The Nurse-Midwife – Her Place in Obstetric Care

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The harried obstetrician telephones the little hospital at the Forks where one of his patients is in labor. How far along is Mrs. Jones, he asked? Do I have time to go home for dinner? The nurse hems and haws. She doesn't know. She can't tell how far along Mrs. Jones really is, so the doctor drives ten miles in the rain and finds on examination that his patient is still in early first stage labor. He scolds the nurse for not knowing better. When he leaves his patient at the tiny Forks hospital, with unsupervised, ill prepared nurses, he has no feeling of security as he goes about his other pressing tasks—nor can he relax and rest as he eats his dinner.

And what about Mrs. Jones—left alone with the scolded nurse—while the doctor goes she knows not where? And what about the scolded nurse—who has not been taught—not even now—and is still left with a responsibility she is not prepared to meet?

A mother recently wrote to the Maternity Center Association about her experience in labor in a large hospital. "The nurse had me pushing for so long" she wrote, "that I became very tired. When the doctor came, he found I wasn't yet in second stage labor. He told me *not* to push! This discouraged and scared me and the doctor seemed so harried and impatient!"

We don't blame the doctor at the Forks for feeling insecure about leaving his patients under the care of the nurse at this tiny unsupervised hospital. We don't blame the nurse, either. Her education in obstetric nursing is sadly lacking in even the basic facts about normal child-bearing. She has not been taught to recognize the stages of labor or the first signs of approaching abnormality or complication. We don't blame the patients for asking their friends about how Dr. Soandso treats you. Does he scare you with grunts instead of answers to your questions? Does he look at you as if you were just another sack of potatoes? How do they treat you at such and such a hospital? Do they keep you waiting in the downstairs hall while they fetch someone to take your history which your own doctor has? Do they put you in a labor room—shut the door and leave you alone? After asking these questions, many select their doctor and hospital with trepidation because the answers of their friends are not reassuring.

Three Makes a Team

Medical philosophers have been suggesting for years that the doctor and nurse work together in obstetrics as a professional team. To that team we would add a third—the *mother*, and as auxiliaries *her family*. Under the present system of education the majority of nurses are unable to fill this partnership role. Until they are able to accept this responsibility with the knowledge and experience to successfully discharge it, making the mother and her family active members of the team, will be difficult indeed.

With the ever increasing trend toward specialization and the ever growing complexity of care and the increased awareness of the expectant mother of the kind of care she wants, the doctor must have a good right hand, a professional person upon whom he can rely. The standard obstetric texts recognize that no obstetrician, no matter what his education or experience may be, can judge unerringly when a patient's baby will be born. He needs someone he can trust who can act for him and whose judgment he can rely upon while he is away from the patient.

Who is that professional? The medical student? In the embryonic state of his medical education, he doesn't possess the background to make these sound professional judgments. The intern? The average intern has seen a number of babies born. Perhaps he has attended a few mothers but his actual knowledge is still inadequate to inspire the patient with confidence, to instruct the nurse—or to

judge when or when not to call the obstetrician. The nurse? Certainly not the majority of nurses graduated from the average nursing school today. One of the most critical blocks to obstetric progress is this unpreparedness of the nurse to fill her role in the obstetric team. But a well educated and experienced obstetrical nurse has a better background than the medical student and most interns. She could be relied upon by the doctor.

This is not an academic generality but has been tested in day by day obstetrics at the nurse-midwifery school of the Maternity Center Association in New York. The term "nurse-midwife" may be confusing because "midwife" signifies to most people in the United States a poor brand of care, if care it can be called, provided by a granny woman whose techniques spring from African voodoo and black magic. The student nurse-midwife who is accepted at the Maternity Center Association's school must be a graduate of an accredited school of nursing and eligible for college matriculation. She is between twenty-five and forty years of age and has two years of professional experience, one of which is in public health nursing under supervision.

The educational experience of the student is continuously developed in the setting of the doctor - nurse - mother team. She is taught by obstetricians the necessary book knowledge of obstetrics, the clinical procedures of obstetrics, the practical and skillful art of the management of pregnancy, labor and the puerperium. She comes to recognize that the emphasis in teaching the mother and in providing obstetric care should be focused on the complete process of reproduction, its emotional as well as its physical aspects, rather than merely upon the dramatic moment of labor and delivery. Her program of education is based upon the assumption that the coming of a baby is a natural, normal event in the lives of people, not abnormality. She learns how to assist nature but at the same time, she is taught to recognize all the signs of departure from the natural and normal. As soon as she recognizes any of these signs, she calls for more skilled help.

The course of study consists of 1100 hours of work, including 185 hours of lectures, 100 tutorial hours; also work in the prenatal and postnatal clinics, field work in the homes of the patients with each student delivering a minimum of twenty patients under expert supervision. No phase of obstetric care is omitted, including the careful techniques of observation and examination, the study of anatomy and physiology of human reproduction, the relation of the emotional health of the whole family to the techniques of obstetric care. She is taught to recognize that her patients are people, not cases, not teaching material—although she learns much from her experience with her patients and they learn much from her. She learns how to teach parents the facts during pregnancy which will help to make the coming of a baby a period of expectancy, labor a time of security, confidence and freedom from tension and the puerperium filled with the joy of accomplishment.

The Association maintains close relations with Teachers College, Columbia University, so that the students at the Nurse-Midwifery School may apply their experience toward formal credits for a degree.

The students who complete this course are awarded the diploma of certified nurse-midwife, are experienced in normal obstetrics and thoroughly competent nursing teammates of the obstetrician.

The Influence of the Nurse-Midwife on Obstetrics

While the number of these graduates is very small—fewer than three hundred—they are making significant contributions to obstetrical nursing leadership in the United States and many other parts of the world, including Canada, Mexico, China, Siam, India, Iran, Iraq, Liberia, Nigeria, Honduras, Hawaii, Alaska and Puerto Rico. More revealing as to the influence of these nurse-midwife graduates are the types of positions held in the United States. Several are professors of obstetric nursing education in university schools of nursing. Several more are on

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the teaching staffs of university nursing schools. A number are on the staffs of various Government departments—federal, state, county and city—acting as consultants in maternal and child health. Some are conducting home delivery services as part of the program of a rural county health department. Some are working in hospitals as supervisors in obstetrical departments and in other responsible capacities. Wherever the majority of these graduates are at work, at home or abroad, they are striving to raise the standard of obstetric nursing care.

Regardless of what this worker may be called—nurse-midwife or *obstetric nursing specialist*—I am convinced that until we require all nurses who work in positions of responsibility in maternity services to know at least as much as these nurse-midwives, we will not be providing nursing service of a quality that every woman should have for her own safety and comfort and which will make it possible for every doctor-nurse-mother team to do their best.

Editorial comment: It has long been recognized that it is no longer possible to regard motherhood and maternity as a simple incident in human experience.

There are too many foreseeable and preventable complications which lead to mortality and morbidity of both mother and infant to regard careful and complete maternal care as anything other than a necessity. This is not merely a medical problem but a most important economic and social one as well. The mother is the keystone in the life of the family.

These problems can only be solved by adequate team work attained by mutual understanding between properly educated and qualified personnel and the proper development of suitable agencies for the education and care of mothers.

It is not the thought that the European system of midwives should be grafted upon our superior plan of medical care for all mothers and infants but we can profit by their many years of experience. There is no thought that we should discard our ideas of nursing standards but rather that all of these should be properly coordinated.

There are many problems and one of the chief one is that of proper and adequate education and experience of necessary personnel. This means a sufficient number of agencies to do the job and do it properly which also requires qualified educators to develop the knowledge, experience and spirit in those whom they instruct.

Education, experience, training, cooperation, mutual understanding and continuing investigation are essential if the desired results of human betterment are to be attained. While we are still concerned about mortality, which has been markedly reduced, our major objective should now be the greatest possible elimination of disabilities associated, in mother or infant, with maternity.