20073-93-059

Midwifery Practice: From the Past to the Future.

'RIVAL' or 'COLLEAGUE'? 12.8.86

Today I want to trace the historical and political threads to show how the medical profession transformed the midwife from a 'rival' to a 'colleague'. I borrow these terms from Professor Dawson, the first professor in Obstetrics & Gynaecology at Otago medical school who discussed the midwife's future role in this context. That was in 1933!

From the very beginning it is questionable whether the New Zealand midwife was meant to be an independent practitioner, i.e. a 'rival'. When the Premier of the day, Richard John Seddon introduced the Midwives Bill into Parliament in 1904, much to the alarm of the 608 doctors registered at that time, he reassured them that they would be 'safeguarded', as

> 'Clause 17 provides for registration and that it should not carry the right to medical practice'. (Hansard 1904, p73)

Did he mean that midwives would not be delivering babies unless there was medical supervision? that they would not, in fact, be independent practitioners? The training/registration of midwives was secondary to the setting up of St. Helens hospitals.

Grace Neill, Assistant Inspector of Hospitals, 1895 to 1906, who played a decisive role in the organisation of the registration and training of midwives, was in no doubt about the role of a midwife: a midwife was trained to practice independently and to take full charge of a normal confinement. Grace Neill did her midwifery training in London and this was the role of the British midwife. Her boss, Dr Duncan MacGregor, Inspector-General of Hospitals & Asylums (1886 - 1907) had the medical view of what constitutes a midwife. In his report to Parliament, 1906, he said:

> 'St Helens hospitals provide careful training for maternity nurses'. (AJHR 1906, H-22 p3)

Grace Neill's successor, Hester Maclean, appears to have been ambivalent about the role of the New Zealand midwife. She reported in 1909 that the medical practitioners are

> 'beginning to realise that the trained midwife or maternity nurse, which is what the St Helens pupils aim to become, is the last to wish to act in any way independently of or in opposition to the doctor'. (AJHR, 1909 H-22 p10)

Since this was a Parliamentary report and since the doctors had so strongly opposed the training of competent midwives, seeing them as a threat in both the short- and the long-term, it's possible that Maclean was being politic. In subsequent reports, 1912 and 1918, she had a 'go' at the midwives for not fulfilling their true role. Referring to the midwives who had established nursing homes in country areas she said (1912),

> 'if these midwives are to be of assistance to the larger class of women that it is desirable they should be, they must by degrees exercise the full power conferred by their certificates - that is assume the function which in older times and the middle ages was exclusively left to women - to act as accoucheuses, only calling in the physician in case of need. To be of much service in the backblocks district nursing it is essential that the nurse-midwife should so act, and she must accordingly recognize her responsibilities'. (AJHR, 1912 H-31 p22)

She was aware that the nub of the problem was that these midwives were dependent on doctors for their clientele, and she stated this in 1918. Pointing out that since 1906, 500 midwives have been trained, yet

> 'they have not acted as midwives, merely as maternity nurses working under doctors. One reason of this is the reluctance on the part of many to take the responsibility of acting without a doctor, and fear that by so doing they would alienate the medical profession, which so far has strongly discouraged women from working independently' (AJHR, 1918, H-31 p9)

The doctor preferred the lay midwife, or handywoman as she was called. She was in no position to question his authority. She also had other advantages - she generally was not dependent on midwifery for a livelihood and she was well integrated into her community. A trained midwife would have to be very compliant to gain a toehold under such circumstances. At that time half the population lived in rural areas, while the lay midwives greatly outnumbered the trained midwives.

At the time of registration there were only 63 trained midwives registered compared to 698 who were registered on the recommendation of a doctor as being of 'good character' and having been in practice for three years.

Compare this with the militant independence of the British midwives, who, although also threatened by doctors, had gained registration on reasonably satisfactory terms. (They were independent practitioners; they administered their own affairs.) Not only did they have support in political circles, they also had extensive networks with the influential civil liberties/feminist leaders of the day. It was this background which enabled them to resist the take-over bid by the British Nurses Association led by Mrs Bedford Fenwick. Fenwick was advocating that the care of all lying-in women should be in the hands of doctors aided by nurses, but then, she was the daughter of one doctor and the wife of another and this may have coloured her thinking!

In this young colony the only organisation open to midwives was the New Zealand Trained Nurses Association founded by Hester Maclean in 1907. At that time there were only 114 trained midwives on the register and 850 untrained ones. In this long, thin country comprised of two islands separated by a stormy strait, the main mode of transport was by coastal steamer. The main trunk railway between Wellington and Auckland was completed in 1908, while roading did not become a national policy until 1922. As Maclean pointed out,

> 'there was no organisation among nurses themselves, and the nurses of the North Island knew nothing of the nurses of the South Island. They might have belonged to different countries'. (Nursing in New Zealand p 65)

On the other hand the opposition forces were well organised in their protective N.Z. Branch of the British Medical Association. The 745 doctors on the register* in 1907 had had 20 years of collective experience in political manoeuvre. In fact the medical profession had been leaders in the controversy which was to lead to the registration of midwives and the setting up of the St Helens hospitals. This was the issue of 'race

* registered as domiciled in N.Z.

suicide' resulting from the declining birth rate throughout the western world. On the one hand the so-called 'better class' women were practising contraception (diaphragm and condoms) thus depriving the Empire of both population and of their superior gene pool; on the other hand the poorer classes were producing enough babies but there was a high incidence of infant mortality among this group. There was also controversy as to whether this 'fertility of the unfit' could be put to good use. Conservationists like Truby King recognised that given proper care this fertility could be utilised to the benefit of the colony.

The issues were both elitist and racist. The European population in New Zealand was small - 770,304 in 1901. The long depression of the late 1880s and early 1890s brought virtual cessation of population gains from immigration. In fact many immigrants left for Australia. The country was dependent on natural increase which stood at 1.9% (1901). Infant mortality 1892 - 1901 was given as 81.4/1000 live births (European). Not only that, the 45,549 Maoris were experiencing a resurgence with a birth rate of 8.2%

The first move was to try and prohibit knowledge and use of contraception. Led by Truby King the medical profession lobbied the government to ban 'corrupt and immoral publications' from entering the colony. Specifically named were The Fruits of Philosophy, a pamphlet on contraception reprinted by Annie Besant and Charles Bradlaugh; George Drysdale's The Elements of Social Science and Emil Zola's Nana. Two years later, 1892, an Offensive Publications Act was passed. In 1901 an abortive bill was introduced into Parliament to ban contraceptives, while the European birthrate continued to fall in both New Zealand and Australia.

In 1903 the New South Wales government set up a Royal Commission on the Decline of the Birth-Rate and Mortality of Infants. New Zealand sent a submission while a public health doctor in Wellington wrote a mind-bogling book entitled The Fertility of the Unfit, 1903, which was a justification for N.Z.s submission which related the fall in the birth rate to the rising incidence of insanity. Although not directly relevant to this paper I must

tell you about one of the recommendations made by W.A. Chappell, that if a man was repeatedly jailed for crimes or drunkeness, on discharge his wife should be given the option either of a divorce or sterilisation. He felt that vasectomy was

> 'grave and serious and an outrage upon a man's nature and sentiment. Society can hope for nothing but evil from the man she forcibly unsexes'. (The Fertility of the Unfit p 108)

In its Report, 1904, N.S.W. made reference to the 'decadence of society' and the 'selfishness of women' and recommended, among other things, improvement in confinement conditions, midwifery practice and hospital accomodation, control of lying-in homes .....and a church crusade. The doctors' political meddling had backfired! Prior to introducing the Midwives Bill in Parliament, Seddon addressed a leaflet to the people of New Zealand calling attention to the falling birth rate and the necessity of overcoming this if New Zealand wished to take a place among the 'Nations of the Earth'.

On passage of the Bill, four St Helens hospitals were speedily set up to provide the 'deserving poor' i.e. the wives of working men, with care during childbirth at a fee they could afford. The better class women were persuaded to make their patriotic contribution on the promise of 'painless childbirth'. Twilight sleep had been developed in Germany in 1902 and soon reached these shores. It consisted of injections of morphine and hyoscine which produced amnesia but not necessarily sedation. During labour women were frequently uncontrollable and had to be strapped down with a surcingle. When they awoke, often several hours after the birth, they had no memory of the 'agony'. The babies were frequently drowsy, needing to fed with a bottle. This created entirely new attitudes towards childbirth; instead of a supportive midwife, the woman and her baby needed nursing care, so, of course it was necessary for this treatment to be carried out in hospital. Private hospitals proliferated. In 1920 there were 178 of them and they accounted for approximately one-third of all births while St Helens hospitals catered for only about 5% of confinements. Care in private hospital was relatively costly - 6s a day, plus 3 guineas for the doctor and a further 3 guineas for twilight sleep. However, there were problems in the private hospitals a total of approx £10. The average weekly wage of workers was £2 p.w. This cost excluded the 'deserving poor'.

which did not exist in the St Helens hospitals, namely an alarming increase in the incidence of forceps deliveries, which in turn increased the occurrence of puerperal sepsis - in the days before antibiotics. There were three enquiries into puerperal sepsis and maternal mortality. The Department of Health tried to clamp down on the doctors doing forceps deliveries in their private hospitals. One of these offenders was Dr Doris Gordon who used and advocated twilight sleep. The Department threatened to close her private hospital in Taranaki if she persisted in experimenting with these twilight sleep drugs. (Backblocks Baby Doctor p241). And Doris Gordon it was who led the movement to form the Obstetrical Society in 1926 so that doctors could give what pain relief they saw fit, to forestall any moves on the part of the Department of Health to establish a midwife-based maternity service and to establish a chair of midwifery at Otago Medical school to replace the lecture-ship.

Actually the 1921 Inquiry into Maternal Mortality had recommended establishmnet of this Chair 'to enhance the status of the subject in the medical curriculum'. It also recommended a standardised aseptic technique - which converted childbirth into a surgical procedure - and improvement of midwifery training 'especially with regard to the supreme importance of a thorough knowledge of asepsis', and the establishment of a Nurses and Midwives Board to organise and supervise this training. Further recommendations were the setting up of antenatal clinics in conjunction with St Helens hospitals and public maternity hospitals; and the appointment of Dr Henry Jellett, former Master of the Rotunda Hospital, Dublin, as Consulting Obstetrician to the Department. [He came to N.Z. after the war & was practising in Christchurch. In his first report, 1925, Jellett recommended the creation of two classes of nurses - maternity nurses and midwives.

By 1928 Jellett reported that the 'maternity nurse is now better equipped to carry out the work of attending the patient with a medical practitioner than was the former midwife .....'
Furthermore, he pointed out that,

> 'when the new regulations for the training of midwives have begun to bear fruit the midwife will be better equipped in the art and practice of midwifery than will the medical practitioner. This is a very serious state of affairs.....it is advisable - or at all events

> customary - that wherever possible a medical practitioner is present in all cases, lest a need for his services should arise. If his education is insufficient....then the principal reason for his presence is lost, if he is unable to deal with emergencies .... he will, amongst other mistakes be led to fall back on radical surgical procedures because of his ignorance of the milder obstetric procedures which would have better served his purpose'. (AJHR 1928, H-31 p39)

The obvious solution was to place childbirth into the hands of the midwives as had been done in England. Jellett was well aware that the B.M.A. in Great Britain was

> 'prepared to hand over the care of the pregnant woman to the midwife, both during pregnancy and the normal labour, and it is left to her to refer the patient to the medical practitioner during pregnancy should she consider it advisable' His proposal, 'on the contrary, was that the entire responsibility for the care of the patient during pregnancy and labour should rest on the medical practitioner'. (Ibid)

This coincided with the political aspirations of the Obstetrical Society which had brought Sir Victor Bonney, Britain's 'most eminent practitioner' to New Zealand (1928) on a speaking tour to influence public opinion. While gowned and masked midwives were learning the exact technique of aseptic panning and swabbing, Bonney, at widely reported civic receptions was appealing to the snobbery and racism of his audiences. He claimed to be

> 'amazed that such a progressive country had a Professor of Surgery and of Medicine, but <u>only</u> a lecturer in Midwifery and Diseases of Women. Did his listeners realise what this defect meant to the immediate future of a country hoping to remain a white man's land?' (Backblocks Baby Doctor p174)

Aided by Rotary and the National Council of Women, the business interests and the women of New Zealand respectively raised £25,000 - during the depression - to establish the Chair. The N.C.W. were led to believe that pain relief under medical control meant safer maternity services. The medical profession have always expressed their pecuniary interests in terms of safety.

The Obstetrical Society engaged the cooperation of Jellett to persuade the government to build a hospital - Queen Mary in Dunedin. By 1931 Bernard Dawson was appointed Professor of Obstetrics and Gynaecology at the University of Otago. Even before his appointment his social sentiments were expressed in a foreword he wrote in conjunction with Lindo Ferguson, Dean of Otago University. This was for a book on abortion written by Doris Gordon and Francis Bennett. Echoing the dangers of 'race suicide' they expressed admiration for the 'crusades' of Hitler and Mussolini, hoping the book would arrest

> 'the present downhill career of the race and ...ensure a future in New Zealand for our civilisation rather than for an Oriental or Teutonic one' (Gentelemen of the Jury, 1927)

Immediately after his appointment Dawson took up the cudgels on behalf of medical control of childbirth - after all, his position was dependent on this. At the 1933 Annual Meeting of the Obstetrical Society, he dealt with the future of maternity services in an address entitled, Doctor and Midwife, Colleagues or Rivals? Admitting that British midwives attended approximately 75% of births and summoned aid on only 25.3% of these he said,

> 'there can be no doubt that there has emerged from the data accumulated the fact that the results of the work of midwives is statistically superior to that of medical men and women.....It is not the purpose of this address to suggest reasons for th(is) superiority...but to emphasise my belief that the question of the employment of midwives will be enforced upon our New Zealand profession in a few years' (NZMJ, 1933, v 32, NZ Obstetrical Society Section p 21)

His argument ran that already in N.Z. there were advocates for the midwife system; economic difficulties were naturally making women seek the least expensive way of meeting the costs of confinements; and the annually increasing body of admirable trained midwives who would more and more seek an outlet for their knowledge and services. Therefore, his suggestion was to make a 'colleague' of the midwife, 'incorporate' her, he said, that is, make this fellow worker a part of the medical team. He warned his audience that unless steps were taken

now to develop such a scheme they would find themselves,

> 'inarticulate and bereft when some Bill for maternity service detrimental to our interests becomes an enactment'. (Ibid)

Should this happen the midwife would become a 'rival' - 'one who tried to equal or do better' according to the dictionary definition.

In the 'free discussion' which followed, Dr Paget, Inspector of Private Maternity Hospitals 'stated emphatically' that the Department of Health

> 'far from encouraging the conduction of deliveries by midwives alone, was now training something like three maternity nurses to every midwife, the former not being licensed to nurse confinement cases except as assistants to medical practitioners'. (Ibid p23)

The meeting took exception to the Department's recent instruction to hospital boards to make provision for indigent maternity cases

> 'on a scheme which was an exact parallel of the English midwife service..(and) this policy introduced as perhaps an emergency measure, might well become the thin edge of a permanent wedge' (Ibid)

Never mind that such a scheme would benefit indigent women, more important was that maternity services should not get out of medical control!

It was therefore resolved,

> 'That the New Zealand Obstetrical Society re-affirms the principle: That the ideal obstetrical service for every confinement in this Dominion is a doctor and a midwife or a doctor and a maternity nurse attending'. (Ibid)

To consider the ways and means of maintaining this ideal service a sub-committee was set up to investigate the direction of the maternity services. Entitled 'Midwife Alone or Midwife and Doctor' as the Regular Service for New Zealand Parturients' it was prepared by Professor Dawson, Drs Averill and Irving of Christchurch and Dr T.F. Corkill of Wellington.

Corkill followed up Dawson's paper at a later meeting. He said

that 65.7% of New Zealand babies were born in hospital while cases delivered by midwives alone were few (1933) therefore adoption of a midwifery-based scheme would

> 'entail a much more radical alteration of present practice than in Great Britain' He argued that 'the competent maternity nurse' would relieve the doctor from being present at a labour 'for hours on end', he could just be present at the actual delivery when 'under his supervision a much more satisfactory anaesthesia can be maintained than can ever be possible when the midwife works alone, whether she uses a Murphy inhaler or chloroform capsules'. (The Trend of Obstetric Practice in New Zealand, NZMJ 1933, v32 Obs Section pp 41-52)

He also argued that it was only through

> 'long personal and practical experience of the normal that reliable judgement concerning the abnormal can be acquired. There are very real dangers in a specialization founded on an imperfect knowledge of normal practice'. (Ibid)

Corkill held a 'prominent position' on the Committee set up to investigate the National Health Insurance scheme. No doubt, here he was able to push his ideas for medical control of childbirth through the use of sedation. One area where sedation was not in routine use was in the St Helens hospitals. Therefore, moves were made to infiltrate this stronghold of the midwives. The N.C.W. was persuaded to lobby for the extension of sedation to their less privileged sisters through 'the Professional Attendance of All Women in Labour'. This was the title of a N.Z.O.&G. Scty Report, 1934, which called for resident medical officers to be appointed at St Helens hospitals to combine the offices of anaesthetist and resident house surgeon. Up to this time the midwives had filled the role of house surgeon.

At their 1935 Conference the N.C.W. put forward a remit from their Auckland branch which urged resident anaesthetists for the St Helens. This motion was opposed by Dr Emily Siedeberg McKinnon, three times president of N.C.W. and medical superintendent of Dunedin St Helens. It was also opposed by several 'ex-nurses' (presumably midwives) who assured the meeting that firstly, there

was no accomodation for resident doctors and secondly, there was no call for them as the Sisters were capable of giving all anaesthesia required. In the face of this opposition the N.Z. O & G Society executive recommended that

> 'in any future building scheme, residential quarters should be provided for house surgeons'. (NZMJ v34, O&G Section p44)

Since hooking all women on sedation was such a controversial issue, sedation was one of the terms of reference of the 1937 Committee of Inquiry into Maternity Services which was held prior to enactment of the Social Security Act, 1938. The committee of which Corkill was one of the seven members were to

> 'inquire into and report on (d) The extent to which anaesthetics are administered to women in childbirth in public maternity hospitals and whether this procedure should be extended'.

The committee had 'reason to believe that there are few countries where the use of some measure of pain-relief, both in the form of anaesthetics and analgesics, is more general than in New Zealand, and this largely for the reasons that so many women are attended by doctors and that such a high percentage of cases is confined in hospitals' (p 117).

However, 'the majority of the Committee (was) of the opinion that to ensure this maximum relief with safety, attendance by a doctor at intervals during labour and at delivery is necessary, and that provision for this should be made in all public hospitals'. (p 118)

This was to be achieved by 'appointing house surgeons to the larger public hospitals' (p 118)

and endorsing 'the principle of doctor-attendance in all cases'. (p141).

These conclusions and recommendations were opposed by Drs Sylvia Chapman, Medical Superintendant of Wellington St Helens and T.L. Paget, Director of Maternal Welfare as 'impractical for the majority of general practitioners in country districts'. In a minority report they charged that the medical profession had insufficient evidence on which to base a definite opinion as to

the best and safest methods of usage and administration of both the old and new drugs. They also maintained

> 'that given the necessary ante-natal attention, the doctor having seen the patient early in labour and being satisfied that the course of labour is likely to be normal, the conduct of the remainder of the labour may safely be left to the midwife, provided the doctor is available in case of emergency'. (p 147)

Even these two Committee members were not prepared to cede that the midwife had the ability to determine whether or not the course of labour was likely to be normal!

Having determined that the maternity services should be mainly hospital-based and the principle of doctor attendance in all cases should apply, the Committee had now to examine,

> (e) whether the training of midwives and maternity nurses is satisfactory and adequate, and whether the number of persons who are being trained is sufficient for the needs of the Dominion.

That would, of course depend on what their role was seen to be - midwife or maternity nurse - and that was already determined by the previous decision. Had it not been for the intervention of Mary Lambie, Director, Division of Nursing (who was <u>not</u> a member of the Committee) midwifery training would have been terminated at this point. The report makes veiled reference to this intercession.

> 'It has also been suggested that since the tendency is so definitely in the direction of doctor-attendance in the majority of cases there will no longer be the necessity to train all midwives as though they were to practice independently, and that therefore the number of cases which the midwife is required to conduct personally might be reduced.
>
> 'There is considerable force in this argument, and the matter might be considered fully by the Nurses & Midwives Registration Board. At the same time the Committee realizes that, since there will always be occasions in

> the practice of a midwife on which her skill will be taxed to the utmost, no measures should be taken which might in any way reduce the efficiency of the midwife's training'. (p141)

Aside from the midwife as a rival, part of the problem concerning midwifery training had to do with the shortage of clinical material expressed as

> 'a certain conflict between the interests of midwives nad medical students in obtaining the necessary amount of all-important practical training in the maternity hospitals' (P 141)

Therefore an advantage of training maternity nurses was that

> 'since the number of cases which each maternity nurse is required to conduct personally during training is only five this does not, however, use up the same amount of clinical material as does the training of midwives'. (p 142)

I suggest that this was the point at which the midwife became an endangered species. From this point onward she was on the downhill skid. As Dawson's 'colleague', a member of the obstetric team, she became the skilled 'obstetric nurse' whose primary loyalty was to the team rather than to the woman. She was no longer a threat as a 'rival'.

The final mopping up was left to the N.Z.N.A. - As predominately an obstetric nurse it was a case of logical progression for midwifery to become a mere post graduate course of nursing, completely 'incorporated'.

> the practice of a midwife on which her skill will be taxed to the utmost, no measures should be taken which might in any way reduce the efficiency of the midwife's training'. (p141)

Aside from the midwife as a rival, part of the problem concerning midwifery training had to do with the shortage of clinical material expressed as

> 'a certain conflict between the interests of midwives nad medical students in obtaining the necessary amount of all-important practical training in the maternity hospitals' (P 141)

Therefore an advantage of training maternity nurses was that

> 'since the number of cases which each maternity nurse is required to conduct personally during training is only five this does not, however, use up the same amount of clinical material as does the training of midwives'. (p 142)

I suggest that this was the point at which the midwife became an endangered species. From this point onward she was on the downhill skid. As Dawson's 'colleague', a member of the obstetric team, she became the skilled 'obstetric nurse' whose primary loyalty was to the team rather than to the woman. She was no longer a threat as a 'rival'.

The doctors' political aims euphemistically called '~~aims~~ ideals' were cemented into place in the Social Security Act, 1938 which guaranteed every woman free hospital/doctor care - the doctor being assisted by the maternity nurse, and later by the general nurse with obstetric training.

Then the Obstetrical Society sprouted another head becoming the O&G Society and developed more 'ideals' like post graduate training which required even more clinical material. This eventually contributed to squeezing midwifery training out of hospitals.

During this time midwives were being remoulded. Insidiously controlled by the medical/hospital heirarchy they were completely 'incorporated' into the obstetric team. And as technology

increased and childbirth became more medicalised, the midwife completed her transition to an obstetric nurse. As such her training was safely left in the hands of the nursing profession, of which she was now a part. Today the midwife has been completely subsumed by the nursing profession and midwifery is a mere post graduate course of nursing. But this was a process of logical progression.

The question today is, what are we going to do about it? Personally, I feel quite optimistic about the future. In 1979 the Maternity Services Committee published a pamphlet entitled 'Obstetrics and the Winds of Change' Today, that wind has become a whirlwind which seems to have awakened the New Zealand midwife from her long slumber. She is now more politicaly aware and militant, and midwives are united as a group. This is demonstrated by this Conference and by their ability to have the W.H.O. definition of a midwife reinstated at the N.Z.N.A. conference.

Further there is a world-wide swing towards community-based primary health care. The critical economic situation favours such a development. The W.H.O. is actively promoting primary health care and it also unequivocally states that 'care during normal pregnancy, birth and afterwards should be the duty of (the midwifery) profession' Dig that word 'profession'! W.H.O. favours establishment of community-based antenatal clonics organised by consumers and midwives. Such clinics would be the 'thin end of the permanent wedge' So who not set up such preventive health/antental clinics at technical schools which could develop into free standing birthing centres for the local community? This would provide on-the-job training for student midwives. The medical profession recognises the value of on-the-job training for medical students, why should midwives be deprived of it? Another possibility for on-the-job training would be to structure the ADN pre-requisite year into a practical and basic midwifery training programme.

Mind you, there will be opposition to any of these proposals - let's call them 'ideals'. Look what happened to Wendy Savage

when she tried to meet women's needs and took maternity care out of the doctors' bastion and into the community - a dangerous precedent which threatened the obstetrical heirarchy. However, an interesting aspect of the TV documentary on Savage was the comment from the American obstetrician who said they were having to give up obstetrics because of the costs of litigation and litigation insurance which runs at $80,000 p.a. Although N.Z. doctors are protected from such suits by the A.C.C., that body is cutting costs. Recently a leading Auckland obstetrician while discussing fetal heart monitoring and c/s expressed the view that 'it's only a matter of time before somebody is sued'.

Finally, let's look at our allies - the consumers. These are quite successfully fighting the medicalisation of childbirth, and since they are the ones who control the clinical material they are in a very strong position, and if they favour us, so are we. That means we have to meet their needs as they define them. Other allies are the feminists who are fighting to reclaim their bodies; and the alternative health movement who are into preventive health care and self-reliance. Referring back to Wendy Savage, it was the consumer support that was instrumental in having her court case dismissed.

The consumers are already one step ahead of the midwives. The recent Homebirth Association Conference, (May 1986, Palmerston North) passed a remit calling for the establishment of an independent College of Midwifery. The Auckland Branch, N.C.W. sent a similar remit to their National Conference. Now it's over to the midwives to demand such a College so they can determine a philosophy on midwifery, define our professional status, draw up a Code of Practice, set our own standards and organise our own training. As the 1921 Inquiry said about the establishment of a Chair of Obstetrics - 'to enhance (our) status'.

As a believer in direct action, what's wrong with this Conference setting up a College as a political organisation? Back in 1885 it was a mere 26 midwives who formed the Matrons Aid Society which became the Midwives Institute and fought a 20-year battle

to upgrade the professional status of the midwife. They also had to fight the medical profession and the ~~XXXXXXXXXXXXX~~ British Nurses Association to define the midwife as an independent practitioner, not a maternity nurse who only undertook nursing duties.

With strong consumer support and an election coming up next year such an organisation could then lobby for official recognition ~~on our terms~~ as the negotiating body for midwives. The time has come to challenge our obstetric nurse, 'colleague' status and declare that we are independent practitioners as defined by W.H.O., that is we are 'rivals'.

Go for it!