

Midwives have been under the spotlight following the death of a baby delivered by midwives at Kenepuru Hospital's birthing unit and the government's announcement of a review of Wellington's maternity services.

But while the New Zealand College of Midwives supports investigating the death, it warns that we risk driving midwives out of the profession and deterring others from joining unless we give them more respect and support.

By Karen Guilliland

While some doctors here call for review, other countries look on our maternity system with envy and continue to ask how they might implement such a service in their countries.

Midwives are the backbone of the maternity service here and overseas. But if we do not provide midwives with a more supportive work environment, nobody will want to be a midwife. Why would a woman want to be involved in a career in which society constantly refuses to accept her expertise?

Midwives have responded willingly to continual reviews and efforts to improve midwifery practice and gain public respect. But this week, they are saying enough is enough. One incident does not represent the whole system. Once again it has been escalated on the word of a doctor without reference, by anyone, to those midwives concerned or with any clinical facts to review.

Of course this birth must be investigated and the family has an absolute right to expect that. The midwife also has a right to be involved in the case review and, hopefully, the process resolves the family's unanswered questions.

But the reality of a midwife's working life is that she will be at the death of a baby at some time in her career. Sadly, death is a part of the birth process for some mothers and 600 babies die every year in New Zealand during pregnancy, birth or shortly after. While this is very low by world standards, it does not reduce the grief for those families, nor the distress for the midwife who knows that family and who grieves with them.

If the midwives' reality is not recognised and they are not supported during investigations of babies' deaths, they will join the medical exodus and we will not have midwives willing to continue to attend births. Our whole health system, not only maternity, depends on supportive, educative frameworks for health professionals to flourish and provide continuing improved services.

This current media deluge is a watershed for many midwives, and the social and political response will dictate whether they choose to remain in the profession. Yet in countries without them, the maternal and perinatal mortality is horrendous. New Zealand needs midwives more than ever.

Medical students and junior doctors have little, if any, training in either the normality or complexity of childbirth, and most of those that do choose not to go on to practice in the demanding, litigious 24 hour maternity service. A global shortage of obstetricians means that, in many places, midwives are the only health professional women have to support, teach and attend them in childbirth.

Many rural women would have no maternity services without midwives. There is no country left in the world that has a GP-predominant maternity service _ and this is also true here. The global shortage of midwives is at crisis level.

Midwives are specialists in normal births. Doctors rely on them to provide the majority of the maternity service, to observe and monitor pregnant women, no matter how well or sick they are, to teach doctors and nurses learning obstetrics, and to educate and inform parents.

Midwives have an undergraduate degree in midwifery, which includes all the sciences, medical pathology, anatomy and physiology, and social and psychological needs of pregnant and birthing women and their newborn. Many of these courses mirror medicine curricula, but midwifery's focus is on the woman and the newborn during childbirth. Most doctors today receive very little education on pregnancy and childbirth, and even less practical experience.

Midwives are mature, educated women with an average age of 47. The average age of midwifery students is 33 and many come with wide life experiences and are mothers themselves. Most have had other careers, many have double degrees and, increasingly, some have PhDs.

Midwives are required to re licence annually by the government appointed Midwifery Council. Ongoing education and updating their emergency skills is mandatory. They require every midwife to update her new-born and adult resuscitation skills every year. Midwives must also update all other emergency skills, including managing breech birth. So, over the past three years, every midwife has ensured she is competent in these skills.

Midwives are multi-skilled. They insert intravenous lines, suture wounds, prescribe, screen for public health diseases, and provide information on life-style and health issues. They assist at caesarean sections, resuscitate babies, administer and monitor drugs, support breastfeeding; they weigh, monitor and reassure mothers and fathers. They advise, comfort, massage, counsel, and laugh and cry with parents. Their practice is broad, women and family centered.

Their expertise is to detect any deviation from normal and to provide referral, or emergency services, if referral is not possible. They work in the acute obstetric hospitals, the provincial hospitals, the 59 birthing units, in the home and community.

Since the reinstatement of midwifery autonomy in 1990, maternity and midwifery services have undergone frequent reviews. All have reaffirmed the quality of midwifery services and not one has resulted in significant No review has substantiated claims of incompetence or that a widespread problem exists with midwifery education, midwifery practice or the maternity service.

The few individual obstetrician, GP and midwife cases that have been upheld have been examined thoroughly for lessons and followed through with education and system change, where appropriate. The practitioners involved have been held to account.

The international evidence strongly supports midwifery as a lifesaving and appropriate maternity workforce.

Here, legislation has been implemented to improve public protection and accountability of all health professionals. And during the past three years the New Zealand College of Midwives has undertaken an annual practice review of all lead maternity carer (LMC) midwives and reviewed hospital-employed midwives every three years.

The Midwifery Council of NZ has also reviewed all undergraduate midwifery education and set new standards, requiring midwifery schools to provide increased experience to students, to ensure competence and confidence of the graduates. All five schools of midwifery expect to meet the new standards

LMCs can be doctors or midwives but 78% are midwives. They work in the community and are self employed, much like GPs, but they cannot charge, and are paid on a set scale by the government. They have a caseload, on average, of 50 women and families per year. Access agreements between LMC and DHBs set out LMCs access beds in hospitals for their clients. They require LMCs to participate in the review in all cases where there are unexpected outcomes.

These agreements were reviewed two years ago and few changes were required as a result, despite the publicity which claimed they were problematic. Four consumer satisfaction surveys since 1999 reaffirmed that the vast majority of women are happy with the service. This level of public support compares favourably with other health services.

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