



## Obstetrician-Midwife Partnership in Obstetric Care

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Certain aspects of medical care can be covered by personnel other than the physician. Because of special skills and motivation, the midwife is a natural partner for the obstetrician-gynecologist in rendering care within the provinces of obstetrics, preventive gynecology and family planning. Such a partnership of obstetrician-midwife would appear to be highly acceptable to both patients and the profession. Experience suggests that this system can yield not only an improved quality of total care for more patients, but also, an opportunity for the obstetrician to concentrate his greatest effort on the patient at risk.

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THE DEMAND FOR MORE AND BETTER MEDICAL care for all people and the worldwide problem of overpopulation make it imperative for the medical profession to devise improved methods of delivering health care.

### OUR DEPLORABLE HEALTH SYSTEM

Although Americans spent an estimated \$60 billion on health care during 1969, for many of them, the existing system proved inefficient, wasteful of manpower and resources and totally incapable of coping with

The illustration at the top of the page depicts Galen lecturing at the Temple de la Paix (The Bettman Archive).

their demands. Despite our expenditure, this nation ranks twenty-sixth in life expectancy for males and twelfth for females. Twenty million Americans receive only part of the health care they need; another twenty million in the ghettos receive less than adequate health care, and two million receive none whatsoever.<sup>1</sup>

Meanwhile, the population continues to grow. Too many babies are born. Too many die. We can only guess at the overall morbidity. Perhaps not related directly to this unhappy situation is the fact that 45% of the women in low-income families receive no prenatal care. Even in urban and suburban areas where 95% of all deliveries occur in hospitals, 45 to 50 thousand of these infants die annually during the neonatal period. In states of low per capita income, the number of obstetricians per ten thousand births is a third below the national average.<sup>2</sup> Unfortunately, the number of infants born as the result of out-of-wedlock pregnancies continues to increase.

In my view, the inefficient and ineffective system of health care contributes to these less-than-optimum results. It may well be not just a matter of the need for more physicians, or the need to redistribute the physicians presently available for medical care. A much more probable cause of the failure to obtain maximum utilization of physician effort is the failure through inefficiency, to direct expertise to the patient at risk.

The increasing demands of obstetric practice, as it has developed in this country, has progressively limited the effectiveness of the obstetrician. Following the example of his teachers and the pattern of practice in general, he has assumed that he must "be all things" to all patients. Although he is amply rewarded for performing many time-consuming, unchallenging, technical procedures, his expertness is diffused and limited to relatively few patients. The real question seems to be: Will the profession continue to care

for only a small segment of the population; or will it, through innovative applications of current knowledge and methods, devise a system which will enable a physician to bring that quality of care he has been educated to deliver to a larger segment of the population? For example, is it reasonable to observe five highly qualified obstetricians, each waiting to deliver his own patient, on the labor floor of any one of our typical obstetric hospital services, while the diabetic, the cardiac, the hypertensive or the emotionally disturbed woman with marital distress is receiving neither the time nor the professional effort she needs and merits? And, in all probability because of the system, the five women in labor will receive less than the total obstetric and psychologic care to which they, too, require and deserve.

The value of prenatal care has been amply proven. Patterns of practice during the past several decades have changed. Because of their increasing sophistication and knowledge, more patients have sought the care of the trained obstetrician. The rapidly diminishing number of generalists who in the past cared for the pregnant woman, as well as the increased number of patients, have added to the obstetrician's burden. Whereas the obstetrician in the early part of this century functioned primarily as a consultant, today he is more and more involved in performing acts which do not require his skills. It is time that the profession take a hard look at how it spends its time: what it does and how it does it.

#### OBSTETRIC NEEDS FOR TODAY AND TOMORROW

In response to these most urgent health care needs and demands, the profession must:

1. Develop and implement effective methods of family planning and population stabilization which will be acceptable to and supported by the population at large;
2. Reduce the infant morbidity rate,

especially in the ghettos and other areas which receive frighteningly substandard medical care;

3. Provide improved prenatal and postpartum counseling for *all* women, including a better preparation for parenthood and family living;

4. Develop effective and efficient screening programs to detect incipient disease before it becomes a life-threatening illness;

5. Provide these services at reasonable cost and with optimum effectiveness.

It requires no great imagination to recognize that neither the discipline obstetrics-gynecology nor the medical profession as a whole is alone capable of providing these needed services. Therefore, a system must be devised which will involve nonmedical people in the delivery of these types of health care. Furthermore, the scheme must assure an overall improvement in the quality of care that will be accepted and enthusiastically supported by patients and physicians. Finally, the plan must offer a challenge and upward mobility to practicing paramedical people as well as be capable of attracting new workers to the field. It is my belief that such ancillary help can best be obtained by involving the midwife as a partner with the obstetrician-gynecologist in the delivery of health care to women, each partner providing those aspects of medical care for which he has skill and motivation. If this plan is to succeed, the results must be better than those of our present system, as measured by the quality of care, the number of people cared for and the reasonable cost of that care.

#### HISTORY OF MIDWIFERY

The practice of midwifery is probably as old as life itself. Historically, the care of women during labor and parturition has been a role assumed by women. Hippocrates sanctioned the practice by instituting a training course for midwives during the fifth century BC.<sup>2</sup>

In Europe, midwives dominated the obstetric field for centuries, and the practice of midwifery has spread gradually throughout the world. By 1968, some 80,000 midwives were licensed in England and Wales alone, but only 20,000 of these were actually practicing during that year.<sup>3</sup> Two years later, 600,000 midwives were registered in 154 nations accounting for 75% of the world's population, but not including China.<sup>4</sup>

Nevertheless, as late as 1905, midwives handled 40% of the births in New York City. When a study revealed that the ineptitude of these midwives caused 60% of the preventable deaths in that city, the practice of midwifery was limited or forbidden by one state after another. By 1965, midwives delivered only 0.3% of the white babies born in the United States, although they were still important in the South.<sup>2</sup>

With the opening of the American School of Nurse-Midwifery in Harlem in 1931, midwifery started on its way to respectability and acceptance. In 1967, some 44 nurse-midwives practicing in New York City delivered more than 2000 babies.<sup>5</sup>

Today, 12 schools train midwives, and they certify about seventy graduates annually. Although approximately a thousand of these nurses have received certificates in nurse-midwifery, less than 200 nurse-midwives, two thirds of whom teach or perform administrative or public health services, actually practice in the country.<sup>5,6</sup> Of the other third, most deliver babies of healthy mothers who come from urban ghettos and for whom the obstetrician is unavailable. Some instruct medical students, others head family planning clinics, and a few supervise clinics for unwed teenage mothers.

Although the term "midwife" carries an unfavorable connotation among the uninformed, as yet, there seems to be no better name. In present context, she is a highly intelligent, broadly educated, sympathetic person with a depth of knowledge in the biology of reproduction and the psychology of

women. No longer is she the repulsive Mrs. Gamp of Charles Dickens' *Martin Chuzzlewit*. We are unwilling to identify her as another paramedical technician, a physician helper, or an obstetric nurse who has had a few additional weeks of training in the clinic outpatient department.

In my belief, she has an extremely important role to play in newly developing systems of maternal and child health care. Because of her training, she is qualified to manage the uncomplicated pregnancy and labor and to recognize the abnormal. Her motivation and background bring to this professional care an important aspect of psychological and educational support which is often neglected by the busy obstetrician. It is logical to assume that the incorporation of her skills and attitudes would improve obstetric care. Her qualifications permit her to share responsibility and much of the routine obstetric care with the obstetrician who could then afford to devote more of his effort to the patient at risk. Such a real professional partnership should deliver optimal obstetric care to a much larger number of patients at no extra cost.

#### METHODS

A model of total maternal care based on this thesis is being developed at our Medical Center. The midwife and obstetrician are both involved in the care of each patient throughout pregnancy, labor, delivery and the puerperium. The midwife is responsible primarily for patient education by conducting mothercraft classes, demonstrations and regularly scheduled interviews at routine prenatal visits.

After the initial interview and evaluation by the obstetrician, the midwife may well alternate with him at follow-up examinations during which she must make value judgments as to the course of pregnancy. In our experience, potential problems have been detected which might otherwise have been

overlooked. Because the midwife establishes rapport with the patient early in the pregnancy, she has an unparalleled opportunity to discuss future family planning and related problems. This is particularly true in her counseling of the unwed mother, where her impact very possibly rivals that of the social worker. In our experience, the obstetrician has had limited opportunity to instruct the patient about nutrition, personal hygiene and general activities. These aspects of obstetric care have never been accomplished so effectively as when the midwife functions as a member of the team. The effect of the program has already eased the pressures of our clinical faculty and permitted greater professional effectiveness.

The program also includes the midwife in the conduct of labor and delivery of the uncomplicated pregnancy. She acts in association with a member of the obstetric staff who serves as a consultant and is available for operative procedures or the management of complex problems demanding his particular skills. It is my firm belief that this type of team approach can and does render superior obstetric care with optimum patient rapport and satisfaction. It has been interesting to observe the response and attitude of medical students and house staff who quickly perceive the overall impact of the program upon the nature of obstetric practice in the future. The involvement of the "gyn-trained midwife" in many aspects of outpatient gynecology has unlimited potential. It also seems likely that a system which permits the obstetrician-gynecologist to function primarily as a skilled professional will have significant impact on recruitment to the discipline.

#### CONSTRAINTS

Even if it has proven to be effective, any innovation in the national system of health care, to be successful, must be accepted and supported not only by patients, but also by the medical profession and by third-party

agencies, both public and private, who provide for medical care.

The medical profession, obstetricians in particular, have historically resisted the interposition of a third person into the traditional one-to-one relationship between doctor and patient. The midwife has never really been considered capable of sharing the responsibility for obstetric care, except for those patients who could neither afford nor otherwise obtain the services of an obstetrician. In some instances, physician reservation has been based upon a fear that the midwife threatened not only his professional status, but his income as well. Practitioners of an older generation understandably may be less than receptive. Changes which threaten their habits and patterns of practice have rarely been received with enthusiasm. Total acceptance may be expected only as the young physician is educated during his student and house officer experience when he is particularly receptive to new ideas.

Gaining patient acceptance of the midwife, in our experience, appears to be a much easier accomplishment. Although she may demonstrate reservation at the outset, the patient will, when informed of the nature of the program, promptly recognize that she is the recipient of a valuable addition to her total care. The importance of the obstetrician's early explanation to the patient of the midwife's role was soon made apparent to our staff. A printed document to this effect was found inadequate. It was vital to emphasize to the patient that the midwife would not take over total care and that the obstetrician would continue in his appropriate role. Obviously, personalities and abilities are important and, in this respect, we have been most fortunate. The patient's additional contact with the midwife at special classes throughout the pregnancy, which revolve about the conduct of labor and the involvement of the patient during labor, as well as the instruction of her husband in this regard, has added greatly to the impact of the mid-

wife's participation during her pregnancy.

Finally, it is my belief that the demonstration of optimum care by obstetrician and midwife, with the appropriate acceptance on the part of the patient, should be adequate justification for acceptance of the program on a fee-for-service basis by the various insuring agencies. It would seem important to demonstrate and to recognize that the goal is optimum care to the total population.

One of the more favorable and efficient developments in medical practice has been the proliferation of groups of specialists who practice together and who share offices, laboratory facilities and manpower. The midwife is a natural member of such a medical group. Where the patient load requires it, two or three midwives could be teamed with as many obstetricians. Since group practice appears to be the norm for the future, what is more natural than establishing an obstetrician-midwife team within each group?

The education and recruitment of young women to this profession is of concern to all of us. A basic curriculum must be established to assure quality in this system of health care. A college education with special training at the Master's level will probably be needed. Whether a degree in nursing should be included is a question to be contemplated. The available upward mobility and the challenge of working in partnership with the obstetrician will unquestionably enhance the recruitment of young women to midwifery. Thought must be given to the postgraduate education of that supposedly large group of nurses who have retired, at least temporarily, from the profession to raise their families. These women might be brought back to active professional life with appropriate educational programs which would qualify them as midwives. Their practical family experience, in proper circumstances, could add to their effectiveness.

It is urgent and necessary at this time to establish the principles of certification and/or licensure, whichever proves to be appro-

priate. In this regard, the complete lack of uniformity throughout the nation places the midwife-practitioner at a tremendous disadvantage. The final details and ultimate reciprocity between states might appropriately become the concern of The American College of Obstetricians and Gynecologists, the American Board of Obstetrics and Gynecology, and certainly, the American College of Nurse-Midwives.

#### CONCLUSION

We are living in a time of tremendous social change. Society will not tolerate delay in accomplishing needed improvements within our health system. The national goal of better maternal and infant care can be met only by positive plans and positive actions designed to improve the overall quality of and the access to the system. Instead of lamenting the doctor shortage within the discipline of obstetrics, we can plan to utilize fully the physicians we now have and will have in the future.

The obstetrician-midwife team will provide maximum utilization of each partner's

skills. Its obvious benefits to patients and team members should help us to bring into obstetrics men and women of the highest caliber.

The obstetrician-midwife team will ensure obstetric care for more women, help to meet the needs of a growing population and provide a workable method of bringing better care to rural areas and ghettos. It should, as well, prove to be a positive step forward in controlling population growth through education.

#### REFERENCES

1. Reuther W: The health care dilemma: New directions. *J Med Educ* 45:96 1970
2. Silver GA: The Midwife in the United States. Report of a Macy Conference, Joshiah Macy Jr Foundation, NY, 1968, p 5
3. Royal College of Midwives, 88th Annual Report, London, 1969, p 10
4. Maternity Care in the World. International Federation of Gynecologists/Obstetricians and Internal Federation of Midwives. Oxford, England, Pergamon Press 3:1966
5. Harris D: The development of nurse midwifery in new york city. *Bull Amer Coll Nurse-Midwives* 14:16 1969
6. Woodville L, Chairman: Research committee nurse midwifery statistics, ACNM *Bull Amer Coll Nurse-Midwives* 14:70 1969