern about the development of thrombosis, which included the condition called *blue leg* (a venous thrombosis) and *white leg*, which was an infection of the lymphatics (Berkeley 1924). Both conditions could be fatal or lead to long-term morbidity. The instructions for the management of these included minimal movement and prolonged periods of bed rest, demonstrating the lack of understanding of the role of mobilisation and health in circulatory disorders. There is no mention of observation of blood pressure in the early textbooks, and even into the 1950s very little attention was given to taking a blood pressure after the birth although the condition of eclampsia was not uncommon (Gibberd 1943).

## Conclusion

This can only be a very limited snapshot into background of key practices and care provision for women following the birth of their baby. While there has been criticism of the content of postnatal care applied on a routine basis with a one size fits all approach (Marchant 2006), it can be appreciated how such patterns of care evolved in an attempt to make childbirth safe for all women, not just the fortunate few. It could be argued that the current status given to the provision of post-birth care, particularly in the developed world, fails to reflect on the huge levels of mortality that was once experienced by many women following childbirth as well as the still quite high levels of morbidity currently reported (Glazener *et al.* 1995; Redshaw *et al.* 2007; Declercq *et al.* 2007). There remains inequality between care provision in countries that have adequate resources compared to those where appropriate resources are not available, resulting in rates of maternal mortality after childbirth that continue to be tragically high. At the same time, contemporary reports suggest that in many developed countries, aspects of postnatal care, in terms of observations of physical recovery as well as psychological and social support, fall short of women's expectations and requirements (Declercq *et al.* 2007; Redshaw *et al.* 2007). The need to understand the complex medical and social issues around early motherhood is essential for the provision of appropriate postnatal care. Therefore, it is no longer the awareness of what causes maternal deaths that is the issue but it is having access to resources that can prevent these events from occurring in the first place that is of most importance. This then gives credibility to reviewing the history of care for women after childbirth where perhaps some of the steps that have

been taken to improve women's health can be made more available in locations where resources are scarce, and in other locations where greater recognition of what level and skills from human resources are needed to provide better care for all women and their babies.

### Key implications for practice

- There remains considerable disparity in the provision of skilled midwifery care on an international level. Where some countries have a regulated professional framework, others are still struggling for this recognition and this is reflected in the numbers of women who die in childbirth or shortly afterwards. It is therefore important that all midwives acknowledge the work of international groups that are assisting in recognition of midwifery on a worldwide basis.
- Registration as a midwife does not always mean that the care offered is of the highest standard. Midwives in countries where midwifery is a recognised profession cannot afford to be complacent about the care made available to women after they have given birth as not only are there still avoidable instances of morbidity and mortality but there is also increasing feedback from women that what constitutes postnatal care fails to meet their needs with regard to their own health as well as their role as a new mother. As with all aspects of midwifery care, treating women as individuals within a balanced partnership should achieve better outcomes for everyone.
- While the history of the profession might be viewed with a degree of amused tolerance where it is considered care was given without real understanding and clinical knowledge, such an attitude should perhaps be adopted with caution. Women who worked as midwives without the resources we now take for granted made use of those things possibly of most importance in the identification of well-being as well as of potential ill health – their eyes, their hands, their ears and their noses. While the centuries have rolled on, competent midwives should still consider the importance of these, alongside the technology that is available, in reducing maternal ill health after childbirth.

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## Additional Resources

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