....at North Central Bronx Hospital, New York City, U.S.A., eighty to ninety per cent of all births are delivered by midwives. We include these figures so that you can compare them to the hospital in your area.

NORTH CENTRAL BRONX HOSPITAL, New York City

1979-1980 PERINATAL DATA (All figures are percentages except for the number of patients)

Total Number of Obstetric Patients: 2,736

Patients defined as high-risk by the Director of Neonatology	80.9	Vaginal birth after previous cesarean	46.7
Premature births (below 2500 grams)	8.9	Elective induction of labor	0.0
Spontaneous vaginal delivery by midwife	87.9	Electronic fetal monitoring	
By obstetrician	1.9	Initial screening	80.0
		Continuous	30.0
Apgar scores of 7 or above at 1 & 5 mins. in infants 750 grams or over	94.4	Prep and enema	0.0
Newborns requiring intensive care	13.6	Mothers delivered spontaneously in	
		Labor bed in labor room	68.0
		Labor bed moved to delivery room	24.0
Neonatal mortality: 1000 gms. or over	.47	Delivery table in delivery room	8.0
750 gms. or over	.76		
Perinatal mortality: 750 gms. or over	1.48	Birth occurred in the semi-sitting position without stirrups	92.0
Analgesia and/or anesthesia	20.0	Birth with intact perineum	46.6
Uterine stimulants during labor (1979)	3.0	Mediolateral episiotomy	1.0
Instrument delivery	1.7	Midline episiotomy	24.0
Low forceps	1.1		
Mid forceps	.4	1st & 2nd degree lacerations)	27.2
Vacuum extractor	.2		
		3rd degree lacerations	2.4
Cesarean section	8.9		
Primary	6.8	4th degree lacerations (All 3rd and 4th degree lacerations followed episiotomy and forceps)	1.2
Repeat	2.1		

...Thanks to "THE CHILDBIRTH EDUCATOR" (Australia) for this data.

SAVE THE MIDWIVES

VOL 1 NO 2 SUMMER 1980

...editorial

The recent disquiet over the Nurses Amendment Bill has highlighted the concern among midwives and parents over the role, and indeed the continued existence, of midwifery.

Within the midwifery profession there has appeared a fundamental split - those who believe midwifery is a profession in its own right oppose those who see midwifery skills as merely a gloss on nursing.

This division has been labelled destructive, and calls have been made for midwives and nurses to ignore dissent and unite to further the interests of the profession.

When a profession issues calls to close ranks and conceal criticism it does so at the expense of both the dissenter and the consumer, with the latter, who both pays for the service and uses it, being denied knowledge of the problem and input to its solution.

Moreover dissent does not create weakness; it merely reveals it. Much can be gained from an honest appraisal of a problem; if all is well an investigation will reinforce confidence - on the other hand, if change does need to be made then it can be done before the situation deteriorates.

The survival of the profession of midwifery is reliant on consumer support; midwives rarely practise in Canada and the U.S. where most births are instead attended by nurses and obstetricians. However, enormous consumer support for midwifery in the last three to four years has seen it begin to make a major comeback in those countries.

Support for midwifery returned because the role of the midwife complements the needs of mothers and babies. Midwives are specialists in the care of normal, uncomplicated birth, which every caring mother desires for herself and the safety of her baby.

Midwives and mothers hold common interests; by sharing a newsletter such as this mothers will remain aware of the special role of the midwife in assisting and protecting normal childbirth, and midwives will stay in touch with what women need and want.

By joining forces in an organisation such as this, with parents and midwives as co-members, we will ensure the survival of the profession of midwifery and of the opportunity for as many mothers and babies as possible to experience safe, fulfilling births.

Judy Larkin

...data on midwives

Did you know.....

...of the 210 World Health Organisation countries, only nine have NO provision for midwifery in the health care system. These countries are; Venezuela, Panama, New Hebrides, El Salvador, Dominican Republic, Colombia, Burundi, and Canada.

...in the Netherlands, 96% of all pregnancies are delivered by midwives. 80% of these are certified non-nurse midwives (C.M.) and 20% are certified nurse midwives. (C.N.M.)

...studies in North America show excellent outcomes with midwives. The University of Mississipi Medical Centre started a nurse midwifery service, and within 3 years the infant mortality rate dropped from 39.1 to 21.3.

...in a rural California hospital, the mortality rate dropped from 23.9 to 10.3 when nurse midwives were introduced.

...in 287 California home births delivered by uncertified midwives and analysed by the Stanford University Medical School Team, the infant mortality was 3.2 versus a 15.1 rate for the general populace in the Santa Cruz area.

...in Tennessee, the Farm, which provides a home birth delivery service by midwives, records an infant mortality rate of 8.6 versus the state of Tennessees average of 26!

...at Su Clinica Familiar (The Family Clinic) in Texas, a free standing birth centre 25 miles from the nearest hospital, midwives managed 1412 births between 1972 and 1979 - their neonatal mortality rate was less than 5 per 1000, and they had no maternal deaths. The clinic's prematurity rates and low birth weight babies are less than half the rest of Texas and the U.S.

.....thanks to the British Columbia Association of Midwives' "Midwifery Fact Sheet" for this information.

thanks

to the members of the working party who responded to our questions for their interest and positive participation;co-operation between the profession and the public can only enhance greater public participation in the health care system,an objective which is,in the long term,in the best interests of all of us.

We regret that Ms Foley and Mr Davidson felt unable to participate.

Judy Larkin.

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W.H.O. DEFINITION OF A MIDWIFE

A midwife is a person who is qualified to practise midwifery.She is trained to give the necessary supervision,care and advice to women during pregnancy, labour and the post natal period,to conduct deliveries on her own responsibility and to care for the newly born infant,

This care includes preventive measures and the detection of abnormal conditions in mother and child,the procurement of medical assistance, the execution of emergency measures in the absence of medical help.

She has an important task in health counselling and education,not only for the parents but also within the family and the community.The work should include antenatal education and preparation for parenthood,and extends to certain areas of gynaecology,family planning and child care.

NEW ZEALAND NURSES ASSOCIATION DEFINITION OF A MIDWIFE

A midwife is a nurse who by reason of her advanced educational preparation, knowledge and skills,is qualified to care for women during pregnancy, delivery and the postnatal period and for the foetus and neonate.This care includes the active promotion of health and comfort by whatever means are most appropriate,and the prevention of complications.

The detection of problems either actual or potential for the mother,foetus or neonate requires that the midwife obtains medical assistance,although she is qualified to carry out emergency measures in the absence of medical help.

LETTERS to the EDITOR

We would like to start a Letters to the Editor section to provide a forum for discussion and comment. If you have any views you would like to express, or questions you would like to ask, please write to us c/o the Editor,STM, 24 Ashton Rd., Mt. Eden, AK 3. In the meantime we include some comments we have recieved over the last three months.

"I am a midwife and I have been greatly concerned at the insidious inroads being made into our profession.Two years ago I stated to my midwife workmates that in 10 years we'd be no more but now after studying the Nurses Amendment Bill I realise I was being far too optimistic".

"To everyone joined in the fight to oppose such an outrageous Bill, I give my support.Thank you for getting the newsletters together and I look forward to reading more."

"In my second copy of Broadsheet I came across the article relating to the Nurses Amendment Bill.My hair stood on end at another piece of repressive legislation. ...It is regretted by us all that home birth attendants are not available here. One of our number has attempted an unattended home birth unsucessfully,but fortunately with a favourable outcome."

"Enclosed is my contribution to Save The Midwives. I saw an article in Broadsheet about it and am definitely for women having home births and controlling their own bodies. I have had three hospital deliveries and the last one was totally centred around my wishes,even to having my 4 and 5 year old daughters witness their sister's birth."

"I am an English trained midwife and general nurse.Because I had the experience of home births while working as a domiciliary midwife for five years in England,I wholeheartedly support your cause and sympathise especially with the direct-entry midwives of N.Z. and the expectant parents of the future,who will be adversly affected by the Nurses Amendment Bill."

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NEWS

* The Australian Childbirth Education and Parenting Association is now publishing "THE CHILDBIRTH EDUCATOR",a bi-monthly newsletter for parents and health care workers.Annual subscription is $ Aus 9.50 for Australian residents - for extra costs outside Australia write to Susan Eddy, 34 Denis Drive, Riverside,TAS 7250, Aus.

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* The Nursing Council has prepared registration criteria for midwives. Copies of these criteria have been forwarded to the Midwives Sections of the NZNA and to the Professional Services Committee for comment.

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* SHEILA KITZINGER is to visit New Zealand in March 1984.Ms Kitzinger is the mother of five daughters, a social anthropologist and a childbirth educator.In Britain she teaches couples and trains teachers for the National Childbirth Trust, and is on its Panel of Advisors.She is also a consultant for ICEA.Since 1958 she has been developing her Psychosexual Method of Childbirth Education, and is strongly supportive of natural birth, midwifery, and home birth. She will be arriving in N.Z. on March 25.For more information,contact Judy Larkin, phone AK 602 301.

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* The Department of Education is about to commence an evaluation of Advanced Diploma in Nursing courses in Technical Institutes.It will be establishing an advisory committee to provide professional guidance to the researchers.The NZNA has nominated a member - Maureen Laws.

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* DEFINITION and ROLE of the MIDWIFE

A working party made up of selected representatives from each region, plus invited representatives from the Nursing Council, the National Executive of the NZNA, and the Technical Institutes met in April to formulate a National Statement on the definition and role of the midwife,and to look at problems within the Midwifery Programme as it now stands.A report with recommendations is being prepared.

Midwifery is nursing. It requires a sound basic knowledge of all aspects of the art and science of nursing to enable the midwife to give comprehensive care to a woman and her baby and family during this child-bearing process.
Therefore my opinion of direct entry midwifery is that it lacks a sound basis. I am not saying that the direct entry midwife is necessarily unsafe but she lacks a depth of knowledge and understanding that will enable her to give the highest quality of patient care. This is, and must be the expectation of every woman who has a baby in New Zealand.

BRUCE FARIS: does not mention direct entry midwifery.See previous question.

JULIE FOLEY: as for previous response.

DAVID DAVIDSON: as for previous response.

JOHN RUSSELL: "Each midwife should be judged on her individual merits, whether she is a nurse-midwife of a direct-entry midwife.There are some excellent direct-entry midwives practising in NZ."

BACKGROUNDER

Mrs Wadey,Ms Lawton,- and Mr Faris kindly provided us,on request, with a resume of their respective backgrounds. (We neglected to ask Dr Russell).

Mrs Wadey is the mother of three children,a trained teacher,is President of Hamilton Parents Centre,and is a member of the Waikato Hospital Boards Service Development Group.

Ms Lawton did both her nursing and midwifery training in the U.K.,and has spent two years at St Helens,Auckland,as Charge Nurse of Delivery Suite, 10 years as a midwifery tutor at St.Helens,Wellington,followed by a position as Senior Supervisor at Wellington Womens Hospital until she took up her current position as Assistant Principal Nurse (Maternal Child Health).

Mr Faris is a specialist Obstetrician and Gynaecologist in private practice and also on the staff of National Womens Hospital,as a Visiting Consultant. He also held a position as Part Time Medical Superintendent of St Helens Hospital,Auckland,during which time he began the first midwifery refresher courses.He has been a member of the Maternity Services Committee of the Board of Health,and since 1972 has been an elected member of the Auckland Hospital Board.He states his main areas of concern re midwifery as being the number of midwives continuing to practise after receiving their diploma, the very small number of midwives graduating with the Advanced Diploma now that Midwifery training has been transferred to the Technical Institutes, and the withdrawal of recognition by the Health Department of the six-months neonatal intensive nursing course at National Womens Hospital.

WHAT IS YOUR VIEW OF THE VALUE OF DOMICILIARY MIDWIFERY?

BARBARA WADEY:"I believe that parents have a right to choose where their baby is to be born but the decision should be an informed one,made in conjunction with their medical advisor.Having a home birth gives the woman the right to choose who will deliver her baby,the procedures followed,and control over who is present at the birth - all very important factors."

MAUREEN LAWTON:

I believe that every woman must be able to have a birth experience that fullfills her own needs yet is safest for both her and the baby. If a woman wishes to have a home confinement and there are no contraindications from a medical or obstetrical point of view then that woman should be attended by a skilled midwife.
Therefore this midwife must have sufficient practice to maintain her skills and should ideally be in close liaison with her colleagues in the hospital setting. The absence of 'flying squad' emergency obstetric services, as a back up,ofs of concern to me. I personally would support the New Zealand Nurses' Association policy which has the belief that the Domiciliary Midwifery Service should be part of the Hospital Board's provision. In the event of the amalgamation to area health boards the same would apply i.e. this service be part of the obstetric services in that area.

BRUCE FARIS:did not mention domiciliary midwifery. However Mr Faris' s very positive response,in the form of a 3 page letter, gave us a lot of additional information which we unfortunately do not have the space to reproduce in this newsletter.

JULIE FOLEY:as per previous question.

DAVID DAVIDSON: as per previous question.

JOHN RUSSELL: "The place of birth should be the patient's choice".Home birth should be available for those who choose it (subject to certain conditions) ,and thus domiciliary midwifery has a place in NZ health care.

WHAT IS YOUR VIEW OF THE VALUE OF DIRECT ENTRY MIDWIFERY?

BARBARA WADEY:"They make a valuable contribution to the midwifery scene in NZ.

MAUREEN LAWTON:

As a midwife who has had experience in hospitals, on the District for a short period in England and as a Tutor in England and in New Zealand, I believe that any midwife who practices in the domiciliary setting should have a sound background knowledge of both medical and surgical nursing. I have taught direct entry midwifery students and I know that their lack of basic nursing knowledge has been a distinct disadvantage to them. I speak from experience of midwifery students in England and New Zealand only and not of those from Holland.

SAVE THE MIDWIVES

Since the Association was formed in September 1983,it has gained approx 280 members,including approx 50 midwives.We will issue 4 newsletters a year, containing news and articles of interest to both parents and midwives. Each newsletter will cover a specific subject area;in this one we have looked at midwifery in detail,in the next we will look at Mothering.

We intend to include items from NZ and overseas,and to further this end we have subscribed to the following organisations/publications:

National Childbirth Trust (U.K.)

Childbirth Educators' Assoc. (Aus)

Mothering Magazine (USA)

Birth (USA)

The British Columbia Assoc. of Midwives.

Parents Centres (NZ)

Home Birth Assoc.(NZ)

NAPSAC(National Assoc. of Parents and Professionals for Safe Alternatives in Childbirth)(USA)

ICEA(International Childbirth Education Association)(USA)

Assoc. of Radical Midwives(U.K.)

ACHI(Assoc. for Childbirth at Home International)(USA)

La Leche League (NZ)

DONATIONS

We thank those members who sent a donation along with their subs;a little over $100 was received which has gone partway to sending a member,Judy Larkin,to Wellington to present a submission to the Select Committee.Any further donations towards covering the cost of the trip ($208) will be very welcome.

THE SELECT COMMITTEE HEARING

Just over 230 submissions were received,which is quite something! In essence, the STM submission covered the following points;

(1)and(2): Clause 3,Membership of Council,which appoints a lay memberto the Nursing Council, and Clause 15,which makes it no longer an offence to give advice to a pregnant woman, both received our full support.

(3)Clause 5,Qualifications for Registration and Enrolment,Section 17 3 (a) and (b) we opposed.This section confines midwifery training to Technical Institutes, and implies that all midwives must also be nurses.

(4)Clause 9,Notification of Disability or Suspected Disability,we opposed. This section removed the previous legally protected confidentiality which existed between a general practitioner and her/his patient if the patient happens to be a nurse.

(5)Clause 15,Offences Relating to Obstetric Nursing,Section 54 3 (a) and (b) we opposed - they restrict domiciliary midwifery to nurse midwives only.

(6)Clause 16,Functions and Powers of Medical Officers of Health,was opposed by us. This clause allowed MOH's power to suspend a midwife on mere "suspicion" of her practising in an "unhygienic manner".This confers very wide and quite vague powers on the MOH which are open to abuse, and are quite unnecessary since s/he already has the power to suspend in order to prevent the spread of infection.

The Select Committee Hearing took place on November 23 (with a second session on November 30) and was very positive with regard to direct-entry midwifery, domiciliary midwifery, the protection of nursing and midwifery from over-control by the medical profession, and the right of parents to determine the kind of health care they will receive.

THE NURSES AMENDMENT BILL

A number of important amendments were made to the Bill before it was reported back to the House for its third reading. They were;

*Clause 5 Section 17A has a new subsection 5(a) which we take to mean that direct-entry midwives cannot be denied registration here on the grounds that the nursing content of their course does not equal that of NZ trained midwives, who of course are all nurses first.

*internal assessment has been eliminated as a means of qualifying as a MW.

*Clause 15 Section 54 has a new subsection 4 (a) which means that any direct-entry domiciliary midwife practising before 1 April 1984 may continue to practise thereafter. (However domiciliary midwifery is still denied to d-e midwives who register after that date)

*Clause 16 Section 58 Subsection 2 has been amended to state that the Medical Officer of Health must have "reasonable grounds to suspect (a midwife) to be practising in an unhygienic manner" and a new subsection 2a states that "Every notice (of suspension) shall state the reason for the suspension and the grounds on which the suspension is based." So this affords quite a bit more protection to the midwife.

* Clause 9 was not altered.

We have just received our copy of the new Act the morning before this newsletter has to go to the printer, so our summary is rather brief and may be incomplete. If you seek further clarification, please write to us c/o The Secretary, (address below).

All of us who sent in submissions against the Bill can feel pleased at what we, and other groups, achieved in the way of changes to it; direct entry midwives still have access to registration in NZ, the jobs of presently practising d-e domiciliary midwives have been protected, and midwives have been afforded considerably more protection from the Medical Officers of Health than was contained in the original Bill. So it was worth all the effort!

.....

SAVE THE MIDWIVES SUBSCRIPTION FORM

NAME _____ ADDRESS _____

PHONE _____

MOTHER ☐

MIDWIFE ☐

OTHER(please specify) _____ $2 sub enclosed ☐

...post to The Secretary, Save The Midwives Association, 24 Ashton Rd., Mt Eden, Auckland, NEW ZEALAND.

.....

our next meeting

to discuss this newsletter, and to determine the content of the next one, will be held at 24 Ashton Rd., Mt Eden, on March 5 (Monday) at 8p.m.

Results

We understand that the conclusion of the working party was that there is no shortage of midwives, but we have not had this confirmed as yet. In the meantime, STM sent a brief questionnaire to the party members canvassing their opinions on the rôle of the midwife, domiciliary midwifery and direct-entry midwifery. We felt this information would be of interest to our members, and the questions and responses are summarised below.

WHAT, IN YOUR OPINION, IS THE ROLE OF THE MIDWIFE IN MATERNITY CARE?

BARBARA WADEY: "Basically, to care for the woman with regard to her health and safety and to assist her to have the kind of birth experience she wants."

MAUREEN LAWTON: "This depends on where the midwife is practising. The midwife has a dual responsibility. One is to the woman and family to ensure that she has the best care possible during pregnancy, labour, delivery and postnatally she is adequately prepared for the subsequent care of herself, her baby and her family. She also has a responsibility to carry out delegated care as prescribed by the womans medical practitioner and to report to the doctor any problems detected during the childbearing process. The midwife has a responsibility to herself and to her patients to ensure she has and maintains adequate knowledge and skills to ensure safe practice at all times." Ms Lawton also states that she supports the NZNA definition of a midwife (see end of this article).

BRUCE FARIS: "I was instrumental in rewriting the International and World Health Organisation Definition of a Midwife" (see end of this article).

JULIE FOLEY: Ms Foley replied, but did not acknowledge receipt of the questionnaire. When asked for a direct response she stated that she did not wish to participate.

DAVID DAVIDSON: Mr Davidson replied "I shall be very happy to establish my credentials with you when you have established the credibility of your association with me". We were unable to meet his conditions in time to obtain a response for this newsletter.

JOHN RUSSELL: Dr Russell sees the midwifes role in maternity care as both valuable and necessary, and would not like to see the midwife disappear from the NZ health care system.

A SHORTAGE OF MIDWIVES ??

In mid 1983 the Hospital Board's Association's biennial conference passed a remit expressing concern at the shortage of midwives in N.Z. and requested the HBA to establish a working party to research the reasons and to advise on ways in which the retention of midwives in employment might be improved. As a result of this the HBA Executive established a working party consisting of representatives from the NZ Medical Association, the NZ Nurses Association, the NZ College of Obstetricians and Gynaecologists, the NZ Federation of Parents Centres and the HBA. The Department of Health declined the invitation to be represented on the working party. The Department is the employer of domiciliary midwives, and given the probable amalgamation of Hospital Boards with the Health Department regional offices into Area Health Boards (now that the relevant legislation has gone through Parliament) the Departments refusal seems illogical.

Is there a shortage of midwives?

The terms of reference of the working party were:

a) to ascertain whether a shortage of practising midwives actually existed

b) if there was such a shortage, to examine the reasons for this situation

c) to recommend ways in which such a shortage might be overcome.

Members of the Working Party

The working party consisted of 6 members: 2 obstetricians, 2 midwives, 1 parent and 1 general practitioner. They were Mr. D. Davidson, an obstetrician practising at Memorial Hospital, Hastings, (representing NZCOG), Mr Bruce Faris, an obstetrician in private practice in Remuera, Auckland, (representing the HBA), Ms Julie Foley, Assistant Principal Nurse, Wellington Womens Hospital, (representing the NZNA), Ms Maureen Lawton, Asst Principal Nurse, Waikato Womens Hospital, (representing the NZNA), Ms Barbara Wadey, President, Hamilton Parents Centre, (representing parents) and Dr. John Russell, a medical practitioner in private practice in Milford, Auckland, (representing the NZMA).

INDEPENDENT MIDWIVES

canada

at the February 1983 " Labour of Love " conference held by the Midwives Association of British Columbia (MBAC) it was agreed that Canada needs a national midwifery association. This in spite of the fact that Canada, (except for the province of Newfoundland), is one of the few countries in the world in which the practise of midwifery (including nurse-midwifery) is illegal. A statement of agreement was drawn up between the midwives to form a basis by which midwives throughout Canada might unify and work together. This statement is ;

1. Recognising that the Canadian public wishes to develop a safe and humane system of maternity care, we will unite to support the legalisation of midwifery services in Canada.

2. To achieve this goal, we will form a "National Association of Midwives".

3. We will work toward united vision and cooperation among midwives from varying backgrounds.

4. We will work toward a sharing of information and resources among midwives in Canada.

5. We will endorse the International Definition of the Midwife.

MABC is based at 1053 Douglas Cres., Vancouver, BC V6H IV4, CANADA.
We hope to have more information about their organisation for our next newsletter.

australia

Australian midwives, who previously were represented by the nurses' union, have formed an independent organisation.
From the 3rd National Midwifery Conference

6

held in April 1983 in Canberra, Lorraine Feilding, midwife in Canberra, reports, "At the General Meeting the Australian Midwives Association voted to separate from the Royal Australian Nurses Federation as it was felt that our professional interests were not being given appropriate time and consideration. The Midwives Association is not a union, but will make statements on the standards and training of midwives."

We have written to Lorraine for some more information about the Australian Midwives Association, and hope to include it in our next newsletter.

new zealand

The Nurses Amendment Bill has clearly demonstrated that if midwifery is to survive as a profession, it is essential that midwives have an independent organisation through which they can protect and/or promote midwifery interests.

At present the only negotiating body N.Z. midwives have is the Midwives and Obstetric Nurses Section of the N.Z. Nurses Association formed in 1969. Midwifery is subsumed by the nursing profession which makes policy in its own best interests.

The definition of a midwife as set forth in the Bill is, in fact, that of an obstetric 'nurse practitioner'. As that name implies the 'practitioner' works in obstetrics (abnormal birth) and nursing (illness). N.Z. has joined Canada, the only other country in the Western world which offers no basic midwifery training and which, for years has offered only a post-graduate course in obstetric nursing.

Midwife or Nurse?

At a Section Study Day recently Bev Crombie, Supervising Sister of St Helens Delivery Unit pointed out that being accountable to another professional body (doctors) has not taught midwives much about being accountable to a mother, a baby, or themselves. This is precisely the difference between being an obstetric nurse midwife and being a midwife. A real midwife is a practitioner in her own right, and the Section midwives uphold this definition. And it is only as such an independent practitioner with the accompanying professional status that a midwife can fulfill her role to protect women from abnormal birth (obstetrics). Professor G.J. Kloosterman has made this differentiation between the nurse-midwives and what he calls the "real midwives". He says the former prefer to share responsibility with a doctor and are very keen on seeing that everything the doctor asks for is done punctually, and of course, the doctor likes to work with these. The real midwives, on the other hand "like to be independent, to give their own opinions... In a hospital I think we need more nurses. But we also need a few midwives for their critical attitude. And at home we need real midwives because nurses become nervous at home, alone and without a doctor to fall back on." 1

Defining the Midwife

Even though the NZNA pays lip service to the consumers' right to an option (home birth), their approval of the Bill's definition of a midwife, in fact, denies this. Their argument is that midwifery is founded and based on nursing skills. This argument justifies the establishment of the Technical school Post-Graduate Diploma course in Maternal & Child Health with Midwifery Option and the phasing out of the midwifery training programme at St Helens, 1979.

We did many antenatal, postnatal and well baby clinics plus many (primarily postnatal) home visits. I spent time working in the local maternity unit and had my first rewarding experiences of total patient care from the antenatal through the postnatal period. During these three months she gave me increasing responsibility doing clincis without her (with G.P.) and visits alone until I spent whole days bag-in-hand walking around town seeing mums and babes. Upon my return to the consultant unit (5,000 births p.a.) I found I had more confidence, a more family/community oriented outlook and more ability to bend the rules.

I also did two post graduate courses. Firstly Intensive Baby Care which made me think much more of the foetus during labour, and showed me how very traumatic it is for mother, father and baby to be separated and to make every effort to avoid this. We also looked at neonatal illness and care.

Secondly, Family Planning gave me a much more accurate knowledge about conventional contraceptive measures which was an area rather neglected during my midwifery training. It made it even more obvious the need for viable alternatives to be more widely utilized although major drug companies would not benefit from this move! The work in Family Planning Clinics was very interesting with much time spent listening and discussing problems with women (mostly) from all walks of life and of all ages.

I then spent ten months as a charge nurse in a small and peaceful maternity unit (350 deliveries p.a.) which reinforced all my ideas. I took full responsibility for ante, intra and postpartum care asking for assistance only when I found it necessary. The conflicts between what women do or don't want and what the ever-absent consultant requires continued.

However, we had two cosy, relaxed and secluded birthing rooms set up by the innovative midwives, and we were left alone to care for a couple often staying after hours to attend to the birth. We would report on progress as required. The degree of relaxation was markedly advantageous to all concerned especially compared to the chaos and processes of the highly technical consultant unit where I had trained in the same city. (Derby, England). The rewards of one-to-one care were that I could get involved and loved it.

I gained more knowledge and realized even more acutely the bounds, particularly in hospitals that need to be stretched and how all of us in the health care service need to keep our eyes open for new ideas, truly serve people who may need us and realize the importance of this time in a families life and its long lasting effects. At times it is possible to do this within a hospital.

The choice between home and hospital is still possible with the National Health Service in England although birth at home is a struggle as pro home birth doctors are persecuted and there is a lot of pressure exerted on the midwives many of whom lack the experience and confidence to do home births.

In London independent midwives (whose fees sometimes restrict their services to the privileged) do much more autonomous work. Here it saddens me greatly to see the choice between home and hospital manipulated by government's economic policy.

From my very positive post qualification year I look forward to venturing out into a more personally adventuresome midwifery life, be it at home or trying to make change from within. Both take strength and I greatly admire those that have gone before me and shown it to be possible.

Veronica Muller.

REFLECTIONS

(This is a personal account of the training and experience of a direct entry midwife, now registered in New Zealand. Section 54(4A) of the Nurses Amendment Act allows midwives as distinct from nurse-midwives to practise domiciliary midwifery only if they are registered and practising midwifery in New Zealand before the 1st of April 1984. Those New Zealand women who are now undertaking a direct entry course in the U.K. will be unable to work as domiciliary midwives. By the stroke of a pen, wielded by the Minister of Health, New Zealand women lose specialist midwives and a profession.)

My experience as a staff midwife (charge nurse) is biased greatly by my short experience of midwifery and by the places where I trained and worked. My training has had a direct bearing on my attitudes after qualification.

Entering into midwifery at an age about seven years older than most entering into nursing or medicine meant I had a little more experience of different lifestyles, relationships with people and more self confidence, yet entering into this hierachical system was a real eye opener, at times horrifying and overwhelming.

Being a direct entrant, without a general nursing qualification seemed to make many think I was at a terrible disadvantage but in fact I found it just the opposite looking at it from the outside world and not systematically treating people as ill.

The six of us in our class became very close over the two (now three) years, united in our struggle against being the underdog midwives (non nurses) and radicals! because we tried hard not to manipulate the childbearing couple to their detriment and spoke out against unnecessary interferences. We all developed a certain capacity to quietly do our own thing and let often severe criticism float over us as we believed we were right. This group support and that of the Association of Radical Midwives were absolutely important, preventing any one of us from giving up, restoring our shattered confidences and reinforcing our beliefs. These alliances were also wonderful for sharing knowledge and ideas in many directions, a welcome contrast to those of the allopathic and obstetrician dominated world.

Then and now I find the hospital hierachy a very complex social system designed by the power hungry to keep those within the system at their appropriate level and also to isolate the staff from the parents and family. How often are we told not to become involved and to treat all individuals with a (sometimes degrading) procedure thus undermining their self-confidence in this alien environment and turning them into numbers.

Three months (towards the end of my training) with an elderly community midwife broadened my outlook a lot. Her openmindedness, motherliness and family oriented ideas made her very accepting of and accepted by the childbearing population of the small town where she lived and worked. She had delivered many babies at home and enjoyed it greatly but the reorganization of the health service made it more difficult for her to organize her own work hours around deliveries. In addition G.P.'s and consultants were losing confidence and looking unfavourably at home birth. Thus the numbers had decreased greatly and sadly I did not attend any home births during this period.

The Bill's definition merely tidies things up and closes any loop-holes - just as the Nurses and Midwives Act, 1924, "put out of court the handywoman." The difference is that in 1924 Dr MacGregor was frank about the elimination of the lay midwife; today, the elimination of the midwife is more devious.
The origins of this definition began in a Policy Statement on Home Confinement prepared by the Section and presented to the Maternity Services Committee (MSC) Feb. 1980. This stated it did "not support the demand for home confinement" but "reluctant acceptance of a fait accompli ... dictated that we now formulate policies...in the absence of positive sanctions against those who condone and support the trend towards home confinement" that is the domiciliary midwives. This encouraged the existing antagonism of the hospital midwives against the domiciliary midwives - 'divide and rule!

NZNA Policy Statement

The next move was the NZNA Policy Statement on Maternal and Infant Nursing, April 1981. This was prepared by an ad hoc committee 'established' by the NZNA National Executive. Impetus was provided through "a small but vocal consumer interest in some aspects of maternal and infant care, and the concern of many midwives relating to their professional role and function and their educational preparation for this."

While the majority of midwives were diverted by the presumed dangers of domiciliary confinements, the Policy Statement laid the basis for the elimination of all programme (hospital) trained midwives to make way for a few 'nurse practitioners' with midwifery option in a contracting labour market. The NZNA Policy Statement "believe(d) that midwifery is a post-basic qualification, in that the midwife utilises the nursing concepts (illness) learned during the basic nursing programme, and builds on these, at the same time acquiring new skills and knowledge relating to the practice of midwifery."

While admitting that "the question of the basic or post-basic nature of midwifery education provokes considerable discussion and divergent opinion among midwives" this April Policy Statement was put before the May Conference. After the Conference while Section branches were studying and debating the clauses, the MSC had already prepared a draft report which incorporated most of the policy recommendations! Having been endorsed at Conference, it was now official policy.

Midwives Submission

It was this policy which was the basis for disallowing the Section's submission to the Bill to go forward to the Select Committee. Among other things, the Section said it wished to "protect the right to practice of the registered midwife who is not a registered nurse..." It further provided the W.H.O. definition of a midwife which says, "A midwife is a person ..." that is, not a nurse. She is also one who is able to "conduct deliveries on her own responsibility..."

Of course these statements directly contradict official NZNA policy passed at Conference! NZNA National Executive member, Pat Carroll who came to Auckland 7th November 1983 to talk to NZNA members about the Bill confirmed this. She felt that the profession (nursing) could not go forward when such outstanding difference existed. She urged that it was necessary to be united. When asked if this 'unity' and progress for the nursing profession was to be bought at the expense of midwifery as a profession she became angry. In the ensuing 'debate' over nurse-midwives versus midwives, she expressed the opinion that for a midwife to accept pay for a nursing qualification while denying its value was 'the worst form of harlotry'. With friends like that, midwives do not need enemies!

This competition between the professions has existed for over 100 years. After throwing off the mantle of the Gamp, English midwives organised, 1882, as independent practitioners, in the Matrons' Aid Society - a women's organisation. In time it became the Royal College of Midwives.

Nurses, on the other hand, the British Nurses Association, founded 1887 by Mrs Bedford Fenwick, allowed doctors into their membership and were influenced by them. Mrs Fenwick wanted to incorporate the independent midwives into her BNA as 'midwifery Nurses'. This they resisted!

In New Zealand although midwives were part of the Nurses Association from the start, 1905, they had sympathetic advocates for their interests in both Grace Neill and later Mary Lambie. Today, the Director, Division of Nursing, Mrs Margaret Bazley, is NOT a midwife.

It is unrealistic to expect a competing profession to act in the interests of midwives. The only means of survival is to form an independent organisation.

H.Arlot.

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WHY NURSE-MIDWIVES ?

The development of the nurse-midwife is in the interests of the O & G's. In 'Men Who Control Women's Health' (Houghton Mifflin, 1980) Diana Scully discusses the tarnished image of twentieth century obstetrics and gynaecology within the medical profession which views O & G's as "substandard surgeons whose ability beyond cesarian section and hysterectomy is inadequate". (p 57)

Obstetrics and gynaecology is depicted as "boring work, limited in scope and involving long hours." The declining importance placed on the specialty in medical schools resulted in recruitment problems. Many candidates were drawn from the low achievers in medical school and from foreign medical school graduates. (1)

Efforts to improve the position of obstetrics and gynaecology within medicine and to encourage more and better American medical students to enter the specialty, have been centred primarily on two tactics, claims Scully. These are: 1) Portraying O & G as a desirable career by emphasising research, promoting group O & G practice and developing more attractive training programmes; and 2) a new interest in the use of nurse-midwives. One study found that obstetricians consider nurse-midwives able to perform those jobs that require a combination of the most time and least skill and unable to perform "skilled or professional functions". (2) The president of the American Association of O & G's, 1972, stressed the importance of the use of such midwives to make the profession more attractive to the students who are "turned off when they see respected specialists delivering their own patients at 2 a.m." (3)

Obviously, it is the nurse-midwife - the obstetricians's handmaiden that is of use to the O & G's, not the midwife, the independent practitioner, who could only pose a threat.

The development of the nurse-midwife is to the advantage of the nursing profession. The nurse-midwife can be incorporated totally into the nursing profession - by making midwifery a post-graduate course of nursing - thus removing a threat of competition from a group of independent practitioners.

(1)Newton,M and Zuspan,F, "A 1969 Profile of Residents in Obstetrics and Gynaecology",Obstetrics and Gynaecology 38,1971,p 164.

(2)Goldsmith,S,Johnson,J,and Lerner,M,"Obstetricians Attitudes Towards Nurse-Midwives",American Journal of O&G,111,1971,p 111-118.

(3)Keettel,W,"One Man's Opinion:Presidential Address",American Journal of O&G, 115.1973,p 594.

spend most of their specialist time on normal antenatal care and birth. They begin their 5 "follow through" cases,where they follow a woman through her antenatal care,birth,postnatal care,and adjustment to home. Time spent with these mothers varies, with a minimum of 1 antenatal check, 1 pre-birth visit to the mothers home, attendance at the birth, postnatal visits each day in the ward, and 1 postnatal visit to the mother's home being acceptable.There is no requirement to follow through a home birth.

In the second term,students spend approximately 60 hours visiting Plunket clinics,Family Planning clinics,Karitane units, and in the delivery units of the maternity hospitals.In this term students begin to concentrate more on deviations from normal, both in the antenatal wards and in deliveries. Part of term 2 is also spent on the follow through cases.

Term 3 is largely spent on the students chosen speciality,midwifery,with a small amount of time on the core components.Attention in this term is concentrated on neonatal care,special baby care,(not intensive care),post natal care and birth. To meet the requirements for registration students must participate in at least 20 normal births and 10 abnormal births.There is no requirement for participation in a home birth.

IS THE ADN THE PLACE FOR MIDWIFERY TRAINING?

The aim of the ADN is "to improve nursing knowledge and skills and enable the nurse to practise nursing at an advanced level"[1] by "providing learning opportunities that enable the preparation of the registered nurse for the role of nurse practitioner"[2] One of the basic assumptions made about students enrolling for the ADN is that they "have a high level of clinical expertise which can be usefully shared with fellow students"[3]

Registered nurses enrolling for the midwifery sub option do not necessarily have a high level of clinical expertise in midwifery;they enrol,rather,to gain a basic qualification.The midwifery suboption is the only one of the four for which students take a (State) exam;and it is the only option within the ADN that leads to registration.

Midwifery training thus appears to be the "odd man out" within the ADN. In 1973 the NZNA set up an ad hoc committee to develop a 12 month midwifery programme which could be undertaken after the 3 year nursing course.The objectives of this programme encompassed the World Health Organisation Definition of a Midwife and specifically stated that a midwife should be able to conduct deliveries on her own responsibility.Perhaps it is time to reinvestigate this programme as a possible alternative to the ADN for (basic) midwifery training.

Judy Lerkin.

References.

1 Report of the Nursing Council to the House of Representatives for the Year ending 31:3:83

2. Written answer from the Minister of Health to Helen Clark,M.P., 6:12:83

3. p.3.,ADN prospectus,ATI Dept of Nursing,North Shore Branch,Akorange Drive, Northcote,Auckland.

4.p.1., ibid.

5.p.1.,ibid.

THANKS to Miss Y Shadbolt,Principal,ATI Dept of Nursing, and to Mrs G.Williams and Mrs G.White,for their assistance in providing information about ATI's midwifery course.

NURSING TRAINING

NZ trains only nurse-midwives,unlike Britain which trains both these and specialist (direct-entry) midwives, who do not train as nurses first. In NZ the basic nursing course takes 3 years,and the student graduates from a hospital based programme as a "general and obstetric" nurse, or from a technical institute as a "comprehensive"nurse. She has had 8 to 10 weeks obstetric nursing as part of her course,which includes 2 weeks of theory. Prior to 1980 each student was required to deliver a minimum of 5 babies- now there is NO minimum requirement at all.Among the reasons for this change are too much competition for deliveries from medical and midwifery students. It appears that there are simply not enough births to go around.

Before applying to train as a midwife,a nurse is required to do at least 2 years "staffing" in hospitals, 1 year of which needs to be in a maternity hospital.The experience that the nurse is exposed to in this year depends very much on the hospital;some hospitals have a comprehensive programme introducing the nurse to antenatal care,birth,postnatal and neonatal care, while in others a nurse may be permitted to spend her whole year working solely in the antenatal clinic,for example.Consequently nurses who enrol in midwifery have varied backgrounds.

THE ADVANCED DIPLOMA IN NURSING

The ADN is a year long course,the fee for which is just under $100,with no salary automatically paid.The student may,however,be sponsored on full salary,elect to be bonded to the Health Dept for two years after graduation in return for $10 per week as a bursary,or be granted the standard tertiary bursary. Nationally there are 150 places available in the ADN, spread over 4 technical institutes and to be allocated between 4 options within the ADN. Nevertheless, Auckland Technical Institute,for example,has had more midwifery places than students.

A nurse can take the ADN in one of 4 options.These are:

1. Community Health .

2.Maternal and Child Health Nursing - (a)Maternal & Child Health sub-option
(b)Midwifery sub-option

3. Medical/Surgical Nursing.

4, Psycho Social Nursing.

All 4 options share a basic "core component" and as the year progresses students spend an increasing amount of time within their chosen option. The core components offerred by ATI in 1984 are:

Nursing, Health, Stress and adaptation, Teaching and learning, Self-Awareness and nurse client relationships, Nursing Science, Nursing Management, Research and Statistics, Behavioural sciences, Multicultural awareness, Groups, including the family and community support systems.

Midwifery students choose the midwifery sub-option of the Maternal and Child Health option.

AUCKLAND TECHNICAL INSTITUTE

Students accepted by ATI vary widely in their backgrounds and are few in number-(6 in 1983 and 15 expected in 1984),so the midwifery sub option needs to be, and can be, individually tailored.In the 1st term the students

the association of radical midwives

The Association of Radical Midwives is a British group that was formed five years ago in response to fears that midwifery as a profession was disappearing. The following is taken from their latest newsletter -

"The Association of Radical Midwives has been growing rapidly.We have received a high response from midwives and others concerned about the erosion of the role of the midwife and the consequent lack of choice for the childbearing woman.So we decided it was time to provide a place to share information,news,and to help us organise ourselves to achieve our objectives.

We will attempt to bring out a newsletter four times a year and it'll cover more ground than the minutes from our six weekly meetings.It will include an editorial,articles,book/film reviews,lists of useful books, addresses etc.,and sections on midwifery abroad,organisations and technical information.

Each issue of the newsletter will be put out by a different regional group.Please send all information and comments to Glyn Kraaij, 108 Woodland View,Stratton Strawless,Norwich NR 10 5LT.

" Why radical? After much discussion about a suitable name for our group THE ASSOCIATION OF RADICAL MIDWIVES was finally agreed on.We realised that the word "radical" may alienate many midwives who might otherwise be sympathetic with the aims of the group.We believe "radical" expresses in its original sense the essence of our group, i.e. relating to roots and origins.

Our overall aim is to restore the role of the midwife for the benefit of the childbearing woman and her baby.We don't see this as going back, but rather as going forward....
Our objectives are;

1. to re-establish the confidence of the midwife in her own skills.
2. to share ideas,skills and information.
3. to encourage midwives in their support of a womans's active participation in childbirth.
4. to reaffirm the need for midwives to provide continuity of care.
5. to explore alternative patterns of care.
6. to encourage evaluation of developement in our field.

CONTACT ADDRESS: ASSOCIATION OF RADICAL MIDWIVES,
c/o 8A The Drive, Wimbledon ,Lomdon .SW20

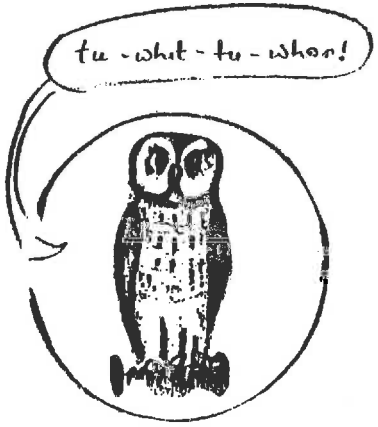
the state of the art in England

The following article by Angela Phillips appeared in the Sunday Times (review) on 25/9/83 and was excerpted by us from the newsletter of the Association of Radical Midwives,

"The new national Board regulating the midwifery and nursing professions held its first meeting last week. Of its five elected midwife members, three belong to the Association of Radical Midwives (ARM). Their election heralds a new mood of self confidence amongst British midwives.

Five years ago the ARM, inexperienced and tentative, joined consumer groups to lobby against the passage of a Bill which they feared would put the last nail in the coffin of midwifery as a profession. The Nurses, Midwives and Health Visitors Act abolished the specialist body (the Central Midwives Board) which had steered midwifery since 1902, proposing in its place amalgamation with nursing under a new national board structure. The ARM feared that midwifery would be sucked into nursing, and midwives replaced by obstetric nurses - doctors' handmaidens.

At that time the prospect of 100% hospital confinements, with an ever-increasing rate of obstetric intervention, seemed almost unavoidable, but, since then, midwives have picked themselves up and joined together to rebuild their professional pride. Now Kate Newson, one of the newly-elected ARM members of the English Board, can say with confidence; "Midwives have stopped blaming the obstetricians for all their problems and started to look at their own practice. We have nothing to fear from obstetricians. They are not interested in "normal" deliveries. We are. Kate represents a new breed of British midwife. Young, self-confident and innovative, she has travelled widely in Europe and America picking up ideas to bring home. At the age of 31, after only 4 years as a midwifery tutor at ST Mary's Hospital, Paddington, She has just been appointed Director of Midwifery Services for Tower Hamlets and the London Hospital.



With 27 years experience, Mary Cronk, a district midwife on the Isle of Wight, is rooted in a very different kind of experience. When she trained, midwives were still expected to take full responsibility for normal pregnancy and labour. She joined ARM when she saw that independence

midwifery training in new zealand

* Prior to 1979 midwives in NZ were trained in maternity hospitals, in a basic post nursing programme that took an extra 6 months.
* In 1979, as a result of a Cabinet decision, midwifery training was transferred to the Technical Institutes as part of an Advanced Diploma in Nursing.
* In 1980, and again in 1982, at the NZ Nurses Association's Annual Conferences, the Midwives Section urgently petitioned the Minister of Education to provide a seperate midwifery cours leading to registration, leaving the Advanced Diploma to midwives wishing to further their education.
* For the year ending 31:3:82 NZ registered 171 midwives of which only 24 trained here. Of the remaining 147, 39 were New Zealanders who trained overseas. [1]
* Over the last 10 years, the figures for the number of midwives trained and registered in NZ were as follows; [2]

YEAR	N° MIDWIVES TRAINED IN N.Z.	N° MIDWIVES TRAINED OVERSEAS	TOTAL REGISTERED
1972	151	90	241
1973	161	160	321
1974	160	158	218
1975	162	121	283
1976	157	126	283
1977	185	106	291
1978	163	96	259
1979	120	96	216
1980	18	128	146
1981	13	121	134
1982	24	147	171

The sudden drop in midwifery trainees in 1980 could be due to one of two things: either dramatically fewer places were available, or the new course was considered undesirable for some reason. We therefore considered it worthwhile to research an article on midwifery training as it is now provided in NZ.

THE SECOND TASK OF THE MIDWIFE is to inspire self confidence and to stimulate the expectant mother in such a way that she considers her reproduvtive task not a burden but a creative deed accepted by her own free will.

THE THIRD TASK OF THE MIDWIFE is to be constantly on the watch for abnormalities. In this way she may take part in preventive medicine. Although the midwife is able to perform many curative measures during labour, e.g. applying forceps and performing manual removal of the placenta, and although the midwife can replace a doctor in many pathological situations, such acts are always considered the expression of a lack of doctors, and must therefore be looked upon as temporary. On the other hand, it will be her permanent task, all over the world, to inspire and coach the healthy woman and to serve as a reliable point of referral to bring every patient under the care of an experienced doctor as soon as there is any reason for it."

The above has been excerpted from Chapter 7, The Midwife: Her Task and Responsibility in a Technologic World, to be found in The Five Standards for Safe Childbearing, by David Stewart, PhD, published by NAPSAC International, P.O. Box 267, Marble Hill, Missouri, U.S.A. 63764.

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advertisements

We would like to include this section for the use of members. The charge for placing an ad is $1. Please send your ad(s) to the Secretary, STM 24 Ashton Rd, Mt Eden, AK 3, by mid April.

REBIRTHING is a simple effective breathing process that enables anyone to integrate the subconscious psychological and physical effects of birth and all other past experiences. The energy released as a result of this technique has the power to free the mind and body of all unpleasant effects. Regular free introductory evenings are offered at 7A Clifton Rd., Takapuna, on alternate Friday evenings at 8 pm. For more information contact Marian Jensen, PH 495 349. Marian is a registered comprehensive nurse (general, psychiatric, midwifery and Plunket) who also offers holistic skills in Touch-for-Health, Adult and Baby Massage and Metamorphic Technique.

being threatened.

Training comes high up on the priority list for both women. They are concerned about plans to bring nursing and midwifery training into the same schools. Already the majority of midwives do three years of nursing training before starting midwifery. Says Kate: "Most of that training is irrelevant. It took me two years to get over being a nurse before I could start being a midwife." She fears that if midwifery training is taken out of the practical atmosphere of the hospital into colleges it could become more "disease-oriented".

In many European countries, midwifery training is separate from nursing. Women enter the three year training direct. The ARM members of the Board are keen to see this direct entry training expanded in England. This year 500 women are competing for just 8 direct entry places in the whole country. It will take an effort of cooperation and will between midwives, nurses and administators to push these numbers up, but with a heavy dropout rate amongst qualified midwives, the profession can no longer afford to ignore those women who want a shorter cut to their chosen profession.

Kate Newsom and Mary Cronk look on their role on the English Board with some trepidation as well as excitement. Says Mary; "We must be careful not to exchange domination by doctors for domination by nurses". They will be no pushover.

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getting together

We are looking for premises which will provide a social centre for mothers and children, meeting/seminar rooms, a playroom, and office and library space for all of us.

We are Save The Midwives, Auckland Parents Centre, Auckland Home Birth Association, La Leche League, Parent-to-Parent, the Downs Association and possibly Contact.

A house or a shop front and dwelling would be ideal, on a main bus route, and available at minimal rental as none of us are flush with funds! We are looking for something in the central Auckland/Mt Eden area, so if you know of anything please contact Judy Larkin on 602 301, or the projects co-coordinator, Leigh Gatt, Mt Eden Council's Community Services Officer, at the Mt Eden CAB, ph 603 139.

MIDWIFERY : AS NATURAL AS MOTHERING

Professor G.J. Kloosterman is Professor of Obstetrics at Amsterdam. For a recently published volume put out by NAPSAC International called The Five Standards For Safe Childbearing, Professor Kloostermen wrote a chapter entitled "The Midwife: Her Task and Responsibility in a Technologic World". Since Prof. Kloosterman is internationally recognised in his field, and well known as a champion of midwifery, we feel it is worthwhile to reprint some of his thoughts here. He writes:

" MIDWIFERY : AS NATURAL AS MOTHERING

My first major point is as follows; The need for a female birth attendant is worldwide and as natural as the fact that small children need the loving care of a mother. Let us accept this fact, and let us assure that these birth attendants are experienced and well trained.

What explains the fact that in present times, even in countries where the word "midwife" has become an abusive word, this need for female birth attendants still exists? How is it that nowhere in the world obstetric care is given by doctors alone, irrespective of whether the doctor is male or female?

Human Reproduction Natural

In my opinion this is a consequence of the fact that human reproduction is a natural phenomenon and not an illness. Spontaneous labour in a normal woman is an event marked by a number of processes which are so complicated and so perfectly attuned to each other that any interference with them will only detract from their optimum character. In the presence of this event, all bystanders are of little use regardless of whether they possess much or little knowledge of obstetrics. The only thing required of bystanders under these circumstances is that they show respect for this physiologic birth by complying with the first rule of medicine, that of NIL NOCERE (injuring nothing). People who have completed studies of more than 10 years at a university are not suited for sitting and watching for hours a natural process taking place as a routine.

Leave Normal Birth To Midwives

My second important point is; Endeavours to bring obstetric care into the hands of doctors without leaving an important part of human reproduction (the physiologic part) in the hands of midwives, change

irrevocably the way in which obstetric care is given.

The doctor, always on the alert for pathology, eager to interfere, will much too often change true physiologic aspects of human reproduction into pathology. The midwife always will have an important task as a specialist in the physiology of human reproduction, working in close cooperation with obstetricians, but with a responsibility of her own. It is her task not only to listen to obstetrician but also to argue with them.

In some situations it will be clear to both parties whether one is working with physiology or pathology, but there are a number of situations where it is difficult to draw the line between normality and abnormality. In these situations the obstetrician needs an experienced midwife who can act as his partner in the discussion and sometimes even as his conscience.

The midwife must be able to advise the expectant mother, to give her moral support, to make her enthusiastic for a natural childbirth, and above all to supervise her in such a way that all minor and major abnormalities are recognised or at least suspected as soon as possible. I am convinced that she is able to do this as well as a doctor, and very often better.

THE SPHERE OF THE PRACTISING MIDWIFE

I should like to define the sphere of practice of the midwife as that big part of obstetrics which belongs to the field of health care. How big this part is is a matter for discussion. In my opinion it covers at least 70% of all pregnant women. During the antenatal period about 25% of all pregnant women have to be referred to an obstetrician. during labour, including the first hour postpartum, another 3 - 5 % will be referred. During the period thereafter, referral will be an exception.

THE FIRST TASK OF THE MIDWIFE is to protect the completely healthy woman against unnecessary interference, impatience, overestimation of technology, and human meddlesomeness. While this is true for the midwife working in poor countries, where the art of midwifery is practised primarily by auxilliary midwives or even traditional birth attendants, it is also true for midwives working in affluent societies.