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The Goodly Art of Orifice Maintenance

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It is mothers and mother's helpers who by tradition and socially-assigned gender roles, by choice and by chance, are caregivers to dependent persons -- infants, children, adolescents, the handicapped, the chronically ill, the elderly, those who are dying, those who are laboring to give birth, those who are newly born -- this is the front line. Those who are depended upon to serve the mental and physical needs of the biological & emotional body are in the trenches of a major and unwinable skirmish with the human alimentary canal and reproductive tract.

Normal functions of the body, the activities of digestive and reproductive processes - breastfeeding, spoon-feeding infants, diapering, toilet-training, menstrual periods, and

especially the orifices and sphincters that control each of these functions - from Time Immemorial have been & continue to be women's work. The care and feeding of "dependents" is usually unpaid, unglamorous, under-appreciated; none-the-less, it is absolutely essential. Neither rain nor sleet nor dark of night can keep the human alimentary canal or the reproductive tract from its endless biological rounds.

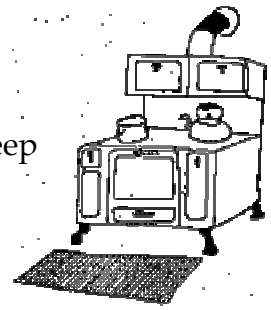
Care and concern necessary to the normal functioning of these biological needs is acknowledged by medical practice statutes of many states as a non-medical & non-regulated activity known as "domestic remedies". Within the domain of domestic remedies are the events of normal childbearing -- the care and concern for a healthy mother experiencing a normal pregnancy followed at term by the spontaneous onset of labor which advances unaided through its expected stages and phases and culminates in the timely and spontaneous birth of a healthy baby. Guidance given by non-medical caregivers during the spontaneous events of normal childbearing is neither a medical act nor an "illegal practice of medicine". Whether expressed in relation to infants, children, the ill or the elderly or in regard to the events of childbearing, domestic remedies are reflections of normal and non-medical responses to the normal and normally non-medical nature of the human condition.

Among human beings, women have the only orifice from which bleeding is "normal"; judging when & just how much bleeding is normal (and when it is not) is an elemental aspect of a women's informal education which must include all the possible situations of menarche, maternity and menopause. While it is doctors and hospitals that treat women who have too much or too little bleeding or bleeding that comes at the wrong time (for instance while pregnant), it is the women in conjunction with other sources of "domestic edification" that make the primary judgment of a "problem state".

In medical-legal terms, defining a `problem state' is considered to be a "diagnosis" but with few exceptions, the medical "diagnosis" eventually rendered by a physician is the sequel to judgments by women (i.e. non-physicians) who made an `a priori' assessment that medical care should be sought out. Diagnosis and medical treatment are third in line from the primary judgment of women based on first-hand experience with the normal biology of the female reproductive tract. Primary judgments by women with the guidance of other women (including midwives) is not a practice of medicine, legal or otherwise.

Guidance is a natural characteristic in which a person with experience makes the benefit of that experience available to others. Following the guidance of another is always voluntary and cooperative. Offering guidance is not a practice of medicine, either legal or illegal but rather a low-tech, high-sociology model known in other places and other time periods as "eldering". This interpersonal & non-medical transaction between the mother and the midwife has historically enjoyed constitutional protection under Angelo-American common law.

Verbs of Service, Tools of the Trade



The verbs of service in regard to childbearing are an expression of deep instincts to nurture and support one another. I believe that the word "midwife" is first and foremost a verb, and as an active verb, it is the oldest helping vocation after motherhood itself. 'Midwifing' is a biological imperative to the normal events of childbearing, and the midwife-mother diad cannot constitutionally be denied without an equal or superior replacement.

The true role of the midwife is to deliver the mother to deliver-ability at which point a truly spontaneous birth becomes an Act of God, no matter who hands are on the baby -- the mother herself, the father, a physician, midwife or simply a soft surface. In order to deliver the mother to deliver-ability, it becomes the work of the midwife to "baby" (i.e. nurture) the mother during labor and thereby assist the mother in surrendering to the natural but none-the-less uncomfortable sensations of cervical dilatation, pushing and expulsion. The tools of the trade for a domiciliary midwife are decidedly unglamorous, non-technological and non-medical. Absorbent linens are high on the list, paper towels, menstrual pads, diapers, plastic trash bags, and other containers for the wet & wild work of childbearing. These verbs of service and tools of the trade are not the things of a sophisticated medical school curriculum.

The Domain of the Domicile

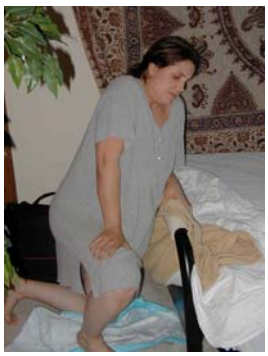
Much of what midwives do during early labor doesn't even look like "doing". Perhaps it is more accurate to call it a "being present". I speak for myself and the long and

honorable tradition of midwifery when I describe this "work" as mastery in "doing nothing". It is a specific skill that must be learned and developed, no less so than any of those busy medical skills associated with the "doing-ness" of hospital-based obstetrics.

As domiciliary midwives, we sit for many long hours doing parents talk about their hopes and dreams, fears and impersonal love. Midwives attempt to be cheerful to keep up the mother's spirit, tell jokes to help pass the time, sometimes we pray silently to ourselves. When frustration brings the mother to tears, we supply her with a Kleenex to wipe her eyes and blow her nose.

As labor progresses, it is the midwife who brings the mother food, holds the straw while she drinks, holds the basin when she gets sick to her stomach, draws a bath in the middle of the night and sits on the floor for hours pouring water over the mother's pregnant abdomen to aid relaxation. We sit face to face for many more hours, breathing with the mother during each contraction, rubbing her back, massaging her feet and working diligently to keep her from being overwhelmed by the painful and often frightening sensations of progressive labor.

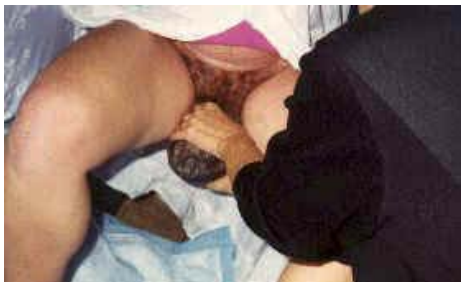
Domiciliary midwives mop up little puddles of amniotic fluids left behind as the mother walks about, we clean little drips of `bloody show' off the inside of her thigh, we sit in the bathroom on a little stool in front of the toilet while she has a bowel movement in the early phase of the pushing stage so that she won't be left alone. We whisper words of encouragement to tired moms, we comfort discouraged mothers, we commiserate with the mother whose labor is, (to her!) too long, too fast, too uncomfortable, or too much to deal with.



Woven almost invisibly into this matrix of emotional support and domestic remedies is a practiced ear for the baby and an experienced eye for the mother's physical well-being. Fetal heart tones and maternal pulses are noted regularly and mothers are scrutinized for signs of dehydration and fatigue by the educated eye of someone who knows them well and who has been continuously observing them for many hours. These low-tech monitoring activities are not a focus of concern or anxiety, nor an impediment to the primacy of the mother's needs. It is the art and not the science that organizes the work of the domiciliary midwife.

During the "labor-intensive" expulsive stage, midwives help the mother to squat low to the floor during each pushing urge and then help her to stand up again between contractions. We hold warm cloths against the mother's perineum to help her relax, we whisper words of encouragement in her ear, we coax her when she becomes tired and wants to give up, we cajole her onward when she insists that she can't last another minute, we would move heaven and earth if it would help the mother to do the work of delivering her baby spontaneously.

Some times we sit on the floor with feet folded back under us and put the mother on our lap to help her to push effectively and to tell the mother kinesthetically that she is not alone, that we are companions in the work of bringing forth her child and gladly bear her weight as our share of that universal reproductive burden.



And as the baby slips over the mother's perineum unaided by "artificial, forcible, or mechanical means", we midwives guide the father's sometimes shaky hands to receive his own child or we catch the baby ourselves before it lands on something hard. It does not matter whose hands are on the baby for spontaneous birth of this kind is an Act of God, it is a sacred and a social event -- not a medical one.

After wiping the blood and amniotic fluid off the baby with `bunny rubs', we hand G*D's newest member of the human family to its Divinely-appointed earthly parents and turn our attention once again to the wet side of life. We begin by sopping up copious amounts of amniotic fluid and blood that precedes the after-birth, all mixed with the black and tarry meconium (baby's first stool) that frequently follows the baby.

Next we help the father to clamp & cut the cord. Then the spontaneously-expressed placenta must be expelled by the mother into a basin, and she must be outfitted with menstrual pads to cope with the normally heavy vaginal bleeding that follows the birth. The mother must be refreshed with good food and drink, and sometimes, in a time-out from ‘midwifely’ duties, a champagne toast is enjoyed or a moment of prayer and a blessing for the new baby.

One might assume that the wet & wild work of the domiciliary midwife was drawing to a close but not so. Next the midwife must deal with the baby who is covered with cheesy lanolin and various drying secretions, and, in most instance, MORE baby poop. After cleaning the baby up, weighing and examining it and returning it to the father or other family members, the mother must be helped to the bathroom to urinate and shower. After toweling her off and helping her into her panties, menstrual pads and nightgown, she must be appropriately outfitted for breastfeeding and the leaking mother's milk which is the next copious body fluid that calls for attention.

Then the birth bed must be stripped and remade, the soiled linens put to soak in the washing machine and everything else must either disposed of properly or cleaned with hot soapy water, soaked in a strong solution of bleach or other germicide, rinsed, dried and repackaged. For many domiciliary midwives, the smell of cleaning products is reminiscent of childbirth. Maternity care remains women's work because men don't want to "waste" their medical education on such mundane and non-medical tasks as drying tears, holding emesis basins, sopping up amniotic fluid, changing menstrual pads, dressing babies and washing linens.

Having babies, for both the mother and the midwife, is wet and messy business. The psychology of childbirth may best be described as bathroom business. It is intimacy skills that permit the mother and midwife to work effectively together so that the midwife may slip in under the mother's emotional radar and, in essence, seduce her into surrendering to the natural and normally painful forces of labor which in due time bring about a spontaneous birth. This is the safest form of maternity care because it is organized around working with nature to prevent the need for medical or surgical interventions and thus avoid the risks such as infection or drug reactions which inevitably accompany the power tools of modern medical practice.

The non-erotic sexual nature of childbearing is such that the major effort of the mother and her caregivers is in getting to that moment referred to in erotic sexuality as the "plateau phase", after which the spontaneous climatic event (i.e. in this instance, unaided normal birth) is biologically programmed and can no longer be stopped. **Births of these kinds come in only two flavors, too slow followed by too fast.** Typically it goes like this: slow, tedious, slow, tedious, slow, tedious, slow, moving a little, better, MOVING FAST -- quick! the baby is barreling down the birth canal, no time to move to a more convenient location, just send someone for the warmed baby

blankets and oops, the baby is crowning, now it's being born and there is only time to catch this "Act of God", for which a smart person simply says a heartfelt "thank you" to the Almighty.

Hospitalizing the mother during this buildup phase (active labor) frequently freezes the psychosexual process, sometimes permanently, which then requires additional medical or surgical interference to deliver the baby. Transferring the mother from labor room to delivery room, from bed to spontaneous nature of the birth process and sets up the need for technological interventions that are themselves risk factors. This is why childbearing in industrialized cultures is so often problematic. It isn't our biology that is usually the culprit, but our ignorance of the psychological and sexual nature of the release mechanism which triggers and permits labor to progress unaided and culminate in a normal, i.e. "spontaneous", delivery.

Healing the Relationship between Midwives and Physicians

The jewel in the crown of traditional midwifery is that it is not intrinsically in conflict with the true purpose and the glory of obstetrical care -- the compassionate correction of dysfunctional states and the treatment of pathological one.

As non-medical caregivers, we seek to augment, supplement and compliment the contemporary medical model, hoping to humanize the maternity care system so that it is both financially accessible and ethically acceptable to all childbearing families, including those of us who choose non-medical domiciliary care. Regardless of our personal religious affiliation, that is a religiously-originating value; religious or impersonal love put into action is the identified means.

The basic premise of non-medical midwifery as it relates to standard medical care is perhaps best described in a little-known story told about Eleanor Roosevelt during the years that she was First Lady as well as mother of young children.

When asked what she put first in her life, her husband (who was President of the United States), or their children, she replied that "together with my husband, we put the children first". I have always appreciated that story as portraying the ideal relationship between physicians and midwives -- that together we put the practical well-being of the mother and baby first.

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