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9. The Birth and Death of Independent Midwifery: Britain, Australia and New Zealand

This Chapter provides an historical overview of midwifery in England, Australia, and New Zealand, where midwives continue to be an integral part of the health care system although their function has changed. Midwife-attended home birth remained the norm in these countries far longer than in the United States. Home birth has, however, declined rapidly in the last 20 years with the proliferation of obstetricians and the routine, active medical management of childbirth in hospitals. This relocation has supported the transformation of the formerly independent occupation of midwifery into obstetric nursing. Home birth remains a legal option in all three countries. However, few midwives in Australia or New Zealand attend home births because of low demand, family responsibilities, low pay, concern about adequate medical back-up and medical opposition. In England, the structure of the national health system rarely gives midwives the option of attending home births. Drawing on interview data with home birth midwives and survey data of hospital midwives collected by the authors, this Chapter discusses the legislative erosion of midwives' authority and autonomy in these societies and the recent appearance of home birth organizations similar to those in the United States. The Chapter concludes with a discussion of the convergent fate of midwifery in all English-speaking countries.

Independent Midwifery

Maternity care has a much shorter history in New Zealand than in the other countries considered. Prior to the Treaty of Waitangi in 1840, New Zealand was inhabited only by warring Polynesian tribes, sealers, whalers, timber traders, former and escaped Australian convicts, and missionaries. The Treaty gave the British Government the exclusive right to purchase land from the Maoris. This land was given to ex-soldiers and distributed by lottery to settlers. As a result, there was a large influx of population; 19,000 came between 1839 and 1843 alone. Gold brought 35,000 in 1863 and land grants attracted a steady stream of free migrants including some British middle class physicians. Return migration was also high (Mitchell, 1983:145), but the population increased sufficiently by the latter part of the nineteenth century to make the establishment of private maternity homes for the more affluent an attractive option for some physicians. The rest continued to rely on lay midwives.

The Early Introduction of Regulation

A desire to increase the birth rate led New Zealand's Parliament to follow the lead of Great Britain and pass a Midwives Registration Act in 1904. As in the mother country, it passed over physician opposition. This Act established the first state-operated maternity hospital to train midwives and to provide maternity care for the poor and working class. A British trained nurse-midwife set up and managed the program. Within two years, two other maternity hospitals with similar midwifery training programs had opened and land had been bought for a third.

The midwifery training programs took one year and allowed for direct entry of non-nurses. The one physician on staff was the medical superintendent, generally a woman, who was called only in problem cases. Midwives trained the students to practice independently and to assume full

responsibility for normal births. As in Australia and Great Britain, nurses interested in furthering their career or travelling typically took midwifery training even though they did not intend to practice as midwives.

Incorporation with Nursing

Midwifery training changed radically in 1925 when Parliament set up a combined Nurses and Midwives Board. As in other countries, the joint regulation of nurses and midwives facilitated the incorporation of midwifery into nursing. Responding to physician complaints that the 20 births delivered and 30 observed by each student midwife deprived medical students of clinical experience, the Board reduced the training period to six months and changed the focus of the program to producing mostly maternity nurses to work under physician supervision rather than as independent practitioners. The intake of direct entry midwifery students was reduced immediately by half.

About the same time, the Health Department contemplated a state-run maternity service staffed only by midwives. Physicians who felt that such a service would encroach on their private practices formed an Obstetrical Society in 1926 and successfully opposed the program. This association enabled physicians to lobby for their interests in a more effective way than could the unorganized midwives.

Midwifery in a Socialized Medical System

The Obstetrical Society proved particularly useful when a Commission of Enquiry into Maternity Services was set up in 1937. New Zealand was about to begin the first comprehensive socialized medical care system in the world and the government wanted to develop a formal policy on maternity care as part of this program. The Commission acknowledged that practicing midwives were highly trained. Under the influence of the Obstetrical Society, however, it expressed concern that physicians were denied access to so many births

occurring in public hospitals which could provide them needed training and practice. Members debated discontinuing all midwifery training and transferring the public maternity hospitals to the general hospital board. Members also considered the increased demand among women for "Twilight Sleep" which was only available at private, physician-run hospitals. In the end, the Commission recommended retaining public maternity hospitals and midwifery training on a small scale, but also recommended promoting hospital childbirth and admitting medical students into the public maternity hospitals.

When the socialized health care system began in 1938, home birth midwives were allowed to continue practicing under contract with the Department of Health. Unlike what was to come later in Great Britain and Australia, New Zealand midwives were paid by the government as independent practitioners on a fee-for-service basis. They only could be paid, however, for one prenatal visit, labor and delivery, and a minimum of 14 postpartum visits. This limitation put physicians, not midwives, in charge of prenatal care. By making physicians the initial care providers, the system encouraged women to use physicians for labor and delivery as well and to go to hospitals for birth.

Although the number of home birth midwives dwindled, a few continued to work under contract with the Department of Health. The Nurses Act of 1971, however, outlawed lay midwifery and took away midwives right to attend clients independently. Clients now must have a back-up physician who takes responsibility for their care. A 1983 Nurses Amendment Bill further diminished the status of midwives; it required that all future home birth midwives also be registered nurses and, like the recent legislation in Western Australia, allowed nurses without midwifery training to supervise hospital maternity

care. As a result, Donley argues, the hospital "midwife is seen as having no more expertise than a nurse" (1985a:5).

This change in status has been facilitated by the continued erosion of midwifery training in New Zealand. Direct entry programs no longer exist. The original public maternity hospitals were transferred to Hospital Boards in the 1970s and only one still operates as an obstetric unit. The six month hospital-based midwifery courses ended in 1979. Under the leadership of the New Zealand Nurses Association, training moved into the Technical Schools where the nursing component was increased and the obstetric component reduced to between eight and twelve weeks, depending on the program. Many New Zealand nurses now go overseas to Australia or Great Britain to do a hospital-based midwifery program. Of the 171 midwives registered with the New Zealand Nursing Council in 1982, only 14 percent were trained in New Zealand. While some of those trained abroad are immigrants, more than one-quarter took their nurse training in New Zealand before going abroad.

Home Birth

Just when home birth midwives had become a virtual anachronism in New Zealand, there was a rebirth of consumer interest. About 1,000 planned home births occurred between 1975 and 1981, (New Zealand Home Birth Association, 1981) for the same reasons home birth has burgeoned elsewhere. The number of obstetrical specialists was increasing, regionalization was closing the smaller hospitals staffed by general practitioners and midwives, and active management in the birth process was expanding. Interested consumers formed numerous local home birth associations beginning in 1978 (New Zealand Home Birth Association, 1982). These have since linked together in a national association. Another group called "Save the Midwives" was set up by consumers in response to the deterioration of midwives' status caused by the 1983 Nurses

Amendment Bill. This group focuses on public education and political lobbying.

About 16 home birth midwives were practicing in the country in 1985. While the number is small in comparison to the United States or even Australia, the population of New Zealand is only 3,295,000. Interviews conducted with eleven of these women scattered around the country reveal that, as in Australia, almost all trained first as nurses and only later became interested in midwifery. Several went to England or Scotland for midwifery training. Almost all have worked as hospital midwives; a few still do on a part-time basis. They began doing home births to provide a better birth experience than they felt was generally available, particularly in large base hospitals where ruptured membranes, fetal monitors, pain-relief medication, episiotomies, and rigid feeding schedules had become routine. As one says, "I thought...if I can deliver babies in hospital bathrooms and trolleys and cars and things, I couldn't see why I couldn't really do it at home."

A few who started practicing in the mid 1970s initially encountered considerable hostility from medical practitioners. One described feeling like a "backstreet abortionist" when she transferred women, even though the Health Department paid her for each case. Now, however, they report feeling "actually quite respectable." In 1984 the out-going Minister of Health for the National Party granted a small raise in their meager pay and a redistribution of two of their 14 postpartum visits to the prenatal period. The new Labour government even promised to expand the role of home births midwives. After a year in office, however, no changes had been made.

The midwives collect a maximum of NZ $167 for three prenatal visits, labor and delivery, and twelve postpartum visits. Any additional visits are at their own expense. Even a midwife with a high volume practice of 50 to 60

births per year would be hard pressed to maintain a household on her earnings. Nevertheless, they cannot charge clients additional fees under the socialized medical care system. In some cases, the local home birth association collects donations and provides midwives with beepers, one of their largest expenses. Many admitted that they relied on an understanding husband for financial support and two of those interviewed lived in communal arrangements. For New Zealand midwives, low pay, not opposition from physicians and hospital nurse-midwives, presents the major obstacle to their practice.

All have at least several general practitioners who will provide prenatal care and take responsibility for home births; some have as many as seven in their local area. Unlike in the mid 1970s, most general practitioners now try to come to the birth, although they only need to see the woman within 24 hours to collect their fee from the government. None of the midwives believe physicians endure the inconvenience of coming to the birth for economic motives. Instead, they point to the opposition of obstetricians to home births and the structure of the health care system which puts prenatal care "in the hands of the doctors... They're the ones who put their heads on the chopping block when it comes to doing home births because they're the ones who are taking the legal responsibility." As a result, the physicians feel more secure if they are present. The midwives also say that most keep coming after they become familiar with midwives' skills both because they build a relationship with clients during prenatal care and because they begin to enjoy home births after attending a few. The midwives welcome their presence. Like the Australian home birth midwives, they work alone and occasionally need an extra pair of hands. More importantly, they believe the exposure to natural childbirth has a positive influence on how the physicians treat their hospitalized maternity patients.

General practitioners' new willingness to cooperate with midwives stems from a growing recognition that their right to practice also is threatened by specialists. General practitioners are still responsible for more than half of the 50,000 annual births in the country, but their participation in maternity care is declining. The move towards regionalization of maternity care, pushed by the Head of the Post Graduate School of Obstetrics; is aimed at phasing out general practitioners who "lack experience [in] managing abnormalities" and lack adequate facilities in the smaller hospitals to provide more than "aggregated domiciliary confinement" (quoted in Donley, 1985a:7). The elimination of maternity care in smaller hospitals will leave general practitioners with no place to attend births since specialists staff the central hospitals.

The home birth midwives who began practicing in the mid 1970s also report a major change in the attitude of hospital midwives toward them. One told about engaging in a "nasty argument" with hospital midwives concerning the refusal of the New Zealand Nurses Association to submit a position paper, written by the Midwives Section, to the select committee that was developing the 1983 Nurses Amendment. She argued that "somewhere along the line you have to make a decision as to what you really are and whether you're a nurse-midwife, which is merely an obstetrician's handmaiden, or whether you're a midwife, which is a practitioner in your own right." When the Amendment undermined the position of hospital midwives as well, Donley (1985b:1) reports, "it politicized the hospital-based midwives as nothing else could have done." Like others, she reports (personal communication, 1985) that "I'm their long lost friend and they ask me to speak at seminars...and they're very supportive of home birth because they're finding out that we're the ones who have the consumer support. They haven't."

Donley's perceptions are supported by the results of a survey that we conducted in 1985 of all midwives working in the Waikato Health District hospitals. Unlike the British midwives that we surveyed, only 37 percent of the New Zealand midwives say that they were trained to conduct normal childbirth without a physicians' supervision and most of these had trained in Britain or Australia. Also unlike the British midwives, 60 percent feel that midwives have become little more than obstetric nurses in New Zealand.

In spite of the recognized reduction in the role of hospital midwives and widespread complaints of staff shortages and low pay, three-quarters of the New Zealand midwives feel that working conditions have improved in the last 20 years. Only 29 percent, however, feel that the Nursing Council adequately represents their current interests. While less than one-quarter support a revival of midwifery training programs for non-nurses, 59 percent would like to see more rigorous screening of applicants for nurse-midwifery training on the basis of career plans. Sixty percent feel that midwives should be allowed to manage normal childbirth in the hospital without a physician's supervision. An even larger proportion, 75 percent, believe that maternity care would be improved if a midwife followed a mother through her prenatal, labor and delivery, and postpartum care, rather than being assigned to only one of these tasks, and two-thirds would be willing to work "longer and less predictable hours" in order to deliver women whom they have attended in labor.

The greatest agreement among the hospital midwives concerns the medicalization of hospital childbirth. Eighty percent feel that there is "too much medical and surgical intervention these days." This belief is linked to favorable attitudes toward home birth. Even though the majority acknowledge that "you can never really say who is a 'low risk' maternity patient until after the delivery" and "homes do not have the necessary technology for

intervention when problems arise," most do not find these persuasive arguments against home birth. Only 24 percent agree that "home births are dangerous, unnecessary and should be discouraged." Although a quarter do not feel adequately trained in labor and delivery to attend home births, 43 percent would be willing to deliver a planned home birth in the future and 60 percent would be willing to assist a physician doing one. Their reasons for not attending home births at this time include: low pay (75 percent), irregular work hours (67 percent), low demand by women (63 percent), lack of an adequate transfer system (54 percent), reluctance to take on so much responsibility (47 percent), and not knowing a physician willing to provide back-up (42 percent).

THE CONVERGENT FATE OF MIDWIFERY IN ENGLISH-SPEAKING COUNTRIES

While the four countries considered share common historical roots and a varying degree of continued cultural exchange, each has developed a different health care system reflecting its unique pattern of demographic, economic, social, and political development. Yet the fate of midwifery may ultimately be much the same.

Midwives virtually disappeared in the competitive free market of turn-of-the-century American medicine. As discussed in Chapter 1, this occurred largely before modern medicine had much to offer and before the transition to hospital had taken place. Midwives' place was taken by general practitioners, who have since been replaced by obstetricians, assisted by staff nurses and residents who monitor the time-consuming labors. when physicians were in short supply in the 1960s, nurse-midwifery was expanded to service poor and rural populations.

In Great Britain, Australia, and New Zealand the competition for maternity care was never as great as in the United States. When the move to hospitals came, midwives went with the women, to service the working class and

poor and monitor labor for the private patients of physicians. The timing of the shift to institutions varied. The transition came first in Australia, long before the incorporation of midwifery with nursing and the proliferation of obstetrical specialists. The transition came because the government's desire for population growth and the general impoverishment of the population led to the creation of numerous charitable institutions and the early introduction of a Baby Bonus. The change came next in New Zealand, where a similar concern for population growth led to the formation of maternity hospitals run originally by midwives, as envisioned by Nightingale. The move to hospitals happened last in Great Britain where it awaited the removal of the financial barriers that had prevented poor and working class women from visiting a general practitioner for prenatal care and having their babies in hospitals.

After the transition to hospital, the role of a midwife in each country depended largely on the location of the hospital, the degree to which midwifery was incorporated with nursing, and the availability of physicians. New Zealand led the others in establishing the joint regulation of nurses and midwives. The rigor of midwifery training began to decline immediately and direct entry programs were phased out to provide more training opportunities for physicians. The majority of New Zealand's hospital midwives now recognize that they function as little more than maternity nurses unless they work in the remaining rural hospitals.

In contrast to New Zealand, fragmented state control in Australia delayed the final incorporation of midwifery with nursing there. Even after control was accomplished in each state, Australian midwives who worked in rural areas continued to function autonomously because of a lack of physicians. But, as in New Zealand, the recent push for regionalization by the increasing number of obstetricians is driving out both general practitioners and functionally

autonomous midwives. The requirements of training programs in several states have declined, and Australian hospital midwives are well on their way to becoming merely highly skilled maternity nurses.

British midwives are still confident of their training and role, and most (65 percent) believe that the Royal College of Midwives represents their interests effectively. Yet the College has not halted the reduction of community experience in their training programs nor the closure of all except one direct entry program. Most importantly, given the experience of New Zealand and Australian midwives, it did not oppose the joint regulation of midwives and nurses, introduced in 1979. As the small, but vocal, Association of Radical Midwives recognizes, while this legislation reduced physicians' legal domination of midwifery, it greatly increased the chances that British midwives too will become highly trained maternity nurses.