20001-113-021

MARCH, 1988.

To the Advisory Committee on the Medical Workforce.

1. Training

Midwifery training in New Zealand is based on the precept that a midwife is a nurse. This maxim is debatable as in most countries in the world a midwife is a person who is specifically instructed and qualified to take professional responsibility and to provide care for women during pregnancy, labour and the postnatal period, and for the newly born infant. The subtle distinction between "nurse" and "person" has many implications, one being that in New Zealand midwifery training is subsequent to registration as a nurse (Reg. Comp. or R.G.O.N.). New Zealand, while paying lip-service to the International Confederation of Midwives, goes against the international definition of midwifery being a profession in its own right. Countries on a par with New Zealand, such as the U.K., Holland, Denmark, France, parts of the U.S.A., parts of Canada and Australia, all allow for an extended course of training (3 - 4 years) so that a non-registered nurse (person) can qualify and practise as a midwife. These countries show better perinatal mortality rates than New Zealand, who is gradually slipping into line with 3rd world countries, i.e. a perinatal mortality rate of 4.6 and an infant mortality rate of 11.7 which puts New Zealand 26th on the world scale.

A typical comment from Dept. of Health Nursing advisors (not always midwives) on the topic of a direct-entry midwifery course is "direct-entry midwifery is an overseas concept," (an untruth, as New Zealand once had provision for direct-entry), and "is not considered appropriate to the New Zealand scene" (it was once when our health and mortality figures were decidedly better), "with our small and widespread population." This is an extremely naive and short-sighted opinion in the light of our poor maternal and infant health statistics, especially among certain indigenous groups.

As you are aware, the latest training programme in New Zealand is a two-tier system for registered nurses:
(1) Involves an advanced diploma of nursing component. Currently this means a 3-year comprehensive nurse training (student based) plus at least 2 years post-basic experience, one being in the area of maternal and child health. An academic year follows which incorporates midwifery theory and practice plus adcanced nursing theory - a massive undertaking which is philosophically and educationally unsound. It is stetching a student's capabilities and capacity to learn far too much so that quality assurance is difficult.

(2) Involves separating the midwifery course from the Advanced Diploma in Nursing. It remains as one academic year and students must be registered nurses.

Both schemes, theoretically, could be run concurrently in any one technical institute. However on the face of it, this would seem bizarre in terms of cost-effectiveness, student competitiveness and one-up-manship, not to mention dispersion of tutors.

With a dearth of midwives in the country, students are hard-pressed to find experienced clinical midwife teachers. There is no incentive for a midwife to advance in the field of midwifery as New Zealand does not have an Advanced Diploma in Midwifery (U.K.) or a Graduate Diploma in Midwifery (Western Australia) or a Bachelor of Applied Science (Midwifery) (South Australia). In fact New Zealand nurses do not appear to view midwifery as separate.

There are no plans for a direct-entry course, although Gillian White Eyres, under the auspices of the N.Z. Home Birth Association, has a research grant from the McKenzie Trust Foundation to look at feasibility and set guidelines for such a course.

Many intelligent, mature women with families, or seeking a second career, can contribute very well to the provision of care for mothers and babies, and are prepared to become student based for 3 years to qualify as midwives, rather than have to undertake 3 years Comprehensive Nursing (student based) plus 1 to 2 years experience plus another 1 year (student based) to undertake midwifery.

This applies particularly to Maori and Pacific Island women whose people greatly desire professionals who understand their cultural, health and social needs.

Each Technical Institute is autonomous, therefore each course produces its own objectives. They are pretty uniform but reflect the philosophy of the individual institute. E.g. the curriculum framework may be based on models such as holism, stress-adaptation, general systems theory. In turn such philosophy and framework depends on who is Head of Dept. at the time, their bias, and belief about nursing vs midwifery.

Each year the objectives are updated depending on how comfortable teaching staff feel with them. Those for 1988 can be requested from Auckland Technical Institute, Waikato Technical Institute, Christchurch Polytechnic and Wellington Polytechnic, the only four centres offering a midwifery course (still within the ADN).

2. Standards

(a) Practice.

The Midwives Section of the N.Z. Nurses Association produced a set of standards for midwifery practice in 1985 (These are available from N.Z.N.A.). The booklet encompasses a philosophy, a difinition which is true to the W.H.O. definition (adopted by I.C.M.) of a midwife; scope of practice; professional responsibility; midwife/medical practitioner relationship; relationship with other health care professional; professional responsibility to clients; professional responsibility to self; professional responsibility to colleagues; as well as standards. Otherwise, at a local level, each employing authority is responsible for the standards of its staff with the N.Z. Nursing Council having authority over disciplinary action concerning professional practice at a national level.

(b) Training.

Each of the four training institutes expects students to reach both theoretical and clinical objectives. Students are monitored in the clinical area by their tutors, but in practical terms this is unsatisfactory. Students go out to various clinical settings and one tutor may be responsible for assessing students (maybe six or seven) in a variety of locations, geographically distant from the Technical Institute, over one to two 8-hour shifts. Thus the actual monitoring of students falls onto the clinical staff who may be inexperienced, lacking in understanding of the objectives, unaware of what is expected from an educational point of view, "threatened" by the "academic" knowledge of the students and generally lacking in motivation as students do not "belong" to them but to an academic institute.
Some clinical skills are set out by some of the tutors, and students expected to reach mastery level on a set of criteria. It is often clinical staff who are asked to assess these and make comment. Tutors write several appraisals on each student- type dependant on the institute concerned e.g. a written report (subjective), objective criteria to tick off, assessment forms which offer a range from does not meet expected standards to meets expected standards. Tutorial staff at each Institute do try very hard to develop practical, useful and objective appraisal tools.
At the end of training the H.O.D. has to satisfy the New Zealand Nursing Council that the student is "a fit and proper person to be registered as a midwife", and finally the student sits an external State final examination set by the Nursing Council.
Each course has to be approved by the Nursing Council of New Zealand before its onset.

3 and 4. Changing trends and Opinions on the politics.

(a) Nursing trends.

There remains dichotomy between generalised - comprehensive and specialist nursing. The current comprehensive nursing course of 3 years in a Technical Institute are Community College aims to produce a beginning practitioner competent to work in the areas of medicine, surgery, psychiatry, obstetrics and the community. Such nurses have a holistic framework with compartments not so clearly cut as I have just pointed out e.g. obstetric nursing becomes a family health module so that the childbearing phase of a couple's life is seen related to health and wellness, and socio-cultural needs. Disease processes, mental or physical, which also affect the childbearing family are assimilated from the pathophysiology or mental health concepts modules. Each Technical Institute or college develops its own curriculum framework and timing. One may look at family health in the 2nd year prior to mental health, another puts it in the 3rd year following mental health and community health concepts and issues.

Whichever way the comprehensive nursing programme is worked out, following registration nurses tend to specialise. Few go into psychiatry which means New Zealand is left with an anomaly - a 3-year hospital-based training for psychiatric and psychopaedic nursing - direct-entry.

Enlightened midwives feel that midwifery deserves the same approach. There are few qualified, there is a decreasing roll, a plunge in our infant health statistics, and thus, as in psychiatric and psychopaedic work, the need is great for a 3-year direct-entry midwifery course.

It is an anachronism to turn a blind eye to the specialisations of psychiatric and psychopaedic nursing and insist that maternal and child health or midwifery can be undertaken by a Registered Comprehensive Nurse, when the theory and clinical practise is so specialised that many other countries in the world recognise midwifery as totally separate from nursing.

Social work, physiotherapy, dental nursing, teaching, dietetics, etc, all have unique specialisations yet are based on broad health concepts which nursing is also based on. Thus nursing is part of a health framework team. Nurses then specialise as do the other professions mentioned. Health concepts are not unique to nursing. Each profession in the health field uses frameworks borrowed from other disciplines and adapts it to their needs e.g. General Adaptation Theory, Systems Theory, Management and Leadership theories,etc.

To forbid Midwifery to develop as a profession in its own right suggests that the Nursing profession is very insecure in its role. Morally it is undermining the health of mothers and babies in this country.

This is the current trend of the Nursing profession as born out by comments from the Division of Nursing, Department of Health, Nurses Association and academic nursing institutes. The policy is to include childbirth within nursing. Historically, that policy has allowed the erosion of midwifery care to the point that social workers, physiotherapists, dieticians (to name a few) all have a hand in the antenatal, parturient and postnatal care of women and babies, which is very contrary to the statement made by a Dept. of Health Nurse adviser, quote - "Childbirth is only one episode in the lives of women and their families, who experience all the health problems of the wider populations. It is therefore essential that women have access to as wide a range of skills as possible" - as an argument against direct-entry midwifery.

Nursing has given away the skills midwives used to possess (and should posess according to the W.H.O. definition of a midwife), to other related professions. Women are counselled about normal emotional responses to childbirth by social workers, taught antenatal preparation by physiotherapists, have their nipples and perineums treated, also by physiotherapists, given advice on nutrition by dieticians. All because the nursing profession decided that midwifery did not exist in its own right, but was part of nursing - and so women and children suffer through lack of trained and experienced midwives.

Developmental psychologists are quick to point out the effect of birthing experiences on women's mental health, marriage, parenting, not to mention the developing personality. The effects of birth span a life-time. Not in terms of pathology, although this happens, but in terms of emotional stability, family life, self-esteem and self-concept.

The previous quote by a Dept. of Health Nurse adviser states: "... who experience all the health <u>problems</u> of the wider population." This is an important statement by a Nurse who sees the childbearing woman in terms of <u>health problems</u>. Midwifery views childbirth as a normal, natural physiological process and is trained to treat it as such whilst being on the alert for situations which are outside his/her province. These are then referred, <u>not to nurses</u>, but to medical practitioners, who are colleagues.

(b) Cultural needs.

As already mentioned certain ethnic groups are crying out for improved maternal and infant health care. It is at that level, that focus, they see a health problem. How depressing, if you are Maori, to know that your infant health statistics are at least three times worse than anyone else's.

In the days of direct-entry midwifery in New Zealand the training was accessible to these ethnic groups. Today not only is the training to become a midwife so long, but it is all student-based (i.e. on a bursary or scholarship) and the academic qualifications so high that it is beyond the reach of a school leaver or mature woman with a family. No wonder maternity hospitals are seen as Pakeha-dominated, rule-making, authoritarian institutes - yet another analogy to psychiatric hospitals. No wonder Maori and Pacific Island women fail to attend antenatal classes and miss benefits of discussing health issues such as smoking in pregnancy, nutrition, alcohol, etc. In their own way, among their own elders, something could be worked out, if more midwives could be recruited from among them. It must be made accessible if we hope to improve Maori health.

(c) Returning to the workforce.

With today's economic trends many women are seeking worthwhile careers following raising their families. Here is a valuable resource of people with knowledge about childbirth and childrearing willing to train as midwives in order to help other women in their role as mothers. It is that specific. They do not wish to nurse the sick or elderly, they want to share their knowledge and experience about childbirth. Again the prolonged training required to reach that goal in New Zealand culls many from trying. The New Zealand Government appears to want to help in women's affairs, underprivileged social and cultural groups and remain cost-effective and efficient. They are missing a perfect opportunity by denying a direct-entry midwifery course which would attract mature women with experience in the life skills.

(d) Early discharge.

An average postnatal stay in about 6 days. In some smaller maternity hospitals this is often extended according to consumer requirements; in the large base hospitals this often markedly reduced. Middlemore Hospital, South Auckland, which caters for the largest Polynesian city in the world, Manukau City, is having to discharge mothers and babies home as early as 6 hours after delivery because of overcrowding. Once again the groups at greatest risk statistics-wise are penalised by lack of maternity care. In itself, there would be no problem IF the community were staffed with qualified midwives - people trained to recognise deviations from normal in postnatal mothers and babies, and, more importantly, trained in the normal physiological, emotional, socio-cultural and spiritual needs of childbearing. Plunket Nurses (only a few of whom are midwives) admit to not being able to cope with the load of early discharge. The third and fourth days postpartum are notorious for potentially at-risk

situations, e.g. perineal infections/breakdowns, nipples sore and cracking, breastfeeding problems and full breasts, infants unsettled, appearance of jaundice, all manner of spots and rashes, bowel upsets, spills, to name a few. It is crucial that proper midwifery care is given in the early days. Apart from physical concerns, the emotional instability, lack of mothering skills, lack of confidence, inadequate understanding and knowledge in the early postnatal days must be assessed and managed if adequate parenting is to be established. It even contributes to the re-establishment of parental roles, relationships and family harmony in the wake of a new addition.

Some families will want to deliver their baby at home and can and should be advised if it is at all possible, counselled if it is not, and, at the least an early discharge plan implemented if delivery is thought to be safer within a hospital setting. It is midwife's role to make this assessment and together with family doctor, consultant, and clients plan the safest place and method of delivery.

(e) Salaries and conditions of employment.

As a profession it its own right midwives should be able to negotiate their own salary and conditions of employment. Some may choose to work for a hospital board, or Area Health Authority, in either an institute or in the community. Others may choose private practice. This could entail simply offering antenatal classes in the community, designed to meet the needs of various socio-cultural groups, or it could mean total midwifery care including home birth, or an early discharge scheme. The latter would be tied in to family practioners. A midwife may belong to a G.P. practice, undertake antenatal assessment of the mother and her environment as to suitability of place and plan with the family doctor and clients the management of care e.g. an early discharge. The social conditions can also be viewed and any assistance required given or referred to the Social Welfare Dept. This system works extremely will in the U.K.

If Midwifery was separated from Nursing one could envisage Birthing Units, such as being considered by Fletcher Challenge in Auckland, units run by midwives in collaboration with G.P.s and in consultations and liaison with base hospitals, sponsored by large, wealthy companies. A National College of Midwifery could be established which would collate material, provide a research base, publish, provide education material, liaise with overseas, sponsor seminars, guests, research fellows and monitor maternal and infant health in New Zealand. Because midwifery is very specific in its role and functions as related to the normal process of birth and childrearing (parenting) it embraces nursing principles but is not nursing.

5. Opinions on various roles.

Throughout this submission so far various opinions have been formulated. To summarise:

[1] Midwifery - a profession in its own right with its own body of knowledge, science, art and skills. Embracing nursing and health principles, along with many allied health professionals. Yet, able to function as a separate profession with its own salaries and conditions.

[2] Nursing - a professional group of people with a broad and comprehensive knowledge and practice base who have a committment to health while caring for the sick. Nurses have a career structure and the means to specialise in a variety of types of nursing care, some of which require postgraduate study.

[3] General Practitioner - community-based medical doctors charged with family care. Some may choose to specialise in obstetrics - which requires postgraduate study. While conversant in the normal physiological process of birth, G.P. obstetricians should be available as a back-up and consultant for midwives when the childbearing process deviates from normal, either physically or mentally. G.P.s have access to knowledge about the family (nuclear and extended), including social conditions, and are valued colleagues. Midwives and G.P.s working together are able to provide a very high quality of care to the family expecting a new baby, with a comprehensive follow-up system.

[4] Plunket, Public Health and/or Family Health Nurses- community based. If attached to family practitioner units, along with the midwife, such nurses are in an ideal situation to take over care of the family past 28 days postpartum until school-age. Once again providing a tight network of family care along with the G.P. This allows the midwife his/her function to supply antenatal and immediate follow-up care to mothers and babies up to 28 days postpartum, the early neonatal period. Any potential problems or risk situations can be discussed with the G.P. and family health nurse. This also allows midwives a role in the delivery, either at home or in the hosptial (with planned early discharge). The workload would be enough for a midwife to concentrate her/his efforts specific to the perinatal period in a family's life.

[5] Obstetricians - a medical doctor who has studied and specialised in the art of obstetrics. Based on the normal, an obstetrician's role is to act as consultant when childbearing (ante-, intra- and postpartum) deviates from the normal. A woman's care may be transferred to an obstetrician, in a base hospital, when considered to be "at risk". Although "at risk" criteria may be generalised and formulated, assessment is made in every case, initially by G.P. and midwife, unless it is obvious from a previous pregnancy that care should be undertaken by an obstetrician from the onset.

Availability of obstetricians should remain as a woman's choice, in a private capacity, even for normal birth. Obstetricians refer non-obstetric problems to their colleagues as they arise e.g. physicians, paediatricians, psychiatrists, surgeons, etc.

[6] Specialist Neonatal Care - any newborn requiring special care should be referred to Neonatal Paediatricians, usually in base hospitals (Level II or III). Sometimes consultation is required before birth. Neonatal intensive care nursing is a specialised function of nursing, not midwifery, although registered midwives (even direct-entry) could undertake the specialised course and practise in that area. Neonatal nursing requires knowledge about obstetrics and certainly about parenting skills and "mothercraft".

6. Training.

What is advocated by the Midwives Section (N.Z.N.A.) is a direct-entry course of three years, for non-nurses to train as midwives.

This has been endorsed by delegates at the 1987 Labour Party Conference.

Nurses should still be eligible to train as midwives with a shortened course provided for them. (Although in some countries, e.g. Denmark and the Netherlands, nurses are not exempt from the full-term midwifery course of three years.)

Midwifery should be headed by Midwives able to liaise at Government level. At present the Director of Nursing, N.Z.N.A. Executives, Nursing Union personnel, etc are not necessarily midwives, and their philosophy differs markedly. The setting up of a National body for midwives, or section of the Nursing Council, or National College of Midwives, may serve to remedy that error.

Mr Caygill, Minister of Health, has already expressed his lack of knowledge about midwifery concerns, and suggested midwives set up their own negotiating body, as he has always seen midwives represented by nurses. This is tantamount to saying that he is unaware of the concerns expressed about the care of mothers and babies in New Zealand.

Thank you for the opportunity to express a qualitative opinion on the role and function of midwives in New Zealand, and particularly the concerns about maternal and infant health.

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