

## **Traditional midwifery or 'wise women' models of leadership:**

### **Learning from Indigenous cultures**

*"...Lead so the mother is helped, yet still free and in charge..."*

(Lao Tzu, 5<sup>th</sup> century BC)

#### **Abstract**

This article originated in a leadership program for Indigenous<sup>1</sup> Australian researchers, where a participant who had worked with traditional midwives in South Sudan reflected on her experiences. While there is increasing interest in how leadership studies can learn from Indigenous leadership experiences, much of this work has focused on men's experiences or has not paid particular attention to women's leadership. In this article we suggest that women's experience as traditional midwives or 'wise women' has been a crucial domain of leadership over millennia. We begin by describing the features of traditional women's leadership through midwifery before reviewing Indigenous and non-Indigenous leadership theories. Drawing on published and unpublished sources, four principles of midwifery leadership are identified: being a leader who empowers and frees others with 'no one person wiser than the other'; embodying wisdom and ethical practice which nurtures social, cultural and spiritual needs of women and mentors the next generation by 'walking together'; being competent and skilled as well as emotionally attuned ('feeling the job') to engender trust and calm which is crucial to birth, 'depending on each other but looking to her to be in charge'; and paying attention and being responsive to emergent change and unfolding present reality rather than being prescriptive,

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<sup>1</sup> The term 'Indigenous' is used when referring to Aboriginal and Torres Strait Islander peoples in Australia collectively, and Indigenous peoples in other countries. This is for ease of reading in this paper only and we respectfully acknowledge the diversity and autonomy of different communities included in this broad term.

'using her knowledge to adjust the situation'. While these emphases are recognisable as part of several ancient wisdom traditions, we suggest that they connect to, and have relevance for, emerging leadership thinking and practice beyond the midwifery or medical context, for men as well as women and for non-Indigenous and Indigenous leadership alike.

**Key words:**

Leadership, wisdom, women, Indigenous, midwives, Aboriginal

## Introduction

Midwifery is an ancient profession, and throughout history, women in traditional settings have been chosen for this role based on a range of qualities deemed suitable for supporting women through the physical, social, emotional, cultural, and spiritual challenges of birth and parenting. In western cultures, the term 'midwife' literally translates from Anglo-Saxon as 'with woman'. In France, a midwife was known as the wise woman or 'sage-femme' and in Germany as the 'weise frau', who understood the 'mysteries of birth and death' (Kitzinger, 1991:1). Thus, these women often held key leadership roles within communities, but have fulfilled these roles in an unassuming way which empowers others, as articulated in the following ancient Tao Te Ching quote by Chinese philosopher Lao Tzu:

*"You are a midwife: you are assisting at someone else's birth. Do good without show or fuss. Facilitate what is happening rather than what you think ought to be happening. If you must take the lead, lead so the mother is helped, yet still free and in charge. When the baby is born, the mother will rightly say: 'We did it ourselves!'"* (Lao Tzu, 5<sup>th</sup> century BC).

Despite the leadership role of traditional midwives throughout history and continuing in many low-income countries, and despite an increasing interest in Indigenous leadership theories and their wisdom traditions (see for example Spiller et al., 2010; Spiller et al., 2011; Sveiby, 2011), there is little written from the perspectives of traditional midwives themselves.

Our interest in this topic emerged from discussions during a 'Graduate Certificate in Indigenous Research and Leadership' program at the University of Melbourne, Australia, in 2014. These discussions included the first author's reflections as a contemporary midwife (and descendant of Aboriginal People in Tasmania, Australia), on working with traditional midwives in Africa. In this article, we explore the perspectives of traditional midwifery and 'wise women' in leadership discourse, and suggest these may be relevant to addressing complex contemporary problems.

First, we provide a brief contextual history of the survival of midwifery through struggles with various patriarchal regimes, including medicalization and colonization, and briefly describe the experiences of working with traditional midwives which stimulated this paper. Second, we review emerging leadership theories, and situate the perspectives of women and Indigenous people in this literature. And finally, we draw on contemporary knowledge of a respected Australian Aboriginal and Torres Strait Islander Elder and midwife, together with published research, to highlight core principles of traditional midwifery practice relevant to contemporary leadership. These principles include: use of transformative approaches and empowerment; development of wisdom and ethical practice and a focus on mentoring the next generation; being skilled, competent, and emotionally attuned to engender trust; and being present and flexible to respond appropriately to emergent change. We see Indigenous women who work in many leadership roles outside of midwifery adopting these principles and we argue that reclaiming the ancient wisdom embodied in these principles is highly relevant for contemporary leaders more broadly, as the nature of leadership becomes more complex and requires deeper relational skills and capabilities in empowerment as well as attunement to broader notions of advancing wisdom and well-being (Spiller et al., 2011).

### **The leadership roles of traditional midwives or ‘wise women’**

The experience of first author and early career midwife, Catherine Chamberlain, working in maternal health in Africa, provided the original impetus for this article. Catherine describes her story thus:

*“In my early midwifery career I spent several years working in maternal and child health programs in Africa. There was often limited involvement of traditional midwives in international aid programs, which had a focus on preventing maternal and infant mortality through improving*

*western medical education and services. However, I would like to reflect on a unique experience of meeting a traditional midwife in a remote village in South Sudan almost 20 years ago. In 1996, I was asked at short notice to make a field trip to investigate and respond to a cholera outbreak in a remote part of South Sudan. This project involved 'outreach' treks, with a Dutch logistician and a South Sudanese military translator, through vast swamplands to small remote villages. After three days on one trek we came to a village where the translator explained we were receiving a lot of attention because a 'white woman' had never visited the village before, though a white man had travelled through about 25 years previously. I was introduced as a midwife to the chief who told me how honored he was to meet the 'wise woman' from our village, and he invited me to meet their 'wise woman'. The translator explained that being a midwife was a highly respected role here. Some women in the village covered the floor of a hut with palm leaves and helped me clean up after a muddy trek. As well as being treated with respect, I observed the gentle and confident way the midwife provided guidance and support for the other women and children, with humility and without a trace of 'bossiness'.*

*We spent the evening sitting around the fire with the chief, the midwife, and other members of the small village, sharing stories from our worlds. With my Dutch colleague, under the stars, we talked about the moon landing and achievements in space travel. We talked about our respective countries and how different they were, with opposite seasons. I explained that while my skin was comparatively pale, I am descended from dark-skinned Aboriginal people from a small island called Tasmania, over the other side of the world. Along with positive stories, I shared the trauma of Tasmanian Aboriginal history, whose culture was decimated so quickly by colonisation.*

*Through these discussions, largely led by questions from the chief, I sat with the 'wise woman'. I observed the way she sat, quietly, and how her opinion was clearly valued and sought. For instance, while I avoided asking specific questions about 'women's business' in this forum, when we asked questions which were about the health of women and children, everyone looked towards her and waited for her to speak. When she spoke, it was warm, calm, slow, mindful, and wise: clearly a 'leader'."*

Midwifery has been recognised as a profession for millennia, but has undergone much challenge and adaption in recent history. Originally, midwives were mothers who developed specific skills to assist women in birth, and often assumed leadership or 'wise women' roles within the community. In western philosophy, the earliest references to midwives are in the Old Testament, where they defied the King of Egypt's decree to slay all the male Hebrew children. Despite its longevity, the profession has faced many challenges (Fahy, 2007). As medicine developed and medical education was introduced, midwives were excluded from formal education systems, starting from the earliest Greek and Italian medical schools. Most women healers subsequently became low status midwives, and were ridiculed by male medical writers from as early as the 3<sup>rd</sup> century BC (Kitzinger, 1991). Later, as the male-dominated priesthood took over healing, some midwives were persecuted as witches. By the 17<sup>th</sup> century, medicine was dominated by men, women were excluded from university education, and efforts to organise training for midwives were strongly resisted (Fahy, 2007). Hence, by the 19<sup>th</sup> century the rising middle classes came to prefer obstetric care, while only the poor still relied on midwives (Kitzinger, 1991). In many high-income countries, the traditional midwifery role has now disappeared, with midwives working as nurses' and doctors' assistants and becoming subsumed and subordinated within the medical system (Fahy, 2007; Kitzinger, 1991).

The struggle for 'control over birth' seen throughout European history is now evident in low-income countries, with traditional midwives relegated to the healthcare fringes, despite homebirth with a traditional midwife being the preferred or only option for almost half the women in low-income countries (Choguya, 2014; Kamal, 1998). Some argue that the 'blind spot' about the crucial role played by midwives is because they are usually women in societies that may not value women's knowledge, and are not part of the 'educated elite' (Anderson and Staugard, 1986).

Traditional midwives have often held a special place in the community, are trusted, understand the local language and context, and often provide additional services such as domestic support for the mother (Walraven and Weeks, 1999). However, international organisations have defined the services of traditional midwives (World Health Organization, 1992) as well as contemporary midwives (International Confederation of Midwives, 2011) in narrow technical terms, excluding recognition of their community, cultural and spiritual leadership in relation to women and their families. At the same time, some Indigenous women receiving care from western-trained midwives report negative experiences, including: being left alone, being confronted with abusive attitudes, lack of respect, visitor restrictions, an inability to practice spiritual and traditional beliefs, and poor postnatal support (Kermode, 2014).

There has been some 'push-back' against unnecessary obstetric intervention and towards women reclaiming 'control' over birth, with some midwives have challenged the dehumanizing aspects of obstetric care (Holmes, 2014). However, most women in Australia (and other high income countries) give birth in a hospital. This means that many Indigenous women in Australia do not give birth on their ancestral lands, or 'on Country', despite the cultural and spiritual importance of doing so, and despite national guidelines emphasizing the importance of

maintaining cultural values around pregnancy and birth (Kruske, 2011). One evaluation suggests that the cultural dimensions of birthing programs are losing emphasis as western knowledge and practice take over (Lowell et al., 2008). A recent study in a remote Indigenous Australian community found traditional birthing practices were breaking down, and that many women were choosing not to access alternative 'western models of care' (Ireland et al., 2013). Some warn that western biomedical models of obstetric care are 'diametrically opposed to traditional Indigenous ways of healing and birthing' (Ramsamy, 2014).

Midwives, including Indigenous midwives, are ideally placed to play an important leadership role in 'bridging cultures' to address the physical, social, emotional, cultural, and spiritual challenges of birth, as they have done for millennia. For example, some senior Indigenous Australian women are reclaiming and practising traditional knowledge about birth, also known as 'Grandmothers' Law' (Ramsamy, 2014), and 'Birthing 'on Country' policies are now being developed at a national level (Kildea et al., 2013). While there are many profound and important lessons that emerge from the experiences of women midwives in history and across cultures, the focus of this article is leadership. We now review changing emphases in leadership theories, both non-Indigenous and Indigenous, noting some themes that are common to midwifery leadership.

### **Non-Indigenous and Indigenous leadership theories**

Despite a proliferation of leadership research and theories over the last half-century or so, there is no consensus about what leadership is. Most theorists recognise leadership is not a position or a person but a process of influence. According to one definition, leadership is 'a social



influence process through which emergent coordination (i.e. evolving social order) and change (i.e. new values, attitudes, approaches, behaviours, ideologies, etc.) are constructed and produced' (Uhl-Bien, 2006). Leadership therefore can be, and often is, exercised by individuals without formal authority, in community as well as organisational settings. Leadership is also often distributed, in the sense that different people take on leadership roles as tasks change, and it is collectively produced.

Some of the earliest documented philosophical teachings on leadership date back as far as the 5th-6<sup>th</sup> century BC, with Lao Tzu outlining leadership philosophies similar to those he proposed for midwives. According to these philosophies: "the key to good leadership was facilitating others to accomplish a task, not through coercion but via a more subtle process of interpersonal influence" (cited in Bolden, 2011: 21). Greek philosophy influenced early understandings of leadership in Western European culture, with emergent theories tending to emphasize the role of the individual rather than the collective, along with the importance of professional competence and 'strong' leadership in times of crisis (Bolden, 2011: 38). In the twentieth century, early leadership theorists often drew on the military and bureaucracies, with a focus on hierarchy, professional competence and the need for leadership during crises (Bolden, 2011; Sinclair, 2007).

From the late 1970s, new emphases began to emerge in western non-Indigenous leadership theory which advocated a leader's role as enabler or 'servant' (Greenleaf, 1977).

Transformational leadership theory put an emphasis on values and ethics in motivating followers (Bass, 1988). More recently, models of authentic leadership have proposed that leader effectiveness rests on behavior that is transparent and aligned with values (George et al., 2007).

There has also been extensive research on spirituality in leadership and the importance of

wisdom and diverse wisdom traditions which we discuss in detail below (McKenna et al., 2009). This research encourages a view of leadership as emergent, dynamic relationships between leaders and their followers, which can occur in a wide range of social contexts and ideally involve a basis in values and ethics.

At the same time, the notion of leadership as a performance by a lone heroic individual remains remarkably resilient (Raelin, 2011). In her call for 'post-heroic' leadership models, Fletcher observes that: 'the everyday narrative about leadership and leadership practices – the stories that people tell about leadership, the mythical legends that get passed on as exemplars of leadership behaviour – remain stuck in old images of heroic individualism' (Fletcher, 2004: 652). She warns against a token acknowledgement of the value of collaborative processes which fail to properly grapple with historically entrenched gender and power dynamics in the allocations of who are seen as leaders and how leadership is seen to be done.

Thus it is important to recognise that definitions and models of leadership are the result of how history is written and how power has been distributed in societies. This is important for researchers interested, as we are, in Indigenous and women's leadership. For example, Indigenous cultures have often not had single all-purpose 'leaders' but complex cultural and other authority structures (Evans and Sinclair, 2015; Warner and Grint, 2006). The designation of 'chief' or leader has often not been given by communities but rather by colonising societies seeking a point of negotiation (Evans and Sinclair 2015). Similarly, historical studies show that many of the ways that women – including migrant, Indigenous and minority women – have led and changed societies have simply not been recognised as leadership, but often given other labels, such as working in community (Damousi et al., 2014; Francis et al., 2012).

Similarly it is important to recognize that models of leadership and learning, including in areas of medical education, have often been developed from research of largely Caucasian male populations, their conclusions then generalized. For example, women scholars in the 1980s noted that psychological models of moral development valuing a logic of justice had been developed and generalized from male samples. Exploring the way women make ethical decisions, researchers have argued that upholding an 'ethic of care' and seeking to minimize the suffering of others are equally morally justifiable positions (Gilligan, 1982). Similarly, Belenky et al. (1999) argued that understandings of education and learning had historically been built on models of 'teaching as banking' where teachers with knowledge deposited it into the empty student. In contrast, Belenky et al. (1999) proposed a 'teaching as midwifery' model, where the teacher's role is to draw out and help give birth to the tacit or 'deep' knowledge that is already in the learner.

The changing role of women and other cultures, including Indigenous peoples, has prompted new interest in 'contextualized' and 'situated' leadership (Porter and McLaughlin, 2006). Following the feminist movement in the 1970s, an interest in women and leadership began to evolve. International women's organizations in developing parts of the world began articulating and practising different modes of organising, and different models of leadership. The principles of this leadership include the use of collective and devolved structures, not seeking leadership as an end in itself but as a means to advance social equality and change (Sinclair, 2012, 2014). Equally, the work of diverse non-Western and Indigenous scholars has contributed to challenging traditional leadership theories and re-making leadership constructs, and it is to this research we now turn.

Developments in Indigenous rights have paralleled developments in women's rights, with Indigenous perspectives on leadership being the subject of increasing research over the last decade (see for example; Evans and Sinclair, 2015; Ospina and Su, 2009; Spiller et al., 2010; Spiller et al., 2011; Warner and Grint, 2006). Because of Indigenous peoples' historic experiences at the hand of colonising leaders, there has understandably been distrust and critique of the very notion of leadership. For example, respected Aboriginal Australian leader Lillian Holt maintains that 'leadership is a white male idea' that will 'steal your spirit'. Institutional pressures often demand untenable things of Indigenous leaders, eroding courage, passion and humour, and wearing the leader down (Sinclair, 2007:154). Yet other scholars, non-Indigenous and Indigenous, are increasingly documenting the multiple and complex ways in which, for example, Indigenous women have provided and continue to provide profound and impactful leadership for their communities (see for example Baker et al., 2014; Huggins, 2004; Moreton-Robinson, 2000; Stanfield et al., 2014; White, 2010).

Indigenous leadership models include Kenny's Liberating Leadership Theory that is grounded in the experiences of American and Canadian Indigenous women working at the 'forefront of change', despite formal leadership positions continuing to be largely held by Indigenous men (Kenny, 2012). Leadership requires spiritual awareness and connections because it draws on the relationship to the earth 'Mother', with guidance provided from ancestors. Leadership styles are non-hierarchical, relying largely on persuasion rather than influence, and are more aligned to eastern teachings than to dominant western concepts. These teachings were passed down by Elders and embodied in oral traditions, arts and traditional practices (Kenny, 2012).

Indigenous knowledge systems tend to be transmitted through oral or artistic traditions rather than written traditions as in western and eastern philosophies. They 'encompass the sophisticated arrays of information, understandings and interpretations' which can continue to

contribute greatly to the body of the world's wisdom (UNESCO, 2000). For example, the Seven Pillars of Wisdom (Lawrence, 1935) were drawn from observations of Indigenous people living nomadic lifestyles (Bolden, 2011). However, the unauthorized appropriation and fragmentation of traditional knowledge into 'useful' and 'useless' knowledge, without contextual understanding of its complex concepts, diminishes the perceived value of these systems (UNESCO, 2000). One suggestion to overcome this challenge has been to consider traditional knowledge as integral to dynamic societies and cultures (UNESCO, 2000).

Another Indigenous leadership theory is the Tahdooahnippah model developed by Warner and Grint (2006) in response to western writings that described American Indian leadership as being 'only a memory'. Their model aligns with 'Indigenist' research philosophies that have been developed to try to regain control of Indigenous knowledge and truth (Martin, 2003; Rigney, 2006; Smith, 2013). Warner and Grint (2006) reinforce Indigenous perspectives of a persuasive model of leadership and sphere of influence in contrast to western 'positional' and authoritarian views of leadership. The model includes several different leadership roles for different purposes, derived from a spiritual core, including; the *Elder*, the *Role Model*, the *Author*, the *Social Scientist*, and *The One Who Speaks For us At All Times* (Warner and Grint, 2006). The 'Elder role' parallels the 'servant leadership' models described by Bolden (2011), where commitment to intrinsic cultural values are seen as an agent for good, and aims are more subtle and nuanced.

Synthesizing some of the themes that emerge across Indigenous traditions, then, we find: value placed on the community/group as the source of leadership; a holistic emphasis that includes concern about the spiritual and cultural as well as material well-being, and an inter-generational focus where current leaders are custodians of ancestor wisdom and have special

responsibilities to hand land and knowledge on to following generations (see Evans and Sinclair 2015; Sinclair 2007; Spiller et al., 2010; Sveiby and Skuthorpe, 2006).

To conclude this section, theories and ideas of leadership have undergone enormous shifts since the late 1980s. Departing from a 'one size fits all' leadership model, there is no one theory of leadership, nor a single template for women's, or for Indigenous, leadership. Rather there is recognition that studying different contexts and traditions can teach us valuable new things about leadership, including aspects that have often been neglected in conventional accounts, such as the role of ethics and empowerment, plus the importance of physicality, culture and spirituality.

### **Indigenous Midwifery principles as a model for leadership**

In this section we outline the principles and practices of traditional midwifery drawing on the accumulated knowledge of Doseena Fergie, a respected Australian Aboriginal and Torres Strait Islander Elder and midwife, as well as on published research. Identifying these core principles from both published and unpublished knowledge, we argue that they form a model for, and of leadership. This model of midwifery leadership, as we have sought to show, has been practised for hundreds of years. Yet it is also of potentially increasing relevance for contemporary leadership challenges which are seeking to empower communities towards economic well-being and self-determination while also preserving cultural values (Spiller et al., 2010; Spiller et al., 2011). We begin by quoting Aunty Doseena at length as her story provides a powerful insight into how traditional Aboriginal and Torres Strait Islander midwifery models work. Then we group the core themes into four categories drawing on the published theoretical literature and key messages from Aunty Doseena's story to illustrate the link between traditional and contemporary knowledges.

Aunty Doseena describes her understandings of the traditional role of Aboriginal and Torres

Strait Islander midwifery principles thus:

*“Aboriginal Ways of Knowing, Being and Doing in community – especially in regard to women’s business – are important to note because we gain our knowledge through being mentored by our grandmothers, mothers and aunties. Learning traditions that have been passed down, spoken about and shown. For me I also gained knowledge through the spirit world. We observe, are guided and have been told principles and issues through storytelling, yarning and deep listening (dadirri).*

*We then trial this perceived knowledge in the practicalities of life and gradually find out what works and what doesn’t. What is appropriate and respectful and what is not. What is acceptable to our ‘mob’ and what isn’t. Through the trialling period respect can be given or taken away from us by others. This not only applies to me but for my sisters and thus all the women belonging to our mob. Along the way I reflect and become aware that I have actually become that which I have been mentored, observed, told-about and participated-in to do. I have also become aware that others have become that way too and we walk together.*

*Somewhere along the line I began doing that which I had been entrusted with to do for the good of others around. In my case it was learning special skills in midwifery etc. that will be useful should there be an important circumstance for it to be used. For example, when there is a problem noted in the birthing process.*

*So the role of communal consultation and consensus is actually quite vital to me, even in midwifery-‘speak’. Talking issues over with others and having their input enables me to make a decision and brings others on board to walk and take interest in what I am doing. A corporate experience, not necessarily a personal one. It is they who will allow me to come forward to practise my skills or stop me from doing so. If I have taken this stance of communal input then the idea of a solo midwife being the holder of ‘birthing knowledge’ is only part of the equation. To me pregnancy, birthing and postpartum care is a communal effort and the other – indeed the greater – part of the equation that must be emphasised in this paper perhaps.*

*The role of the community’s chosen midwife is one which only applies to Women’s Business. At a time when women are at their most vulnerable (fragile), dependent, yet celebratory stage of*

*life. A very special time for a woman and her community. The midwife is called upon because she is required to have input, given her peculiar knowledge and skills, in order to supervise the normal birthing experience. If something goes upside down, she uses her knowledge to adjust the situation in order to allow a baby to be born and ensure the mother is not compromised in any way. She assumes a natural leadership that is respected, which according to community principles she has the right to have at that point in time. So the midwife ensures that women's business is delegated, others are learning (i.e. those she is mentoring), and her special skills will be used at that crucial time to ensure safety and an uncompromised birth. She and other respected women (grandmothers and mothers) will rely on the learnings from the traditional stories passed onto them. For the younger generation involved it is their time to observe, obey and learn.*

*So the birthing experience emphasizes the importance of relationships and belonging. It involves reciprocity on the part of the wise midwife, the community, the environment and the spirit world. They depend on each other, but they look to her to be in charge, to have that authority delegated to her for such a time.*

*It is ethical practice because it is a relationship built on trust and it takes humility on the part of everyone, i.e. for others to submit to one another, for the good of either the pregnant woman, the woman who is birthing and/or the mother who cares for her newborn baby. It is a relationship in which there is shown respect, caring and shared responsibility by every woman present. It is the cultural values of the community that keeps everything in-tact and in-check. People are equal, but given responsibilities that must be used for the purposes to which they are given and in/at the right time/circumstance.*

*So I think that this wise woman/ midwifery role may demonstrate transformational leadership, but also servant-led leadership and when needed, a hierarchical or transactional leadership that is exerted when required. In contemporary Aboriginal community, there is no one person who is wiser than the other. Certainly the wise and 'educated competent' midwife in the western worldview from my perspective has a different connotation in the Aboriginal worldview.*

*We/I look at a person's track record of what has gone before and give them the respect that is due. Their actions will prove their worth. That worth is given more respect and their value is acknowledged by the community so that when the appropriate time comes, they will be required*



*to give input and are obeyed because they have been given informal authority acknowledged by everyone and they hold 'specialised' knowledge that others of the mob have not been privy to."*

Turning to published sources, there is little in the leadership literature which directly discusses traditional midwifery. However, one paper exploring the perspectives of contemporary midwives, suggested that there were 'evolutionary similarities' between contemporary midwifery and leadership (Byrom and Downe, 2010) including moving away from hierarchical models towards those based on relationships, particularly transformational models that empower others.

Reviews of midwifery/maternity care identified emerging themes of: wisdom and enacted vocation (Downe et al., 2007); skilled practice (Downe et al., 2007; Nicholls and Webb, 2006); and emotional intelligence (Goleman, 1996; Hunter, 2000, 2005; Kirkham, 2000;) including communication and compassion (Nicholls and Webb, 2006) to engender trust (Byrom and Downe, 2010; Downe et al., 2007). In the following, we discuss each of these principles of midwifery as a model for leadership, and build on the model by adding dealing with emergent change, emphasized by ~~both Lao Tzu and quotes from~~ Aunty Doseena.

1. Empowerment, servant, and transformational leadership: *'There is no one person who is wiser than the other'*

Notions of empowerment have been a central part of many leadership theories, especially those that distinguish between transactional and transformational leadership. While transactional leadership seeks to influence followers through applying incentives and sanctions, transformational leadership seeks to motivate through overarching goals and values (McKenna et al., 2009). Studies confirm that leadership that is transformational or empowering is generally more effective, and that women's leadership is more likely to exhibit genuinely devolving and empowering qualities (Alimo-Metcalfe, 2010).

Midwifery is a case study of leader empowerment *par excellence*. Aunty Doseena identified transformational, transactional, and servant leadership as models which could be used by traditional midwives, which are similar to 'collaborative' and 'shared' leadership (Bolden 2011b). Only the mother can give birth and traditional midwifery is oriented towards helping mothers feel supported and empowered to undergo the risky, physically and mentally taxing endurance test that is childbirth. During birth, many midwives consciously 'minimize space' and aim to be as unobtrusive as possible during an intimate time, while remaining available. An example of one strategy employed to do this is the preparation of 'doula soup', whereby the midwife can be available as needed, while doing something practical for the mother (similar to 'servant leadership'), without encroaching on the women's space as they settle into the rhythm of the early stages of labour. There are other, similar examples of strategies traditional midwives use in 'Grandmothers' Law' to distribute power to the mother (Ramsamy, 2014).

One study which researched the qualities of a 'good midwife' and 'good leader', found that those who did not meet these standards failed to empower the mother. Rather, there was a perceived 'exploitation of power' by those who 'lose what they are doing in midwifery' (Byrom and Downe, 2010). Midwives themselves, of course, are often situated in wider webs of power. They themselves may find it hard to empower mothers if they are, for example, having their authority and judgement doubted or undermined.

Empowerment in midwifery is, importantly, based on caring. These notions of caring as a central philosophy are aligned with those proposed by Noddings (2002), who argues caring should be a foundation for ethical decision-making. In his work with social change leaders throughout the world, Kahane (2010) argues that power and love must be exercised together in

leadership. It is love or caring for others which differentiates between empowerment or generative 'power to'; and degenerative, or 'power over' others.

## 2. Wisdom, mentoring and enacted vocation: '*We walk together*'

Wisdom and related phenomena such as judgement, insightfulness, and character, have been relatively neglected parts of leadership until recently (McKenna et al., 2009). Many contemporary challenges seem to require more wisdom, not less, yet in leadership training there is not much said about how to preserve wisdom and pass it on in the ways described by Aunty Doseena (Srivastva and Cooperrider, 1998). ~~Current~~ While there are models that identify wisdom as critical, ~~they~~ often value ~~the~~ strategic and cognitive capabilities, without acknowledging the embodied, cultural and spiritual aspects of wisdom (Sveiby, 2011; Sveiby and Skuthorpe, 2006).

While conventional ways of knowing are integral to developing wisdom, wisdom also requires connections across multiple knowledges to create meaning, find answers and make decisions. For example, in their model of developing wisdom, McKenna et al. (2009) and McKenna (2013) propose five elements including careful observation; allowing for the non-rational and subjective (including spiritual) elements; valuing humane and virtuous outcomes; being practical and orientated towards everyday life; understanding the aesthetic dimensions; and contributing to the good life. Extending McKenna's work, Suarez (2014), suggests wisdom includes the ability to take an historical and multi-generational perspective. This is consistent with ancient laws of the Iroquois Nations in the United States, which recognise the importance of considering the impact of decisions on the next seven generations (Gilbert, 2009; Lyons, 2008). Suarez (2014) suggests wise people develop the ability to see an objective and balanced perspective, which is an adaptive system associated with 'flourishing'. Organizational and leadership scholars have in

the last decade begun to articulate the role of wisdom (Biloslavo and McKenna, 2013; Spiller et al., 2010), and Weick, 2004) suggest~~ings~~ that because ancient principles of wisdom are flexible and intuitive they are ideally suited to complex modern problems.

Traditionally, birthing practices were led and managed by Indigenous women, and there was a complex set of traditional beliefs, rituals and taboos (Ramsamy, 2014) taught to traditional midwives by their grandmothers and Elders, passed down through complex mentoring systems (Ramsamy, 2014). Women with appropriate qualities were selected for the role, and respect and authority were given to the extent that they are earned by demonstrated actions, ensuring that those taking on the role are supported to the level of their capacity in an incremental way. Learning is through talking, listening and observing, but it is also deeply experiential and practical. 'Practical wisdom' or *phronesis*, first proposed by Aristotle, aims to clarify roles, interests and power relations and has become increasingly popular in organisational wisdom research (Flyvbjerg, 2004). Experiential learning enables deep tacit learning that is practical and teaches midwives to respond appropriately to feelings and emotions that can be intense around pregnancy and birth. The learning process allows for reflection, which deepens learning to enable development of wisdom, and the emotional aspects may open pathways to deeper 'spiritual' dimensions. The traditional ways of teaching and mentoring midwives, as advocated by Belenky et al. (1999), are designed to develop wisdom.

3. Skilled practice and emotional intelligence to engender trust: '*They depend on each other but look to her to be in charge*'

The importance of trust in leadership has been highlighted by Ciulla (1998:1) who defines leadership as 'a complex moral relationship between people based on trust, obligation, commitment, emotion, and a shared vision of the good'. In addition to skills and knowledge,

'emotional intelligence' is recognized as a critical element of good leadership (Goleman, 2004). Elements of emotional intelligence include self-awareness, self-regulation, motivation, empathy, and social skills, and are most likely to be developed through a supportive mentoring system. Frost (2003) uses nursing as the 'best' example of emotional intelligence and 'professional intimacy'. Labour and birth is a personal and emotional experience, and midwives need to be alert and sensitive to 'emotional clues, no matter how subtle' (Frost, 2003).

Developing a trusting relationship with women is also a critical aspect of midwifery care, which has been shown to improve physical outcomes (Hodnett et al., 2013), as well as provide vital emotional support during a challenging life event. Hence the skilled, knowledgeable, and compassionate care of childbearing women and their infants are key principles of midwifery care (Horton and Astudillo, 2014).

The importance of these principles in engendering trust was evident in a review of midwives' perspectives which found a 'good midwife' is 'good clinically'; is someone whom people trusted and 'felt safe' with; and who could 'feel their job'. A 'good leader' was someone who could 'do the job', was confident, competent, caring and empathetic (Byrom and Downe, 2010). These important traits, described as 'leading from the heart' (Kouzes and Posner, 1995), and 'skilled help from the heart', have been identified as vital in a model integrating traditional and hospital care which combines the safety of evidence based care and technical skills with caring emotional support (El-Nemer et al., 2006).

4. Dealing with emergent change: *'If something goes upside down, she uses her knowledge to adjust the situation'*

Dealing with emergent change was highlighted in ancient times by Lao Tzu who said the role of the leader was to 'facilitate what is happening rather than what you think ought to be

happening'. It is a pivotal insight for leaders, as one of the traps in leadership is to be so caught up with executing one's agenda or strategy that the leader fails to notice key changes in circumstance. In her research, Kenny finds Canadian and American Indigenous leaders as particularly adept at enacting the fluidity required in situational leadership (Kenny, 2012). Leadership researchers have, similarly, become interested in musicians, dancers and other artists who show highly developed skills in responding and improvising to continually unfolding circumstances (Bolden 2011; Ladkin and Taylor, 2014). Mintzberg and Waters (1982) similarly described leadership in emergent change as being in a 'dance' that involves intricate collaborative manoeuvres encompassing improvisation to deal with unpredictability and unintended consequences. Sinclair (2007) has suggested that good leaders don't always arrive at the intended destination, but work through difficulties by stopping, listening and venturing again.

Midwives require a high degree of mindfulness and 'being with' women in the moment and situation as it unfolds. Accordingly, in a midwifery model, leaders need to adapt their interventions and style according to the situation and the individuals involved. This includes assessing situations where women are feeling confident and in control, and the need to 'step back' and empower women to take the lead in the process of birth, to those situations where complications develop and women and their family members may feel afraid. Then there is a need to 'step up' with confidence and skill to support them safely and effectively through the situation as it evolves. There may also be a need to advocate on behalf of families to address social, emotional, and spiritual needs within a medically-orientated health service.

We have outlined four key leadership principles used by midwives for millennia, namely: leadership which is based on empowerment and a deep care for others; mentoring to foster

wisdom; skilled practice and emotional intelligence to engender trust; and ability to deal with emergent change. In contemporary societies, where women have leadership opportunities outside childbirth, these principles have survived and been adapted. While they have been exemplified in midwifery practice, we suggest that they provide a model for leadership beyond the birthing context. The women involved in these practices provide leadership to communities by mentoring and passing on precious cultural knowledge, along with sound professional expertise. They provide a model of adaption and flexibility, working at the intersections of traditional knowledge and western medical models. As shown in Aunty Doseena's accounts and other research, women midwives provide leadership by listening, learning and creating trusting environments in which others feel empowered.

Each of the principles described above has also been explored to varying extents in leadership research, yet we argue there is value in articulating how they are interrelated in the context of women caring for mothers and communities. The interweaving of physical, emotional, cultural and spiritual considerations in a moment-by-moment, highly adaptive, yet generationally-informed responsiveness can surely be a model of leadership for many contemporary contexts.

## **Conclusion**

The role of 'wise women' and traditional midwives has been integral to communities and the flourishing of healthy societies for millennia. These roles, and the leadership provided by women in them, have survived and adapted despite being undermined by colonial and patriarchal structures, and often not recognised as a leadership contribution. Midwives have been chosen by communities for the qualities they possess, and then often trained and inducted in knowledge and understanding that is multi-generational and uniquely suited to context and culture. As a vocation, traditional midwives have developed sophisticated strategies that support

and empower mothers through the critical life events of pregnancy, birth, and becoming a parent. Importantly, traditional midwives employ mentoring models which are designed to foster wisdom, skills and emotional intelligence in the next generation to intuitively consider physical, psychological, cultural and spiritual dimensions; and to respond flexibly to emergent change.

We argue that while women and men are no longer bound by strict gender roles, the ancient leadership approaches used by traditional midwives provide a model and metaphor for contemporary leadership in many ways. Using the lens of midwifery may allow us to put back into ways of doing leadership, practices that have been de-valued, and illuminate a way of re-inscribing leadership with embodied, community, cultural and spiritual understandings.

Particularly in Australian Indigenous, but also in many other societal contexts, multi-generational women – including aunts and grandmothers – play a key role in helping hold communities together, in preserving and passing on cultural knowledge, and in instilling young people with confidence and optimism to achieve. By respecting, valuing and documenting their ways of providing leadership, we enable these models to flourish. The models may be particularly well suited to addressing complex contemporary social issues such as those affecting Indigenous peoples but also in society more broadly.

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