THE DOMICILIARY MIDWIFE:

HER ROLE AND PROFESSIONAL STATUS

IN THE COMMUNITY

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Under the legal restrictions pertaining in New Zealand, the role of the domiciliary midwife is limited to the care and support of the woman in labour and during the postnatal period - UNDER THE SUPERVISION OF THE DOCTOR! It is during our 12 postnatal visits that we most clearly fulfil our role as defined by the W.H.O., i.e. counselling and education within and including all members of the family. In the important antenatal period our role falls far short of the W.H.O. definition, i.e. necessary supervision, care and advice during pregnancy which includes preventive measures and detection of abnormal conditions. We get paid for only three antenatal visits and these are mainly social and preparation for birth - what to have ready, when to call the midwife etc. The doctor does all the clinical antenatal care. Even back in the days when midwives were more or less independent practitioners, that is they could book women for home births on their own responsibility, there was no provision for payment of antenatal care. Possibly this was done at the public antenatal clinics established by the Department of Health in 1924, mainly, as a response to maternal mortality from eclampsia. These clinics were run from St Helens hospitals and public maternity annexes. Midwives were specially trained in antenatal care and medical practitioners were encouraged "to avail themselves of the facilities offered".

It took the medical fraternity only six years to realise the political importance of control of antenatal care and measures were taken to safe-guard this crucial area. In 1930 Dr Henry Jellett, Consulting Obstetrician to the Department of Health told the House of Representatives that the British medical Association had handed over the care of the pregnant women to the midwife, leaving her to make referral to the doctor should she consider it advisable. He said, 'my proposal, on the contrary, was that the entire responsibility for the care of the patient during pregnancy and labour should rest on the medical profession . . . I trust (my proposed scheme) will not imitate that part of the British scheme which hands over antenatal care to the midwife' (AJHR, 1930, H-31, p46).

Significantly, when the present state-subsidised domiciliary midwifery service was set up in 1939 under the Social Security Act, 1938, there was no provision for midwifery involvement in antenatal

care. No doubt, antenatal care even in this limited area was seen as the thin end of the wedge

When domiciliary midwifery had a resurgence in 1974 in direct response to the increasing medicalisation of childbirth, we three domiciliary midwives then practising - Carolyn Young and myself in Auckland and Ursula Helem in Christchurch - were advised by the Department of Health, 1975, that we should "make a visit to the place of confinement prior to the delivery". We had, in fact, been doing just this, at our own expense, only our reasons were different, based on different values. While the Department wanted us to visit to assess her home, we visited to meet the woman and discuss her expectations for the birth and what she saw as the midwife's role!

But since the Department had recommended a visit we felt it was logical that they should pay for it, so Carolyn and I wrote and made this point. We were advised that since this was not a statutory requirement no fee was payable! Nonetheless, the following year, 1977, we not only got an increase in fees we also got $3.00 for one antenatal visit. It was not until 1984 that we were paid for three antenatal visits, plus another increase in fees. although lagging far behind inflation these increases did not just happen. They were the result of political pressure.

That political pressure was:

1978: The Homebirth Association (HBA) was founded in Auckland by a small group of politically aware consumers who had had home births. Its aims were to support the home birth option by encouraging and supporting more domiciliary midwives and G.P.s to become involved and to educate the community in the benefits of birth at home. Branches sprang up spontaneously throughout N.Z. Its potential threat was quickly recognised by the Maternity Services Committee (MSC) which made reference to this 'vociferous minority' in 'Obstetrics and the Winds of Change', 1979.

1981: The Domiciliary Midwives Society Inc. (DES) was formed by seven domiciliary midwives because the N.Z.N.A. which played no role in negotiating our pay assumed the right to recommend policy for domiciliary midwives which was in their interests, not ours. As well as a protest group which made numerous submissions we also investigated the possibility of enhancing our political strength by affiliating with the F.O.L.!

In essence it was consumer support that resulted in the pay increases we achieved, just as it has been consumer support and involvement which has enabled us to extend our role in the antenatal period. In Auckland we have four Support Groups working as a voluntary collective of consumers. These organise antenatal classes covering a wide range of topics - nutrition, preventive antenatal care,

relaxation, preparation for birth, father's role, siblings at birth, breast feeding etc etc. Resource material is researched and parents are encouraged to feel comfortable with their choices and able to stand against the medical and social pressures against home births. Home birth is about taking responsibility for one's own health care, i.e. self-reliance. In all this the domiciliary midwives are intimately involved, we are the catalysts and leaders in primary health care (PHC). Even before the W.H.O. Alma Ata declaration, 1978, we have been involved in PHC at the Community non-institutional level and also as a strategy that cuts across institutional boundaries. We have had to develop these skills otherwise the home birth option would not have survived.

We have also played a role in pioneering alternative health care. It was the domiciliary midwives who introduced the use of acupuncture for pain relief in labour, and later to turn breeches and lower blood pressure. These were then adopted by the doctors with whom we work who in turn took them into the hospitals. We have also played a role in changing doctors' attitudes towards birth. One Auckland doctor who recently retired after 15 years in obstetrics said he had gained a 'whole new philosophy'. He wrote home birth 'came as a revelation to me and had a profound effect not just on my obstetric practice but on my whole professional thinking. Home birth opened my eyes to things which had been staring me in the face, and yet, until then, I had never seen'.

As a reasonably well established primary health care service domiciliary midwifery meets the three A's guidelines. It is accessible as it caters to parents in their own homes; it is acceptable since it is the consumers who determine their needs; and it is affordable, i.e. cost effective. According to the Department of Health it costs the state $1200 to provide clinic based maternity care - antenatal, lab tests, appropriate specialist assessment, delivery and post natal care. A home birth mother who goes to her G.P. and has a domiciliary midwife costs the state approximately $750.

And, of course the state is further relieved of all capital costs, i.e. the home, the bed, plus service costs - heating, cleaning, meals, laundry etc. Making midwives autonomous would further reduce costs!

I feel that PHC should add another A - accountable. Since our care is personalised and one-to-one we are accountable. We have to take responsibility for advice we give, we can't hide behind the 'team'. This has made us question both our values and the conventional wisdom in the light of current trends in parenting, alternative medicine and scientific research. It has helped us to listen to and learn from consumers and thus to extend our horizons. Any domiciliary midwife who fails to this will soon find her bookings dropping off. Therefore our status in the eyes of the consumer is dependent entirely upon how well we are meeting their needs as they define them. At present we have widespread and enthusiastic consumer support. The Women's Health Committee reports that 13% of the total submissions made some reference to midwifery and the great majority of these submissions were concerned with domiciliary

midwives and safeguarding the home birth option (Midwifery Discussion Paper). We can safely say that our status in the eyes of the consumer is high.

Our status in the eyes of the medical hierarchy is low! This deteriorating professional image can be traced through the various Acts and Regulations and official documents. If we are going to be realistic we have to admit that the status of all midwives is low. However, since the domiciliary midwife practises relatively independently outside the bureaucratic structure and is seen as a threat to the status quo many of the rulings are more obviously directed against her than against the majority of midwives still floating in the hospital womb, electronically monitored by the obstetric team!

Once upon a time domiciliary midwifery was approved and even encouraged by the state. Between one-third and one-half of the early St Helens cases were domiciliary or 'outside' cases.

However, even then midwives were being undermined by doctors. Hester Maclean remarked in 1918 that the N.Z. trained midwives 'had not acted as midwives, merely as maternity nurses working under doctors'. She considered the reason for this was that they feared to alienate the medical profession if they took responsibility of action without a doctor (AJHR 1918, H-31 page 9). There were, nonetheless, some midwives who were prepared to claim their autonomy in the only area open to them, that is in the domiciliary field. She was only required to call a doctor in 'certain (abnormal) circumstances', and these were outlined in the Nurses & Midwives Act, 1945 and embodied in the Obstetric Regulations, 1963, Part 111, 56-60.

Only the 'maternity nurse' was required to work under the supervision of the doctor.

In 1971 a major change occurred. Although it actually affected all midwives it was only obvious in the domiciliary field which was at a low ebb. The Nurses Act, 1971, 52(1)(b) converted the midwife into a maternity nurse.

Henceforward, except in an emergency, only a registered midwife or a registered maternity nurse could carry out obstetric nursing where a medical practitioner had undertaken responsibility for the patient. And 'every person' was liable to a fine of $200 who carried out 'obstetric nursing' in any case where a medical practitioner had not undertaken responsibility for the care of a patient. 'Carries out obstetric nursing' was defined as providing an antenatal service or advice; or attending a woman in childbirth or during the succeeding 14 days in a nursing capacity.

That completely secured maternity care under medical control. It is also interesting to note that from 1965 the domiciliary midwife

received the same fee for labour whether or not the doctor was present. So, what happened between the Obstetric Regulations, 1963 and the Nurses Act, 1971?

In 1960 the Nurses and Midwives Board was toppled. The maternity Services Committee (MSC), a group of predominantly politically oriented, white, male obstetricians took over the role of adviser to the Board of Health on all matters of maternal and infant welfare. National Womens Hospital, the clinical school for the training of postgraduate obstetrics and gynaecology opened for business in 1963 with Professor Bonham at its head! Midwifery has been replaced by obstetrics and this was reflected in the Nurses Act, 1977 which renamed the maternity nurse an 'obstetric nurse', (61(b)), quite significant considering that obstetrics deals with abnormal birth.

The categories 'registered general and obstetric nurse' and 'registered comprehensive nurse' were added. The registered midwife was denigrated. Under 61(e) she would henceforth be referred to as 'nurse' along with the comprehensive, psychiatric, psychopaedic or enrolled nurse within the meaning of the Act.

The Nurses Regulations, 1979 further reduced the midwife to a mere member of a nursing team under the supervision of the doctor. Section 26 says, 'Notwithstanding anything in Section 54(1) of the Act(1577), a registered general nurse, or an enrolled nurse may carry out obstetric nursing under the supervision or control of a registered comprehensive nurse, or of a registered midwife, or of a registered general and obstetric nurse, in any case where a medical practitioner has undertaken responsibility for the care of the patient'.

What else was happening in and prior to 1979? The two remaining basic midwifery training programmes at Wellington and Auckland St Helens were terminated. The 1976 MSC Report, Maternity Nursing in New Zealand, laid the basis for regionalisation of maternity services with the consequent closure of a number of small maternity hospitals. This centralisation and increasing medicalisation of childbirth pushed more women into the arms of the domiciliary midwives who were then seen as an even greater threat to the obstetric monopoly. Because ff this growing consumer resistance hospitals were being forced to make some (minor) concessions in order to protect the lives and IQ's of our future citizens and counter this move away from our hospitals as the MSC expressed it in 'Obstetrics and the Winds of Change' (Oct. 1979). Noting that 'a lot of antenatal care and an increasing number of births are taking place outside Hospital Board institutions', the N.Z.M.A. Council formed the Obstetrics Standards Review Committee, 1979, to ratify and renew the contracts of doctors with hospital boards to ensure 'monitoring of obstetric standards in New Zealand' (NZNA Auckland Division, Editorial, Newsletter, June 1980).

Early the following year (Feb. 1980) a Policy Statement on Home Confinement was submitted to the MSC by the Midwives & Obstetric Nurses Section, NZNA. This document claimed to respect the right of every woman to choose (but not necessarily to have) the birth experience she wished, as it went on to say that the health service could ill afford to develop a service for a minority and that the Section did not support the demand for home confinement. Instead, it suggested alternatives - improvement in hospital attitudes and early discharge. However, stuck with a 'fait accompli' it said that 'in the absence of positive sanctions against those who condone and support the trend towards home confinements' (presumably the domiciliary midwives and supportive doctors) 'the responsibility of the health services is quite clear' (pii). This Statement was incorporated into the NZNA Policy Statement on Maternal & Infant Nursing, April, 1981, which recommended that the NZNA formulate criteria to ensure a continual updating of the skills and knowledge of all practising midwives. However, the preamble to this Recommendation 13 indicates that it was directed at domiciliary midwives who are generally represented as lowering the standards of all midwives. The NZNA admitted it had created a 'dilemma' in proposing conditions for one group of its members when none similar exist for other practitioners in other settings (p17).

This Policy Statement was followed by the MSC Report, Mother & Baby at Home: The Early Days, which incorporated the NZNA recommendations and was a direct attack on domiciliary midwifery. It affirmed that it could not recommend the practice of domiciliary confinement (p21). It proposed that the control of domiciliary midwives be transferred from the Health Department to the hospital boards and their practice be monitored by the OSRC, and midwives were accordingly appointed onto the local committees. However, the domiciliary midwives through their DMS and solid consumer support demanded only peer review - not assessment by obstetricians who have little or no knowledge of normal birth and are opposed to home births.

The Nurses Amendment Act, 1983, rehashed and revoked Section 26 of the Nurses Regulations 1979 (9).

It also revoked Obstetric Regulations, 1975, which prohibited a nurse who is not a midwife from attending a maternity patient except in an emergency or in the presence of a doctor. However, under section 58 of the Nurses Act, 1971 the Governor-General in Council had the power to make exceptions. These exceptions were incorporated into the Nurses Act 1977, Section O (r) and (w).

A 1980 legal opinion considered that Obstetric Regulation 34 (1975) went beyond the power of the Nurses Act 1977, 60 (r) and (w). The Nurses Act 1977 widened the categories of nurses who could carry out obstetric nursing. The definition 'carries out obstetric nursing' remained the same.

The Nurses Amendment Act 1983 increased the penalties relating to obstetric nursing from $200 to $1000 but it deleted giving 'antenatal advice' from penalties, which was realistic since it was happening anyway, e.g. Lamaze, active childbirth, antenatal yoga etc. It extended the powers of the MOH over domiciliary midwives.

It also prevented a direct entry (non-nurse) midwife from registering as a domiciliary midwife after 1 April 1984 (10) (54(3)(a)(b)). I might point out that the majority of Dutch midwives are midwives only, not nurse-midwives.

It was only the strong representation to the Select Committee from the 'vociferous minority' which had now formed the Save the Midwives Society that caused modification of the powers of the MOH as presented in the Bill and inclusion of a grandfather clause to protect those direct entry midwives already working in the district.

Having demonstrated their considerable political power the middle class consumers continued to have their babies at home in growing numbers with the professionally low status midwives.

The next move was Guidelines for Domiciliary Midwives prepared by the Division of Nursing, September 1985. Their purpose was to ensure that we maintained a high standard of care, were aware of our legal responsibilities and to establish a system of periodic evaluation, - by obstetric unit staff! We eight Auckland domiciliary midwives pointed out the source of this hodge-podge, i.e, NZNA Policy Statement on Maternal & Infant Nursing, and MSC Report Mother & Baby at Home, and that they were 'archaic' and completely ignored the concepts embodied in Health for All by the year 2000 which calls for people taking responsibility for their own health care.

The Department then came forward with an independently monitored Study Proposal to be carried out in two stages over a period of 14 months to make a 'qualitative' survey of domiciliary midwifery. It recognised that 'contentious political issues' would be raised and stated that 'the Nurses Association and those who work within level 2 end 3 maternity services have maintained the status quo on domiciliary midwifery at a political level. They see a change in the conditions of practice on domiciliary midwives as a threat to the scope of their own practice. Therefore their views on domiciliary midwives and midwifery also need to be canvassed and presented as a basis for further discussion, research or development.

Aside from being divisive, I find this an amazing statement, tantamount to a confession of the role played by the NZNA in undermining midwifery as a profession in New Zealand. It also raises crucial questions:

(1) Was the National Executive of the Midwives Section asked for an opinion when this document was being drawn up; or is it an opinion from midwives on the NZNA Executive?

(2) NZNA documents make reference to the 'relative independence' of the domiciliary midwife. In fact, domiciliary midwives and those working in the few remaining small maternity hospitals are the ones working most closely to the W.H.O. definition of a midwife. Do midwives working as practitioners undermine the status of those whose power derives from being the obstetricians' handmaidens? And how will independent midwives undermine the power of the NZNA?

While these questions await analysis the Obstetric Regulations 1886 replaced the Obstetric Regulations 1975. They 'deal only with a few residual matters' according to the explanatory note. They incorporate Sections 36, 37 & 38 of the Obstetric Regulations 1975 which deal with basic routine procedures for domiciliary midwives, now defined as 'registered nurses'. Matters pertaining to midwives working in hospitals 'are now considered best left to good professional practice or administrative decisions'. This, of course infers that our professional practice is neither good nor trustworthy, which aptly sums up the official opinion of the domiciliary midwife. And this is reflected in our pay - workers with low professional status are not worth as much as those with high professional status. Before the recent 50% increase our pay was the equivalent of a Karitane nurse. Even this increase does not bring us up to parity with a hospital colleague shouldering the same responsibility.

At our recent Homebirth Association Conference, Palmerston North, we formed a five-member negotiating committee (3 DMS & 2 HBA members) and arranged for a professional negotiator who will be paid by the HBA. This is further evidence of the consumers' estimation of our worth. Also, as attitudes towards childbirth in hospitals have improved in response to consumer pressure, our status among our colleagues has generally improved.

Besides consumer and professional opinion, one further aspect of status is self-esteem - and ours is rather high! In our struggle for survival we have become politically mature. Very early we learned not only to read, but also to analyse, the writing on the wall; to unravel the threads in the old boy network that manipulates the Department of Health and public opinion; to understand who makes the balls and who fires them. We recognised the O&Gs as the political power which, when it suited their needs, was prepared to hide behind the NZNA skirts, while the NZNA benefited from the symbiotic relationship. This is why we are able to see quite clearly the need for an independent College of Midwifery if midwifery is to survive as a Profession.

In the long term we feel that our strong consumer support and our extensive international networks will be of benefit to all midwives - provided that the interests of the mother and her baby are unequivocally understood to be primary. Consumers are now too politically aware to allow midwives to use them as pawns in a power struggle to replace obstetricians as the professional elite. Such opportunism would merely drive then into calling on lay midwives.

The NZNA says that Changes in the conditions of practice of domiciliary midwives would affect the status quo. We cannot allow such divide and rule tactics to undermine our progress to date. Improvement in the role and status of domiciliary midwives is not only in line with the primary health care concepts spelled out at Alma Ata, it can only enhance the position of all midwives as independent practitioners.

Citation: Joan Donley, 'The domiciliary midwife: her role and professional status in the community', c.1986, unpublished paper, in Anne Sharplin, 'Papers relating to domiciliary midwifery and home birth, 1981-1997', (2002/1.4), held by Wise Woman Archives Trust, Hamilton.