# EDITORIAL

## AMERICAN OBSTETRICS NEEDS *NURSE*-MIDWIVES

ACCOMPLISHMENT of obstetric objectives could be immeasurably assisted by recognition of and help from the nurse-midwife. Unfortunately the word "midwife" has some very unfortunate connotations for all of us. The "*nurse*-midwife," however, is not even a distant relative—not even a descendant of Sary Gamp, the untrained, dirty, and incompetent woman that our predecessors did so much to eliminate from the big cities after the turn of the century. So first of all let us eliminate this nondescriptive designation.

The word "midwife" actually pictures such a different person from the modern type of trained-nurse obstetric associate that the latter should really be called by a different name. "Midwife" derives from the Anglo-Saxon words "mid" meaning "with" and "wife" meaning "woman"—describing anybody who is with a parturient woman at the time of her confinement. There is nothing in this word which implies training or capability. Therefore, although some Anglo-Saxon words may be extremely expressive at times, this one should be discarded as a designation of competence and our time-honored Latin derivatives such as obstetric, maternity, nurse should be used to convey to our minds the trained, responsible, capable woman, member of an honorable and admired profession which the modern trained obstetric nurse really is.

Let us, therefore, rid ourselves of this archaic semantic inheritance and call these trained obstetric associates, Obstetric Nurses, or Maternity Nurses or even Nurse Obstetricians; for this is what, by character, intelligence, and training they really are. Such associates might help immeasurably the busy, sometimes frenetic, obstetric profession.

Who knows better than the obstetrician how rapidly the population of this country is increasing? It is becoming routine for records of numbers of deliveries in hospitals in this country to be broken almost month by month. This places a tax on the facilities and the personnel of our labor and delivery room suites which, in many places, is so severe that it is necessary to dangerously compromise the ideals of obstetric care which we have all been taught to be essential and necessary for maternal health and welfare.

The obstetrician today is likely to be so critically involved in long and irregular hours of work that he not only has no time for thinking, contemplation, and recreation, but he must sacrifice health, time with his family, and sometimes even his skill in order to make himself available to care for this ever-increasing obstetric load. Chronic fatigue forces him to go through life on a "subtentorial" level. Also because of the hard work involved, again the irregular hours required and the generalized nursing shortage everywhere, it is becoming increasingly difficult to

The illustration above shows the medieval doctor surrounded by classic reference works. Fifteenth-century German woodcut. (The Bettmann Archive)



history-of-obgyn.com

obtain the competent and skilled nursing care so crucial for maternal welfare.

This is a challenge which we cannot avoid. Quite frankly, if we as obstetricians and obstetric nurses do not accept this challenge and find a solution for it the solution will probably be found for us, and probably to the detriment of everybody.

The ideal assistant—or one might even say associate—of the obstetrician in the labor and delivery room is not only a registered nurse, but also a nurse who has had special graduate training in obstetrics so that she can recognize danger signals which will convey to her intelligent and well-trained obstetric consciousness the fact that some abnormality during the course of labor may have arisen which demands immediate and possibly even emergency attention. Were such specially trained nurse obstetricians available in the labor and delivery room suites of hospitals throughout the country, were such specially trained nurse obstetricians possibly available for association with the obstetrician in his office in the carrying out of the responsibilities of ante partum care, were such associates available to make house calls or assist the obstetrician in any way or manner which he saw fit, it would render tremendous benefit not only to the obstetrician but to the patient, and would very materially assist the obstetrician in his increasingly difficult problem of trying to put thirty-six hours into one day.

In all honesty, it must be admitted that probably the great majority of obstetrics practiced in this country today is what some imaginative obstetric-genius designated as "perineal obstetrics." This very apt phrase describes the technic by which the obstetric practitioner in whose care the patient has placed herself arrives at the hospital and the appropriate labor and delivery room at about the time when caput is in sight, delivers the baby and the placenta, checks in on the mother and baby after he has changed again into his street clothes and is about ready to go home; and finding everything to be apparently under control leaves the patient again to the ministrations of whoever it was that was taking care of her before he got there.

Sometimes facetiously, but more often than not with a real grain of truth, we evaluate the obstetric capabilities of a house officer or delivery room supervisor in terms of his *or her* ability to call us at exactly the right moment so that we will not lose time and possibly sleep by arriving at the hospital when a patient has several hours of labor yet to go, and still be absolutely sure that we will be called before and not after the baby is delivered.

It is probable that the majority of deliveries are carried out in this country in labor and delivery room units where the assistance of a house officer is only occasionally available, if at all. Would it not be a tremendous advantage under these circumstances to have as delivery room supervisor a graduate nurse who has had at least one year of concentrated training in theoretical and practical obstetrics? She would then be competent to follow patients through labor, to evaluate the progress of labor by rectal or vaginal examination, to immediately recognize danger signs, if and when they do occur, and even under certain emergency circumstances to scrub and assist in a delivery and postoperative or postpartum care.

We all know, of course, that at the present time all around the country there are many delivery room supervisors who, simply by a process of experience, trial and error learning, and close association over the years with obstetricians and patients have, in fact, become this type of nurse obstetrician. Most of us would agree, however, that this is a sort of hit or miss type of education, born of necessity, and that if this education could be formalized into a concentrated postgraduate year of training in the theory and practice of



history-of-obgyn.com

obstetrics, we would have invaluable associates. Obstetrics and the parturient woman would then have a real friend in need.

There are, of course, numerous other situations where such a nurse obstetrician would find a busy and helpful life of service. Already mentioned is the possibility of association in the obstetrician's office. Also, there are areas in this country, surprising as it may seem, where doctors are not available for obstetric care and the nurse obstetrician is already a devoted and loved obstetric emissary. A nurse trained in this way is also in great demand in underdeveloped countries throughout the world where populations are in such desperate need of good obstetric care. There are only about 500 trained "nurse midwives" in the country now, most of whom are members of the American College of Nurse Midwifery. A program for increasing their members and responsibilities in no way infringes on the rights of obstetricians or in any way competes with obstetricians professionally or financially. The development of such a program should be considered in terms of maternal welfare, reduction of maternal morbidity, and even maternal mortality, and invaluable aid to the obstetrician and the parturient woman.

There are five schools of nurse-midwifery already in existence in this country, the Maternity Center in New York, Columbia, Catholic University (Sante Fe), Frontier Nursing Service (Hyden, Kentucky) and Yale, which enroll only about thirty graduate nurses every year for special obstetric training. The graduate course in nurse-midwifery at the Yale Graduate School of Nursing, for instance, has about ten applicants per year even though it has been in existence only two years.

At present only four applicants are enrolled at Yale each year for a concentrated course conducted by an associate professor of obstetric nursing—but also in close conjunction with the Department of Obstetrics and Gynecology. These nurses attend lectures and classes with medical students, interview and examine patients in the clinic and on the wards with the resident staff, attend special clinics such as Medical Complications, Infertility and Endocrine, and the Director's Consultation Clinic. During June and September when the medical students are on vacation, these graduate nurses in training fill in for them on the labor and delivery room floor, attend patients in labor, and carry out deliveries under the same supervision which the medical students have.

To date, graduates of this course are carrying on the following types of work: One is engaged in a research project as a research nurse and three are teaching obstetrics in nursing schools in various parts of the country. There are no graduates of this or any of the other schools who are actually practicing obstetrics in areas where there is any professional or financial competition with physicians, nor is this in any way the purpose of their training.

It seems essential that some such trained type of associate should be available to fulfill the needs of the future. We need this type of help today, and the future apparently holds in store for us an even more time-consuming preoccupation with details which can be supervised by the trained obstetric specialist through the trained nurse obstetrician. We, as obstetricians, should be the leaders in the development of an educational program for—not "midwives"—but trained maternity nurse associates.

C. LEE BUXTON, M.D.
*Yale University School of Medicine*
*333 Cedar St.*
*New Haven 11, Conn.*

---

Here is a movement worthy of further exploration and development. Since semantics play such an important role in the acceptance of any new idea in this era of persuasive advertising, one must agree that



history-of-obgyn.com

the terms "midwife" or "nurse midwife" should be dropped. Likewise an "associate" means equal, an "obstetric" or "maternity" nurse connotes merely a nurse working in the obstetric department. "Nurse obstetrician" cannot be used, unless the individual holds both R.N. and M.D. degrees.

Might not "obstetric assistant" carry sufficient meaning and dignity?

THE EDITOR



history-of-obgyn.com