

**OUT ON A LIMB: THE PERSONAL MANDATE TO PRACTISE MIDWIFERY BY
MIDWIVES OF THE DOMICILIARY MIDWIVES SOCIETY OF NEW ZEALAND
(INCORPORATED), 1974-1986.**

by

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A thesis submitted to Victoria University of Wellington

in fulfilment of the requirements for the degree of

Doctor of Philosophy

in Midwifery

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Abstract

As an archival and oral herstory of domiciliary midwifery in New Zealand during 1974-1986 this research makes an original and significant contribution to midwifery knowledge both nationally and internationally. It explored the herstories of the Domiciliary Midwives Society (Incorporated) and eight of its midwives to reveal the exercising of the personal mandate to practise within the full scope of midwifery in the community during a time when all but a handful of midwives worked in the hierarchical and institutional structures of hospitals.

The significant findings of this study included a new 'with-woman' process for positioning midwifery research, and gathering, analysing and expressing evidence. This process engages and embeds the philosophical underpinnings, process and method of home birth midwifery practice into the research process with the intention of breaking down barriers between these two midwifery activities. Further, this study evidenced the role midwifery played in medicine's (and nursing's) colonisation of midwifery in reframing the midwife's identity as a nurse, imposing obstetric nursing standards of practice and diminishing the full scope of the midwife's practice as a discipline separate from, and independent to nursing. Amongst considerations of this colonising process are the investigation of domiciliary midwifery undertaken by midwives of the New Zealand Nurses Association (NZNA) and Midwives and Obstetrical Nurses Special Interest Section (MSIS) of NZNA and the subsequent 'Policy Statement on Home Confinement' authored by MSIS in 1980. Thus, this thesis elaborates a dissenting view on the oppression of midwives by medicine in that midwifery created and exercised mechanisms to both ensure a 100% hospitalisation of childbirth during the study period and limitation of the domiciliary midwifery service.

It is hoped that this study will provide a pathway for midwives to move fluidly between the practices of both research and midwifery, as well as ensuring that domiciliary midwifery herstory in New Zealand becomes secured.

Thank you to the support people

During physiological birth no one can do the work for the woman but many can support her to do so. Similarly, this thesis is the result of over five years of my work but I have been well supported along the way by the following people.

Thank you to those who assisted me to access archival material - Barbara Brown, previous Maternity Manager for the Ministry of Health, who made Ministry of Health files available to me in Hamilton and Lynda Stopforth, New Zealand Nurses Organisation librarian, who helped me find archival documents and facilitated my access to these. I thank Joan Donley for her generosity in allowing access to her personal papers at her home in 2001 and Glenda Stimpson for her diligent guardianship of, and generous access to Auckland Midwives Special Interest Section files before their permanent lodgement in the Auckland Medical Library.

My thanks go to the midwives of the Domiciliary Midwives Society (Incorporated) who supported my study and particularly Carolyn Young, Joan Donley, Bronwen Pelvin, Sian Burgess, Gillian Wastell, Anne Sharplin, Jenny Johnston and Sue Lennox for participating in the study so openly and willingly.

I particularly thank Margi Martin for voicing her belief that a university is a place in which one can stand and argue one's own reality – a belief without which I could not have sustained my PhD candidature. I am indebted to Rose McEldowney and Maralyn Foureux, my supervisors, for both the support I received to 'just do it' and their rapid and wise responses to the times when I needed help.

Many describe the PhD journey as a lonely one. I have not found it so. I have been surrounded, sustained and grounded by my family. Thank you, Pandie, Hannah and Sam. Gabriel and Tobin – you have been very patient about Nannie finishing the 'thesist'. And last, but absolutely not the least – thank you Tony for your sustained ability to respond with interest to the "listen to this, Tone!" that you have been subjected to over the last five years.

Dedication

This thesis is dedicated to the women of home birth - consumers and home birth midwives
- and to their, and our, families who provide the essential support.

Abbreviations

AGM	Annual General Meeting
BoH	Board of Health
CSU	Combined State Unions
DGoH	Director-General of Health
DHO	District Health Office
DM	domiciliary midwife
DMS	Domiciliary Midwives Society (Incorporated)
DMSRC	Domiciliary Midwives Standards Review Committee
DoH	Department of Health
DoN	Director of Nursing with the Department of Health
DTI	Department of Trade and Industry
FoL	New Zealand Federation of Labour
GP	General Practitioner
HBA	Home Birth Association
HBSG	Home Birth Support Group
LSCS	Lower segment Caesarean section
MOH	Medical Officer of Health
MoH	Minister of Health
MP	Member of Parliament
MSB	Maternity Services Benefit
MSC	Maternity Services Committee
MSIS	Midwives and Obstetric Nurses Special Interest Section
NCNZ	Nursing Council of New Zealand
NHSC	National Health Statistics Centre

NMRB	Nurses and Midwives Registration Board
NSNZ	Nurses Society of New Zealand
NZCOM	New Zealand College of Midwives
NZMA	New Zealand Medical Association
NZNA	New Zealand Nurses Association
NZNO	New Zealand Nurses Organisation
NZOGS	New Zealand Obstetrical and Gynaecological Society
NZRNA	New Zealand Registered Nurses' Association
OSRC	Obstetric Standards Review Committee
PMR	Perinatal Mortality Rate
PN	Principal Nurse (of a hospital)
PPHN	Principal Public Health Nurse
PSA	New Zealand Public Services Association
ToR	Terms of Reference

List of players

BARKER, Dr R.A.	Chairman, Maternity Services Committee of the Board of Health.
BASSETT, Dr Michael	Minister of Finance, July 1984 to December 1988.
BAZLEY, Margaret	National President NZNA, 1972-1974. Director, Division of Nursing, DoH, 1978-1984.
BIRBECK, Adele	Domiciliary midwife, Dunedin.
BOYD, G.R.	Assistant Director, Division of Clinical Services to Medical Officer of Health, Christchurch.
BURGESS, Sian	Domiciliary midwife, Auckland.
CAREY, Shona	Executive Director, NZNA, 1976 - February 1983. National Secretary of Nurses Union, 1976- February 1983.
DONLEY, Joan	Domiciliary midwife, Auckland.
ELLIS-CROWTHER, Vera	Domiciliary midwife, Auckland.
FELL, Thelma	Domiciliary midwife, Hamilton.
HELEM, Ursula	Domiciliary midwife, Christchurch.
HOGAN, Irene	Domiciliary midwife, Auckland.
JOHNSTON, Jenny	Domiciliary midwife, Hamilton and Wellington.
KEMP, Henrietta	Home Birth Association National Lobbying Coordinator and National Newsletter Editor.
LAWTON, Maureen	Supervisor, Wellington Women's Hospital in 1969. Charge tutor at St Helens Hospital, Wellington in 1977.
LENNOX, Sue	Domiciliary midwife, Lower Hutt.
LIVINGSTONE, Allison	Accountant for Auckland domiciliary midwives.
MALCOLM, Hon. A.G.	Minister of Health, 1981-1984.
McGOWAN, Margaret	Canterbury/West Coast MSIS Chairperson in 1978.
McLEAN, Lynne	Domiciliary midwife, Wellington. Secretary, Domiciliary Midwives Society of New Zealand, 1981- May 1983.
NICHOL, Jennie	Senior Advisory Officer, Department of Health
NIGHTINGALE, Anne	In charge of midwifery education St Helens Hospital, Auckland, 1967-1972. Auckland Branch President of NZNA, 1972. Chairperson of Nursing Council of New Zealand, 1975-1984. Principal Nurse of St Helens Hospital, Auckland, 1972-1990.

PELVIN, Bronwen	Domiciliary midwife, Nelson. Secretary, Domiciliary Midwives Society (Incorporated), June 1984 – c.1995.
PHILLIPS, Dr J.S.	Director of Clinical Services, Department of Health, Wellington. Chairman, Medical Services Advisory Committee in 1980.
SAGE, Jennifer	Domiciliary midwife, Wellington.
SALMONE, Beatrice	Nursing academic.
SHARPLIN, Anne	Domiciliary midwife, Thames and Bay of Plenty.
TEW, Margorie	Epidemiologist.
VOADEN, Chris	Domiciliary midwife, Nelson.
WASTELL, Gillian	Domiciliary midwife, South Auckland. Secretary, Domiciliary Midwives Society of New Zealand, June 1983 – May 1984.
WILLIAMS, Gill	Domiciliary midwife, Bay of Plenty.
YOUNG, Carolyn	Domiciliary midwife, Auckland.

Table of contents

Abstract.....	i
Thank you to the support people	ii
Dedication.....	iii
Abbreviations	iv
List of players	vi
Table of contents	viii
List of tables	xiii
List of figures	xiv
CHAPTER 1: MEETING AND GREETING THE THESIS.....	1
How is this thesis woven?	4
What led me to this study?	8
Re-search intentions and questions	15
Why was this study necessary?	16
Overview of the thesis	19
CHAPTER 2: A HOME BIRTH MIDWIFE’S PHILOSOPHICAL UNDERPINNINGS, PROCESS AND RE-SEARCH METHOD	22
Part 1 - Philosophical Underpinnings.....	23
The politics of naming difference.....	23
Marginalisation and difference.....	26
Control by law	26
Financial control	27
Control by politics	28

Beyond subordination.....	29
A colonised profession takes stock.....	30
The knowing of the home birth midwife	31
With-woman environment.....	32
With-woman language.....	33
With-woman text	35
With-woman storytelling	36
With-woman re-search	38
With-woman knowledge	38
Engendering midwifery knowledge through ‘bare-footing’	40
Part 2 - Process and Method.....	42
Evocation of the with-woman spirit	42
Upholding each midwife’s right to free, informed choice and consent.....	43
Working in partnership	44
Holding information in confidence and ensuring protection of rights during advancement of midwifery knowledge.....	45
Upholding professional standards and avoiding compromise.....	45
Supporting and sustaining professional roles and actively nurturing safety	46
The re-search process and Ethics Committees	46
Working with the voices of the study.....	47
The archival voices	47
Working with and selection of archival material.....	52
The domiciliary midwives’ voices	54
Selection of the midwives	54
The guiding questions and the catch-ups.....	55

Flecking the archival voices	58
CHAPTER 3: A ROAD LESS TRAVELLED	59
The domiciliary midwife's contract	60
The Obstetric Record.....	63
The domiciliary midwife's service	63
The General Practitioner.....	64
Supervision of the domiciliary midwife	64
Domiciliary midwife and home birth numbers, 1968-1980	65
Eight domiciliary midwives of the study.....	70
Carolyn Young	70
Joan Donley	71
Bronwen Pelvin	72
Gillian Wastell (McNicoll).....	73
Sian Burgess (White).....	74
Jenny Johnston.....	74
Anne Sharplin	75
Sue Lennox	76
Beginning domiciliary midwifery practice.....	76
The Domiciliary Midwives Society (Incorporated).....	82
Concluding remarks.....	85
CHAPTER 4: THE POWER OF THE PURSE.....	88
The Maternity Services Benefit.....	89
Unequal pay for equal work	92
Domiciliary midwives: the poor sister	96

Surviving financially	98
Establishing a negotiating voice	102
A voice of their own	106
A dawning understanding	110
Concluding remarks.....	112
 CHAPTER 5: DOMICILIARY MIDWIFERY UNDER THE MICROSCOPE.....	116
Suits, shiny blouses and handbags.....	117
Gaining a contract.....	117
Day to day supervision	118
Practising in other health districts	121
Working the system.....	123
With and without the home birth doctors	126
A landslide of sectional opinion	131
Rhetoric versus evidence	134
Concluding comments	139
 CHAPTER 6: CAPES, COLLUSION AND CONTROL	142
The voice of nursing and midwifery - NZNA	143
Midwives and Obstetric Nurses Special Interest Section of NZNA	145
Domiciliary midwives in NZNA and MSIS	147
Domiciliary midwifery comes into view	148
The strategy for control	155
The New Zealand Nurses Association and the New Zealand Medical Association	156
Midwifery affronted	157
The ‘Policy Statement on Home Confinement’	158

The obstetric nursing cape.....	164
Concluding remarks.....	166
 CHAPTER 7: AMAZING DISGRACE	169
Maternity services in New Zealand, 1969-1982.....	170
The growing consumer voice	175
Humanising the hospitals	176
The nursing ethos of the study period	180
Domiciliary midwives during midwifery training and hospital employment	183
Domiciliary midwives in hospital.....	185
Early Discharge schemes.....	190
Concluding remarks.....	192
 CHAPTER 8: THESIS-MOON, AND BEYOND.....	194
The Cardigan Brigade's choice to stand.....	195
So what is significant about this re-search?	203
Reflections on the re-search	206
 APPENDICES.....	207
 REFERENCES	252

List of tables

Table 1.1	Overview of time, events and publications relevant to thesis.....	7
Table 2.1	Folder numbering of the Domiciliary Midwives Society Incorporated) Archives, 1978-1997, Hamilton.....	49
Table 2.2	Domiciliary Midwives Society Incorporated (DMS) Archives, 1978-1997, Hamilton.....	51
Table 3.1	The domiciliary midwife's documentation.....	62
Table 3.2	Number of midwives by Health District, claims and visits, year ended 1977..	66
Table 3.3	Home delivery and postnatal care by Health District... (c. 1978).....	67
Table 3.4	Number of home delivery figures by Health District and year	68
Table 3.5	Numbers of home births and domiciliary midwives by Health District, 1977- 1980.....	69
Table 4.1	Rates of benefits payable to domiciliary midwives, 1971 – 1987.....	91
Table 4.2	Comparison between Maternity Services Benefit fees paid to General Practitioners and domiciliary midwives, 1986.....	93
Table 5.1	Maternal, foetal and neonatal death of out-of-hospital births, 1972-1976.....	135
Table 5.2	Perinatal mortality rate, births per thousand, 1960, 1974 and 1975.....	137
Table 5.3	Comparison between planned home birth and hospital data, 1975-1979.....	138
Table 6.1	Regional membership of Midwives and Obstetric Nurses Special Interest Section of NZNA, 1973 and 1984.....	146
Table 7.1	Rates of intervention for 195 women having first babies in St Helens Hospital, Auckland, December 1981- January 1982.....	174

List of figures

Figure 4.1	Hours of labour attendance by domiciliary midwife, May 1987–April 1988.....	94
Figure 4.2	Domiciliary midwife labour and birth attendances, percentage of hours, May 1986 – April 1987.....	95
Figure 4.3	Comparison between domiciliary midwife and hospital midwife annual income, 1972-1981.....	97

CHAPTER 1: MEETING AND GREETING THE THESIS

This thesis is a story of the personal mandate to practise midwifery by members of the Domiciliary Midwives Society of New Zealand Incorporated (DMS). It explores the embodied experience of personal autonomy. That is, it investigates the exercising of choice and the personal power to make and act upon decisions¹ of domiciliary midwives (DMs), focusing particularly on the period 1974-1986.

This thesis records my search for, and identification of the knowledge of connectedness and interconnectedness of the midwife as woman and the woman as midwife – the personal autonomy which enabled practice. Moreover, this study reflects the interconnectedness of domiciliary (home birth) midwifery practice and the practice of research or, as I refer to it – re-search. This latter term reflects that her-stories – the stories of the individual contributing midwives, both oral and archival, as well as the archival story – existed and had meaning to the contributors prior to this study. It is that meaning for which I re-searched – looked for again. This is the first study of its kind on domiciliary midwifery in New Zealand – it is a lived midwifery herstory. As such, it is a fusion of primary source archival material and oral stories of seven midwives of the DMS positioned in the ‘knowing’ of a home birth midwife, which I will explain later in the thesis. I explored the political, financial and professional climate for these midwives and as the title suggests, what gave rise to their personal mandate to practise domiciliary midwifery during a time of, what proved to be, little support from their professional communities.

The DMS, instigated in May 1981² by Auckland DM, Joan Donley,³ had the primary role of lobbying the Department of Health (DoH) for improved remuneration so domiciliary midwifery practice could be sustained.⁴ In essence, the DMS provided a separate voice to the New Zealand Nurses Association (NZNA), which at the time represented professional nursing and midwifery. By 1989, the DMS had a membership of

1 Katherine Pollard, ‘Searching for autonomy’, *Midwifery*, 19, 2 (June 2003), pp. 113-124.

2 Joan Donley to Lyn McLean, Letter, 28 May 1981, DMS, ‘1981 Correspondence, DMS/00 4/1’.

3 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 16.

4 Ibid., p. 17.

thirty-nine⁵ – 30.46% of all DMs (n=128), as I evidence later in the thesis, and approximately 1.01% of midwives (n=3,838) in New Zealand in 1986.⁶

The DMS midwives were those providing the continuum of antenatal, labour and birth and postnatal care in women's homes during a time when all but a handful of midwives provided fragmented care in obstetric hospitals and/or community settings. Identifying strongly with the consumer movement that would develop into Home Birth Associations (HBAs) and Home Birth Support Groups (HBSGs) throughout the country from 1974, consumers and DMs led the way for The Partnership Model⁷ that would later be embraced by the midwifery profession in New Zealand.

Domiciliary midwives would support the exponential growth in home birth numbers from the all time national low of thirteen births⁸ in 1973 to at least 534 in 1986⁹ – 0.02% and 0.99% respectively, of all births in New Zealand.¹⁰ This 'new generation' of self-employed midwives would mirror the growing home birth numbers from 1974 as DM numbers grew, albeit more slowly, in an attempt to meet the demand for home birth.

Opposition to the home birth option and domiciliary midwifery by the medical, nursing and, indeed, midwifery professions in New Zealand, is evidenced throughout the thesis – an opposition equally reflected in the international literature.¹¹ This would have a

5 Bronwen Pelvin, Secretary, DMS, to Health Development Units, Letter, 15 October 1989, DMS, '1989 Correspondence, DMS/00 4/9'.

6 Elaine Wang, Marion Clark and Suzanne Smith, *The Nursing Workforce in New Zealand 1987*, Department of Health, Workforce Development Group, Wellington, 1988, p. 40. As there was no published information on the number of Registered Midwives in New Zealand with Annual Practising Certificates in 1989, the 1986 figure has been used.

7 For information on the New Zealand College of Midwives Partnership Model, see Karen Guilliland and Sally Pairman, *The Midwifery Partnership: A Model for Practice*, Monograph Series: 95/1, Department of Nursing and Midwifery, Victoria University of Wellington, 1995.

8 'Number of home delivery figures by health district and year', Table, c.1978, in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

9 'Home birth statistics 1987', c.1987, DMS, 'Home birth statistics, DMS/00 11'.

10 Department of Statistics, *New Zealand Official Yearbook 1974*, Government Printer, Wellington, p. 86 and Department of Statistics, *New Zealand Official Yearbook 1988-1989*, Government Printer, Wellington, p. 158. In 1973 and 1986 there were, respectively, 60,727 and 52,824 live births.

11 Mary M. Lay, *The Rhetoric of Midwifery: Gender, Knowledge and Power*, Rutgers University Press, London, 2000; Marjorie Tew, *Safer Childbirth? A Critical History of Maternity Care*, Free Association Books, London, 3rd edn., 1998; Marsden Wagner, *Pursuing the Birth Machine: The Search for Appropriate Birth Technology*, AceGraphics, Camperdown, 1994; Suzanne Arms, *Immaculate Deception II: A Fresh Look at Childbirth*, Celestial Arts, California, 1994; Sheila Kitzinger, ed., *The Midwife Challenge*, Pandora, London, 1988; R. Campbell and A. McFarlane, *Where to be Born? – The Debate and the Evidence*, National Perinatal Epidemiology Unit, Oxford, 1987; World Health Organization, *Having a Baby in Europe: Report on a Study*, World Health Organization, Copenhagen, 1985, pp. 86-87; Ann Oakley, *Women Confined: Towards a Sociology of Childbirth*, Martin

negative influence on the financial viability of domiciliary midwifery which would not be officially acknowledged until 1986. In that year, the Health Benefits Review Committee recognised that the opposition to home birth from a large part of the medical community had links to the low rates of remuneration for DMs.¹² Moreover, the overt hostility towards DMs, engendered by NZNA and its Midwives and Obstetric Nurses Special Interest Section (MSIS), again evidenced throughout the thesis, would include active measures to control domiciliary midwifery and bring it under the hospital auspices. Thus, while medicine's role in trying to 'stamp out' domiciliary midwifery and the home birth option is acknowledged, I explore the influential role nursing and hospital-based midwifery played in this matter.

While I discuss selection of, and working with, the archival material (and midwives' stories) in the next chapter, prominent in the archival material is that of the DMS. This collection, as catalogued in Table 2.2 on pages 51-52 of the thesis, comprises membership lists, documents of Incorporation, submissions, reports and minutes of meetings and conferences, agenda, invitations, correspondence, DMs and home birth reports, as well as published reports and papers. The Domiciliary Midwives Standards Review process, Home Birth Statistics, legislation, newspaper clippings and one midwife's personal papers are also included. Covering the time period 1978-1997, this is a contemporaneous record of the work of the DMS and the DMs' lobbying, networking and sustenance of each other as they provided home birth services. This material is enriched by additional archives from the New Zealand Board of Health's Maternity Services Committee (MSC) for the period 1978-1984 and that of NZNA for 1973-1987.

This finely woven analysis of archival material is illustrated (or flecked, as I refer to it) by the her-storying of the DMs, that is, the individual reflections – both oral and archival – of the embodied experience of 'being' a DM. These provide reflections on both the professional and personal consequences to each as domiciliary midwifery not only survived, but flourished despite professional, political and financial barriers raised and sustained by medical, nursing and midwifery colleagues.

Robertson, Oxford, 1980; Jean Donnison, 'The role of the midwife', Paper presented to the Association of Radical Midwives on its formation, c.1978, DMS/00 15/1.

12 Health Benefits Review Committee, *Choices for Health Care, Report of the Health Benefits Review*, Health Benefits Review, Wellington, 1986, p. 56.

Rather than continue with introductory comments now to be followed by discrete chapters on literature search, theoretical positioning, research method and so on, I must alert the reader, at this point, as to the manner in which the thesis is laid out and the rationale for this, as follows.

How is this thesis woven?

This study was conducted and the thesis is presented in the manner in which I, as a domiciliary or home birth midwife¹³ since 1989, would practise. This is to maintain the congruence of connectedness and interconnectedness which I assert exists between home birth midwifery practice and home birth midwifery re-search that I now introduce.

At the beginning of a home birth midwife's relationship with a woman, two women come together, perhaps unknown to each other, but each with her own story to share. The starting point of this relationship necessitates an introduction to the midwifery service. Similarly, in the preceding pages, I have introduced a starting point to the study.

The home birth midwife then talks to the woman about the style of care she can provide and elaborates why she chooses to work only in home birth rather than taking on the care of women who plan to birth in the hospital. Hence my elaboration of the structure of the thesis before continuing to explain what led me to the study.

Each woman comes to birth with goals in mind and knowledge as to why these are important to her. Perhaps she wants simply to know the person who will be with her during birth, so her shyness is reduced. More widely ranging, she may be planning a natural childbirth at home as she believes that this will provide the best opportunity for herself and her unborn baby to avoid unnecessary intervention. She may see the knowledgeable companionship of a midwife as integral to facilitating this. In parallel fashion, I define my goals in my re-search intentions and questions on page 15 and follow with informing the reader as to why this study was necessary.

13 The term 'home birth midwife' replaced 'domiciliary midwife' following the Nurse Amendment Act 1990. Some former domiciliary midwives use this term to differentiate between the self-employed midwife who provides both home birth and hospital services and those who provide only planned home birth services.

Over time the home birth midwife has all important discussions with the woman concerning the ‘rules, assumptions and procedures’ that exist in maternity services in New Zealand, which the Ministry of Health laid out in what is commonly called ‘Section 88’.¹⁴ Equally, there are ‘rules, assumptions and procedures’ to guide midwifery practice in the *Midwives Handbook for Practice*.¹⁵ This details the scope of practice and competencies expected of a midwife, the standards of practice and the philosophical underpinnings, all of which determine the ‘what, how and why’ of practice.

The *Midwives Handbook for Practice* informed this study. It gave me a position in which to stand to ensure the connection and interconnection of the practice of home birth midwifery and the practice of re-search. I named this position as ‘bare-footing’ as it reflects the ‘staying grounded’ – with-woman – in practice, in living one’s own ‘truth’ and in valuing one’s own knowledge. This, therefore, positions the study in the ‘being’ of a home birth midwife, which determined the re-search process, which I expand on in Chapter 2.

This thesis reveals a story that has built over time. The study developed to fruition from my interest over a period of seventeen years, which I soon explain. Equally, the study period extends over at least twelve years. This thesis is divided into eight chapters: five deal with individual themes which follow a timeline of various events, reviews, policy statements, publications and professional and practice issues, which I will introduce at the end of this chapter. Yet each chapter is not separate from the other in that there were often many things happening at once. For example, Chapter 4 examines the financial position of the DMs and their efforts to gain adequate remuneration for their service, starting from the late 1970s. This would overlap the time period during which MSC investigated domiciliary midwifery and NZNA developed its ‘Policy Statement on Home Confinement’.¹⁶ Growing dissatisfaction was being voiced by women’s health activists and the women’s movement about interventionist birthing practices in hospitals, all of which I evidence later in the thesis. These four groups of people and their activities are focused in four individual chapters but neither their activities nor the chapters stand in isolation from each other.

14 Ministry of Health, *Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000*, Ministry of Health, Wellington, 2002.

15 New Zealand College of Midwives, *Midwives Handbook for Practice*, New Zealand College of Midwives, Christchurch, 3rd edn., 2005.

16 ‘Policy Statement on Home Confinement’, in New Zealand Nurses Association, *Policy Statement on Maternal and Infant Nursing*, New Zealand Nurses Association, Wellington, April 1981, pp. i-iv.

Each provides a context for the other. To assist the reader in maintaining the interconnectedness of each of these chapters to the whole, I provide an overview of time and events and publications influential to, and influenced by, each other in Table 1.1.

Table 1.1 Overview of time, events and publications relevant to thesis

Event	Pre 1974	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	Post 1986
Founding and functioning of the DMS															
Reviews of maternity services in New Zealand															
Consumer demand for home birth increasing															
Domiciliary midwife numbers increase															
Publication of <i>Maternity Services in New Zealand</i> ⁱ report															
Nurses Act 1977															
Establishment of the New Zealand Home Birth Association															
Publication of <i>Obstetrics and the Winds of Change</i> ⁱⁱ policy statement															
'Policy Statement on Home Confinement' ⁱⁱⁱ															
Publication of <i>Policy Statement on Maternal and Infant Nursing</i> ^{iv}															
Publication of <i>Mother and Baby at Home: The Early Days</i> ^v report															
Nurses Amendment Bill 1983															
Publication of <i>Choices for Health Care, Report of the Health Benefits Review</i> ^{vi}															

Table notes: i) New Zealand Maternity Services Committee, *Maternity Services in New Zealand*, Report Series: No. 26, Wellington, Government Printer, 1976; ii) R.A. Barker, *Obstetrics and the Winds of Change*, Maternity Services Committee, Board of Health, (October 1979); iii) Midwives and Obstetric Nurses Section, NZNA, 'Policy Statement on Home Confinement', February 1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139); iv) New Zealand Nurses Association, *Policy Statement on Maternal and Infant Nursing*, New Zealand Nurses Association, Wellington, April 1981; v) New Zealand Maternity Services Committee, *Mother and Baby at Home: The Early Days*, Wellington, Government Printer, 1982; vi) Health Benefits Review Committee, *Choices*.

So the reader can identify with the many key ‘players’ who appear and reappear throughout the thesis, I have prefixed a List of Players naming the positions each held as relevant to the study. This enables quick re-identification with someone in the text who may reappear several chapters after being initially introduced. To maintain the interconnectedness, I also provide ‘concluding remarks’ at the end of Chapters 3-7 so the threads from each sequential chapter can be drawn together in a continuous way throughout the thesis. Also threaded throughout the thesis is the literature which informs both my position (additionally) and the study rather than it being an independent chapter.

Where a secondary source citation is referenced a second or subsequent time following the first full footnoted reference, I have abbreviated it to the author, brief title and relevant page numbers, as is the convention for historical referencing. The reader will be able to readily find the complete reference for a publication in the thesis bibliography. However, as each individual document of archival material is not fully detailed in the bibliography, I have repeated the full footnote each time with sequential numbers and footnotes starting, or restarting, with the number one in each chapter.

Having explained how this thesis is woven, I now continue by detailing what led me to the study.

What led me to this study?

By 1989, I had worked within hospital environments as a nurse, then a midwife, over a period of nearly twenty years. Within that time, I had always been noted to be an efficient, productive and ‘safe’ member of staff, receiving positive staff appraisals. I had been called on to fulfil positions of responsibility, such as being ‘in charge’ of the Delivery Suite in the absence of a Charge Nurse and I was a member of the Neonatal Retrieval Team which collected sick newly born babies from outlying districts.

In the two years following my registration as a midwife in 1987 I, like some midwives I worked with, felt increasingly isolated from the experience of ‘normal’ childbirth and had become increasingly dissatisfied with the degree of birth injury that I witnessed in the Delivery Suite where I worked. While the national induction of labour rate was 7% in 1988/89, this District Health Board was recorded as having over four times this

rate (29.3 per 100 births),¹⁷ nearly three times that which the World Health Organisation determined as acceptable for any geographical region.¹⁸ Most days I would care for women who received routine but unnecessary interventions¹⁹ in what had the potential to be otherwise physiological labours, as both they and their babies were well. The starting point of this ‘Cascade of Intervention’²⁰ began with the interruption of physiological pregnancies by way of induction of labour simply because women were at forty to forty-one weeks gestation – a practice based on spurious evidence.²¹ The induction of labour process included rupturing of the unborn baby’s amniotic membranes, the screwing on of an electrode into the baby’s scalp to monitor his or her heart beat, liberal use of intravenous infusions of Syntocinon,²² frequent painful vaginal examinations and the sudden end to labour if strict time frames for cervical dilatation or the woman’s pushing out her baby had not been achieved. That sudden end meant delivery of the baby through the use of Caesarean section or obstetric forceps - procedures that create injury to both woman and baby with each forfeiting the optimal opportunity inherent within physiological birthing, to respond fully at the critical time of ‘the first hello’.

Rather than having any knowledge of home birth, which would come later, my increasing dissatisfaction paved the way for me to agree to another midwife’s request for support in home birth practice in 1989. Also taking on my own caseload, I found my relationship with the women I served became a ‘walk in oneness’ – a journey of mutual goals and strategies of support – to do that which most are very capable, that is, grow, give birth to and mother their babies. Thus, working as a DM and attending home births turned the tables on the isolation I had felt from fulfilling my role as a midwife in supporting physiological childbirth. I would, however, come to intimately know a new isolation engendered by nursing, midwifery and medical colleagues, who did not share a healthy

17 Ministry of Health, *Obstetric Procedures 1988/89-1997/98*, Ministry of Health, Wellington, 2002, p. 20.

18 World Health Organisation, ‘Appropriate technology for birth’, *The Lancet*, 2, 8452 (24 August 1985), p. 436, and, World Health Organisation, ‘Summary Report: Joint Interregional Conference on Appropriate Technology for Birth, Fortaleza, Brazil, 22 April 1985’, DMS, ‘Articles (Journal) – Publications, DMS/00 15/2’.

19 For information on routine interventions in labour, see Doris Haire, *The Cultural Warping of Childbirth – A Special Report*, International Childbirth Education Association, Seattle, c.1972.

20 For information on the Cascade of Intervention, see Sally Inch, *Birthrights: A Parents’ Guide to Modern Childbirth*, Hutchinson, London, 1982, pp. 36 and 244.

21 For a critique on the validity of evidence for routine induction of labour at forty-one weeks, see S.M. Menticoglou and P.H. Hall, ‘Routine induction of labour at 41 weeks gestation: nonsensus consensus’, *BJOG: an International Journal of Obstetrics and Gynaecology*, 109 (2002), pp. 485-491.

22 This synthetic labour hormone is administered intravenously during labour to contract the uterus during an induction of labour process.

approach to women's birthing. As I exemplify later, this would take the form of numerous complaints about my practice from the obstetric, nursing and midwifery management of the hospital following my supporting women in options each chose for her birthing, the first occurring within a month of leaving the hospital embrace.

There were two groups that provided the sustenance for my work as a DM in the first three years of practice - the Waikato HBA and the DMS. The Waikato HBA exposed me to the articulate voice of Nature's reasoning when well women come to birth enriched by adequate housing, sanitary environments, nutritious foods, clean water supplies and healthy life styles. Before me in my practice and the Association's work, were both the stories and the results of healthy birthing for women who were in general, nourished, supported and valued by their families. I was shown time and again during my attendance at home births, how birth unfurled in these circumstances and how it could occur without medical intervention. Encompassed within the Association's work was the Domiciliary Midwives Standards Review Committee (DMSRC) which at that stage offered the only local forum to talk of my work as a DM. This provided the nurturing, support and encouragement needed to be able to exist and persist. The DMS provided the only other forum twice a year for me to discuss my work until the Home Birth Midwives Collective (Waikato) was established in 1991. Of one mind, the midwives of the DMS shared the same commitment and midwifery belief system as well as many strategies that were used to hurdle common barriers in practice, for example, managing the supervisory role of the Principal Public Health Nurse (PPHN) or gaining access to supplies. As each shared our experiences, the familiar pyramidal hierarchy of the hospital felt nonexistent as inspiration and experience was laid before me, shared by and for all, with my own contributions valued and integral to the forum.

But the clearer this home birth 'truth' became, the more isolated I was from those who practised our societal norm – obstetric management in hospital with its routine, time-fixed interventions. Evidence of the enormity of the gulf between what I saw as a home birth midwife and what was commonplace in the experience of childbearing women and midwives alike, would extend beyond my own practice in those first five years. More and more women, knowing of me through mothers, sisters, friends or other midwives, would contact me from throughout New Zealand. Their requests for support always focused on the same issues – they believed one thing in their hearts but their caregivers or the local

politics were, these women reported, drawing them ever closer to the obstetric precipice of the ‘Cascade of Intervention’, as previously discussed.

As was anticipated, the 1990 Amendment to the Nurses Act 1977, which returned professional autonomy to midwives, resulted in many midwives leaving the employ of the obstetrically-dominated environments of base hospitals. What was not anticipated as midwives came into the community was that they would bring the practices of the dominant discipline with them. However, from approximately 1992, there was mounting anecdotal evidence that increasing numbers of midwives, bereft of the understanding and experience of natural and healthy (physiological) childbirth, were providing home birth services within a medicalised framework. Artificial rupture of amniotic membranes, routine use of Syntocinon,²³ use of inhalation gases and narcotics, immediate umbilical cord clamping and cutting, as well as umbilical cord traction to precipitate placental birth, were becoming commonplace within the home birth environment. It was as if, as Judi Strid, an Auckland women’s health consumer activist, stated – “the enthusiasm with which midwives have individually seized any and all windows of opportunity, since the change in legislation which restored midwifery autonomy, has alienated them from the partnership that helped to make them strong”.²⁴

As the first Coordinator of the New Zealand College of Midwives (NZCOM) Midwifery Standards Review in the Waikato – a process I set up locally in 1994 – and during the first three years as a reviewer, the anecdote was confirmed as the lack of midwifery identity and the impact it had on childbearing women came clearly into view. While the discipline of the caregiver may have switched from doctor to midwife, the philosophical framework had often remained the same - medicalised childbirth. Intervention rates continued to escalate²⁵ despite midwives being 65.8% of the Lead

23 This synthetic hormone is also used following the baby’s birth as an active management of labour strategy to stimulate contractions, hasten birth of the placenta (which is delivered using controlled traction on the cord while simultaneously applying supra-pubic counter pressure) as well as to avoid excessive blood loss through atonic uterine muscles. This drug is sometimes referred to by midwives as an ecobolic.

24 Judi Strid, ‘Consumer viewpoint, four years post independence’, in *The Culture of Midwifery: Celebrating Women and Families*, Proceedings of the New Zealand College of Midwives 3rd Biennial Conference, 12-14 August 1994, Te Papaiaouru, Rotorua, p. 92.

25 For discussion on this, see Maggie Banks, ‘Nurturing our strengths’, in *Seasons of Renewal: A Celebration of Birth in Aotearoa New Zealand*, Proceedings of the New Zealand College of Midwives 6th Biennial Conference, St Peter’s School, Cambridge, 28-30 September 2000.

Maternity Carers²⁶ by 1999.²⁷ It was clear that some midwives, perpetuating obstetric practices, had assumed that the focus of home birth was on a physical structure rather than that of a healthy life event that did not require medicalised strategies to ensure healthy outcomes for well women and babies. It had been these same interventionist and unsafe practices overtaking natural childbirth²⁸ that had driven me out of the hospital and into domiciliary midwifery.

Equally, an overarching lack of acceptance by many hospital staff of the woman's right to control and to remain autonomous in her decision-making would become painfully clear to me within my first two years of home birth practice as I experienced numerous complaints against me from these practitioners over this period. It would become apparent that four transfer situations from 14 June 1990 to 24 March 1992 had been collated by the hospital management, formalised into a complaint and, unbeknown to the women who had received my care, lodged with the registering body for midwives, the Nursing Council of New Zealand (NCNZ).²⁹ While all the women were supportive of me and the complaints were not upheld, I was catapulted into answering to this highest midwifery authority in the land. Overt paternalism by the hospital managers denied these women the right to have a say in how their maternity services were provided by their midwife. Instead, their private information was abused and their autonomy usurped by a strategy carefully orchestrated to reign in and annihilate their midwife – me.

Repetitiously, the tenuous hold individual women have on their right to decision-making in childbirth would be reiterated for me with another situation, some eight years after being in home birth practice. I supported a woman to give birth to her baby at home in 1996 when the baby was known to be in a breech presentation. This woman specifically enlisted my support when she was thirty-eight weeks pregnant, after she had exhausted the miniscule support for natural birthing from medicalised attendants. Her baby's healthy birthing was interrupted by a placental abruption of unknown cause just prior to being born. As is the case for at least half of such situations, irrespective of whether the woman

26 A Lead Maternity Carer (LMC) is nominated by the woman and is responsible for providing or accessing all the midwifery and obstetric care necessary for that woman. The LMC may be a midwife, general practitioner or specialist obstetrician.

27 Ministry of Health, *Report on Maternity, 1999*, Ministry of Health, Wellington, 2001, p. 78.

28 Marjorie Tew, *Safer Childbirth?* and Suzanne Arms, *Immaculate Deception*.

29 Mrs E. Johns, Acting Convenor, Preliminary Proceedings Committee of Nursing Council of New Zealand to M.M. Banks, Letter, 3 October 1992, Personal papers.

is in hospital or at home,³⁰ her baby died. This woman's grieving became interrupted by the politics of childbirth in New Zealand as a paediatrician and seven neonatal nurses and midwives laid a complaint about my practice with NCNZ. Again, the focus of their concern was that I supported a woman in a choice with which they did not agree. Six successive investigations followed and each would identify my practice as devoid of negligence.

Of significance in the processes of complaints has been the role of midwives who have driven them. While this latter complaint was initiated by a medical practitioner, nurses and midwives lent their support to the complaint. While each of these vexatious complaints was dismissed at the lowest level of inquisition (the Preliminary Proceedings Committee), it had the affect of making me focus very acutely on the philosophy of midwifery, the herstorical witch hunts³¹ and the oppression of women, both as those oppressed and those oppressing.³²

The search for understanding as to why I was experiencing disapproval from medical, nursing and midwifery colleagues when I was simply working within the full scope of midwifery practice had begun with the first complaint. I wondered if my own experiences were a universal reflection of domiciliary midwifery in New Zealand and pondered the herstorical genesis for this antagonism. As I strove to understand the way forward from these complaint processes, I found the status of participant gave way to that

30 Murray Enkin, Marc J.N.C. Keirse, Mary Renfrew and James Neilson, *A Guide to Effective Care in Pregnancy & Childbirth*, Oxford University Press, Oxford, 2nd edn., 1995, p. 135.

31 Barbara Ehrenreich and Deidre English, *Witches, Midwives and Nurses, A History of Women Healers*, Feminist Press, New York, 1984; Elaine Papps and Mark Olssen, *Doctoring Childbirth and Regulating Midwifery in New Zealand: A Foucauldian Perspective*, Dunmore Press, Palmerston North, 1997, pp. 59-60; Helen Ellerbe, 'The witch hunts: the end of magic and miracles', in *The Dark Side of Christian History*, Morningstar Books, Berkeley, 1995, available http://thenazareneway.com/dark_side_of_christian_history.htm, retrieved 13 June 2006.

32 Denis Walsh, 'Feminism an intrapartum care: a quest for holistic birth' in Mary Stewart, ed., *Pregnancy, Birth and Maternity Care: Feminist Perspectives*, Books for Midwives, London, 2004, pp. 64-65; Christina Leibold Sieloff, 'Leadership behaviours that foster nursing group power', *Journal of Nursing Management*, 12, 4 (July 2004), pp. 246-251; Mavis Kirkham and Helen Stapleton, 'The culture of maternity services in Wales and England as a barrier to informed choice', in Mavis Kirkham, ed., *Informed Choice in Maternity Care*, Palgrave Macmillan, New York, 2004, pp. 117-145; Katy Dawley, 'Ideology and self-interest: nursing, medicine, and the elimination of the midwife', *Nursing History Review*, 9 (2001), pp. 99-126; Irene Calvert, 'Midwives should nurture their young not eat them', *New Zealand College of Midwives Journal*, 23 (January 2001), pp. 28-29; Gerald A. Farrell, 'From tall poppies to squashed weeds: why don't nurses pull together more?' *Journal of Advanced Nursing*, 35, 1 (2001), pp. 26-33; M. Kirkham, 'The culture of midwifery in the National Health Service in England', *Journal of Advanced Nursing*, 30, 3 (September 1999), pp. 732-739; Gerald A. Farrell, 'Aggression in clinical settings: nurses' views', *Journal of Advanced Nursing*, 25 (1997), pp. 501-508; E. Beatrice Salmon, 'Our anabasis', in Pat Carroll, Alice Fieldhouse and Sally Shaw, eds., *A Profession in Transition: Issues in Nursing in New Zealand over Two Decades, 1961-1981*, The C.L. Bailey Nursing Education Trust, Wellington, 1982, pp. 67-68; Nadine Pilley Edwards, *Birthing Autonomy: Women's Experiences of Planning Home Births*, Routledge, London, 2005; Margaret Llewelyn Davies, ed., *Maternity: Letters from Working Women*, Virago, London, 1978.

of an observer. The inevitability of consequences for a midwife who practises as just that – a midwife - rather than an obstetric nurse - became exposed. Equally, in reflecting on my conversations with members of the DMS and the Home Birth Midwives Collective; my study of our herstory³³ and work as a home birth midwife, the personal autonomy of many home birth midwives became almost palpable. As the experience of litigation and being called to account for practice in inquisitorial forums has become the reality for increasing numbers of midwives, there is frequently considerable pressure exerted on the midwife to moderate the essence of midwifery so it is acceptable to those who have most to gain from her disabling – the birth industrialists.³⁴

I began to look for reason as to why so many midwives exhibited so little faith and trust in women's abilities to birth. Critical to understanding this issue was Joan Donley's book *Save the Midwife*³⁵ in which she elaborates on the assimilation of midwifery into nursing and therefore, by proxy, bringing it into a subordinate role under the control of medicine, a position also held by others.³⁶ It raised many questions for me. How had this assimilation been achieved? Who were the main players in this? Why did nursing participate so eagerly in midwifery's assimilation? What was it that enabled DMs to be so focused on a midwifery identity which others appeared to not recognise? The last of these questions was answered in an international context³⁷ yet it was not until I discovered the writing of Beatrice Salmon,³⁸ a New Zealand nurse academic, that the relationship of nursing to midwifery began to have meaning, as I explain later in the thesis.

As a founding member of NZCOM in 1989, I was involved in the heady days when the Midwives Special Interest Section of NZNA burst out and became the College. It was a dynamic time. The sharp focus of midwifery soon overshadowed the subsuming influence of nursing as midwives, fired up with a whiff of autonomy, strove to explore their own

33 For examples of this, see, Joan Donley, *Herstory of the NZ Home Birth Association*, Joan Donley, Auckland, 1992; Joan Donley, *Save the Midwife*, New Women's Press, Auckland, 1986 and Philippa Mein Smith, *Maternity in Dispute New Zealand 1920-1939*, Historical Publications Branch Department of Internal Affairs, Wellington, 1986.

34 Marsden Wagner, *Pursuing*.

35 Joan Donley, *Save*.

36 Evan Willis, *Medical Dominance: The Division of Labour in Australian Health Care*, Allen & Unwin, Sydney, 1989; J. Donnison, *Midwives and Medical Men*, Historical Publications, London, 1988.

37 For examples, see Barbara Katz Rothman, *In Labour: Women and Power in the Birthplace*, Norton, New York, 1991 and Mary M. Lay, *Rhetoric*.

38 Pat Carroll, Alice Fieldhouse and Sally Shaw, eds., *A Profession in Transition: Issues in Nursing in New Zealand over Two Decades, 1961-1981*, The C.L. Bailey Nursing Education Trust, Wellington, 1982.

separate and distinct professional bounds. The formation of NZCOM and developing the philosophy and *Midwives Handbook for Practice*³⁹ was energising and liberating.

Aware of the pioneering in establishing a midwifery philosophy that DMs had done, I contemplated the practice reality of the late 1970s and 1980s when domiciliary midwifery was re-establishing strength. What was it like when the first of these midwives started home birth practice? How did they differentiate between necessary and unnecessary interventions in a medicalised birth culture when General Practitioners (GPs) were 'in charge'? What was it that enabled DMs to make the transitions from hospital to home birth practice? Did they have some inherent belief system which survived the obstetric hospital? If so, how did it survive? I also wondered how other midwives of the DMS managed relationships with colleagues who expressed hostility so openly.

Thus this study has developed out of the embodied experience of being a domiciliary and then a home birth midwife over many years.

Re-search intentions and questions

This study is intended to make visible the context of domiciliary midwifery practice, from predominantly, 1974-1986. It gives voice and visibility to both the DMS as an organisation and many of its members by capturing an accurate representation of the midwives who personified personal and relative (in the context of the time period) professional autonomy. I wanted to explore the basis for opposition to domiciliary midwifery - who engendered it and who sustained it? How was it engendered and sustained? How did DMs continue to practise amid hostility?

The guiding questions to elucidate these things were - what critical events initiated formation and influenced continuation of the Domiciliary Midwives Society (Incorporated)? What shaped the DM's understanding of her personal autonomy? How was this personal autonomy applied to midwifery practice?

39 New Zealand College of Midwives, *Midwives Handbook for Practice*, New Zealand College of Midwives, Christchurch, 1993.

Why was this study necessary?

An examination of New Zealand literature revealed an absence of writing on the Domiciliary Midwives Society (Incorporated), and little on domiciliary midwifery other than its brief mention within discussion on nursing and/or midwifery in general.⁴⁰ Juliet Thorpe's historical background to her Masters' thesis on collegial relationships within a New Zealand home birth practice concluded that the two Christchurch midwives she interviewed (Ursula Helem and Maria Ware), who respectively commenced domiciliary practice in 1974 and 1986, "struggled against the dominant medical model" of birth.⁴¹ Jennie Nicol's 1987 information gathering paper on home birth and domiciliary midwifery undertaken for the Department of Health concluded that provision of the home birth option was precarious in 1987 as workload, poor income and medical opposition to home birth brought domiciliary midwifery close to crisis point, despite it being part of a dynamic trend supported by home birth consumers.⁴²

Similarly, little international literature on domiciliary or home birth midwives during 1974-1986 was identified, though two biographies of individual 20th Century midwives in the United States (Onnie Lee Logan and Margaret Charles Smith) relate stories of black women and midwives from the late 1940s to early and late 1980s.⁴³ Studies of 20th Century midwifery practice commonly end with the 1950s, for example, Australian Mavis Gaff-Smith examines midwifery practice in the Warren area between 1890-1950 and in Wagga Wagga from the 1850s-1950s.⁴⁴ Equally, Jennifer Worth records her early years of midwifery training in London's East End focusing on the 1950s,⁴⁵ and Nicky Leap's and Billie Hunter's oral history of midwives and handywomen examines the period

40 Joan Donley, *Save*, pp. 104-106; Elaine Papps and Mark Olssen, *Doctoring*, pp. 130-131; Laura Hawkin, *Nurses Who See Themselves As Independent Practitioners: A Research Report*, New Zealand Nurses' Association, Wellington, 1989, p. 17.

41 Juliet Thorpe, 'A feminist case study of collegial relationships within a home birth midwifery practice in New Zealand', MMid thesis, Otago Polytechnic, Dunedin, 2005, p. 42.

42 Jennie Nicol, *A Choice of Birthing. Part I: Homebirth and Domiciliary Midwifery*, Department of Health, Wellington, 1987, p. 21.

43 Onnie Lee Logan as told to Katherine Clark, *Motherwit, An Alabama Midwife's Story*, Plume, New York, 1991 and Margaret Charles Smith and Linda Janet Holmes, *Listen to Me Good: the Life Story of an Alabama Midwife*, Ohio State University Press, Columbus, 1996.

44 Mavis Gaff-Smith, *Midwives of the Black Soil Plains*, Triple D Books, Wagga Wagga, 2003 and Mavis Gaff-Smith, *Riverina Midwives from the Mountains to the Plains*, Triple D Books, Wagga Wagga, 2004.

45 Jennifer Worth, *Call the Midwife*, Merton Books, Twickenham, 2002.

prior to the foundation of the Britain's National Health Service in 1948.⁴⁶ Only Julia Allison's retrospective study describing the lives of the hard working District Midwives providing care during 62,444 home births in the city of Nottingham during 1948-1972 extends towards the period of this study on domiciliary midwifery.⁴⁷

As can happen in any herstorying process which is held in the memory and shared orally, events of the past can become altered. This can occur because inaccurate information is set to print, for example, Elaine Papps and Mark Olssen wrongfully state domiciliary midwives were registered with the Department of Health and that all DMs were Direct Entry midwives,⁴⁸ both issues which I examine later in the thesis. Equally the record of the past can be altered due to multiple interpretations of events, experiences and practices or as a result of a changing emphasis on what is now desired or needed politically – a changing world view. It may also be lost, simply because there are not enough people around with first hand experiences and/or the oral sharing of the knowledge has not continued. Two such examples of this 'rewriting' of midwifery herstory are evident in accounts of the origin of NZCOM's Midwifery Standards Review process – a process with its foundation in the DMSRCs established in 1988.⁴⁹ It has since been credited in one account as established in the 1980s by NZCOM⁵⁰ and in another, by NZCOM and a number of maternity hospitals throughout New Zealand⁵¹ with acknowledgement of its true origin omitted.

As time has gone by, midwives in New Zealand have embraced the opportunity to be self-employed. However, I have observed many exhibiting signs that their autonomy sat poorly with them. Used to being governed by the 'rules and regulations' of the obstetric world – the policies, protocols and guidelines of their previous employers (the obstetric hospitals), many were quick to seek 'guidance' with new rules, this time set by NZCOM. It

46 Nicky Leap and Billie Hunter, *The Midwife's Tale: An Oral History from Handywoman to Professional Midwife*, Scarlet Press, London, 1993, p.xi.

47 Julia Allison, *Delivered at Home*, Chapman & Hall, London, 1996.

48 Elaine Papps and Mark Olssen, *Doctoring*, p. 129.

49 Joan Donley, 'Peer review for domiciliary midwives' Position paper, 1st draft, April 1988, 'Domiciliary Midwives Standards Review', DMS, 'Domiciliary Midwives Standards Review, DMS/00 10' and Joan Donley, 'Why the Domiciliary Midwives Review Committee?' Paper, April 1989, DMS, 'Domiciliary Midwives Standards Review, DMS/00 10'.

50 Helenmary Walker, Midwifery Council, 'The recertification programme', Presentation at Midwifery Council Forum, 1 November 2006.

51 S. Pairman and K. Guilliland, 'Midwifery Standards Review: a strategy for credentialing', *New Zealand College of Midwives Journal*, 25 (2001), p. 24.

has not been seen as every midwife's (and woman's) organisation that could be developed and directed, but rather the new 'they' to whom to defer.

Equally, in practice, midwives appear to either devalue or not recognise their own knowing, which I describe in the next chapter. Instead the dominant knowing of obstetrics is, in general, frequently heard and legitimated by many midwives. As Brigitte Jordan, probably the most influential pioneer in framing the study of medical anthropology in the mid 1970s, explained of this phenomenon:

*In many situations, equally legitimate parallel knowledge systems exist and people move easily between them, using them sequentially or in parallel fashion for particular purposes. But frequently one kind of knowledge gains ascendance and legitimacy. A consequence of the legitimisation of one kind of knowing as authoritative is the devaluation, often the dismissal, of all other kinds of knowing.*⁵²

This acceptance of the 'authoritative knowledge' of obstetrics, I assert, reflects the absence of a sure midwifery foundation within practice. While attempting to fulfil the Scope of Practice,⁵³ midwives do so in a medically-dominated society. In trying to moderate the plethora of complaints that abound, numerous affected midwives have verbalised their vulnerability and survival strategies. These strategies often reflect a lack of personal determination, which undermines their midwifery autonomy. An example of this can be seen in the midwife who will undertake any task which the woman requests, rather than, as I state in *Home Birth Bound*, honour "the innate promise embedded in the relationship of a midwife"⁵⁴ to not perform unnecessary interventions. Instead, these midwives are in danger of embracing the smorgasbord of unnecessary obstetric interventions, while verbalising them as 'women's choice'.

It was my own knowing of interconnectedness, as I introduced previously, that enabled me to see the whole meaning of being a home birth midwife. Once visible, I became aware I was on a parallel but separate path to hospital-based midwifery practice. This guided my

52 Brigitte Jordan, 'Authoritative knowledge and its construction', in Robbie E. Davis-Floyd and Carolyn F Sargent, eds., *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, University of California Press, Berkley, 1997, p. 56.

53 New Zealand College of Midwives, *Handbook*, 2005, p. 4.

54 Maggie Banks, *Home Birth Bound: Mending the Broken Weave*, Birthspirit, Hamilton, 2000, p. 213.

practice in the way I talked with women, provided midwifery care, documented labour and birth, valued evidence or framed up ‘new’ knowledge – I had transitioned from ‘doing’ as a midwife to ‘being’ a home birth midwife. This same interconnectedness has been influential in establishing the philosophical underpinnings which both presuppose the theoretical workings of this study and pre-determined the way it was carried out.

I now conclude this chapter with an overview of the remainder of the thesis.

Overview of the thesis

This chapter, while having given an introduction to the study and the re-search intentions and questions, has detailed what led me to further explore domiciliary midwifery herstory. I have established that the enquiry developed over many years as I came to understand intimately that domiciliary midwifery was not supported by many of my midwifery and medical colleagues who practised in hospitals, and as I strove to understand why this was so. Having detailed the professional isolation that I felt personally, apart from other DMs, I have enabled the reader to understand my position as a DM who commenced practice in 1989, a time when midwives practised under medical supervision and, predominantly, in hospitals.

I have also introduced a fundamental thread which exists throughout the thesis - that the study has been conducted as a midwifery re-search consistent with home birth midwifery practice. I elaborate on this position – one which I have called ‘bare-footing’ – in the next chapter.

Chapter 2 is divided into two parts – the first explains the philosophical underpinnings of the study which replicate the position of a home birth midwife in practice. Framing this in a way which acknowledges difference and similarity for the individual, the collective and the universal, I inform the reader of the interconnectedness between a home birth midwife’s practices of client care and re-search and explain the various facets that constitute the knowing of the home birth midwife. Key constructs, namely, difference, marginality, power, subordination, colonisation and decolonisation - influential in home birth midwifery practice and throughout the thesis – are discussed with reference to supporting and informing literature.

In Part 2 of this chapter, I describe the method of the study. I begin with the study’s ethical components before discussing how I worked with the archives and selected material

to be used both from this and the oral her-stories. The guiding questions and the way in which the midwives' voices are used within the predominating archival story conclude this part and chapter.

In Chapter 3, I explain the mechanism by which a midwife could contract to the Minister of Health (MoH) for payment through the Maternity Services Benefit (MSB). Detailing the midwife's service and documentary obligations, I also introduce the legal onus on the MOH to supervise the DM and the relationship she had with the PPHN and GP. I examine the regeneration of DM numbers, beginning in 1974. This is tracked until 1980 – a time period chosen because the MSC would review domiciliary midwifery in the late 1970s and early 1980s, as I explain shortly. After introducing the main eight midwives of the study, the beginnings as they started in practice is elaborated, as is the formation of DMS.

Remuneration through the MSB is considered in Chapter 4 with comparisons made between that which DMs received and that received by GPs and hospital-employed midwives. The financial impact of what, as I introduced earlier, was a substandard income for domiciliary midwifery is discussed - both the personal impact and the affect this had on midwife availability and, therefore, the growth of the home birth option. I follow the midwives' (and consumer groups') efforts to achieve an equitable and living income for domiciliary midwifery until 1987. This time was selected as in 1986, official recognition by the Health Benefits Review Committee was signalled of the influence that the attitudes of many in the medical community had on maintaining the penury of the DM.⁵⁵ This would affect a philosophical change at governmental level the following year which would subsequently be reflected in the level at which the MSB was set.

Supervision of the domiciliary midwife by the MOH, the PPHN and the GP is examined in detail in Chapter 5, along with the midwives' experiences of these supervisory relationships. As mentioned earlier in this overview, the MSC would begin an investigation of domiciliary midwifery from 1979, instigated by the DoH's desire to better manage supervision of the DM. I examine the data on home birth which was available to the Committee and analyse health professional opinion which informed the MSC.

55 Health Benefits Review Committee, *Choices*, p. 56.

In Chapter 6 I discuss the growing awareness, position and actions of the nursing and midwifery professions regarding the home birth option and domiciliary midwifery. Particular focus is given to the 'Policy Statement on Home Confinement'.⁵⁶ This document, submitted to the MSC by the MSIS in February 1980,⁵⁷ would later be appended in NZNA's 1981 *Policy Statement on Maternal and Infant Nursing*.⁵⁸ Little attention appears to have previously been given to the 1980 Policy but I will clarify its influence on MSC's review of domiciliary midwifery and its *Mother and Baby at Home: The Early Days*⁵⁹ report.

I examine how Early Discharge⁶⁰ schemes were promoted as potentially assuaging the demand for home birth in Chapter 7. Following an examination of maternity services in New Zealand from 1969-1982, I discuss the nursing (and midwifery) ethos of the time and 'how it was' for the DM not only when the labouring woman was transferred into hospital but also if she needed hospital admission during the births of her own babies.

In Chapter 8, I draw together the threads of the embodied experience of domiciliary midwifery to speculate on the various facets of personal autonomy that were demonstrated in the study. I conclude this chapter and the thesis with reflections on the research process after discussing the significant and substantive contributions this work makes to midwifery knowledge.

56 'Home Confinement', in New Zealand Nurses Association, *Policy*.

57 Midwives and Obstetric Nurses Special Interest Section, NZNA, 'Policy Statement on Home Confinement', February 1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

58 New Zealand Nurses Association, *Policy*.

59 New Zealand Board of Health, *Mother and Baby at Home: The Early Days*, Series Number 30, Wellington, Government Printer, 1982.

60 The term Early Discharge referred to a service where, following labour and birth in hospital, a woman was discharged home between six and forty-eight hours postpartum and visited at home by either a domiciliary midwife or a district nurse/midwife.

CHAPTER 2: A HOME BIRTH MIDWIFE'S PHILOSOPHICAL UNDERPINNINGS, PROCESS AND RE-SEARCH METHOD

Following this introduction, I discuss the philosophical underpinnings of midwifery in general before elaborating on my home birth midwife's 'knowing' which, along with informing literature, grounded this study as a midwifery practice of re-search. Explanation is given as to why I differentiate between midwifery in general and home birth midwifery in particular. Having done this in Part 1 of this chapter, discussion on how I undertook the study – the ethical positioning and working with the archival material and the midwives oral her-stories – is advanced in Part 2.

I begin Part 1 with the discussion of midwifery in general.

Part 1 - Philosophical Underpinnings

Midwifery - the caring of one woman during childbirth by another – has her roots in antiquity.¹ The word midwife, purported to derive from 14th century Old English 'mid-wif' meaning 'with-woman',² has in modern day meaning framed midwifery as a woman-centred profession. Feminism is integral to the philosophical underpinnings of midwifery³ which determines care to be given in a "flexible, creative, empowering and supportive"⁴ manner. Midwifery philosophy shares the three basic principles of the 'feminisms' – "a valuing of women and a validation of women's experiences, ideas and needs; a recognition of the existence of ideological, structural, and interpersonal conditions that oppress women and a desire to bring about social change".⁵

1 Sheila Kitzinger cites a 2,500 year old description of a midwife's role by the Tao Te Ching, in Sheila Kitzinger, *Midwife Challenge*, p. 1.

2 *Collins Concise Dictionary*, HarperCollins, Glasgow, 5th edn., 2001, p. 947.

3 Mary Stewart, ed., *Pregnancy, Birth and Maternity Care: Feminist Perspectives*, Books for Midwives, London, 2004; Meg Taylor, 'Is midwifery dying?' *Midwifery Matters*, 84 (2000), pp. 3-6; Deborah Davis, 'Embracing the past, understanding the present, creating the future: Feminism and midwifery', *New Zealand College of Midwives Journal*, 20 (April 1999), pp. 5-10; Liz Tully, Rea Daellenbach and Karen Guilliland, 'Feminism, partnership, and midwifery', in Rosemary Du Plessis and Lynne Alice, *Feminist Thought in Aotearoa New Zealand: Connections and Differences*, Oxford University Press, Auckland, 1998, pp.245-253; Karen Guilliland and Sally Pairman, *Midwifery Partnership*.

4 New Zealand College of Midwives, *Handbook*, 2005, p. 3.

5 Halls and Smith, 1991, cited in Jane Sigsworth, 'Feminist research: its relevance to nursing', *Journal of Advanced Nursing*, 22 (1995), p. 896.

Being ‘with-woman’ (midwife) is singular and it is the individual woman with whom the midwife develops a professional, if not personal, relationship by, in the main in New Zealand, providing continuity of care maternity services. The majority of these services are provided by midwives⁶ who work in small or group practices, independent from doctor-led services and settings.

Midwifery care can be provided in any setting – home, hospital, woman’s work place or other community setting such as marae,⁷ women’s refuge or community centre. During birthing, the midwifery service is usually, though not exclusively, confined to the woman’s home or a hospital. Rather than being focused only on the physical manifestations of pregnancy, midwifery also embraces the context of the woman’s life both in her family and the wider society. The philosophical underpinnings of midwifery, therefore, embrace the individuality of each woman with the existence of multiple realities for women evident on a daily basis.

The Definition of a Midwife and the Scope of Practice⁸ contribute to the framework of the midwife in New Zealand, irrespective of her self-employed or employed status and her practice environments. And yet difference(s) exist for midwives because, like women and as women, midwives also have multiple views on practice, as I explained previously.

The politics of naming difference

Naming difference can be interpreted as creating both a difference where universality exists and division where unity exists. Naming difference is counter to the Professional mantra of ‘a midwife is a midwife is a midwife’ – an NZCOM saying commonly used with the intention of creating unity amongst midwives and universality in the practice of midwifery. This is irrespective of the midwife’s place of practice or commitment to the principle of partnership in working with women. Such a seemingly divisive activity as naming difference invokes a not infrequent counter response. I penned my reflection of one such occurrence as a midwifery leader responded to consumer criticism of midwifery⁹ at

6 For information on midwives as maternity service providers, see ‘Lead Maternity Carers’ in Ministry of Health, *Report on Maternity, Maternal and Newborn Information, 2003*, Ministry of Health, Wellington, 2006, pp. 59-64 and 106.

7 A marae is a meeting area for whanau (family) or iwi (tribe) of Maori - the indigenous people of New Zealand.

8 New Zealand College of Midwives, *Handbook*, 2005, p. 4.

9 Judi Strid, ‘Consumer viewpoint’, pp. 92, 96, 97, 101, 102-103 and 107.

the 1994 NZCOM Conference. I interpreted this subsequent response as dismissive of the consumer's concerns and alienating of one who critiqued midwifery in other than an effusive manner, as follows:

Crisp and brisk, no ums and ahs
Silver brooch glinting
Each hair perfectly placed to the next
Fingers run through to fashion the look
A flick of the head and the helmet reforms.
She surveys all before her
scanning the placement of those she will address.
The generic Midwifery talk
The clicking of words, rhythm-a-hum
massaging the masses
warning of dangers to the Profession
reminding of victory and the tentative gain
Creating distance between the two hearts.
Securing the breastplate, she separates the woman-walk
The gap between the walkers grows.
*The wind in her words drowns out the woman's cry.*¹⁰

The universality of the oft-spoken mantra, as above, is a truism when considering the Scope of Practice and Definition of a Midwife - the legally enshrined representations of the range and sphere of midwifery practice to ensure public safety. However, this does not embrace the gamut of knowing, as discussed later, that gives rise to different ways as to how midwifery is practised. It is one such variation which gives rise to the home birth midwife's own 'truth'. As exemplified in my poem below, different knowing can marginalise the midwife from others simply because of different practice environments and, as a consequence, different opportunities for knowledge development, as I elaborate

10 Maggie Banks, Poem, unpublished, 1994.

later. Yet what is rejected by those with dissimilar minds can be readily recognised by like-minded others, as I recorded on my first time meeting with another home birth midwife in 1998 whom I had asked to speak at an education forum¹¹ I organised:

*She stood in the light
body loose, joints fluid
glasses burdening the end of her nose
fogged, but not needed for sight
as the vision was within.
I had not met her before
I knew her by her life's work.
As she started to talk, she joined my heart
Within a sentence I knew we were one.
Her slow smile grew as she took the step
exposing herself
She knew of the danger
She knew of the death
She could no longer hide her walk.
She stood before the sea of eyes
They saw her mother's form
Her voice filled two hundred ears
They heard her drawl
Their breath sucked in as she spoke her truth.
They could not see
They could not hear
They had not lived her journey to the light.*

11 Maggie Banks, 'Water birth: debunking the myths', Seminar held for NZCOM Wellington region, December 1998.

She spoke my words

*She lives within.*¹²

Marginalisation and difference

Roots of difference existed prior to the 1990 Amendment of the Nurses Act 1977 and the subsequent return of midwifery practice autonomy in New Zealand, when the home birth midwife was called a DM. So too did the consequences of being different exist in that the DM was marginalised by her hospital midwife colleagues as surely as she was from those in nursing and medicine. This a continual thread throughout the thesis which I evidence throughout subsequent chapters, but I will now introduce the role that medicine and nursing played in exerting power in the conquest, subordination and construction of midwifery identity. Further, preliminary consideration is also given as to how this impacted most specifically on the DM in terms of the control by law, finance and politics, as follows:

Control by law

In NZNA's attempt to control DMs, it framed up requirements for domiciliary midwifery practice more stringently than any required for hospital midwives. The DM was required to have "excellent"¹³ standards of practice while those of her hospital counterpart needed to be only "minimum requirements".¹⁴ Moreover, NZNA wanted to ensure the "proper control"¹⁵ (to be exercised through each local Hospital Board) and enforcement of "rigid requirements"¹⁶ that obstetrics had been seeking from 1977.¹⁷ NZNA's specifications for control were adopted by MSC and incorporated into its 1982 report *Mother and Baby at*

12 Maggie Banks, Poem, unpublished, 1998.

13 'Policy statement on maternal and infant nursing', *The New Zealand Nursing Journal*, 74, 9 (September 1981), p. 16.

14 New Zealand Nurses Association, *Policy*, p. 18.

15 H.H. McCrostie, President, New Zealand Obstetrical and Gynaecological Society (NZOGS) to R.A. Barker, Chairman, MSC, Letter, 19 June 1978, DoH, 'Board of Health – Maternity Services Committee, 1982', ABQU 632 W4415, 29/21 (54019).

16 Ibid.

17 D.H. Bashford, Secretary, NZOGS to the Health Department, Wellington, Letter, 16 December 1977, DoH, 'Board of Health – Maternity Services Committee, 1982', ABQU 632 W4415, 29/21 (54019).

Home: The Early Days.¹⁸ On 1 September the following year, the Nurses Amendment Bill 1983 was introduced in Parliament.¹⁹ Many of the submissions to the Select Committee that followed would link directly to attempts by medicine and nursing to bring about the demise of domiciliary midwifery.²⁰

Financial control

Domiciliary midwives experienced financial oppression throughout the late 1970s until the late 1980s.²¹ Their concerns were ignored by an unsympathetic MoH who, unsupportive of home birth, did not expect DMs to earn their total income from home birth practice.²² Minimal support to achieve pay parity with their hospital colleagues was given to the DMs by NZNA- the negotiating body for DMs' remuneration through the Maternity Services Benefit, as will be discussed in Chapter 4.

It took a change of Government and Minister of Health, along with a philosophical shift in the Department of Health, before the cause of the continued economic oppression of the DMs would be acknowledged. In 1986, the Health Benefits Review Committee reported:

*Domiciliary midwives offer a service which is frowned upon by a large section of the medical community who consider home birth as an unsafe, second-best option which is best discouraged. The low rates of pay may not be entirely unrelated to this attitude.*²³

Control by politics

The midwife's Professional body, until 1989 when NZCOM was founded, was NZNA, in which few midwives had political power. Midwives, always in the minority within the organisation, were reminded that while they numbered only 600, the nursing membership

18 New Zealand Maternity Services Committee, *Mother*.

19 A.G. Malcolm, MoH, 'Nurses Amendment Bill: Introduction', *New Zealand Parliamentary Debates*, 452 (1 September 1983), p. 2005.

20 Committee on Women's Health, 'Midwifery: a discussion paper', Wellington, 1986.

21 For examples of this, see Allison Livingstone to Dr Claudia Scott, Chairperson, Health Benefits Review Team, Submission, 28 May 1986, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

22 A.G. Malcolm, MoH to Mrs R. Blomfield, Letter, 5 April 1983, DMS, '1983 Correspondence, DMS/00 4/3'.

23 Health Benefits Review Committee, *Choices*, p. 56.

numbered 20,000, and, “such a small group of midwives cannot expect to sway the opinions of the nursing profession”.²⁴

How little control midwives had to determine their own identity during the study period was apparent. In June 1980, the Auckland branch of MSIS of NZNA met to form a statement of belief about midwifery as to the scope of practice, environment, and role of midwifery. It concluded that the midwife was a professional in her own right and her environment could include domiciliary practice. Midwifery practice was identified as different from obstetric nursing because of the midwife’s ability to make independent judgements, undertake independent actions and the legal right to perform and function as a midwife.²⁵ The National Executive of NZNA, in the midst of writing what would become its 1981 *Policy Statement on Maternal and Infant Nursing*,²⁶ chose to ignore the specific concerns and issues around professional identity as expressed by midwives in favour of nursing. The Executive stated “while the midwife, by definition, is a professional vitally concerned with maternal and infant health nursing not all nurses working in this area are midwives, or share their interests or concerns”.²⁷

Joan Donley reflected the opinions long held by other midwives from all spheres of practice²⁸ that NZNA used its dominant position to control midwives leaving them voiceless and un-represented. In 1988, she wrote:

... the NZNA Executive which holds the power and has the responsibility to carry out Conference decisions, did not support midwives. In fact as the elected executive recognized by government as representing nursing interests, the National Executive has ample opportunity to sabotage the efforts of midwives at the grassroots (Conference) level. National Executive members hold meetings with and deal directly at the administrative level

24 Joan Donley, ‘Midwifery education – A lolly scramble?’ Paper, 15 February 1988, Joan Donley Personal papers, ‘Texts of articles, papers, talks and speeches at workshops and seminars’, (MS93/7 1).

25 ‘Report on NZNA Midwives Section’, Minutes, 18 June 1980, Joan Donley Personal papers, ‘Midwives Section: Minutes 1980 - 1989, Missives 1984’.

26 New Zealand Nurses Association, *Policy*.

27 ‘Current Issues for Midwifery Practice: Opinions from Practitioners’, August 1980, NZNA 25/5/31 47.

28 M.A. McGowan, ‘Letters to the editor’, *The New Zealand Nursing Journal*, 72, 12 (December 1979), p. 21; Bronwen Pelvin, ‘Letters to the editor’, *The New Zealand Nursing Journal*, 72, 12 (December, 1979), p. 21; Gillian White, ‘Letters to the editor’, *The New Zealand Nursing Journal*, 72, 12 (December 1979), p. 21; Jackie Gunn, New Zealand Nurses Association, Midwives Section, Auckland Branch, ‘Minutes of Annual General Meeting’, 6 November 1982, ‘Midwives Section: Minutes 1980-1989, Missives 1984’ and Edwina M. Andrews to Health and Welfare Select Committee: Nurses Amendment Bill 1983, Submission, 5 October 1983, ‘Nurses Amendment Bill, 1983’, HW/83.

*with the Departments of Health & Education, Hospital Boards Association, NZ Medical Association and the Nursing Council of New Zealand. In addition it nominates the nurse advisors to the senior administrative structure of the Departments of Health & Education. None of these nurse advisors have a midwifery qualification yet midwives have no advisors to represent their interests.*²⁹

Beyond subordination

That midwifery became a subordinated profession to medicine with the passing of midwifery registration acts has been opined by many.³⁰ Sociologist Evan Willis determined medicine's method of domination of midwifery occurred through "subordination, limitation and exclusion". While acknowledging the complexity of these factors, he summarises:

*In the simplest terms the subordination of midwives was achieved by its incorporation into nursing, an occupation which was already structurally located in a position of subordination to medicine. By becoming in effect a special branch of nursing, something the leaders of the occupation of nursing themselves encouraged as a strategy in their own attempts at professionalisation, midwifery changed its structural location within the health division of labour from an independent status to a subordinate one.*³¹

However, due to previously mentioned controls, I contend that the midwife in New Zealand experienced a process more reflective of colonisation by medicine (and nursing), being assimilated into an already subordinated nursing profession, rather than a process of simple subordination. As Linda Isaza, prominent in facilitating Treaty of Waitangi workshops for Pakeha³² in the 1980/90s, points out, colonisation is:

29 Joan Donley, 'Midwifery education – A lolly scramble?' Paper, 15 February 1988, Joan Donley Personal papers, 'Texts of articles, papers, talks and speeches at workshops and seminars', (MS93/7 1).

30 Nadine Pilley Edwards, *Birthing*, p. 85; Elaine Papps and Mark Olssen, *Doctoring*, pp. 83-96; Katy Dawley, 'Ideology', pp. 99-126; Liz Tully, Rea Daellenbach and Karen Guilliland, 'Feminism', p. 246; Robbie E. Davis-Floyd and Carolyn F. Sargent, eds., *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, University of California Press, Berkeley, p. 322; Evan Willis, *Medical*; and, J. Donnison, *Midwives*.

31 Evan Willis, *Medical*, p. 93.

32 Pakeha is the Maori word for non-Maori, European or Caucasian.

*A political, legal and primarily economic process whereby metropolitan, [that is], European powers took over the territory of other peoples to settle their own subjects for economic, social and political reasons...Power in colonised societies is based on relationships maintaining a sharp distinction between the ruling nation/race and the subordinate populations = colonised. Power is expressed through the law as well as in the fact of conquest and subordination and the construction of racial identity.*³³

The effects of that colonisation – namely, “cultural disintegration, loss of self-sufficiency, loss of personal and cultural identity and individual and community dysfunction”,³⁴ were present during the study period. With the passing of the Nurses Act 1971 the midwife lost her legal right to practise independently to a medical practitioner.³⁵ She was renamed as an obstetric nurse in the *Social Security (Maternity Benefits) Regulations 1939*³⁶ and nursing policy statements³⁷ and as I evidence in Chapter 7, she commonly participated in medicalised childbirth. This was also evident at the point of the return of autonomy of midwifery practice in 1990, as I explained earlier. Some effects of this colonisation continue to have a presence within midwifery today, as I now explain.

A colonised profession takes stock

Midwifery has in the last thirty years been re-establishing her with-woman roots. This process, initiated in the home birth movement³⁸ by women and DMs from the mid 1970s, as I will discuss later in the thesis, has accelerated since 1990. The Profession in regaining its identity has adopted ‘professionalism’ as an indicator of an independent profession. Karen Guilliland and Sally Pairman, two acknowledged leaders of midwifery, state:

New Zealand midwifery’s definition of professional focuses on its ability to practice independently from other disciplines; to define its own scope of

33 L. Isaza in, M. Pittman, P. Brownlie and L. Isaza, ‘Colonisation’, *Project Waitangi Resource Kit*, 1985.

34 *Ibid.*

35 Nurses Act 1971: Section 52(1), cited in Elaine Papps and Mark Olssen, *Doctoring*, pp. 94-95.

36 Social Security (Maternity Benefits) Regulations 1939, 13(1) and 13(2), p. 5, DMS, ‘Legislation, DMS/00 17’.

37 New Zealand Nurses Association, *Policy*.

38 The women’s health movement was fundamental in initially raising issues concerning childbirth. The majority of ‘drivers’ of those issues would later form the Home Birth Associations and Support Groups throughout New Zealand. The use of the term ‘home birth movement’ is therefore used inclusively of the women of the former.

*practice; to regulate its standards of education and practice and to hold members accountable for the quality of their practice.*³⁹

In their germinal work, *The Midwifery Partnership: A Model for Practice*, Karen and Sally contribute a specific woman-midwife relationship in their framing up of 'The Midwifery Partnership'. While this document and its reasoning contributes significantly to developing midwifery knowledge(s), the authors' focus on professionalism omits the common attribute of any profession - its own body of knowledge. This invisibility again reflects midwifery's previous position of assimilation within nursing and an accompanying reliance on the nursing (obstetric) knowledge gained from medically-managed birth.

Thus, to date, a discrete 'midwifery theory' - "a [midwifery] system of rules, procedures, and assumptions used to produce a result"⁴⁰ which may assist the re-establishment of midwifery knowledge through research, does not exist. Should such be the case, I would argue that generalities of a single midwifery theory could have unlimited application to this study. This is because the culturally specific way for me, with my home birth midwife knowing, is to ground the philosophical underpinnings specifically within home birth practice rather than superimposing a generic framework, such as Socialist Feminism.⁴¹ The 'knowing' of a home birth midwife, a knowing that presupposes the theoretical workings of this study and the way in which it was conducted, is now elaborated.

The knowing of the home birth midwife

The distinct and separate 'knowing' of the home birth midwife leads her to identify the childbirth continuum of pregnancy, birthing, breastfeeding and early mothering as a life phase that seldom needs medical care, hospitalisation or technological assistance. Explanation of this knowing and how it influences the thesis is elaborated in the following sections: with-woman environment; with-woman language; with-woman text; with-woman storying; with-woman re-search and with-woman knowledge.

39 Karen Guilliland and Sally Pairman, *Midwifery Partnership*, p. 20.

40 *Collins Concise Dictionary*, p. 1566.

41 For information on this, see Alison M. Jaggar and Paula S. Rothenberg, eds., *Feminist Frameworks: Alternative and Theoretical Accounts of Relations between Men and Women*, McGraw-Hill, Boston, 3rd edn., 1993, pp. 187-189.

With-woman environment

The home birth midwife is cognisant of a physiological birth process needing familiarity of sound, light, speech, smell, taste, people and environment to dampen down the woman's conscious state so that she can give herself over to birthing and early mothering. Rather than separated into stages, each requiring a shift to a separate environment – for example, home in early labour, a hospital labour room for birthing, a hospital postnatal room for early mothering and then a final shift back to the woman's home for ongoing mothering – the process is recognised as a continuum with maintenance of the familiar integral to its physiological unfurling.

Home is more than about a place of domestic furnishings, food, people and routines. I concur with those who propose place is fundamental to the control and maintenance of the woman's power⁴² rather than simply the background to her individuality and context of her life. The woman's home has been identified as the place where her power is able to be maintained more than the home of medicine and nursing – the hospital.⁴³ That power is about the ability to control the specifics of her childbearing experience – who attends her (both professionally and socially) and how her social and ethnic customs and rituals will contribute to birthing.

In recognising the need to 'humanise' the institutions, some hospitals, such as birthing units or birthing centres, have created a 'home-like' environment, mimicking that which is needed for an optimal birth process. However the mimicry is not of home but of the obstetric hospital, albeit with the obstetric bed and high technological equipment (electrocardiograph monitors and resuscitation tables) concealed beneath or within home furnishings, ready for disrobing and disclosure on the caregiver's decision to transform the room into the high tech environment.⁴⁴

Equally important in similarity to obstetric hospitals is the management of these facilities. It is the District Health Board managers or commercial operators who ultimately

42 Viisainen, Kirsi, 'Negotiating control and meaning: home birth as a self-constructed choice in Finland', *Social Science & Medicine*, 52 (2001), pp.1109-1121; Sheila Kitzinger, 'Sheila Kitzinger's Letter from Europe: Home Birth Matters', *Birth*, 27, 1 (March 2000): 61-63; Marie O'Connor, *Birth Tides: Turning towards Home Birth*, Pandora, California, 1995; Trudi Fersterer, 'Empowerment in childbirth – Women's home and hospital birth experiences', Masters thesis, University of Waikato, 1993 and Barbara Katz Rothman, *In Labour*.

43 For an opposing view, see Nadine Pilley Edwards, *Birthing*, pp. 148-149, 176 and 219.

44 To see this transformation, see photographs by T. John Hughes in Maria Fannin, 'Domesticating Birth in the Hospital: "Family-Centered" Birth and the Emergence of "Homelike" Birthing Rooms', *Antipode*, 35, 3 (July 2003), pp. 514 and 518.

determine the way in which facilities will be used and the activities which will occur within them. The regulation of its activities and staff are evident in the corporate clothing (uniforms), language (medical-ese), pre-determination of behaviours and responsibilities (hierarchy) and service delivery (protocols and clinical guidelines).

A woman's ultimate lack of control in the hospital environment is evidenced by the absence of locks on labour room doors and, therefore, her inability to exclude unwanted people from her birthing. Thus the woman is not assured of a most basic human right of privacy and the ability to control who will attend her during birth.

Women have reported hospital as the place where they are regularly exposed to bodily 'takeover' with the unnecessary use of medical interventions and techniques that can be routinely prescribed.⁴⁵ These include time-regulated vaginal examinations and labour progress, artificial rupturing of the baby's amniotic membranes, administration of oxytocics, as well as separation of mother and baby by clothes, beds and procedures. Most obvious in the lack of control for women is the inability to prevent the superimposing of childbirth as a health crisis, or midwifery services as a prescription of care.

The home birth midwife provides continuity of care and carer throughout the childbirth continuum from (usually) at least early pregnancy and until six weeks after birth, all of which occurs in the woman's home. In fact, the deeply held belief that place is all important to the maintenance of the woman's birthing power and a physiological process, disables the home birth midwife from providing services in hospitals, except where ill health is apparent or additional health care is necessitated. As such, the home birth midwife enacts a 'trusteeship' - "the doctrine and practice of 'do no harm' "⁴⁶ throughout the continuum by knowledgeable companionship, including her knowledge of, and respect for the abundant variations which exist for women during the childbirth continuum.

With-woman language

Embraced in the principle of Midwifery Partnership is the woman's right to define her own needs and education, and to evaluate her midwife's practice. The woman (through

45 Peter Butler and Hilary Butler, *Just a Little Prick*, Robert Reisinger Memorial Trust, South Auckland, 2006, pp. 34-46; Maggie Banks, *Home Birth*, pp. 9-18; Marion De Ras and Victoria Grace, eds., *Bodily Boundaries, Sexualised Genders and Medical Discourses*, Palmerston North: Dunmore Press, 1997; Phillida Bunkle, *Second Opinion: The Politics of Women's Health in New Zealand*, Oxford University Press, Oxford, 1988, pp. vii-ix.

46 Maggie Banks, *Home Birth*, p. 214.

consumer representation) is integral in the development of midwifery policy, service specifications and educational development, as well as reviewing midwifery practice.

For a partnership to be effective and so information is readily accessible to women, common language is used. Within my practice there is a constant need to translate information into everyday language so the non-health professional childbearing woman is able to access meaning. The necessity for such activity, illustrates that non-health professionals are not intended to be privy to information contained in the majority of medical research. This same observation can be applied to the secret society of academic writing where authors create an “intellectual assault course”⁴⁷ in their use of language that maintains a barrier for the ordinary (but extraordinary) woman.

Language has the power to pull the reader or listener in so she can personally identify with the voice, becoming more receptive to the story. As I explain in *Home Birth Bound: Mending the Broken Weave*:

*It is customary, when discussing statistics and birth procedures, as in [the chapter on] ‘Birth Injury’, to use euphemistic language. Thus, cutting a woman’s vagina open with scissors becomes an episiotomy; having a baby pulled out of her - a forceps delivery; injury to the mother or baby - maternal or perinatal morbidity, and so on. These euphemisms objectify women’s experiences, distancing the reader from the reality for the individual woman. It can be said that to use women’s own language creates an emotional charge. This is entirely intentional, for giving birth is an experience full of high emotions...thus, the language used reflects how women view and articulate these experiences.*⁴⁸

Equally, research science parades its dominance in the language used. The words ‘participants’, ‘interviews’ and ‘data’, reflect a dispassionate and hierarchical relationship of ‘the doer’ (the researcher) to ‘the done’ (the researched) which invoke the public (male) domains of hospitals, universities and corporate and institutional processes.

Specific words which evoke a sense of the private, secret or deeply personal intimate the home domain. These represent both the home birth midwife’s relationship and

47 Sue Stanley and Liz Wise, *Breaking Out Again*, Routledge, London, 1993, p. 22.

48 Maggie Banks, *Home Birth*, pp. 3-4.

the environment in which the woman-midwife relationship unfolds. So such words are used in this study, as follows. 'Participants' are named simply as domiciliary midwives. Just as the word 'woman' in practice is known for its inclusion of her baby, the midwives know they are participating in the re-search. The 'interview' is named a 'catch-up' in recognition of the words home birth midwives use when they want to meet, discuss practice, share experiences and work on planning. While some key tasks may be formally placed on an agenda, the totality of the catch-up usually embraces more extensive content, such as family matters. It also reflects the ease in the relationship between myself and the midwives sharing her-stories, which is appropriate to a shared journey when each is known to the other or when commonalities are known. 'Data' collected in catch-ups is referred to as 'her-storying' to indicate both an evolving process over several catch-ups and the open-ended flow of conversation at depth, as opposed to the staccato of question, answer and tick sheet.

This 'knowing' is reflective of that which Ann Oakley argued as important in feminist research to avoid 'objectifying' the woman being interviewed.⁴⁹

With-woman text

One of the most readily digestible forms of written language is the novel. Uninterrupted by bracketed referencing it flows as one story with many nuances held within it. Academic writing is often compounded (and confounded) by introduction within the text of authors' names, dates and page numbers that jolt the reader's sensibilities unless she is familiar with such presentation.

Utilizing an open pathway to knowing with the use of everyday language and style engages the reader as if in a story. The use of footnote referencing, customary in historical writing, prevents interruption of the text while imitating conversation - a backhanded whisper triggered by a text note, signalling more to the story that will be shared by glancing below.⁵⁰ It hints of the secret, the sharing of gossip and of sisterhood.

Hospital institutions and their processes attach an importance to titling, for example, 'Director of Obstetrics', 'Director of Nursing' or 'Midwifery Advisor'. Titles,

49 Ann Oakley, 'Interviewing women: a contradiction in terms', in Helen Roberts, ed., *Doing Feminist Research*, Routledge, London, 1981, pp. 41-51.

50 "Did you know that ...?"

always starting with an upper case initial, are often used to denote a hierarchical position and their existence is important to the maintenance of that hierarchy. The use of upper case in the thesis, for example, 'The Midwife' and 'The Profession', reflects the disconnection from the grassroots of midwifery, midwives, women and the midwifery service. While it is not intended to suggest ongoing perpetuation of this hierarchy today with my continued use, I have done so as it reflects the context of the study period of 1974-1986. Conversely, the use of lower case text to name, for example, 'the domiciliary midwife', reflects a non-hierarchical position and the connectedness to the principle of being with-woman. The exception to this strategy is where for ease of reading, I use capital letters to abbreviate a title repetitiously used - for example, 'Principal Public Health Nurse' is abbreviated to PPHN. To assist continual re-identification of the meaning of initials, a list of abbreviations is prefixed.

A justified alignment of text creates a symmetrical, neat and orderly text, moderating any variation in line length. It represents the same principle of containment and averaging out of women's labours that has occurred with medicalised childbirth. To the contrary, my use of 'align left' suggests a shared starting point - a beginning - of a labour or a story and then the infinite variation that exists until its end.

The writing, thoughts and her-storying of others when differentiated by italics, a single right and left tab indentation and a footnote reference, ensures that contributions beyond the author(s) of a book, text or archival document remains connected and interconnected to the whole. Where authorship is referred to once only, full referencing appears in the footnotes as well as the bibliography at the end of the thesis. If repeated, it is abbreviated in subsequent footnotes to author's name, shortened title and relevant page numbers. The exception to this is in referencing archival documents. For these I repeat the full footnote reference as is the convention in historical referencing.

With-woman storying

Story telling, often at depth, is fundamental to the woman and home birth midwife relationship that develops during antenatal visits. Rather than visits being a time of data collection and ensuring that all the items of a care plan are tick-listed, the home birth midwife asks open-ended questions and provides observations which can trigger a cascade of the woman's thoughts.

Beginning from the first visit, the woman's storying builds over time to become an interweaving of the important feelings, people and events that are central in her life and which have brought her to her belief systems focused around birthing and mothering. Some women choose to explore how people and events have enriched or detracted from her sense of self. For some, considering and verbalising thoughts and experiences at depth over the period of a pregnancy can bring new understanding of how these have impacted on her beliefs about herself and possibly affected, either negatively or positively, her ability and place to stand in the world.

With the question being asked and the answer being valued with the home birth midwife's time, attentiveness and reflection - in other words, being with-woman - the woman's story telling has the potential to provide a "lived experience in its purest, and rawest, form".⁵¹

'Being heard' may be a unique experience for some women – 'the first time I have ever spoken (or thought) about it like that'. At times the woman's perceptions of events and their impact on her and her baby's lived experience of childbirth can vary markedly from the written word of the obstetric record, one that exemplifies valuing only physical outcomes by its omission of women's stories. Story telling can illuminate events that have been omitted from written record, sometimes events with life-changing consequences. For example, upon reading her obstetric record a woman was surprised to see the only description of her birth was 'normal delivery'. No mention was made of any perineal trauma, yet this woman related her experience as also having included her vagina being cut open and stitched without anaesthetic – a trauma which prevented her from lovemaking for six months. At the point of her-storying some six years later, she had never allowed herself or her husband to look 'down there'.⁵²

However, as I introduced earlier in the thesis, each story already exists for the woman, despite it being unknown to others. It may already exist as a whole or it may be fragmented - lying hidden, waiting to be gathered and woven back and forth to allow one

51 Robert Atkinson, 'The life story interview', *Qualitative Research Methods - Vol. 44*, Sage Publications, California, 1998, p. 74.

52 Personal communication: V. to Maggie Banks, December 2004.

to see the whole, as the whole.⁵³ For this reason, the activity of research and the knowledge that it generated has been called 're-search' rather than being referred to as 'research'.

With-woman re-search

An insider-outsider relationship is a common issue for midwifery practice. Woman and midwife may be unknown (outsider) at the start of the midwifery relationship, but the nature and longevity of the relationship over the childbearing year (and possibly over many successive pregnancies) usually creates a closeness and intimacy that results in a deep knowledge of each other, centred on a shared journey (insider). This relationship is constantly reflected on to ensure that foundation principles are maintained. These apply equally to a re-search process as Linda Tuhiwai Smith states in her text on *Decolonizing Methodologies*:

*Insider research has to be as ethical and respectful, as reflexive and critical, as outsider research. It also needs to be humble...because the researcher belongs to the community as a member with a different set of roles and relationships...*⁵⁴

With-woman knowledge

A body of knowledge is accepted as an essential component of any profession. In an attempt to raise credibility of The Midwifery Profession in the eyes of those who have historically been the greatest opponents, The Midwife has incorporated obstetric knowledge into her practice adopting its hierarchy of the validity of evidence.⁵⁵ The Midwife, encouraged by The Profession, strives to emulate the apex.⁵⁶ The authoritative

53 Robert Atkinson, 'Life story', p. 68.

54 Linda Tuhiwai Smith, *Decolonizing Methodologies: Research and Indigenous Peoples*, University of Otago Press, Dunedin, 1999, p. 39.

55 For further information on the hierarchy of evidence, see Iain Chalmers, 'Evaluating the effects of care during pregnancy and childbirth' in Iain Chalmers, Murray Enkin and Marc J.N.C. Keirse, eds., *Effective Care in Pregnancy and Childbirth, Volume 1, Parts I-V*, Oxford University Press, New York, 1989, pp. 3- 38. For critique of the hierarchy of evidence, see Susan Hodges, 'A consumer viewpoint: challenges for birth-related research', *Birth*, 27, 4 (December 2000), pp. 281-285.

56 For an example of this, see Maggie Banks, 'But whose art frames the questions?' *The Practising Midwife*, 4, 9 (October 2001), pp. 34-35.

knowledge – “the knowledge on the basis of which decisions are made and actions taken”⁵⁷ – is obstetric knowledge and it is highly valued.

The home birth midwife, while cognisant of the knowledge of others, values highly her own ‘expertise’ of being a woman, which often includes having given birth herself. Her many hours spent in the company of childbearing women and the ‘thoughtful exchange’⁵⁸ process with women and other midwives is recognised for its ability to widen the parameters of the experiences of childbirth, adding depth to understanding.

A central component for the home birth midwife’s knowledge (re)generation is through story telling – a level of Evidence given least value in Science’s hierarchy of evidence, as previously mentioned. However, just as the midwifery relationship is with each individual woman, so too does each individual story add a fragment to the home birth midwifery knowledge mosaic.

Of major consequence in my journey were the experiences I had as a mother, grandmother and midwife to my second daughter (and first grandchild) in 1995 and 1996. In my relationship as my daughter’s midwife, I was burdened by the task of trying to keep separate my ‘selves’ as woman, mother and midwife. Throughout her childbirth experiences (one a miscarriage and the other her first child), the last vestige of this separateness fell in tatters. I was no more a selection of part selves than I had put on a new pair of shoes when I started practice as a DM. Within my midwifery practice, there had always been 100% of me. While I had always spoken to women about how they brought the wholeness of their lives into their birthing, this circumstance focused me on the fusion of the many facets of my life that totalled ‘the whole me’ - the midwife as woman and the woman as midwife, interwoven and inseparable.

It is these with-woman principles which have informed this study and determined its methodology – an interconnected process which grew from practice that I describe below as ‘bare-footing’.

57 Robbie Davis-Floyd and Elizabeth Davis, ‘Intuition as authoritative knowledge in midwifery and home birth’, In Robbie E Davis-Floyd and Carolyn F Sargent, *Childbirth*, p. 316.

58 ‘The Canadian Consensus on Breech Management at Term’, <http://sogc.medical.org/sogc-docs/public/guidelines/cbree12.htm>, retrieved 8 February 1998, p. 6.

Engendering midwifery knowledge through 'bare-footing'

Continuity of carer practice – one midwife providing care throughout the childbirth continuum with a second midwife providing back up - has necessitated me being continuously on-call. The cumulative hours spent with each woman are variable as also are the times of attendance, particularly during labour, but not exclusive of the pregnancy and early mothering periods. Impossible to divide practice into an eight hour day, a forty hour week or a Monday to Friday 'job', I have experienced and valued home birth midwifery practice as a life style connected and interwoven with my personal life.

Robbie Davis-Floyd and Elizabeth Davis note that connection is enormously valued by midwives attending home births. In their study on the role that intuition plays on their behaviour at births, home birth midwives:

*insisted that the degree of connection they are able to maintain with mother and child depends on the degree of connection they maintain to their own thoughts and feelings. So basic is the importance of this interconnectedness that many of them actively seek it during and even before a birth.*⁵⁹

In similar fashion, interconnectedness has been actively sought in the thesis as this interconnectedness and interweaving of practice and personal life is also applicable to a home birth midwife's re-search endeavours related to with-woman principles, and provides the philosophical underpinnings that inform this study. As such it also determined the method of the study.

The naming of this interconnectedness as 'bare-footing' is reminiscent of the act of taking ones shoes off when entering a woman's home. While recognising the need for inviolability of the woman's home during the childbearing experience and reflecting a common social norm in home birth midwifery, this act also reflects the staying grounded - with-woman - in practice, in living one's own 'truth' and in valuing one's own knowledge. Thus bare-footing represents the interconnected workings of practice with the interconnected workings of re-search practice and determines the 'how' of the home birth midwife's practice of re-search.

59 Robbie E. Davis-Flyod and Carolyn F. Sargent, *Childbirth*, p. 324.

Bare-footing reflects that within practice, the home birth midwife cannot afford to work with a pre-conceived notion of the journey involved in the childbirth continuum, as these pre-conceptions can affect the experience in itself. As Greg Newbold articulates:

*to lay a theoretical mantle on a piece of research is to make a presumption about the results which affects not only the research method, but also the interpretation of the findings. It is likely, for example, that findings contrary to the chosen theory will be ignored, while those favourable to it will be given exaggerated importance.*⁶⁰

Another important aspect of keeping re-search practice connected to midwifery practice lies in the re-establishing of midwifery knowledge as well as retaining meaningfulness and accessibility to midwives. Bare-footing offers an opportunity for new insight - boundless, eternal and self-generating - a necessity as midwifery continues its de-colonisation process.

Linda Tuhiwai Smith notes colonised groups want to not only tell their own stories but to do so in a way that reflects culturally specific ways.⁶¹ In flagging up this importance, she sees it as “inextricably bound to a recovery of our language and epistemological foundations of language...about reconciling and reprioritising what is really important about the past with what is really important about the present”.⁶²

Home birth midwives need to tell their own stories and in their culturally specific way, including, as Marian and Helena Court flag as important, to “rewrite and revalue difference(s) ‘and the building of (albeit shifting) connections that are based on an ‘openness to unassimilated otherness’ ”.⁶³

I have already elaborated on naming difference, a stand that triggers rebuke to marginalise the home birth midwife today as equally as that experienced by the DM in New Zealand prior to 1990. One may assume only a negative connotation to marginalisation. In fact, DMs used this marginality to protect themselves and their ideals

60 Greg Newbold, ‘Historical research’, in Carl Davidson and Martin Tolich, eds., *Social Science Research in New Zealand: Many Paths to Understanding*, Longman, Auckland, 1999, p. 289.

61 Linda Tuhiwai Smith, *Decolonizing*, p. 27.

62 *Ibid.*, p. 39.

63 Marian and Helena Court, ‘Positioning, subjectivity, and stories: feminist poststructuralist research narratives’ in Rosemary Du Plessis and Lynne Alice, *Feminist*, p. 134.

from colonisation by nursing, medicine and midwives who did not share their belief system.⁶⁴ Of this “space of resistance”, bell hooks notes:

*marginality...is a site of radical possibility...a site one stays in, clings to even, because it nourishes one's capacity to resist. It offers to one the possibility of a radical perspective from which to see and to create, to imagine alternatives, new worlds.*⁶⁵

In the same vein, the marginality of the home birth midwife today is utilised in her ‘alternative and new world’ to focus on ‘coming out from under’ through her secure identity and practice culture, albeit not recognised within Midwifery but certainly recognised by home birth midwives.

Lastly, bare-footing invigorates midwifery research in general, offering a previously invisible stepping stone between this and the activities of midwifery practice. Maintaining this congruence nurtures easier movement between the two and is effective in breaking down an academically-determined barrier.

Part 2 - Process and Method

In this section of the thesis I describe the process and method of the re-search - how I worked with and selected the archival material and midwives’ her-storying. I begin with how I evoked the with-woman spirit through using the Code of Ethics.⁶⁶

Evocation of the with-woman spirit

An effective relationship between woman and midwife relies on mutual trust and respect as well as acceptance of each woman’s right of autonomy to control her childbearing experience. Those features inherent in the midwife’s Code of Ethics include working in a relationship of mutual respect, accepting the individuality of each woman and respecting the importance each woman places on people and events. Specifically these include the midwife’s responsibilities to:

64 In 1982 membership of the Domiciliary Midwives Society was “necessarily exclusive” in order to protect natural childbirth and the midwives who provided the home birth services, see ‘Report of meeting of Domiciliary Midwives Association (DMS), 28.3.82, at Palmerston North’, DMS, ‘DMS meetings, DMS/00 2/1’.

65 bell hooks, *Yearning: Race, Gender and Cultural Politics*, South End Press, Boston 1990, p. 149, cited in Rosemary Du Plessis and Lynne Alice, *Feminist*, p. 15.

66 New Zealand College of Midwives, *Handbook*, 2005, pp. 10-11.

work in partnership with the woman;
uphold each woman's right to free, informed choice and consent...;
hold information in confidence in order to protect the right to privacy...;
support and sustain each other in their professional roles and actively
nurture their own and others' sense of self-worth;
uphold their professional standards and avoid compromise just for reasons
of personal or institutional expedience; [and],
ensure that the advancement of midwifery knowledge is based on activities
*that protect the rights of women.*⁶⁷

In keeping with the philosophical underpinnings which informed the study, I engaged the specifics of the with-woman spirit (though in a different order), both in relation to the DMs and the archival material, as I now discuss.

Upholding each midwife's right to free, informed choice and consent

Each midwife had the right to agree to, or, decline participation in the re-search, withdraw from the study and to control her own information.

Initially, I made contact with each midwife to discuss the proposed re-search. If she was agreeable to me informing her about the project, I discussed the project aims, design, time involvement and her rights to withdraw at any time and to control the use of any portion of her information. If she was interested to receive further information, she was given the written information outlining the project as in Appendix 1.

In order to facilitate the decision-making process without coercion, the contact to signal her willingness to participate was negotiated individually as to whether she would contact me or I would telephone after she read the written information. After receiving an affirmative verbal agreement to participate, I gave or sent each the Consent Form (Appendix 2) and covering letter confirming this agreement to participate (Appendix 3).

One midwife, though initially appearing interested to participate in the study, did not respond further to my sending her information after my first contact. As we had

⁶⁷ *Ibid.*

arranged that she would contact me to signal her willingness, I did not make further contact with her.

Each midwife retained the right to withdraw her information throughout the study period until a week before submission of the thesis for publication. None chose to do so. This right to withdraw her-storying in subsequent articles prior to being submitted for publication will continue.

Working in partnership

During catch-ups with the midwives, an open and interactive discussion was engendered - a relationship of mutual trust - which enabled relevant information to be shared. Respect for unique values systems and 'world views' meant interactions took place in a mutually agreeable manner and environment, which ensured the re-search process was culturally safe. There was one face-to-face catch-up with each midwife and an additional phone conversation with one.

To ensure opportunity to reflect on shared information and align any discrepancies between myself and the midwives, each had her own transcript of the catch-up and was also sent excerpts of the thesis in which her contribution appeared. Any decision to alter, omit and/or readdress issues which arose – which occurred once - was resolved using a mutually agreeable solution.

I originally intended to ask each member of the DMS for release of the material she had contributed to the archive and I established a process to so do (Appendices 4, 5a, 5b and 6). However, three of the midwives who provided oral her-storying, as well as various members of the now defunct DMS, felt that the archive was part of their herstory and of considerable herstorical interest. Each determined that, ultimately, it should be publicly available as an uncensored whole following the study. Therefore archival document release was not sought from the previous membership.

The DMS archive is currently stored at my home. The whereabouts of its future storage has been initiated with several previous members of the DMS but no suggestions were offered. As the DMS is no longer in existence, once the thesis has been externally examined, I will address the issue of permanent housing with previous DMS secretaries.

Holding information in confidence and ensuring protection of rights during advancement of midwifery knowledge

To ensure all information gained by me remained confidential, each midwife was asked if she wished to be identified as herself or by a pseudonym. It was possible that because of their high profiles and leadership in the midwifery profession in New Zealand, some of the midwives may have been identifiable despite all precautions – a matter discussed with each midwife. If choosing to be identified by a pseudonym, then pseudonyms would have been negotiated, no identifying information would appear in any report or publication and each midwife's identity would remain confidential. Moreover, audiotapes would be encoded to protect the true identity from all but myself and transcribing would be done by me.

No midwife wished to use a pseudonym, as each wished to claim her individual her-story as her own and naming was part of this claiming.

Ongoing negotiation ensured they remained comfortable with the information prior to publication or presentation.

Confidentiality of all audiotapes, notes, logs and any other her-storying made available to me by the midwives was ensured by storage of these in my separate and private study and on my personal and private computer in my home. Any person who may have been employed to transcribe the midwives' her-storying would have signed a statement of commitment to maintain confidentiality of the material as in Appendix 7. However, all transcribing of audiotapes was done by me.

Information was made available only to my Supervisors as was necessary to fulfil the Course requirements. These Supervisors are governed according to the Victoria University of Wellington Code of Ethics.

Audiotapes of her-stories were agreed to be kept for five years following completion of the study, after which time they will be electronically erased. A copy of each midwife's transcript was given to her following completion of the study.

Upholding professional standards and avoiding compromise

The collected her-storying will not be used for any other purpose than specified in the Consent Form. Should a desire to vary this occur, a new process of gaining informed choice and informed consent would be initiated if the tapes still exist.

Supporting and sustaining professional roles and actively nurturing safety

There were potential threats to the safety of midwives, such as being identified despite my best efforts even if protection of their identity and confidentiality had been chosen, as discussed previously. Equally, distressing memories could have surfaced during our catch-ups.

Each midwife retained the right to stop the catch-up at any stage and was made aware of how to stop the audio tape recording. Proximity to the tape recorder's on/off switch ensured she could do this at will. One midwife exercised her right to do this for one portion of a catch-up – not through distress but because she wished to elaborate on a deeply personal issue.

Each midwife was also made aware of her continued right to either stop the research process altogether at any stage or to have any particular comments, discussion or information withdrawn which may have caused distress. None chose to do so.

I provided my contact information so any issue which may have arisen in relation to the re-search could be dealt with expeditiously to maximise her continued safety. Should there have been any concerns regarding the re-search process she was able to contact my Supervisors or the Human Ethics Committee at Victoria University of Wellington. None of these circumstances arose.

The midwife's own words were used to tell her story and it is clear in the analysis whether it is her voice or mine that is heard. While any discrepancy in the analysis and interpretation was to be negotiated as to which contributions were ultimately included, my and each individual midwife's analysis and interpretation were compatible.

The re-search process and Ethics Committees

Having established this re-search is interconnected as a midwifery practice, I was diverted from the consistency of using my midwifery framework alone by the University's need for me to seek ethical approval for the study through its own process, one which became superimposed over my own ethical framework.

The Ethics Committees' process and prescription as in Appendix 8, while separate from my own guide, were filled as a requirement of VUW to promote protection of 'the researched' from an unethical researcher. The prescriptive Consent Form phraseology of

the former does not reflect women's language or process and is therefore incongruent with this study.

Applications for ethical approval were sent to eight Ethics Committees of New Zealand as this was a multi-centred study. Approval was granted with Waikato Ethics Committee nominated as the Lead Committee.

I continue now with discussion on how I worked with the archival material and the midwives' her-storying.

Working with the voices of the study

There were two strands to the voices of this study – archival material and individual DMs of the Domiciliary Midwives Society (Inc.). Her-storying on its own can create a “complete and meaningful picture”⁶⁸ but this study, as mentioned previously, includes an interconnection between her-storying of past DMs and archival material. Each is complimentary as the archival material provides a “closed door” to domiciliary midwifery herstory of the time period, and the “open door” of her-storying can provide opportunity for the DMs to interpret events and discuss their significance.⁶⁹ I now elaborate on the voice which is ‘heard’ most frequently through the thesis – the archival one.

The archival voices

A robust collection of archival material on domiciliary midwifery was, prior to this study, secreted in the secretarial archive of the DMS. This comprehensive and contemporaneous record of the Society and its members represents a life of its own – an embodiment of domiciliary midwifery from the 1978 to 1997 – a vibrant story, albeit dishevelled and neglected as I recorded in a journal entry entitled ‘The Archival Tart’ six weeks after ‘she’ was delivered to my home:

You were bursting out of your tights

68 Ruthellen Josselson and Amia Lieblich, eds., *The Narrative Study of Lives - Vol. 1*, Sage Publications, London, 1993, p. xi.

69 Valerie Raleigh Yow, *Recording Oral History. A Practical Guide for Social Scientists*, Sage Publications, London, 1994, p. 10.

Split seams and flesh bulging
Your blouse with its lost buttons couldn't contain your form
Sitting slumped at the bottom of my stairs for a fortnight
before I could heave you up
Your flaking skin waving every time I pass.
I knew from the start I would not be able to leave you alone
Just one little pile
Just enough to lessen your spillage
A loose paper, worried I would loose sequence
And then there were two and three and ten.
Stuffed in a corner, silent but shouting at me...
Babies have come and I am forced to ignore you
Your dank smell fills my study
The grime of ten years, many shifts and unprotected life
I put you in boxes, hoping to ignore you.
A fortnight passes
My study is orderly but I see you every time I pass
I need to speak to you, but only a few words
I lift the lid and see your fullness
A file called 'membership'
Shouldn't take more than half an hour
Twelve hours later we are still talking
You have enchanted me with a jewel
A snapshot of the domiciliary midwives
And the first huddled meetings of the brave six
I am back with the women who started you

*And their spirit is alive on your skin...*⁷⁰

The DMS archive, delivered to me by the Secretary, was housed in two large cardboard cartons and two plastic carry bags, the latter having some bundles of unsorted papers. Storage to protect the archive was a priority. After initially storing it in boxes, I sorted the archive into permanent storage folders. File names were retained as they presented with the exception of the general correspondence. Originally ordered from May of each year until April of the next - this being the timing of Home Birth Conferences each year and, therefore, one of the times of DMS meeting - correspondence was broken into calendar years. Many of the A4 envelopes were torn and edges of foolscap documents were curled and scuffed. To prevent the documents becoming more damaged by my (and subsequent others) removal from, and replacement in, (some) overfull envelopes, all files were placed flat but loose in manila folders. Original envelopes were retained. Each file was allocated initials to identify it as DMS archival material (DMS), the last two numerals of the year 2000 in which it was received (00), a category number (for example, '1' to denote 'Documents of Incorporation') and a subset number, if this was relevant - as illustrated in Table 2.1.

Table 2.1 Folder numbering of the Domiciliary Midwives Society (Incorporated) Archives, 1978-1997, Hamilton

File numbering	Explanation
DMS	Domiciliary Midwives Society (Incorporated)
//00	The last two figures of the year 2000, that is '00', represent when the archive came into my possession
4	The major category of the material file, for example, 'Correspondence'
4/1	The subset of this category, for example, '1981 Correspondence'

Grouped manila folders were then placed in archive pouches, for example, three separate manila folders for 1981, 1982, 1983 correspondence were placed in one archive pouch with contents marked on the spine. Loose items, such as books and pamphlets, were placed together in an archive pouch and named on the spine, for example, DMS/00 15/1.

These forty separate folders or bundles, as shown in Table 2.2, hold social, economic and practice documentation, as well as attesting to the financial, legislative and

70 Maggie Banks, Journal, unpublished, 3 August 2000.

professional context of domiciliary midwifery throughout the study period. The complete archive is now stored in two drawers of a vertical filing cabinet measuring a total of sixty-three by sixty-three centimetres.

Table 2.2 Domiciliary Midwives Society Incorporated (DMS) Archives, 1978-1997, Hamilton

Folder and/or Pouch No.	Folder Name	Years
DMS/00 1	Documents of Incorporation	1982-1997
DMS/00 2	Meeting Minutes, Reports, Agendas and Invitations DMS Meetings, DMS/00 2/1 NZCOM, DMS/00 2/3 Home Birth Reports, DMS/00 2/2	1982-c.1992 1989-1992 1982-1992
DMS/00 3	Membership Lists	1989-1992
DMS/00 4	1981 Correspondence, DMS/00 4/1 1982 Correspondence, DMS/00 4/2 1983 Correspondence, DMS/00 4/3 1984 Correspondence, DMS/00 4/4 1985 Correspondence, DMS/00 4/5 1986 Correspondence, DMS/00 4/6 1987 Correspondence, DMS/00 4/7 1988 Correspondence, DMS/00 4/8 1989 Correspondence, DMS/00 4/9 1990 Correspondence, DMS/00 4/10 1991 Correspondence, DMS/00 4/11 Correspondence, re Maternity Benefits, DMS/00 4/18 Correspondence, re Hamilton, DMS/00 4/19	1981-1990 1986-1987
DMS/00 6	<i>The Domiciliary Midwives Newsletter</i>	1984-1989
DMS/00 7/1	Newspaper Clippings Book	1979-1981
DMS/00 7/2	Newspaper Clippings Envelope	c.1982-c.1990
DMS/00 8	Domiciliary Midwives Reports	1987-1993
DMS/00 9	Home Birth Association Reports & Newsletters	1986-1993
DMS/00 10	Domiciliary Midwives Standards Review	1983-1989
DMS/00 11	Home Birth Statistics	1974-1988
DMS/00 13	Direct Entry Midwifery	1986-1990
DMS/00 15/1	Publications: Books and Pamphlets	c.1984-1991
DMS/00 15/2	Articles (Journal) - Publications	c.1982-1988
DMS/00 16	Bronwen Pelvin Personal papers B.L. Pelvin, DMS/00 16/1 B. Pelvin, DMS/00 16/2	1978-1993 1986
DMS/00 17	Legislation	1939-1990
DMS/00 18	Submissions and Unpublished Papers	1981-1990
Unnumbered folders and envelopes	Standards for midwifery services – Midwives Section – NZNA, February 1989 Wellington Domino proposal, c.1989 Submissions: ‘Policy Recommendations for Care for Pregnancy and Childbirth’ - 1989 Working group on ‘Safe Options for Low Risk Pregnancy - 8 th draft, November 1989’ ‘Policy Recommendations for Care for Pregnancy and Childbirth: 8 th draft, November 1989, 6 th draft, October 1989’ <i>NZCOM National Newsletter</i> , November 1989-June/July 1993 Stationery Loose bundle of papers	

Working with and selection of archival material

I familiarised myself with the whole archive. After having thoroughly read all the DMS correspondence and minutes and reports of meetings, I started to gather computer notes grouping issues into separate files – DMS meetings, submissions, NZNA policy, economics and so on. However, within two months I found that, if I continued with this, I was in danger of losing the interconnections between one event and another, one conversation and another, one publication and another, as well as negating how each was nestled into the broader context - a situation acknowledged by historians as potentially problematic with a thematic framework in studying historical material.⁷¹ Overwhelmed with the volume of material, I was also acutely aware that I could not afford to go into each document of the whole archive a second time. I needed to be able to get all the information from each document accurately recorded during my first note taking, irrespective of attempting to classify whether it was, for example, a financial or a professional detail. So, I created a timeline in one file, named ‘Archival Message’ – some 250 pages of typed notes from approximately 1,200 documents, a process which took me over three years.

Within a year I became aware that I had not found an apparent starting point as to why domiciliary midwifery came under review by MSC and NZNA, a matter which I discuss later in the thesis. I had done a computer-assisted literature search at the beginning of the study using Cumulative Index of Nursing and Allied Health Review (CINAHL), Consortium of University Research Libraries Online Public Access Catalogue (CURL) via Copac, Te Puna National Bibliographic Database, Historical Abstracts, ProQuest, Google Scholar and ScienceDirect. Words used individually or in combination were: Zealand, midwifery, nursing, nurse-midwife history, nurse midwives history, home birth, domiciliary, autonomy. While sources came to light that are evident throughout the remainder of the thesis, nothing to assist me in determining a starting point had been found.

I performed a hand search of the *New Zealand Nursing Journal*, 1977-1981 which revealed linkage between NZNA and MSC from the late 1970s during MSC’s review of domiciliary midwifery⁷² (which I discuss in a later chapter). I accessed MSC’s correspondence, meeting and submissions files from 1978-1984 from Archives New

71 W.H. McDowell, *Historical Research: A Guide*, Pearson Education, London, 2002, pp. 10-11.

72 New Zealand Maternity Services Committee, *Mother*.

Zealand (see references). As the activity of the NZNA National Executive and MSIS was prominent in matters arising in the DMS archive, I also accessed from NZNO's Wellington building basement, NZNA minutes of meetings - National Executive, Board of Health Committee, and Maternal and Infant Ad Hoc Committee, as well as Executive Director's Reports, Branch Circulars and National Conferences, variously from 1973-87 as detailed in the thesis references section. I also reviewed NZNA's Midwives Section files from 1972-1987 prior to their deposit in the University of Auckland library (see 'Auckland Branch of Midwives and Obstetric Nurses Special Interest Section (MSIS) of New Zealand Nurses Association' in references). My final sources were gained from two personal archives of Joan Donley's held in the Auckland Museum ('Joan Donley 93/7' and 'Joan Donley 95/20'), and her papers ('Joan Donley, ca. 1956-ca. 2002') which now form part of the collection of the 'New Zealand College of Midwives, Auckland branch' in the University of Auckland Library.

I was aware with the arrival of the DMS archive that containment would be an issue. My search into these other archival sources had compounded this issue but I now felt satisfied I was able to look at the issues from all sides – DMS, NZNA, MSIS, DoH and MSC – and, as a result, had a robust enquiry process.⁷³ Equally, I had found the starting thread. I added all relevant documents from these sources into my time line.

The re-search questions 'what critical events initiated formation and influenced continuation of the Domiciliary Midwives Society (Inc)?', 'what shaped the DM's understanding of her personal autonomy?' and 'how was this personal autonomy applied to midwifery practice?' were asked of the archival material. I wanted to know the political, financial and professional issues that affected domiciliary midwifery and midwives of the DMS – what did the DoH, MSC, NZNA and MSIS think about domiciliary midwifery? How did these views come about? What were the information sources? What actions were taken as a result of their deliberations? What effects did their actions have on midwives of the DMS?

The 'archival message' forms the cloth of the re-search with its many sources of archival material interwoven to form a finely textured analysis of all the material. Into this

73 Martha Howell and Walter Prevenier, *From Reliable Sources: A Introduction to Historical Methods*, Cornwell University Press, London, 2001, pp. 70-71.

whole I flecked the experiences of DMs, which I will explain further after elaborating on the voices of the domiciliary midwives, as follows.

The domiciliary midwives' voices

Nine midwives were invited to contribute oral her-stories on their lived experience of practice as DMs. Eight midwives agreed to participate – the ninth, as I explained previously, did not respond to the invitation following being sent the study information. Prior to formal contribution of her her-story, one midwife (Joan Donley) became unwell and was unable to participate in the study. My contact with Joan over the last sixteen years and the knowledge of her participation in domiciliary midwifery signalled that a study on domiciliary midwifery in New Zealand would not be complete without her voice. Joan has been a prolific contributor of books, unpublished papers, journal articles, submissions, radio interviews and magazines, as well as to the DMS archive. Her 'voice' has been teased out from many of these sources and I have included introductory notes about her in Chapter 3, alongside the midwives who contributed orally to the study.

The decision on the number of midwives and those to be invited was partly informed by my personal and practice knowledge of the midwives' commitment and/or contribution to domiciliary practice. Their selection was also informed by the DMS archive.

Selection of the midwives

In October 1989, Bronwen Pelvin, then the secretary of the Society, wrote to all Health Development Units in New Zealand requesting the names of midwives contracted to the MoH as DMs.⁷⁴ The responses indicated there were 128 such midwives.⁷⁵ Thirty-eight out

74 Bronwen Pelvin to Health Development Units, Letter, 15 October 1989, DMS, 'Membership lists, DMS/00 3'.

75 Frances Brown, Southland Area Health Board to Bronwen Pelvin, Secretary, DMS, Letter, 24 October 1989, DMS, 'Membership lists, DMS/00 3'; Diane Long, Heath Development Unit, Waikato Area Health Board to Bronwen Pelvin, Secretary, DMS, Letter, 25 October 1989, DMS, 'Membership lists, DMS/00 3'; Beverly Thomas, Napier Heath Development Unit, Hawke's Bay Area Health Board to Bronwen Pelvin, Secretary, DMS, Letter, 30 October 1989, DMS, 'Membership lists, DMS/00 3'; Jenny Mienis, Manager Resource Development, Health Development Unit, Bay of Plenty Area Health Board to Bronwen Pelvin, Secretary, DMS, Letter, 20 November 1989, DMS, 'Membership lists, DMS/00 3'; The Otago Area Health Board to Bronwen Pelvin, Secretary, DMS, Letter, 27 October 1989, DMS, 'Membership lists, DMS/00 3'; Miss S.E. McElroy, PPHN, Department of Heath, Timaru District to Bronwen Pelvin, Secretary, DMS, Letter, 20 October 1989, DMS, 'Membership lists, DMS/00 3'; S.M. Wallace, Manager, Health Development Unit, Canterbury Area Health Board to Bronwen Pelvin, Secretary, DMS, Letter, 3 November 1989, DMS, 'Membership lists, DMS/00 3'; Lena van der Meulin, Health Development Unit, Wellington Area Health Board to Bronwen Pelvin, Secretary, DMS, Letter, 26 October 1989, DMS, 'Membership

of thirty-nine fulfilled the selection criteria of having had Society membership, had been contracted to the Minister of Health, provided a domiciliary midwifery service throughout the continuum; and, worked in partnership with a home birth consumer group where one existed.

Of the seven who contributed orally, two were secretaries of the DMS (Gillian Wastell and Bronwen Pelvin), one was the first midwife to start practice in Auckland (Carolyn Young), one was a Direct Entry trained midwife (Anne Sharplin), three trained overseas (Sian Burgess, Anne Sharplin and Sue Lennox), one worked long term in two geographical regions (Jenny Johnston) and one provided an Early Discharge scheme (Sue Lennox). Carolyn and Bronwen were also chosen because of their early commencement of domiciliary midwifery practice – 1974 and 1978 respectively. This selection was also made knowing these midwives practised over the spectrum of urban to remote rural settings.

Her-storying was collected during semi-structured, audio-taped catch-ups, taped telephone conversations and email contact. The first two methods lasted 60-90 minutes each. While being physically present together during catch-ups was the preferred method, financial and geographical constraints were a deciding factor in the method chosen. In each case, one catch-up was ‘face-to-face’. Catching up initially with the midwives spanned five months.

The guiding questions and the catch-ups

I had already explored the first question in the archival material, that being, ‘what critical events initiated formation and influenced continuation of the Domiciliary Midwives Society (Inc)?’, though this came up in the catch-ups with several of the midwives. I

lists, DMS/00 3’; V.G. Cowan, Community and Environmental Health Division, Wanganui Area Health Board to Bronwen Pelvin, Secretary, DMS, Letter, 6 November 1989, DMS, ‘Membership lists, DMS/00 3’; R.C. Black, Health Development Services, Taranaki Area Health Board to Bronwen Pelvin, Secretary, DMS, Letter, 19 October 1989, DMS, ‘Membership lists, DMS/00 3’; T. Webby, PPHN Manager, Northland Area Health Board to Bronwen Pelvin, Secretary, DMS, Letter, November 1989, DMS, ‘Membership lists, DMS/00 3’; Helen Richardson, South Auckland District Office, Auckland Area Health Board, ‘10/25/89 SAK contracted DMs’, List, October 1989, to Bronwen Pelvin, Secretary, DMS, 3 November 1989, DMS, ‘Membership lists, DMS/00 3’; Annie Fernie, Director, Community Health Services, Health Development Unit, Tairāwhiti Area Health Board to Bronwen Pelvin, Secretary, DMS, Letter, 31 October 1989, DMS, ‘Membership lists, DMS/00 3’; MS Boyd, Central Auckland District Office, Auckland Area Health Board to Bronwen Pelvin, Secretary, DMS, ‘Register of domiciliary midwives: Auckland Health district’, List, c. November 1989, DMS, ‘Membership lists, DMS/00 3’; D.A. Hunt, Takapuna District Office, Auckland Area Health Board to Bronwen Pelvin, Secretary, DMS, ‘3/15/86 Domiciliary midwives list’, List, c. November 1989, DMS, ‘Membership lists, DMS/00 3’; T. Webby, PPHN, Northland Area Health Board to Bronwen Pelvin, Secretary, DMS, c. November 1989, DMS, ‘Membership lists, DMS/00 3’.

originally intended having at least two catch-ups with each of the midwives. Each catch-up was to focus consecutively on the second, then the third re-search questions, that is, ‘what shaped the DM’s understanding of her personal autonomy?’ and ‘how was this personal autonomy applied to midwifery practice?’ With the second question I wanted to explore background, family, events, influential people, experiences, educational path to midwifery, and belief systems and identify key issues that shaped interpretation of the scope of midwifery practice and each one’s path into domiciliary practice. The third question - ‘how was this personal autonomy applied to midwifery practice?’ - would enable individuals to personally reflect on the challenges or ease of practising within the DM’s paradigm in a subsequent catch-up.

However, consistent with practice, the catch-ups had their own vitality that grew from the anticipation of talking about domiciliary practice. This meant the midwives had already considered the questions and established what was important to them. This process I captured in my journal entry called ‘Tumble Jumble’ following catching up with a DM who had practised during the 1970s and 1980s:

...Cool drinks and a shady spot

A breath of fresh air

Poised for a start...tumble jumble

The years spill forward, no questions asked

No tape, no Ethics Committee approval and no stopping her!

“You okay if I jot down as we go?”

“Oh yes, you’ll have to!”

Eight pages of dates, names and incidents...

Her stories are bound up with who birthed when

A progression of births punctuating her life

The births of her own children, her marriage’s end...

The lost sequence

Later, a remembered date

Further on the name of a connection

Another birth that places a deed...
We order some dinner and the pace settles
I am able to look at her.
The lipstick's worn off
And she's rubbed off the eye shadow
A woman to turn sixty next month
Strong bodied, broad shouldered, big stubby hands
Soft eyed, strong-hearted woman
A solid companion...
It's been like a booking visit the week before labour
So much to cover and so little time
Yet knowing the jigsaw will all fit...⁷⁶

Thus, the catch-ups were reminiscent of antenatal visits where discussion is wide ranging and matters were commented on as they came to the midwives and not necessarily in an orderly fashion. My 'being present' as the dialogue flowed was greatly assisted by the knowledge gained from midwifery practice that, at times, apparently disjointed monologues were important enough to be furthered and would eventuate in threads that could be drawn together to form the whole. While the two previously mentioned questions continued to guide the catch-ups, the 'messiness' of the process meant aspects of each question were integral in each and all catch-ups – again reflecting home birth midwifery practice. There was one face-to-face catch-up with each midwife and an additional phone conversation with one.

The midwives were also invited to contribute photographs, journals, diaries, correspondence, papers and so on, and six did so. The contributed material was found generally to be copies of material already accessed from the DMS secretarial archive.

Following each individual catch-up, audio-tapes were transcribed to include all words and features, for example, long pauses, laughter, sighs, and so on, so correct emphasis was given to each. The transcript was sent for verification, elaboration and

76 Maggie Banks, 'Tumble jumble', Journal, unpublished, 11 February 2002.

amendment. There were few changes to transcripts made by the midwives and these generally involved only ensuring anonymity of other practitioners.

Important to this study is my position of being both a DM and member of the DMS along with the intimate knowledge I had prior to catch-ups with six of the midwives. My familiarity with the known women allowed me to use my knowledge of their speech patterns to utilise phrases such as ‘I think’ and ‘and so’ which individuals commonly used as punctuation, to give greater readability to the text. As a past participant in research, I know of the daunting and time consuming task of being asked to comment on one’s transcribed ‘interview’ that has no ‘readability’.

Flecking the archival voices

As previously mentioned, the archival voices feature strongly in this study. While not more important than the midwives’ voices as such, the former are explicit in detail and more expansive in range than the latter. I chose to use individual midwife’s contributions, both archival and her-storied, as flecks to illustrate the personal in the archival material – an important textural addition to elaborate the personal mandate by midwives of the DMS to practise midwifery prior to 1990 in New Zealand.

By transcribing tapes of catch-ups myself along with numerous repeating readings of transcripts, I immersed myself in the midwives’ her-stories. Having developed the archival herstory prior to catching up with the midwives I was seeking lived experiences of the legal, political and financial climate of the archival story. Common themes and those of difference were teased out of each her-story to reflect these individual and collective experiences.

Additional to this flecking was an individual background on each of the oral her-storying midwives and Joan, as previously discussed, by way of introduction which appears in the next chapter.

In summary, the manner in which this study was undertaken reflects the interconnectedness between the practice of home birth midwifery and the practice of re-search – a process called bare-footing. Having established the philosophical underpinnings, process and method used in the re-search, I will, in the following chapter, begin to reveal the re-searched herstory.

CHAPTER 3: A ROAD LESS TRAVELLED

Until the 1920s, the majority of women in New Zealand birthed at home attended by neighbours, relatives and ‘handywomen’ and, increasingly from 1905, registered midwives. The need for a state-funded home birth service in New Zealand received official recognition in 1937 with a Board of Health (BoH) Inquiry into maternity services.¹ The Committee of Inquiry considered “the aim of the Government should be to promote hospitalisation of all maternity patients”² but the development of rural services was hampered by a lack of doctors and antenatal clinics. The Committee therefore deemed it necessary to still provide for “a certain amount of [domiciliary] attendance”³ and recommended a benefit be paid directly to those who provided maternity (medical) and hospital services.⁴ This recommendation, picked up by legislators, led to the passing of the Social Security Act 1938.

Whereas, prior to 1938, domiciliary midwifery services were provided by Hospital Boards,⁵ a midwife could from this time receive payment through the Maternity Services Benefit provided she was contracted to the MoH.⁶ The midwives who did so were known as DMs - the only ‘nurses’ in New Zealand to be self-employed and contracted to the DoH⁷ despite, from 1925-1971, the registered midwife having a legislated right to provide care to women in childbirth independently from medical practitioners. Following the passing of the Nurses Act 1971, and until the Nurses Amendment Act 1990, the midwife, wherever

1 New Zealand Board of Health, *Report of Committee of Inquiry into Maternity Services*, Government Printer, Wellington, 1937.

2 *Ibid.*, p. 101.

3 *Ibid.*, p. 135.

4 *Ibid.*, p. 133.

5 Adelheid Wassner, *Labour of Love: Childbirth at Dunedin Hospital, 1862-1972*, Adelheid Wassner, Dunedin, 1999, p. 47. A register of ‘Outdoor Cases’ of the Batchelor Hospital in Dunedin documents 200 cases up until August 1934. The last birth on the register was recorded as ‘Case no. 1499’; New Zealand Nurses Association, *Report on Community Health Nursing in New Zealand*, Wellington, New Zealand Nurses Association, 1980, p. 3.

6 Social Security Act 1964 (110 [2] p.531-532).

7 Other ‘nurses’ who worked in the community were employed by Hospital Boards (District Nurses), District Health Offices (Public Health Nurses), other organizations (Royal New Zealand Plunket Society, Nurse Maude District Nursing Association, General Practitioners or voluntary agencies such as the Family Planning Association) or by other government departments (Occupational Health Nurse in the New Zealand Post Office). New Zealand Nurses Association, *Report*, p. 7.

she worked, was legally required to work under the supervision of a medical practitioner but her ability to set up her own domiciliary midwifery practice continued.

In this chapter I describe the DM's contract along with the mechanism and process for it. I introduce the supervision requirement of the MOH and the role the GP played in domiciliary midwifery.

The paucity of DMs and home births in the early 1970s is discussed - the latter being at their lowest ever level in 1973. Carolyn Young, the first of the DMs in this study would commence practice in Auckland the following year. She would be joined by Joan Donley, another midwife of the study, within three months. This would herald a renewal of domiciliary midwifery in response to the increasing demand for home birth by childbearing women. Carolyn, Joan and six other DMs of the study – Bronwen Pelvin, Gillian Wastell, Sian Burgess, Jenny Johnston, Anne Sharplin and Sue Lennox - are introduced. The experiences these midwives faced in commencing domiciliary practice when little was known about the practice of home birth are elaborated. Five of these DMs would found the Domiciliary Midwives Association in 1981. This organisation would go on to become the Domiciliary Midwives Society (Incorporated) in 1982. My account of its inception and functioning concludes this chapter.

I begin with detail of the contractual arrangement for intending domiciliary midwives.

The domiciliary midwife's contract

The DM's ability to practice did not require a contract with the MoH – this she had of right in the fact that she had attained registration by the Nurses and Midwives Registration Board (NMRB) or, after 1971, the NCNZ. However, to receive the MSB from the State for services provided, she did require a contract⁸ with the MoH. To attain this, the midwife made application to the local MOH via the PPHN informing them of her intention to practise and the geographical area in which she would provide services. Along with her name, address, qualifications and the number of her current practising certificate, she provided information on her relevant work experience, and involvement in up-to-date and continuing education. At interview, she had to show an understanding of relevant

8 'Terms of contracts between the Minister of Health and Obstetric Nurses with respect to nursing services in relation to Maternity Benefits under the Social Security Act 1938', in New Zealand Board of Health, *Mother*, pp. 35-40.

legislation⁹ and give particulars about the type of services she planned to give and whether her service would be part or full time and would include her residing with the woman.¹⁰ A confidential report from her last nursing (sic) employer was seen as desirable but was not mandatory. The MOH could not refuse any midwife a contract if she had the necessary qualifications as a Registered Midwife and held a current practising certificate.¹¹

A formal acceptance letter was sent to the midwife with the reminder that she needed to notify the MOH in each District Health Office (DHO) in which she wished to practise. A Maternity Benefits file was then commenced for the newly contracted midwife.¹² Once the contract was signed, the necessary stationery (Table 3.1), the MSB fee schedule and travel expenses formula were made available to the midwife and the inspection of records was outlined.¹³

9 Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

10 'Paper IV, Legislation, comments and recommendations', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

11 Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

12 Ibid.

13 Eleanor Calvesbert, DOH to Bronwen Pelvin, Letter, 19 September 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

Table 3.1 The domiciliary midwife's documentation

Document Name	Number
Practising certificate and Claim form	H555
Terms of Contract	H556
Notice by obstetric nurse to provide services	H557
Recommended Practices and Advisory Notes	H666
Notification of foetal birth, stillbirth or near neonatal death	H671
Notification of case of puerperal pyrexia	H673
Obstetric Record	H678
Register of patients	Form A
Case prescription chart	Form B
Notification of transfer of patient	Form C
Notification to Medical Superintendent	Form D

Source documents: Department of Health, 'Appendix 2 - Equipment' and 'Paper II', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', March 1979, Paper, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

The Obstetric Record

The Obstetric Record (H678) was completed by the DM for each woman for whom she provided care. The details recorded in the antenatal period included the woman's name, address, age, previous pregnancies (specifying gestation including abortions, method of delivery, birth weight and outcome), the names and dates of booking with both GP and midwife, as well as results from blood testing (syphilis serology, blood group and antibodies) and urine testing (protein and glucose) and the woman's weight and blood pressure. During labour, she recorded the times of contraction onset, amniotic membrane rupture and her and the GP's arrival at the home. Following birth, the date, time and duration of each of the three stages of labour was recorded.¹⁴ The 'method of delivery',

14 Obstetric and midwifery texts describe labour as having three stages – the first stage being from the onset of painful, regular contractions which dilate the cervical os until full dilatation. The second stage lasts from full dilation until after the birth of the baby with the third stage being from this point until after birth of the placenta.

presentation, birth weight, Apgar¹⁵ scores, weight of the placenta, blood loss (up to an hour), subsequent blood loss, state of the perineum and any suturing completed her documentary requirements for labour and birth. Postnatally, the H678 detailed the GP's examination of the baby soon after birth and prior to discharge. The DM's notes elaborated the baby's method of feeding, temperature of woman and baby and the number of visits by both doctor and midwife. A record of any specialist consultations or transfers completed the record.¹⁶

The Obstetric Record was sent to the base hospital immediately in case of transfer from home – an occurrence of which the midwife had to give notice in writing to the MOH and the supervising GP¹⁷ – requirements additional to notifying the Medical Superintendent (Form D) of a home birth¹⁸.

Following discharge from the DM's care, a copy of the Obstetric Record was sent to the DHO for inspection by the PPHN, after which time it was copied and returned to the midwife¹⁹ or stored at the DHO as per the Obstetric Regulations 1975, section 38(b).²⁰

The domiciliary midwife's service

The DM was expected to keep informed of antenatal events by contacting the woman's medical practitioner and to notify him when the woman went into labour. She was required to attend the woman throughout labour, remain until at least one hour after the expulsion of the placenta and accompany the woman to hospital if transfer to hospital occurred during labour, unless a midwife came out with the ambulance crew. Postnatally, she was required

15 The Apgar score (named after Virginia Apgar) provides a means of assessing a newborn's condition at one, five and ten minutes after birth. Breathing, heart rate, tone, colour and irritability (response to stimulation) are scored from zero to two with a score of ten indicating the baby's best possible condition.

16 'Maternity Services Committee – Information on home births to be available in District Health Offices', 5 October 1979, ABQU 632 W4415, 29/21 (50925).

17 Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

18 'Paper II', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879). The DoH did not know what the Medical Superintendent did with the Form D notification, which was not always sent in by the DM. It would later suggest it could form a yearly register of all DMs to be held at the obstetric base hospital.

19 Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

20 Division of Nursing, DoH, 'Proposal for change in domiciliary midwives' services', 23 October 1979, Paper, DoH, 'Board of Health – Maternity Services Committee, 1982', ABQU 632 W4415, 29/21 (54019).

to visit the woman “not less than twice on each of the three days immediately following the birth of the baby and not less than once on each of the eleven succeeding days”.²¹

The General Practitioner

The GP was responsible for the ‘supervision’ of the woman throughout the childbirth continuum.²² The DM was legally unable to provide home birth services unless the woman had engaged a GP to provide this overarching supervision. The DoH would only authorise payment to the midwife “where a doctor has indicated that he is in charge of the patient throughout and is in agreement with proposed, private domiciliary service”.²³

Supervision of the domiciliary midwife

Supervision of the DM rested with the local MOH under Section 58 of the Nurses Act 1977, a responsibility that was not clearly defined in the Act. While I detail supervision in Chapter 5, the DoH supposed supervision could be taken to mean that of the midwife’s qualifications, equipment and facilities or it could be extended to also include the actual service she provided. While the MOH’s duties in regard to supervision in the practice setting were a ‘grey area’, the DoH determined he was clearly responsible for the midwife’s competency to practice.²⁴ However, as previously mentioned, the MOH could not refuse a midwife a contract if she had the necessary qualifications and a current Practising Certificate. Equally, the MOH lacked the authority both to ensure a midwife was ‘up to date’ and to insist on an orientation or ‘upgrading’ programme.²⁵

21 Department of Health, ‘Self-employed midwives (domiciliary): the Department’s responsibilities’, Paper, March 1979, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

22 Professor R.J. Seddon, Wellington School of Medicine to N.G. Robinson, Secretary, MSC, Letter, 29 September 1980, DoH, ‘Board of Health – Maternity Services Committee, 1980-1981’, ABQU 632 W4415, 29/21 (53013) and G.R. Boyd, Assistant Director, Division of Clinical Services to MoH, Christchurch, Memo, 3 July 1981, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

23 Head Office letter, 18 February 1977, in Department of Health, ‘Paper IV, Legislation, comments and recommendations’, in ‘Self-employed midwives (domiciliary): the Department’s responsibilities’, Paper, March 1979, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

24 Division of Nursing, DoH, ‘Proposal for change in domiciliary midwives’ services’, 23 October 1979, Paper, DoH, ‘Board of Health – Maternity Services Committee, 1982’, ABQU 632 W4415, 29/21 (54019).

25 Department of Health, ‘Paper II’, in ‘Self-employed midwives (domiciliary): the Department’s responsibilities’, Paper, March 1979, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

The MOH's supervisory function was limited under the legislation to only midwives contracted to the MoH and those employed by private obstetric hospitals,²⁶ and not those without contracts.²⁷ Nor did he have the authority to refuse medical attention to a pregnant or labouring woman on the grounds of the environment being unsuitable for birthing, or on any other ground, as his authority to supervise was in relation to the midwife and not the environment.²⁸

Supervision of the DM was a duty delegated to the PPHN, despite the MOH having no legal authority to do so.²⁹ This delegated duty occurred irrespective of whether or not a PPHN held a midwifery qualification and, therefore, could occur where there was a deficit in the necessary skills and experience to assess midwifery practice. The PPHN's official role was primarily to administer the midwife's claims and ensure compliance with legislation but, as will be discussed in Chapter 5, the level, type and effect on the DM of that supervision was variable throughout the country's health districts.

The PPHN reported on the midwife in 'The report of the Principal or Supervising Public Health Nurse'. This occurred at the time of applying for the contract, six months later, then, every twelve months "if the midwife's performance is considered to be satisfactory"³⁰ - the criterion for a continued contract being her 'satisfactory performance'.

Domiciliary midwife and home birth numbers, 1968-1980

As the BoH had predicted, the numbers of DMs had steadily declined since the Social Security Act 1938, the introduction of the Maternity Services Benefit and the promotion of hospitalisation for childbirth. By 1968, neither of the only two contracted DMs in the

26 'Paper IV, Legislation, comments and recommendations', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

27 'Paper III', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

28 'Paper II', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879). The Department of Health gained an internal legal opinion on 4 December 1978 regarding the MOH's supervision responsibilities.

29 'Paper IV, Legislation, comments and recommendations', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

30 Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

Christchurch Health District attended home births, both claiming only postnatal care. In 1974 this number had increased to four but only one midwife (Ursula Helem) claimed labour and birth care, the other three submitting claims for postnatal care only. No midwives lodged claims in either 1968 or 1976 in New Plymouth, Wellington and Nelson or in Whangarei in 1968 and 1974. While none of the four contracted midwives in the Auckland Health District submitted claims in 1974, two new DMs (Carolyn Young and Joan Donley) would start claiming for labour and birth care as well as postnatal care that same year.³¹

At the end of 1977, there were eight DMs with contracts throughout New Zealand – five in Christchurch (though still only three had claimed in that year) and three in Takapuna (Carolyn), Auckland (Joan) and South Auckland (Irene Hogan³²) Health Districts.³³ (Table 3.2).

Table 3.2 Number of midwives by Health District, claims and visits, year ended 1977

District	No. of Midwives	No. of Claims	No. of Deliveries & Postnatal Visits	No. of Postnatal Visits Only
Christchurch	5	27 31 2 - -	- 15 - - -	27 16 2 - -
Auckland	1	64	64	-
Takapuna	1	48	48	-
South Auckland	1	3	3	-
TOTALS	8	175	130	45

Source: 'Appendix 1 - Statistic data', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', March 1979, Paper, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

31 'Home delivery and post natal care by Health District...', Table, c.1978, in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

32 'On the home birth front', Paper, 10 June 1985, Joan Donley Personal papers, 'Texts of articles, papers, talks and speeches at workshops and seminars', (MS93/7 1).

33 'Number of midwives by Health District, claims and visits, year ended 1977', Table, c. 1978, in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

Of the sixteen midwives claiming by the end of 1978, nine provided care during birth at home as well as postnatal care, four provided only postnatal care at home and three did not lodge any claims, as shown in Table 3.3.

Table 3.3 Home delivery and postnatal care by Health District... (c. 1978)³⁴

District	No. of Midwives	No. of Cases	Deliveries Plus Postnatal	Postnatal Only
Christchurch	5	5	-	5
		30	28	2
		-	-	-
		-	-	-
		3	2	1
Auckland South Auckland Takapuna	6	62	45	9
		14	10	4
		7	5	2
		66	48	17
		2	-	2
		4	-	4
New Plymouth	1	1	-	1
Wellington	2	19	18	1
		-	-	-
Whangarei	1	1	1	-
Nelson	1	5	3	5
TOTALS	16	219	160	53

Source document: 'Appendix 1 - Statistic data', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', March 1979, Paper, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

From 1974 the steady decline of home birth numbers that occurred each year (with the unexplained exception of 1971) began to reverse. Within a further two years, as Table 3.4 indicates, home birth numbers had doubled in Auckland and had nearly tripled nationally. The all time low of thirteen home births in 1973 would not be revisited.

³⁴ The full title of this document was illegible.

Table 3.4 Number of home delivery figures by Health District and year

Name of Health District	1970	1971	1972	1973	1974	1975	1976	
Auckland/Takapuna	26	49	14	13	31	52	62	
South Auckland	-	-	-	-	-	-	-	
Christchurch	-	-	2*	yes	1	2	28	
Total	26	49	16	13	32	54	90	240

*Domiciliary care only after early discharge from hospital

Source: 'Appendix 1 - Statistic data', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', March 1979, Paper, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

The occurrence of home birth had been restricted to the Auckland and Christchurch regions until 1974. By 1978, numbers would be boosted by the increasing number of midwives commencing domiciliary practice, not only in Auckland and Christchurch, but also Wellington and Nelson as, respectively, Lynne McLean and Bronwen Pelvin commenced practice. By 1980 DMs had also commenced practice in Hamilton, Palmerston North and Lower Hutt and home birth numbers increased correspondingly, as shown in Tables 3.4 and 3.5.

Table 3.5 Numbers of home births and domiciliary midwives by Health District, 1977-1980

District	1977		1978		1979		1980	
	Home Births	Domiciliary Midwives	Home Births	Domiciliary Midwives	Home Births	Domiciliary Midwives	Home Births	Domiciliary Midwives
Auckland	55	1	63	2	115	2	94	4
South Auckland	3	2	7	2	7	2	-	1
Takapuna	37	1	56	3	88	4	112	4
Hamilton	-	-	-	-	-	-	6#	1
New Plymouth	-	*	-	*	-	*	-	*
Palmerston North	-	-	-	-	1	1	8	1
Rotorua	-	-	-	-	-	-	-	-
Wellington	-	-	15	1	27	1	31	1
Lower Hutt	-	-	-	-	-	-	17	1
Nelson	-	-	5	1	17	1	28	2
Christchurch	27	1	30	2	34	2	29	2
TOTALS	122	5	176	11	289	13	325	17

Data source: 'Numbers of (A) Home Confinements and (B) Domiciliary Midwives in Each Health Area, 1977-1980', in Maureen Laws to Tony Cochrane, Letter, 10 June 1981, DoH, 'Board of Health – Maternity Services Committee, 1982-1983', ABQU 632 W4415, 29/21 (54816)

Two of the Hamilton births were attended by an Auckland DM.

* In New Plymouth there was one DM who provided “postnatal supervision only” throughout the time period but no indication was given as to specific years she provided this.

Thus it was into a rarely available midwifery service that Carolyn Young – the first of the ‘new wave’ of midwives - commenced domiciliary practice in 1974. Carolyn, like the other seven midwives of the study - Joan Donley, Bronwen Pelvin, Gillian Wastell, Sian Burgess, Jenny Johnston, Anne Sharplin and Sue Lennox - all commenced practice at various stages from 1974 – 1986. I introduce them now in the chronological order that they started domiciliary practice.

Eight domiciliary midwives of the study

Carolyn Young

Carolyn, a “midwife by default”, trained as a nurse in 1966. Returning to West Auckland after travelling overseas, she had anticipated working in an old people’s home – the only other hospital alternative being the Waitakere Maternity Hospital. Her maternity nursing experience during her training had been overwhelming and not something for which her modest upbringing had prepared her. Influencing her equally, was her feeling that working in the maternity hospital was “like a death sentence really”. However, the latter was the only place she could get work.

Carolyn’s entry into midwifery training was prompted by a directive from the Matron after a year of working in the maternity hospital. As was common at the time, nurses were urged to undertake training or shift employment to relieve problems of nursing (sic) shortages. Following her six months training at Auckland’s St Helens Hospital in 1970, Carolyn returned to Waitakere Hospital where she would later become the midwife in charge of the delivery suite. There she would remain for at least three years until her newly developed need to arrange regular time off to attend her university courses became an area of conflict with the Matron of the hospital. Denied the time off despite it being allowed for within her employment arrangements, this conflict resolved only when Carolyn apprised the Matron’s superior, the Chief Nurse, of the situation. While the time off became available, this concession was followed by reprisal from the Matron. Carolyn was shifted from delivery suite - an area in which she loved working - to the postnatal area which as the Matron knew, Carolyn did not enjoy. Carolyn responded by resigning from the hospital and took up full time university studies.

While Carolyn enjoyed studying English literature, she soon began to question ‘what kind of difference is this making out in the everyday world?’ and was drawn back towards midwifery. Her colleague from Waitakere Hospital, Joan Donley, suggested Carolyn take up domiciliary practice as the only remaining DM in Auckland, Vera Ellis-Crowther, then in her late seventies, was planning to retire. Attending a birth as orientation with Vera would be all the prompting that Carolyn would need to commence her own

domiciliary practice in West Auckland in 1974, something which she continues today after thirty-two years, now as an Independent Midwife.³⁵

Joan Donley

Born and raised in Canada, Joan graduated as a nurse in 1938. Following her marriage at twenty-five years of age, she went on to birth and raise their five children in Canada, predominantly in a hand-to-mouth self-sufficient existence in a coastal fishing village. The family shifted to New Zealand in 1964 and Joan and her husband set up a fish shop.

Joan entered midwifery training at St Helens Hospital in Auckland in 1972 after the break up of her physically and emotionally abusive marriage. Reducing her age by ten years to be eligible to train as a midwife,³⁶ Joan undertook midwifery training in 1972.³⁷ Following training Joan worked at St Helens, National Women's and Waitakere Hospitals as she secured her home and bought a van before, encouraged by Vera Ellis-Crowther, she entered domiciliary midwifery in 1974.

Joan, influenced by her father's teachings as a 'health nut', knew of the body's ability to heal itself, something which was put to the test with a health crisis in her late thirties. Healing herself through good nutrition and a natural lifestyle, these would become major foci for ensuring natural childbirth.³⁸

Joan's leadership role is evident throughout all aspects of New Zealand midwifery as she was pivotal in initiating the founding of the Home Birth Association in Auckland,³⁹ the Domiciliary Midwives Society (Inc.) and the New Zealand College of Midwives.⁴⁰ Throughout the study period (and beyond) Joan would be active in motivating consumers to fight for the home birth option⁴¹ and midwives to take control of midwifery.⁴² The

35 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004.

36 Personal communication: Jenny Johnston to Maggie Banks, 12 December 2005. At Joan's funeral service, her son disclosed that Joan had two birth certificates – one recording her true age, the other altered to show her birth date ten years after the fact.

37 Kimberley Paterson, *The X Factor: Finding Inner Courage*, Penguin Books, Auckland, 1997, pp. 88-97.

38 *Ibid.*

39 Halina Ogonowska-Coates, *Born: Midwives and Women Celebrate 100 Years*, New Zealand College of Midwives, Christchurch, 2004, p. 6.

40 Kimberley Paterson, *X Factor*, pp. 88-97.

41 Joan Donley, 'Home birth under attack', *Broadsheet*, May 1982, pp. 36-37.

42 Joan Donley, 'Midwives or moas?', *Save the Midwives*, 16 (August 1988), p-p. 22-26.

leadership role in midwifery that Joan would play was recognised from the start of her practice at Waitakere Hospital in West Auckland. As Carolyn related about first meeting Joan in the early 1970s and working with her:

The Matron of the day, most kindly described as formidable, took me aside to suggest that I kept an eye on the latest staff recruit. “Watch that one,” to be precise...Even as a new graduate, our not so beloved Matron recognized that Joan’s qualities would ultimately challenge the current hierarchy. There was an air of ‘not to be squashed’ tenacity about Joan that even her prissy little uniform and regulation shoes could not disguise.⁴³

Joan would cease practice in her late seventies but would continue to be active in the development of midwifery until 2001 when a fall permanently incapacitated her. She died on 4 December 2005.

Bronwen Pelvin

Bronwen was a newly registered nurse when she attended her first home birth in 1974. Having attended five births during her nursing training at Christchurch Women’s Hospital, Bronwen offered her assistance to a pregnant woman living in Jerusalem – an alternative community near the Wanganui River. It was this birth that would commit Bronwen to becoming a midwife and she undertook the six month midwifery training at Christchurch Hospital in 1976. To consolidate her experience she worked in Palmerston North Hospital for fifteen months before a friend, wanting to birth at home in Canvastown outside Nelson, needed a midwife. While Bronwen had attended a home birth in Palmerston North following midwifery registration, her friend’s birth would formalise Bronwen’s path into domiciliary midwifery in Nelson as she contracted with the Department of Health. Bronwen continued to attend home births until 1996 when she left active practice to take up managerial and advisory positions in midwifery.⁴⁴

43 Halina Ogonowska-Coates, *Born*, p. 5.

44 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004.

Gillian Wastell (McNicoll)

English-born Gillian⁴⁵ had moved to New Zealand with her parents when she was nineteen after a Canadian childhood. A falling out with her parents after six months in New Zealand provided the impetus to leave home and start hitchhiking throughout Australia. The desire to return to New Zealand to her two younger siblings was accompanied by a spiritual awakening, one which influenced her to accept a hospital matron's recommendation that she go nursing when she applied for a health assistant's job on her return to New Zealand. As a registered nurse she worked in Te Kuiti Hospital where she would assist the midwife during births. Two incidents at work left her feeling vulnerable and lacking in the knowledge necessary to deal with these birth complications so Gillian determined to undertake midwifery education to be better prepared.

As part of an alternative life-style community where home birth was the norm, Gillian was exposed to the idea of home birth by her many social contacts who chose to birth at home. A friend had given her a copy of Ina May Gaskin's classic book *Spiritual Midwifery*⁴⁶ to ensure that she became "the right sort of midwife". While encouraged by her friend's focus, at that stage, Gillian had no thought of becoming a domiciliary midwife. Following midwifery training at St Helens Hospital in Auckland in 1976, Gillian left the profession intent on a life of some leisure, though this lasted only a few months before she conceived her first child. The place of birth required no consideration – it would be at her parents' home in Glen Dowie and she engaged Joan Donley to be her midwife.

Approximately a year after her son's birth in 1977 Gillian moved to Langholm in South Auckland. Joan, who had at the time broken her wrist, asked Gillian to be her "left hand" at a birth in the area where Gillian lived, which the latter did. From that point, as Gillian stressed - "she had me". Gillian, wanting to increase her midwifery skills and confidence, would be mentored by Joan, as the latter assured her that building on skills and confidence was unlikely to happen as a result of hospital practice. Thus began Gillian's domiciliary practice in 1978. She would continue this until mid 1983 when, pregnant with her second child, Gillian chose to be a fulltime mother at home. While she would not

45 Gillian used her married name (McNicoll) while practising as a DM but has subsequently reverted to her family name (Wastell).

46 Ina May Gaskin, *Spiritual Midwifery*, The Book Publishing Company, Summertown, 1977.

return to domiciliary practice, Gillian would return to part-time midwifery practice in the obstetric unit at Middlemore Hospital in 1984, where she continues to work today.⁴⁷

Sian Burgess (White)

Sian⁴⁸ grew up with home birth as her family norm and always had a sense she would be a midwife. Her grandmother, aunt and her father's cousin were all midwives and she saw "it was genetic really", something which her mother nurtured. Sian entered midwifery training at the Bristol Maternity Hospital in 1974 as a twenty-one year old after gaining nursing registration. The second part of her training was completed in Sussex in a small country hospital, during which times Sian was exposed to both birth at home as well as in hospital. Following registration and some practice in Guys Hospital in London, Sian worked in Thailand for three years. Newly arrived in New Zealand, she took a job at St Helens Hospital in Auckland where she worked during her pregnancy in 1979 and 1980 with her first child.

Sian's initiation into home birth in New Zealand began when Sian's baby was ten days old. Rhonda Jackson, the midwife who provided her postnatal care, asked for her support at a home birth. From this point Sian readily developed an increasing involvement in domiciliary practice. She continued domiciliary practice, then independent midwifery, until 2004 when a back injury forced her immediate and permanent withdrawal from active midwifery practice after twenty-five years.⁴⁹

Jenny Johnston

Jenny's desire to become a midwife had germinated following the birth of her two daughters. She acted upon this following her divorce as she wanted something positive in her life. Already a registered nurse after completion of her training at Tauranga Hospital in 1969, she shifted to Hamilton in 1977 where she undertook the midwifery programme at Waikato Hospital. Jenny worked in the Delivery Suite for a couple of years on night shift following midwifery registration. Given the opportunity on night shift to see women birth

47 Catch-up: Maggie Banks with Gillian Wastell, 2 November 2004.

48 Sian used both her family name (Burgess) and her married name (White) at various stages. I have used her family name unless signed otherwise as this reflects the predominant use of this name in the archival material.

49 Catch-up: Maggie Banks with Sian Burgess, 7 January 2005.

with less intervention than during the day, she became increasingly aware that the women who did not receive interventions birthed well. After working as a Supervisor on the general nursing side, Jenny returned to night shift in the Delivery Suite, which suited her lifestyle of mothering before commencing university study in the late 1970s.

Home birth came gradually into Jenny's consciousness through the reading and questioning she was exposed to in her everyday reading of books such as *Spiritual Midwifery* and Ingrid and Paul Johnson's classic New Zealand book *The Paper Midwife*.⁵⁰ It was further prompted through her study of psychology and sociology at university. This reading exposed her to research which indicated that many of the obstetric practices of the time had no beneficial basis for inclusion in maternity care. Practices that did have positive effect, such as active birth, were areas which she incorporated into practice as she became aware of them. While home birth had been in Jenny's consciousness, once she explored it, she was both fascinated by it and convinced of its merits. On contacting the Waikato Home Birth Association, Jenny found there were women who wanted to birth at home and she commenced domiciliary practice in Hamilton in 1980 after being engaged by a woman due to birth within the following two or three months. Jenny continues today as a home birth midwife in Auckland.⁵¹

Anne Sharplin

The seed for midwifery practice was given to Anne in 1976 by a good friend. This woman, a lay person who attended the births of the women in the community who did not want to go to hospital, told Anne she needed to train as a midwife to help women have their babies at home. Anne determined that she would go to the United Kingdom for this training as she had no desire to undertake the nursing training which was the pre-requisite in New Zealand at the time. This she did as a Direct Entry midwife at the Oldham School of Nursing and Midwifery in Birmingham starting in 1980 as a twenty-six year old. She returned home to New Zealand in 1983. Pregnant with her first child, Joan provided her home birth care.

The introduction of the Nurses Amendment Act 1983 would prohibit direct entry midwives from domiciliary practice unless they had practised prior to 1 April 1984. Therefore, within seven months of giving birth, Anne was tasked with having to attend a

50 Ingrid and Paul Johnson, *The Paper Midwife: A Guide to Responsible Homebirth*, Reed, Sydney, 1980.

51 Catch-up: Maggie Banks with Jenny Johnston, 23 August 2004.

home birth, which she did. Anne continues today to provide home birth services as part of her independent midwifery practice in Tauranga.⁵²

Sue Lennox

Not originally drawn to midwifery as a profession, Sue undertook midwifery training in Australia in 1971 to gain a second certificate following nursing registration. On her return to New Zealand, Sue settled in Palmerston North, keen to use the expertise she had gained internationally in coronary care or intensive care units. However, much to Sue's dismay, the only part time hospital work she could secure was in the maternity unit. Despite not wanting to work there, Sue did so for a year.

During this time, she heard of Joan who was attending home births. Up till this point Sue had never heard of home birth and had no understanding of what 'home birth' meant. In her curiosity, she contacted Joan and arranged to spend six weeks with her at the end of 1976. Sue had previously experienced women's desires for natural childbirth amongst her acquaintances and she had supported them to do so. However, the effect on Sue of her experiences with Joan was profound and life-changing and made Sue question all her previous knowledge. Sue returned home determined to gain experience to "feel secure enough to do what she [Joan] did". In 1981, Sue provided an Early Discharge⁵³ service to women in the Hutt Valley who returned home 6-48 hours after birth in obstetric hospitals. It would be 1986 before Sue started attending home births herself by which time she was the mother of two children born in 1983 and 1984. Sue continues providing homebirth services as a self-employed midwife and provides mentoring services for newly graduated midwives.⁵⁴

Beginning domiciliary midwifery practice

Sian and Anne had experienced birth at home as their cultural norm, as a child in the case of Sian, and as an adult for Anne in her alternative community. While Anne did not attend

52 Catch-up: Maggie Banks with Anne Sharplin, 24 October 2004.

53 Early Discharge is defined as a woman was discharged from the hospital between 6 hours and 3 days following 'normal' birth home. She would be visited in her home postnatally for up to fourteen days by a District Nurse employed by a hospital board or by a self-employed DM.

54 Catch-up: Maggie Banks with Sue Lennox, 3 December 2004. For further information, see Susan Maree Lennox, 'Honouring the sacred in childbirth: a midwife's stories of women's developing sense of self', MA (Applied) thesis, Victoria University of Wellington, Wellington, 2002.

any home births until during her midwifery training, the normality of birthing had been established through the knowledge of her ‘untrained’ friend who attended births in her community. Sian had been raised with the “having babies story” of the home births of herself and her four siblings, two of whom were twins. This story was repeatedly told during Sian’s special time alone with her mother. She had also experienced the role of helper to her mother as a child:

[My mother] had us five, and I had a brother of three and a brother of eighteen months and my mum had twins, so she had these five kids at home and I think her having twins was [how] I really got to know what it was to be the mother’s helper...I don’t think it’s so much...looking after the little kids, which inevitably you do a lot of, but you become your mother’s ally, and certainly when mum had the twins I sat on the bed when she breastfed them and she had one and I had the other and then we swapped and you get to know how it is to be with women.⁵⁵

Sian also experienced home birth during her midwifery training in the United Kingdom during 1974 and 1975. Part of this training had been in a small country hospital in Sussex which included approximately fifty home births. Though uniformed and having a routine which reflected “the English way”, the family was central to the service.⁵⁶

Gillian and Bronwen were both registered nurses when they attended their first births at home while Sue, Carolyn and Jenny all experienced birth at home following their midwifery training. In contrast to the cultural norm of hospital birthing, which I elaborate in Chapter 7, all of these five except Gillian were confronted, by varying degrees, with the need to rethink their midwifery practice after their first experience of home birth. Bronwen related that “it has to be the most pivotal experience of my whole life because what it said to me at that moment was ‘this is how birth can and should be’...it just happened as nature intended it to”⁵⁷. For Sue that life-changing experience was so profound that her six weeks of working with Joan in Auckland resulted in an overwhelming of her reasoning:

I’d...been completely blown away by that experience...[it] completely disrupted the way I had the world set out, actually...I just didn’t know really

55 Catch-up: Maggie Banks with Sian Burgess, 7 January 2005, pp. 1-2.

56 Ibid., pp. 2-3.

57 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 8.

*how to... reconstruct my world, because basically I lost the world in the persona that I had had. It didn't work anymore with what I understood from when I went out from her.*⁵⁸

Carolyn had come to understand how natural childbirth could occur when she worked in the hospital system:

*...after a little while I started to realize that the births that were the most joyful were where women came in late...or the ones that came in with the baby born and the placenta in the fry pan, that there was something magic there that just wasn't there in the other births.*⁵⁹

Yet, in 1974, she was confronted with having to rethink her previous experiences following the first birth at home that she attended with Vera Ellis-Crowther, Auckland's only practising DM attending home births:

*So this woman, with her partner there, and she had two other little kids that were there, had her baby on the bed, and then hopped up after a little while, had a shower, we all had a cup of tea and off we went. I went away gob-smacked. I thought, what the hell are we doing because this phenomenon is nothing like what I've seen in hospitals. I was used to women looking like they'd been lost at sea for six weeks and lifted off a raft by the time they'd had their babies - and going back post-natally and seeing the family all functioning and the woman normal. It just was an absolute eye-opener that we're doing something really, really wrong here to have polluted the birth I had just seen to the births that usually took place in the hospital environment.*⁶⁰

Not only were the moments of birth different at home but the midwife's role of caring for the woman in labour varied markedly from birth in hospital. Jenny's initiation into birth at home was supported by Thelma Fell, an older and more experienced Hamilton midwife who had preceded Jenny into practice by a number of months. Accompanying Thelma to a home birth, this would be Jenny's first experience of non intervention, such as

58 Catch-up: Maggie Banks with Sue Lennox, 3 December 2004, p. 2.

59 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, p. 2.

60 Ibid., p. 4.

suctioning the baby at birth or giving an oxytocic drug to the woman. Jenny was struck with the different, but valuable care the DM provided that she witnessed at this birth:

Thelma was quite a laid back person really, very relaxed person, I had worked with her on night duty for many years. She was an older, experienced person and I remember this woman - it was her first baby and she was in quite strong labour - and we went round and Thelma said, oh well, you're only three centimetres, we'll probably come back in the morning, and just...trotted off and left her to it...I kept thinking, oh, there's someone in really strong labour and we're going away. And then they called us back in the morning, hours and hours later, and she had her baby....⁶¹

From the beginning the DMs recognised that, in itself, practising in the community afforded a valuable form of on-going education in which the women they cared for actively participated. Challenged by a lack of knowledge necessary for community practice, the openness to development was a characteristic of the transitions Carolyn and Jenny made in practice:

I looked after a woman - I knew nothing about it [homeopathy] - who used homeopathy and her husband was a homeopath and she wanted to use homeopathy and not ecbolics⁶² and I thought, oh well. I said, so give me something to read about it, and so I did. Now I never even think to use an ecbolic so it was a learning and you learnt together.⁶³

Someone said they were quite keen on having a water birth and I said, oh, well I'm really quite nervous about that, never been to one but I'll do some more reading up about it and see what I can find out - and then they decided to and I decided to support them...When that water birth first happened I wasn't actually nervous at all, that it actually happened. It was all just good. I had read that stuff about you should get out for the

61 Catch-up: Maggie Banks with Jenny Johnston, 23 August 2004, p. 3.

62 Ecbolics are a group of drugs which when given intramuscularly or intravenously cause the uterus to contract, for example, Syntocinon, Syntometrine of Ergometrine.

63 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, p. 5.

*placenta...but I didn't seem to bother so we didn't do it. It didn't make sense to me that you were going to get a water embolism or anything if you weren't doing anything. How could you get a water embolism unless you were pulling on things or whatever...and after that...they started to happen a bit more. I think after that they happened quite regularly actually. It was no big deal really...*⁶⁴

Rather than the DM attending the woman as 'the expert' who owned all the knowledge and the woman being simply 'the body to be delivered of its baby' by the expertise of the practitioner, Sian recounted the knowledge partnership that was present between woman and domiciliary midwife:

*...the women that we looked after to me seemed to be so extraordinarily knowledgeable. They were knowledgeable about homeopathy and herbs and nutrition and truly my experience of those early years was very much how it was in Thailand, that you think you're going to contribute and you learn so much more than ever you give...*⁶⁵

Bronwen faced a unique challenge at the beginning of domiciliary practice. She could not drive and did not have a car – two deficits which were corrected by her father when he taught her how to drive and bought her a car.⁶⁶

Sue never saw herself working independently. Following her experience with Joan, Sue gradually built up her confidence through the early 1980s through her Early Discharge scheme - confidence which she felt she lacked due to her midwifery training.⁶⁷

Carolyn, as the first midwife in Auckland to commence practice in many years, faced additional challenges. Though having attended one home birth with Vera, the second woman she was to attend with Vera gelled with Carolyn, asking her to come on her own. While agreeing to do so, Carolyn was faced with difficulties in establishing exactly what equipment was necessary and what care occurred in the home birth environment. The scarcity of the occurrence of home births meant "there was nothing to know".⁶⁸ The

64 Catch-up: Maggie Banks with Jenny Johnston, 23 August 2004, pp. 21-22.

65 Catch-up: Maggie Banks with Sian Burgess, 7 January 2005, p. 8.

66 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 12.

67 Catch-up: Maggie Banks with Sue Lennox, 3 December 2004, p. 5.

68 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, p. 3.

H.Mt.20 – *The General Principles of Maternity Nursing – including The Management and Aseptic Technique of Labour and the Puerperium*,⁶⁹ first issued by the DoH in 1926, detailed specifics of necessary equipment and aseptic technique for “maternity district patients”. Offering detail of the “nurse’s outfit” and equipment in 1949,⁷⁰ by 1960, this specific detail had been omitted from the H.Mt.20⁷¹ as the midwifery service had become an almost exclusively hospital-based service. The document itself would be replaced by the Obstetric Regulations 1975, the year after Carolyn commenced practice.

Carolyn remembers the only documentation given to her by the DoH in 1974 offered no guidance for domiciliary practice beyond having a nail brush and a clean uniform:

*They [the DoH] were a little taken aback to have new blood, because I was probably the first one to apply...and they didn’t know any more about it than I did. They really didn’t know. You were governed by the current Obstetric Regulations but they were riding by the seat of their pants too. I think they were hanging in waiting for Vera to drop off the perch and then this nasty business would go away.*⁷²

While Carolyn had been able to attend a home birth with Vera before the latter stopped practice, such orientation at the time, appears to have been available only in Auckland. Thus, for Carolyn, establishing the necessary equipment for domiciliary practice developed over time:

I thought, oh okay, what do I need? And the only stuff I had was pre-war 1934 documentation which basically told me I needed a clean uniform and a nailbrush. That was all. And so yeah, I had a prissy bloody uniform...so started off thinking, oh well, I need that, I’ll need this and I’ll need that and I’ll need that. And you do a birth and think, it would have been handy to

69 Department of Health, *The General Principles of Maternity Nursing – including The Management and Aseptic Technique of Labour and the Puerperium*, 5th edn., Government Printer, Wellington, 1949.

70 *Ibid.*, pp.48-51.

71 Department of Health, *The General Principles of Maternity Nursing – including The Management and Aseptic Technique of Labour and the Puerperium*, 7th edn., Government Printer, Wellington, 1960.

72 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, p. 5.

*have had something else, so you'd get that and gradually you built up a bit of a kit.*⁷³

This process of differentiating between standard hospital equipment and practice and what was required and appropriate to the home environment stimulated gradual change for Carolyn as she unlearned institutionalised practice and adapted to the new, woman-controlled environment:

*Joan and I are dressed up in, you know, the (sterile area) guards and the greens, the masks, the rubber gloves. It's embarrassing but it's the way it was. So for a while, we did take hospital into the home because we didn't know any better. It was a real process of constantly questioning...The first birth I went to, the woman was having a cup of tea in advanced labour and I'd set up my little guard and trolley and 'oh that's a strong contraction' and put her tea cup down on my little guard and I thought, shit! She's going to die - at least bubonic plague - I haven't got a spare set with me! That's, of course, lesson one and that just kept happening and happening and happening...*⁷⁴

The learning process and sharing of information and skills with other DMs would stimulate the midwives into networking nationally as other DMs started practice. This would be formalised into the Domiciliary Midwives Society (Incorporated) to which all of the midwives in the study belonged with Carolyn, Joan, Bronwen, Sian and Gillian amongst the signatories for an application to incorporate the Society.⁷⁵ The supportive, educational and political work of the DMS is discussed throughout the thesis but some introductory background as to its inception is detailed now.

The Domiciliary Midwives Society (Incorporated)

The DMs of what would become the DMS had begun networking together nationally from at least 1978 as problems arose with supervision by PPHN,⁷⁶ which I discuss in Chapter 5.

73 Ibid., p. 4.

74 Ibid., p. 4.

75 'Application for Incorporation', Application form, 29 March 1982, DMS, 'Documents of Incorporation, DMS/00 1'.

76 Bronwen Pelvin to Ursula Helem, Lyn McLean and Joan Donley, Letter, 14 December 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

While Aucklanders, Carolyn and Joan, were able to have regular contact together, Bronwen, resident in Nelson, Ursula Helem in Christchurch and Lynne McLean⁷⁷ in Wellington were initially the only DMs in their areas in 1978. Lynne would be joined by Jennifer Sage within two years and the two would start corresponding with Dr RA Barker, Chairman of the Board of Health's MSC, from at least September 1980 in an attempt to have the remuneration rate of the MSB reviewed.⁷⁸ Joan had spearheaded various submissions to the MSC from the Auckland DMs from at least February 1981.⁷⁹ However, following the NZNA Conference in April 1981 and the passing of the *Policy Statement on Maternal and Infant Nursing*⁸⁰ with its overt opposition to domiciliary midwifery (both matters of which I evidence later in the thesis), networking was discussed at the second National HBA Conference in May 1981. It was determined that the DMs needed to have their own voice and the yet to be named group was instigated by Joan.⁸¹ Originally named the Domiciliary Midwives Association, it was made 'official' in 1981 with the opening of a bank account and a donated letterhead.⁸² Amongst its first tasks, in an authoritative gesture, was the notification of the MSC that the Domiciliary Midwives Association had formed to speak for DMs. It requested that the MSC notify it of any submissions NZNA may put on its behalf.⁸³

Incorporation of the Association was seen as necessary to financially protect the members and to ensure a legal status.⁸⁴ The latter was an important strategy to being taken seriously in order to "have more sway"⁸⁵ for lobbying the DoH for an improved level of the MSB. Following a failed attempt to achieve incorporation due to incorrectly witnessed

77 Lynne McLean spelt her name variously as 'Lyn' and 'Lynne'. To avoid confusion, I have spelt it as 'Lynne' throughout the body of thesis, but have used 'Lyn' in the footnotes where it appears in correspondence.

78 Lyn McLean and Jennifer Sage to R.A. Barker, 22 September 1980, DoH, 'Board of Health – Maternity Services Committee, 1979-1980', ABQU 632 W4415, 29/21 (50925).

79 Auckland Domiciliary Midwives, 'Submission to Maternity Services Committee of the Board of Health', 22 February 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

80 New Zealand Nurses Association, *Policy*.

81 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 16.

82 Letterhead was donated by Homeprint, a company owned by a home birth woman and her husband -Allison and John Brebner of Feilding, Allison Brebner to Lyn McLean, Letter, 12 October 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

83 Joan Donley to Lyn McLean, Letter, 28 May 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

84 Joan Donley to Lyn McLean, Letter, 24 September 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

85 Chris Voaden, 'Report of the first meeting of the national Association of NZ domiciliary midwives', c. 1982, Joan Donley Personal papers, 'Papers re Domiciliary Midwives Society of NZ', (MS95/20 15).

signatures on the application form,⁸⁶ application for incorporation was again lodged on 29 March 1982, this time with fifteen correctly witnessed signatures.⁸⁷ The DMS existed as an incorporated society from 9 June 1982 until 7 March 2001⁸⁸ with the aims and objectives:

*To enable members to communicate efficiently, speak out effectively as one body, and manage their own affairs; to oppose and correct misrepresentation and misunderstanding of the philosophy of home birth and the policies of domiciliary midwives, and to protect the reputation and interests of all domiciliary midwives by seeking to obtain membership from all midwives doing home births.*⁸⁹

Membership was restricted to midwives who provided the continuum of care throughout pregnancy, labour, birth and postnatally rather than post-natal care only⁹⁰ as occurred with Early Discharge. As a result Sue would not be eligible for full membership until 1986 when she started to attend home births. Those who were practising DMs held full membership while those not practising (affiliated members) could retain their membership and attend meetings but had no voting rights. As other DMs became known to DMS members, each would be informed of the Society and invited to join.⁹¹ The intending member applied in writing and paid the membership fee of \$10.00 per annum.

While a Chairperson, Secretary and Treasurer were stipulated in the Rules, there was only one named office holder - the Secretary who also functioned as the Treasurer. The egalitarian nature of the Society ensured meetings were run informally and decision making was by consensus. The quorums - three for a Committee meeting and five for an Annual General Meeting (AGM) – were specified as representatives from areas rather than

86 'Minutes: Domiciliary Midwives Society', 28 March 1982, DMS, '1981 Correspondence, DMS/00 2/1'.

87 'Application for incorporation', 29 March 1982, DMS, '1981 Correspondence, DMS/00 1'. Fifteen midwives signed this document - Lyn McLean, J. Sage, Ursula M. Helem, L.L. McFarland, F. Barnett, C. Voaden, B.L. Pelvin, T. Fell, Joan E. Donley, Sian White, I.C. Hogan, C.M. Young, G. McNicolll and R. Evans. The fifteenth signature was illegible.

88 The DMS was struck off the Incorporated Societies register in 2001 due to a five year lapse in financial returns being submitted to the Companies Office - see <http://www.companies.govt.nz/pls/web/dbssiten.main>, Incorporated Society number 218965.

89 'Rules: Domiciliary Midwives Society of New Zealand', 9 June 1982, DMS, 'Documents of Incorporation, DMS/00 1'.

90 Ibid.

91 Roslyn Livingstone to Lyn McLean, Letter, 15 June 1981, DMS, '1981 Correspondence, DMS/00 4/1'; Lyn McLean to Jane Biddle, Letter, 13 July 1981, DMS, '1981 Correspondence, DMS/00 4/1'; Lynne McLean to Kate Collins, Letter, 7 October 1982, DMS, '1982 Correspondence, DMS/00 4/2' and Chrissie Sygrove to Bronwen Pelvin, Letter, 12 February 1986, DMS, '1986 Correspondence, DMS/00 4/6'.

individual midwives.⁹² These small numbers reflected the small membership. It (as the Association) had started with six members and increased to thirty-nine by October 1989, as previously mentioned.

The DMS met twice a year in midwives' homes in various locales throughout the country - Palmerston North, Wellington, Auckland and Nelson. The opportunity to meet was always utilised at or before the annual national HBA conferences. Sian reflected on the essence of the Society in supporting each other:

... that beginning of the Domiciliary Midwives Society, before we created an entity of that, I remember going to a meeting in Wellington with me and Joan, Lynne McLean and Lynley Macfarlane [then of Palmerston North] and Ursula[Helem] and the satisfaction of being with people who you know...are all thinking the same thing so you immediately can operate at depth and have the sort of conversations that are uncommon and that there was a sort of an easy intimacy that begins so there's this huge level of disclosure and support... after that whole [Ms] X case and being able to come and talk about that from a purely 'selfish' point of view, you know – how this was for me – was what...enabled me to then carry on – to get what there was to get.⁹³

From the beginning, the group, as the Domiciliary Midwives Association with its first meeting of six DMs, would establish itself as the voice of domiciliary midwifery. As an Incorporated Society, the group would achieve recognition from the DoH as being the appropriate body to consult with regarding review of the Terms, Conditions and Fees applicable to DMs – a recognition that was formalised into the amended contract of 1987.⁹⁴ The DMS would go on to establish the DMSRC in partnership with the HBAs in 1988 which, as previously mentioned, would set the precedent for NZCOM's Midwifery Standards Review from the early 1990s.

92 'Rules: Domiciliary Midwives Society of New Zealand', 9 June 1982', DMS, 'Documents of Incorporation, DMS/00 1'.

93 Catch-up: Maggie Banks with Sian Burgess, 7 January 2005, p. 11.

94 Michael Bassett, MoH, 'Terms and conditions, for approved midwives and registered nurses providing domiciliary maternity services', Wellington, 20 July 1987, DMS, 'Submissions and unpublished papers, DMS/00 4/18'.

Concluding remarks

I have established the mechanism for the DM's contractual arrangement with the MoH which enabled payment for domiciliary midwifery services through the MSB. During 1939-1985 only two changes were made in its Terms – firstly, a payment for one antenatal visit added in 1977 and, secondly, an additional provision for three antenatal visits (with a corresponding reduction in postnatal visits from fourteen to twelve) in 1984.⁹⁵ This contract remained otherwise unchanged, receiving little attention due to the small numbers of planned home births and, therefore, the little demand for legislative change until the late 1970s,⁹⁶ which I detail later in the thesis.

The responsibility of supervision of the DM by the MOH was interpreted by the DoH in 1979 as he being responsible for her practice – interpreted because it was unclear in the legislation what his supervision should entail. That this should not have been clarified in the previous forty years reflects the lack of review of the DM's contract due to ever diminishing home birth numbers from 1939. This would change from 1974 with the commencement of practice in Auckland of Carolyn and Joan, and Ursula in Christchurch. From 1974 the demand for home birth was rapidly increasing though the number of DMs grew more slowly and would lag behind this demand until the mid 1980s.

I have introduced Carolyn, Joan, Bronwen, Gillian, Sian, Jenny, Anne and Sue and captured how it was as they commenced domiciliary practice. By June 1987 DM numbers had increased nationally to thirty-three,⁹⁷ swelling to 128 by October 1989, as evidenced in the preceding chapter. However as discussed previously, while 30.46% were DMS members, it is probable that the Society represented the vast majority of DMs who provided labour and birth services at home throughout the study period. With the establishment of the DMA in 1981 followed by its incorporation in 1982, DMs began to have a collective voice of their own in the DMS. This voice - separate from NZNA - would become recognised by the DoH as the 'official' voice of domiciliary midwifery in New Zealand. The Society's inception would herald the personal independence of DMs in supporting each other, speaking out effectively and managing their affairs. Upon its

95 Bronwen Pelvin, Secretary, DMS to Health Benefits Review Wellington, Submission, c.1985, DMS, 'Submissions and unpublished papers, DMS/00 4/18'.

96 Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979' ABQU 632 W4550, 29/21 (49879).

97 Jennie Nicol, *Choice, Part I*, pp. 5-6.

establishment the DMS would immediately begin to lobby for an increased MSB which I continue with in the next chapter.

CHAPTER 4: THE POWER OF THE PURSE

The contractual process enabling DMs to access the MSB was long established, as was the mechanism for her to obtain specified supplies free of charge through the Midwifery Orders.¹ However it was the very low level of remuneration that provided a constant and real cause of concern for DMs, one which created ongoing challenges to their ability to continue in practice, which I discuss in this chapter.

At the 1977 United Women's Convention in Christchurch, participants at a home birth workshop advocated that the DoH make available a grant to DMs to set up practice and buy equipment.² Thus began a fourteen year long campaign by home birth consumers, women's health lobbyists and DMs aimed at achieving a level of MSB payment that would ensure a viable home birth option. After detailing that effort and the MSB, I make comparisons between the DM's income, the remuneration for GPs and the income of the hospital-employed midwife. The means by which DMs survived financially is recounted as is the pivotal role home birth families and the consumer groups played.

I expand on the uneasy relationship between the DMs and NZNA that would become evident from the late 1970s. While detail of events that gave rise to this are detailed in later chapters, my explanation of this lack of ease gives context as the primary impetus for DMs to form the DMS, as previously mentioned.

While individual DMs, and the HBAs once established, had started to lobby for an improved income for domiciliary midwifery, the DMS would continually lobby the DoH from 1981. I follow that struggle until August 1987. This point would mark a considerable lessening of the income gap compared to hospital-employed midwives, though there would still be no parity of income. However, while the substantial rise in the rate of the MSB of 1987 was still inadequate, it would signal a shift in DoH thinking as to a more appropriate

1 'Appendix 2 - Equipment', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879). Dettol and chlorhexidine solutions and creams, Savlon, weak iodine and iodophor, olive, peanut and soya bean oils, glycerine suppositories and Hiruroid anti-inflammatory cream were specified.

2 *Changes, Chances, Choices: A Report on the United Women's Convention, 3-6 June 1977*, Christchurch, United Women's Convention, 1978, p. 29 and 'Paper V, Alternative ways of providing maternity services', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

level of remuneration for DMs. This shift, as I will elaborate later, had been heralded by the Maternity Benefits Review Team which, in 1986, flagged up the link between health professional opposition to home birth and the below subsistence level of the financial reward for DMs.

I begin with discussion on the MSB – the mechanism by which the DM was remunerated for her home birth services.

The Maternity Services Benefit

The MSB, funded indirectly through taxation, was payable to the woman for her maternity care. Rather than the woman receiving this money to pay her medical practitioner or DM, the practitioner claimed on the woman's behalf once services had been provided. The amount of the claim was paid according to the Fee Schedule in relation to the type of practitioner claiming and the services provided.

The MSB remunerated only episodes of maternity care, that is, labour and birth care, postnatal visits and, for the DM after 1977,³ an antenatal visit. No provision was made for the twenty-four hour 'on call' nature of the work, penal or overtime rates, statutory holiday payments, time off for holiday or sickness or equipment and medical supplies.⁴ While the responsibility for providing and maintaining a car fell to the DM,⁵ 'actual and reasonable' travel expenses were paid at current public service mileage rates without restriction to a mileage radius.⁶ From the Nurses Act 1977, these payments could be authorised only if a doctor agreed to the woman birthing at home and if he would be 'in charge' of the woman throughout her pregnancy.⁷

The Social Security Act 1964 empowered the MoH to fix the fees of the MSB⁸ and these were set "from time to time"⁹ following negotiation between the Arbitration Section

3 Medical practitioners were paid for antenatal care prior to 1977.

4 Bronwen Pelvin to Health Benefits Review, Submission, c. 1985, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

5 Ibid.

6 'Paper IV, Legislation, comments and recommendations', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

7 Department of Health, Head Office Letter, 18 February 1977, in 'Paper IV, Legislation, comments and recommendations', in 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

8 Social Security Act 1964 (110 [1] p.531).

of the DoH and NZNA.¹⁰ The fees were full recompense for the services the DM provided to women birthing at home. Even if they had been able, midwives of the DMS were unanimously committed to not charging women additional fees so as to avoid financial discrimination against low income women who may, as a result of a charge, be unable to access the service.¹¹

From 1971 – 1987, the MSB payable to DMs was increased two to four yearly,¹² while for the preceding years from 1941, the rates were adjusted upwards at intervals of up to nine years,¹³ as shown in Table 4.1.

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- 9 'Paper IV, Legislation, comments and recommendations', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).
- 10 R.A. Barker to MoH, Memorandum, 31 July 1980, DoH, 'Board of Health – Maternity Services Committee, 1980-1981', ABQU 632 W4415, 29/21 (53013).
- 11 Chris Voaden, 'Report of the first meeting of the national Association of NZ domiciliary midwives', c. 1982, Joan Donley Personal papers, 'Papers re Domiciliary Midwives Society of NZ', (MS95/20 15).
- 12 Bronwen Pelvin to Health Benefits Review, Submission, c. 1985, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.
- 13 Joan Donley, 'Domiciliary Midwives' wage negotiations: analysis of options and suggestions', Paper, March 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

Table 4.1 Rates of benefits payable to domiciliary midwives, 1971 – 1987

Year	1971 \$	1975 \$	1977 \$	1980 \$	1984 \$	1985 \$	June 1987 \$	August 1987 \$
Antenatal visits (number)	-	-	3.00 (1)	4.25 (1)	5.00 (3)	6.00 (3)	13.00 (3)	16.00 (3)
Labour and Birth	11.50	20.00	25.00	36.00	50.00	54.00	75.00	150.00
Postnatal visits (number)	2.25 (14)	4.00 (14)	5.00 (14)	7.25 (14)	8.50 (12)	9.00 (12)	13.00 (12)	16.00 (12)
Daily live-in allowance *	7.50	13.25	17.00	24.50	28.50	30.00	45.00	45.00
Maximum payment per case (excl. live-in allowance)	43.00	76.00	98.00	141.75	167.00	180.00	270.00	390.00
Total p.a. (caseload of 60, excl. live-in allowance)	2,580.00	4,560.00	5,880.00	8,505.00	10,020.00	10,800.00	16,200	23,400.00

Data Sources: Joan Donley, 'Domiciliary Midwives' wage negotiations: analysis of options and suggestions', Paper, March 1982, DMS, '1982 Correspondence, DMS/00 4/2'; 'Table 1, Rates of Benefits payable to domiciliary midwives since 1971', in Bronwen Pelvin to Health Benefits Review, Wellington, Submission, c.1986, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'; A.J. Cooke, Chief Executive, Nelson Area Health Board to Director-General of Health, Wellington, Letter, 26 June 1987, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'; Department of Health Circular Memorandum, Head Office No 1987/12, c. June 1987, DMS, 'Correspondence, re Maternity Benefits, DMS00 4/18'.

* The live-in allowance was payable if the midwife stayed in the woman's home or vice versa. This was not to exceed 30/- per week in 1941 and £3 a week in 1948 but any excess could be met by the woman. In Joan Donley, 'Domiciliary Midwives' wage negotiations: analysis of options and suggestions', Paper, March 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

Despite the lack of payment for midwifery antenatal care until 1977, the DM provided a 'social' visit in pregnancy to get to know the woman from at least 1974. In December 1975, the MoH specifically asked DMs to provide this visit but there would be neither funding nor a mileage allowance to achieve it¹⁴ until 1977 when provision was made for payment of one antenatal visit.¹⁵ A further two antenatal visits, suggested by the

14 Joan Donley, *Herstory*, p. 32.

15 'Paper IV, Legislation, comments and recommendations', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

DoH in 1979,¹⁶ would be paid for from 1987. With this funded increase in antenatal visits, the number of postnatal visits, previously limited to seventeen, was reduced to twelve.¹⁷

In 1979 the maximum income per case that the DM could receive for one antenatal visit, labour and birth attendance and seventeen postnatal visits was \$98. However, on average, she received a payment of \$80 per case.¹⁸ This meant, therefore the DM could earn, on average, an annual income of \$4,800 – \$5,880 prior to taxation and expenses for sixty cases – this being established by the DMS as the manageable annual maximum caseload¹⁹ over an eleven month period. While there was no funding for time off, and the DM received no income for the period, the twelfth month was allocated as a ‘holiday’.

Before comparing the DM’s income to that of the hospital-employed midwife, I will address the issue of unequal pay for equal work that existed throughout the study period (and until the Nurses Amendment Act 1990) between the DM and the GP.

Unequal pay for equal work

There was a general absence of adequate statistical information as to the length of time maternity services took to provide as well as the costs of running a practice. This created difficulty for the DoH in its ability to assess services and establishing appropriate fees to be set in the MSB.²⁰ However, some inequities were glaringly obvious in that not only was the remuneration inadequate when compared to hospital nursing colleagues, the DM had less remuneration in each service category for providing services to achieve the same goals as the GP – a safe maternity service (Table 4.2).

16 Ibid.

17 Department of Health, ‘Increase in fees for domiciliary midwives’, Circular Memorandum, c. June 1987, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

18 Auckland Branch of NZHBA to MSC, Submission, 23 September 1979, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

19 Lynne McLean to Department of Trade and Industry, Letter, 6 December 1982, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’; Bronwen Pelvin to Dr Bassett, MoH, Letter, 5 March 1983, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’. The calculations submitted to the MSC by HBAs and DMs alike had not factored in annual time off for the midwife. Rather it reflected a caseload for twelve months of the year.

20 The Maternity Benefits Tribunal 1985, ‘Decision of the Tribunal’, 11 November 1985, NZNA, ‘Midwives 1981-1989, 65/9/5’, p. 24.

Table 4.2 Comparison between Maternity Services Benefit fees paid to General Practitioners and domiciliary midwives, 1986

Service	General Practitioner \$ April 1986	Domiciliary Midwife \$ June 1986
Initial consultation	26.50	-
Ordinary antenatal consultation	13.25	13.00
Living-in fee (per day)	-	45.00
Labour and birth	185.00	75.00
Puerperium/postnatal visits	13.25	13.00
Postnatal examination ²¹	39.75	-

Data source: Health Benefits Review Committee, *Choices for Health Care, Report of the Health Benefits Review*, Wellington, 1986, p. 133.

This inequity of service payment was irrespective of the proportionately longer hours the midwife spent in attendance throughout antenatal, labour and birth and postnatal care than the GP, the labour and birth fee reflecting most disparity. In 1986, the GP received \$185.00 for this service – this being approximately fourteen times the standard antenatal fee which benchmarked that labour and birth fee. For this he was commonly in attendance for between 1–1.5 hours.²² Rather than using the same rationale of antenatal visit multiples to set the DM’s labour and birth fee at \$182.00, this fee was set at \$75.00,²³ recompensing her for a benchmarked six hour labour and birth attendance. Thus, the DM was paid 40.54% of the GP’s fee for essentially the same service, without consideration of the four to six times greater time period she would spend with a woman in labour.

This gap would prove even greater with my analysis of information submitted by DMs to assist DMS negotiations with the DoH. Twenty-one DMs provided information on hours of labour and birth attendance for 345 births during a twelve month period (May 1987-April 1988). For the majority of the midwives, their submissions represented a time period of six to nine months’ practice. Hours of attendance at each labour ranged from 1.5-

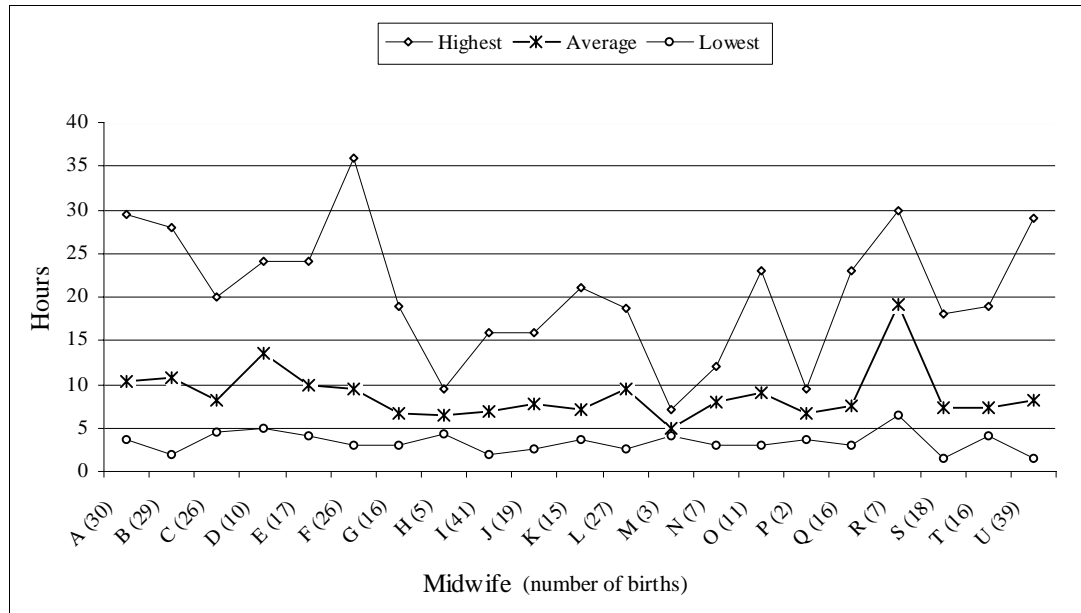
21 The final postnatal examination was not undertaken by the midwife until after the Nurses Amendment Act 1990.

22 The Maternity Benefits Tribunal 1985, ‘Decision of the Tribunal’, 11 November 1985, NZNA, ‘Midwives 1981-1989, 65/9/5’, p. 14.

23 Health Benefits Review Committee, *Choices*, p. 133.

36 hours with an overall average attendance of 8.9 hours. The average labour attendance for any individual ranged from 5.0-19.14 hours,²⁴ as indicated in Figure 4.1.

Figure 4.1 Hours of labour attendance by domiciliary midwife, May 1987–April 1988



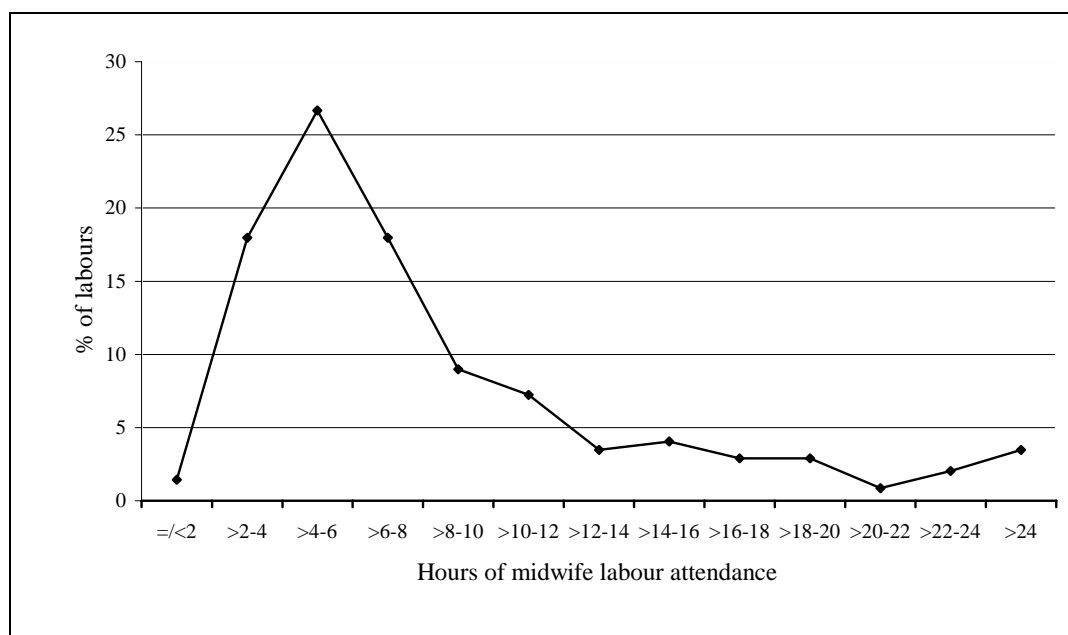
Data sources: Bronwen Pelvin to Kelly Grovehills, 'Compilation of times spent attending labours to 31/7/87', 20 August 1987 and 'Labour Times' c. May 1987 - April 1988, Bundle of papers, c. 1987, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'. NB: Figures for Midwives D, E, F, J and K included travelling time.

Only 46.08% of labour attendances were six hours or less which, as previously mentioned, was the benchmark for establishing the labour and birth fee. In fact, 27.25% (n=94) required the midwife's attendance for more than twelve hours – double that benchmark, as shown in Figure 4.2. The MSB was purported to operate on a "swings and roundabouts principle".²⁵ Yet, because the allocation of time a DM would spend with a woman in labour was set at such an unrealistically low level, there was never an opportunity for her to 'operate' either swing or roundabout.

24 Bronwen Pelvin to Kelly Grovehills, 'Compilation of times spent attending labours to 31/7/87', 20 August 1987, and 'Labour Times' c. May 1987-April 1988, Bundle of papers, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

25 The Maternity Benefits Tribunal 1985, 'Decision of the Tribunal', 11 November 1985, NZNA, 'Midwives 1981-1989, 65/9/5', p. 8.

Figure 4.2 Domiciliary midwife labour and birth attendances, percentage of hours, May 1986 – April 1987



Data sources: 'Labour Times' c. May 1986-April 1987, Bundle of papers, c. 1987, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18' and Bronwen Pelvin to Kelly Grovehills, 30 November 1987, Letter and attachments, c. 1987, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'. Figures for midwives D, E, F, J and K included travelling time.

This disparity of income was made greater by the fact that, while it was opined that GPs should provide or make arrangements with the midwife to provide adequate equipment at a birth,²⁶ GPs generally came 'barehanded', relying on the DM to provide and fund the necessities which included those he may use.²⁷ The cost of this equipment – sterile linen, oxygen, suction equipment, intravenous fluids, intravenous giving sets and suture material – represented 31% of the midwife's fee paid in 1986.²⁸ While some Hospital Boards allowed free access to these supplies, others did not²⁹ fearing a precedent would be set for all health professionals in private practice to be supported with supplies and

26 M. McKerr, St Albans Medical Centre, 'The responsibility of the General Practitioner in the management of home confinements', Submission, 12 August 1980, DoH, 'Board of Health – Maternity Services Committee, 1980-1981', ABQU 632 W4415, 29/21 (53013).

27 Catch-up: Maggie Banks with Sian Burgess, 7 January 2005, p. 14. In my personal experience, only one doctor brought his own equipment and disposables to home births.

28 Allison Livingstone to Dr Claudia Scott, Chairperson, Health Benefits Review Team, Submission, 28 May 1986, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

29 Chris Voaden, 'Report of the first meeting of the national Association of NZ domiciliary midwives', c. 1982, Joan Donley Personal papers, 'Papers re Domiciliary Midwives Society of NZ', (MS95/20 15).

equipment.³⁰ Some of these Boards, it was purported, would hire equipment to the DM for a fee.³¹

When the level of the MSB was renegotiated, it exposed and further compounded inequities. For example, when fees were reassessed and increased in 1985, the GP would receive what amounted to a 115% increase in fees previously set in 1981,³² whereas the DM would receive a 26.98% increase from 1980 to 1985. Equally, the amount at which travel expenses were reimbursed disadvantaged the midwife when compared to the GP or his Practice Nurse, both of whom had higher rates of mileage reimbursement.³³

As inequitable as the MSB was for the DM when compared to that applicable to the GP, it was parity of income between the DM and her hospital-employed midwifery colleague that the DMS sought.

Domiciliary midwives: the poor sister

The calculated income of the MSB would continually lag behind waged hospital- and community-employed midwifery and nursing colleagues from at least 1972. In that year, the latter was paid \$3,555³⁴ before taxation while the DM's calculated income, prior to costs and taxation, for a full-time caseload was \$2,580 – representing 72.57% of the former.³⁵ By 1979 a Public Health or Plunket Nurse would, according to her experience, earn \$10,000 – \$12,000 per annum and receive holiday pay. By comparison, in the same year, the DM might earn \$5,880 working full-time, this being 49.0 – 58.8% of her colleague's income before the former's taxation and costs were subtracted,³⁶ as illustrated

30 A.J. Cooke, Chief Executive, Nelson Area Health Board to Director-General of Health, Letter, 26 June 1987, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

31 J. Foley, 'Equipment for domiciliary obstetrics' to MSC, Letter and list, 8 August 1980, DoH, 'Board of Health – Maternity Services Committee, 1980-1981', ABQU 632 W4415, 29/21 (53013).

32 The Maternity Benefits Tribunal 1985, 'Decision of the Tribunal', 11 November 1985, NZNA, 'Midwives 1981-1989, 65/9/5', p. 22.

33 Division of Nursing, DoH, 'Proposal for change in domiciliary midwives' services', Paper, 23 October 1979, DoH, 'Board of Health – Maternity Services Committee, 1982', ABQU 632 W4415, 29/21 (54019).

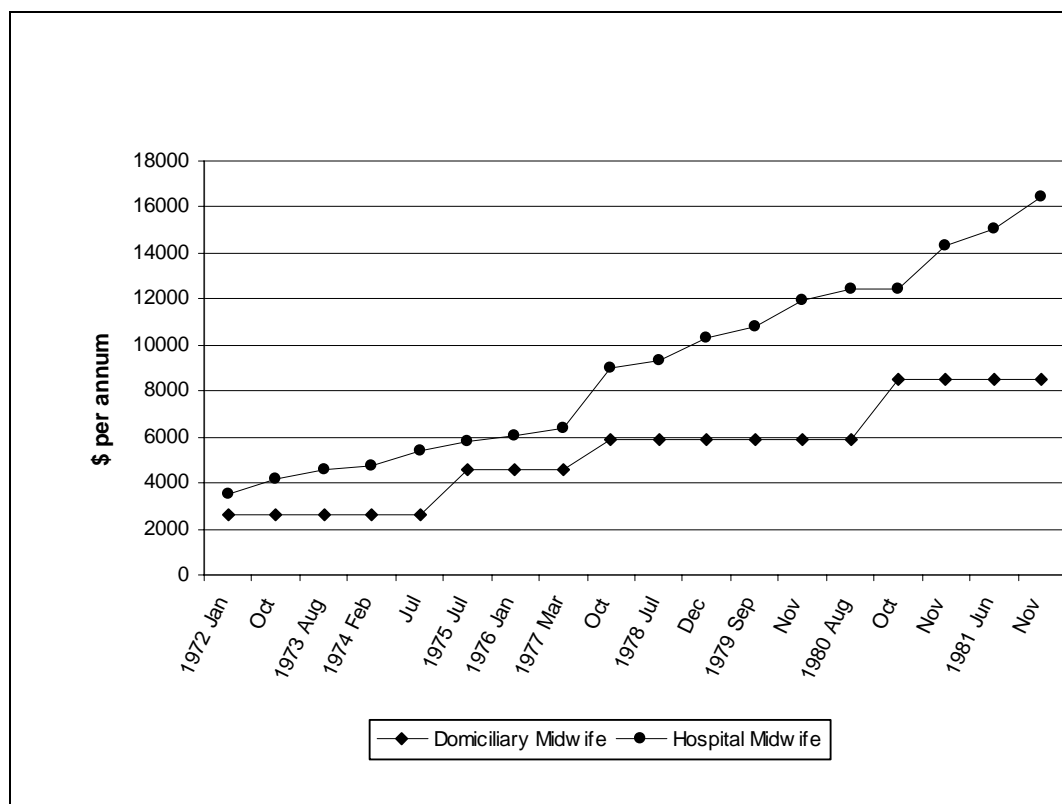
34 Decimal currency replaced pounds sterling in 1977. The conversion used is £1 = \$2.00.

35 Lynne McLean to Department of Trade and Industry, Letter, 6 December 1982, 'Correspondence, re Maternity Benefits', DMS/00 4/18.

36 Auckland Branch of the NZHBA to MSC, Submission, 23 September 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

in Figure 4.3. By 1982, the gap had reduced somewhat but hospital midwives continued to be paid 55.12% more than their domiciliary counterparts.³⁷

Figure 4.3 Comparison between domiciliary midwife and hospital midwife annual income, 1972-1981³⁸



Data sources: Lynne McLean, Secretary DMS, to Secretary, Department of Trade and Industries, Letter, 6 December 1982, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'; Joan Donley, 'Domiciliary Midwives' wage negotiations: analysis of options and suggestions', Paper, March 1982, DMS, '1982 Correspondence, DMS/00 4/2'; 'Table 1, Rates of Benefits payable to domiciliary midwives since 1971', in Bronwen Pelvin to Health Benefits Review, Submission, c. 1986, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

By May 1986 the DM's average net income before tax was \$7,679 – only 28.97% of the basic net income before tax of the \$26,500 per annum earned by the hospital-employed midwife (or nurse). After expenses, the amount paid to the former, according to Allison Livingstone, accountant for the Auckland DMs since 1982, would reward a forty

37 Lynne McLean to DTI, Letter, 6 December 1982, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

38 Rates of income were analysed by Lynne McLean on a seventy-two cases per year basis while all others were based on a caseload of sixty per year. Lynne's calculation has therefore been adjusted by me to a caseload of sixty per year which reflects the ongoing benchmark for negotiation.

hour working week with an amount less than half of that which one would receive through the Unemployment Benefit.^{39, 40}

The DMs aimed for parity of income with the highest level of Staff Nurse until July 1980. At that point, the HBAs identified that the level of responsibility and skill was more commensurate with that of a Charge Nurse,⁴¹ a position which several of the midwives had held prior to commencing domiciliary practice. This point of reference would continue to be used by the DMS in further negotiations.

Surviving financially

Such a poor level of remuneration meant DMs working with a full caseload were unable to financially sustain themselves and their families. Anne, the breadwinner of her family, summed up her situation succinctly – “we were poor, we were always poor; we were always beneficiaries, always”.⁴² Jenny, parenting two daughters on her own, was totally dependant on her income from practice. She had commenced domiciliary practice in Hamilton in 1980 but the low number of planned home births there at that time prevented full-time work. She needed to shift locales which she did in 1983 after enquiring into the demand for home birth in other regions. The Wellington branch of the HBA welcomed her with open arms, funding her visit to a HBA meeting in Wellington, offering both moving expenses and to find accommodation for her and her two daughters. Jenny took up this opportunity but she struggled financially:

I sustained myself through donations and handouts. My first year in Wellington I did fifty to sixty births – it was sixty actually – and I earned half what I would earn as a staff nurse in hospital...I think I earned seven [thousand dollars] officially..., something totally ridiculous, so I supplemented my income by teaching antenatal classes and the Home Birth

39 This is a government funded benefit to unemployed people.

40 Allison Livingstone to Dr Claudia Scott, Chairperson, Health Benefits Review Team, Submission, 28 May 1986, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

41 ‘National Conference’, July 1980, Joan Donley Personal papers, MS95/20 1.

42 Catch-up: Maggie Banks with Anne Sharplin, 24 October 2004, p. 16.

*Association paid me for that, quite well. I think I got something like \$50 an evening which was a lot in those days so that helped a lot.*⁴³

Jenny explained the strategies of support that the HBA and home birthing families took to maximise her financial situation:

*Everyone who had a home birth, it was more or less pointed out to them [by the HBA] that if they wanted to keep a midwife in Wellington that they had to join [the HBA] and they had to go to the classes and they had to pay, if they possibly could...We weren't allowed to charge [for midwifery care] but it was also encouraged that they would recompense me in some way through goods or service or money. Some people would actually give me money or, if they couldn't give me money, they would give me services or goods...I looked after a mechanic and I had my car serviced free for a year. I looked after a plumber and he came and fixed my taps. I looked after a builder and he came and fixed up my rotten boards. I looked after a farmer and he gave me meat and firewood. Some people would give me vegetables. At the end of the year, the Home Birth Association would always have this amazing party and they would collect all these goodies...and give me a huge basket with everything you could ever need for Christmas in it and my kids used to love it and I'd come home and there were Christmas cakes.*⁴⁴

A commitment to knowing the woman prior to labour meant both the time and travel costs were born by the midwife as this remained unfunded by the MSB until 1977 when one visit was paid. As mentioned previously, it would be another ten years (1987) before the three visits the midwife provided would be funded. In the meantime, as Carolyn described, home birth families supported the midwives:

You got nothing for antenatal care and at that time, of course, we worked in with GPs but you made three social visits to the woman in the antenatal period...It was so poorly paid that you only just survived. Working hard, you got less than if you were on the dole, but you'd come home and there'd be a big box of groceries on your door and someone would have a note saying, our baby's a year old today and we're thinking of you. So the

43 Catch-up: Maggie Banks with Jenny Johnston, 23 August 2004, pp. 13-14.

44 Ibid., p. 14.

*community knew that we were standing on the line with them, to care for them, and there was tremendous support from the community in that sort of way, helping us out.*⁴⁵

While payment in kind and food hampers were welcomed and appreciated, this did not address the shortfall in money of a single income household. Jenny was forced to take on part-time work booking women into hospital in the antenatal clinic and supervising midwifery students in clinical placements. Jenny also supplemented her income by working hospital shifts while being on call for births. She eventually missed a birth as she was unable to leave her employment in the geriatric hospital on the day a client laboured.⁴⁶ While Jenny decided to avoid this happening again and ceased her employment, the late payment of claims became the last straw over one Christmas period. Jenny continues the story:

Eventually after about five years I had one bad time where I completely ran out of money and it was towards the end of the year and I was supposed to be getting paid for all of these births and I was waiting for it to go in and it didn't go [into her bank account] and it was like Christmas eve and I hadn't been paid. It was terrible. I couldn't pay my mortgage. I was supposed to be going away with my daughter for a little while and just didn't have any money and I remember ringing up the people who pay you and just bursting into tears and - I haven't got any money and I can't pay my mortgage and how come? They were having a Christmas party in the background and it was terrible and I remember I had to borrow money off my relatives to get over the Christmas period and then in January, I just thought - this is no good, it's no good, if something comes up I'm going to do it. And so I opened the paper the next day and they were looking for a tutor at Polytech – urgently. So I rang up, went the next day and it must have been the end of January, and they said, can you start the next week? And I said, yes, as long as I can still go to my births for the next couple of months, I'll do it. So I

45 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, pp. 8-9.

46 Catch-up: Maggie Banks with Jenny Johnston, 23 August 2004, p. 14.

*went to Polytech for a year...I still did twenty births that year that all came in the weekends apart from one which came at lunchtime.*⁴⁷

The same financial penalties affected Bronwen but the Riverside Community in Nelson where she lived supported her financially, thereby playing an “absolutely pivotal” role in her ability to continue in practice. By bearing the cost of the inadequate funding of the MSB in this way, the Riverside Community ‘provided’ Nelson with a home birth service.⁴⁸

Others were so affected by the low level of remuneration that it prevented their ability to continue in practice. Sian returned to hospital employment as, in 1982, she had earned just under \$5000 for a caseload of sixty-six clients.⁴⁹ Lynne McLean of Wellington ceased practice in March 1983 “after months of agonising”⁵⁰ and Chris Voaden of Nelson planned to stop after June 1983.⁵¹

Equally challenging was the uncertainty of income as a midwife’s caseload built. There would be a point where the midwife had to leave her rostered hospital employment to ensure her availability to women birthing at home or, as Jenny had experienced, miss a birth. Gill Williams in the Bay of Plenty, having attended eighteen home births in the two years she had been practising, had worked at the Whakatane Hospital for eighteen months to make ends meet. In 1984, with five home births booked for one month and three for the next, she had resigned her hospital position to ensure her availability, hoping to get Early Discharge work to tide her over till other bookings eventuated.⁵²

Where HBAs and HBSGs existed, they played a pivotal support role for the midwives as Jenny’s her-storying illustrated. Further, the Tauranga HBSG facilitated build up of Gill Williams’ caseload by advertising for her in the personal column of the local newspaper each week.⁵³ The Auckland HBA paid its midwives’ subscriptions to the

47 Ibid., pp. 14-15.

48 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 12 and Bronwen Pelvin to Lynne McLean, Letter, 18 April 1983, DMS, ‘1983 Correspondence, DMS/00 4/3’.

49 ‘Poor Pay Has Midwife Back in Hospital’, *The New Zealand Herald*, 3 November 1982, DMS, ‘Newspaper clippings envelope, DMS/00 7/2’.

50 Lynne McLean to DMS members, Letter, 23 February 1983, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

51 Bronwen Pelvin to Lynne McLean, Letter, 18 April 1983, DMS, ‘1983 Correspondence, DMS/00 4/3’.

52 Gill Williams to Bronwen Pelvin, Letter, c. June 1984, DMS, ‘1984 Correspondence, DMS/00 4/4’.

53 Ibid.

HBA.⁵⁴ The Wellington group, acknowledging the financial difficulty in getting to HBA Conferences, asked that a delegate be elected to represent them.⁵⁵ These consumer groups also provided a concerted lobby to improve conditions for the DM over many years as will be shown as I now describe the process of developing an effective negotiating voice.

Establishing a negotiating voice

Participants at the 1977 United Women's Convention had recognised the relationship between the low number of DMs and poor remuneration and the impact this had on maintaining a viable service.⁵⁶ Ensuring economic viability of the service became a focal point of each HBA branch as they established – the first in Auckland on 1 May 1978.⁵⁷

Aware domiciliary midwifery was being reviewed by the MSC in 1979 (which I discuss later in the thesis), comprehensive detail on the DM's financial position was sent to the Committee by the Auckland HBA. It urged that she be remunerated at the same level as a Public Health or Plunket Nurse. While these earned \$10,000 – \$12,000 per annum and the DM earned \$5,880 per annum, as in Figure 4.3, the nurses shouldered less responsibility than DMs and were provided with better back-up services.⁵⁸ In late 1979, the newly formed Wellington HBA lobbied the MoH, DoH and MSC urging that the MSB be increased to a more realistic level to ensure that the increasing demand for domiciliary midwifery services was met.⁵⁹ The Auckland, Manawatu, Dunedin and Nelson branches of the HBA would all submit detail to the MSC when submissions on domiciliary midwifery were called for during 1979 and 1980.⁶⁰ The HBAs would receive the same response as received by Lynne McLean and Jennifer Sage, another Wellington DM, when inquiring about the progress of the MSC's review a year after submissions were called for.⁶¹ They

54 Joan Donley to Lynne McLean, Letter, c. June 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

55 Marilyn Walker, Conference Co-ordinator, Dunedin HBA to Jennifer Sage, Lyn McLean and others, Letter, 17 December 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

56 *Changes*, p. 29.

57 Joan Donley, *Herstory*, p. 3.

58 Auckland Branch of NZHBA to MSC, Submission, 23 September 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

59 A Brewer, Chairman, NZHBA, Wellington Branch to R.A. Barker, Letter, 14 September 1979, DoH, 'Board of Health – Maternity Services Committee, 1979-1980', ABQU 632 W4415, 29/21 (50925).

60 Maternity Services Committee, List of submissions, c. December 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

61 Lynne McLean and Jennifer Sage to R.A. Barker, Letter, 22 September 1980, DoH, 'Board of Health – Maternity Services Committee, 1979-1980', ABQU 632 W4415, 29/21 (50925).

were advised to take up the matter of remuneration with the Clinical Services Division of the DoH⁶² as the MSC Terms of Reference did not include the quantum of payment and it would not consider the financial implications for the midwife.⁶³

As previously mentioned, as far as the DoH and the MoH were concerned, NZNA was the appropriate arbitrator for DMs. While it was the professional body for all nurses and midwives, NZNA was the negotiating body only for those working in public hospitals.⁶⁴ However, a remit passed at the April 1981 NZNA Conference determined that NZNA would negotiate for an increased MSB on behalf of domiciliary midwives.⁶⁵ Further, it was remitted that NZNA urge review of the MSB and that it be reviewed on a regular basis.

That process was started but two months later no word of what negotiations were taking place had been received by DMs.⁶⁶ The matter had been referred to NZNA's Economic Welfare Committee for 'consideration and action' at the May meeting. A request had subsequently been sent to the MoH for another MSB Schedule review, the last having been done in October 1980. NZNA had not received a response by towards the end of July.⁶⁷ Lynne McLean's further enquiry to NZNA in September⁶⁸ revealed a 'recent' reply, which gave no assurance from the Minister beyond acknowledging NZNA's request would be borne in mind during consideration of an extension of health benefits later in the year.⁶⁹

The DM's hopes of having NZNA lobby vigorously on their behalf appeared in vain. While there could be individually supportive midwives within NZNA,⁷⁰ the DMs

62 R.A. Barker to Lynne McLean and Jennifer Sage, Letter, 25 September 1980, DoH, 'Board of Health – Maternity Services Committee, 1979-1980', ABQU 632 W4415, 29/21 (50925).

63 George F. Gair, MoH to J.K. McLay, Minister of Justice, Letter, 15 November 1979, DoH, 'Board of Health – Maternity Services Committee, 1979-1980', ABQU 632 W4415, 29/21 (50925).

64 Joan Donley, 'Domiciliary midwives' wage negotiations: analysis of options and suggestions', Paper written for the DMS, March 1982, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

65 Lynne McLean to Secretary, NZNA National Executive, Letter, 15 July 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

66 Ibid.

67 Glenn Harris, Advisory Officer, NZNA to Lynne McLean, Letter, 21 July 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

68 Lynne McLean to Glenn Harris, Letter, 30 September 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

69 Glenn Harris to Lyn McLean, 5 October 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

70 Margaret McGowan, President MSIS, asked Ursula Helem if the DMs wanted to put in a remit for Conference about financial matters. In Ursula Helem to Lynne McLean, Letter, 18 September 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

were suspicious of NZNA's commitment to negotiate on their behalf. I will elaborate on this fully in Chapter 6 but by at least February 1980, NZNA had made known its opposition to home birth and self-employed DMs in its 'Policy Statement on Home Confinement'.⁷¹ Further, NZNA had developed its 1981 *Policy Statement on Maternal and Infant Nursing*⁷² in an attempt to curtail increasing home birth numbers. As Joan Donley surmised:

NZNA have proclaimed their opposition to home births. In their Policy Statement, April 1981, they say they now have to 'formulate policies that admit reluctant acceptance of a fait accompli', (domiciliary midwifery). They also recognise they 'are unable to bring positive sanctions against those who condone and support the trend to home confinement'. However there is nothing to stop them from starving us out of existence!⁷³

Moreover, DMs were not supported by the Midwives Special Interest Section of NZNA. For example, the HBA and several DMs joined forces in January 1981 to request a conference remit amendment at the Auckland MSIS meeting. This proposed NZNA urge the MoH to formulate policy so intending DMs could be paid a three month, fully paid period of working with an experienced DM prior to commencing practice. Further, they remitted that five yearly refreshers be available for all practising DMs, basic equipment be provided, remuneration reflect their profession status and that the MSB be reviewed annually. This remit amendment was not accepted.⁷⁴

While NZNA determined to await the review of MSB,⁷⁵ the DMs began to explore other avenues for representation. All available possibilities were reported to the DMS by Joan with a recommendation of affiliation with the New Zealand Federation of Labour (FoL).⁷⁶ Affiliation to the Trade Union Council in the United Kingdom by British

71 New Zealand Nurses Association, 'Home Confinement'.

72 New Zealand Nurses Association, *Policy*.

73 Joan Donley, 'Domiciliary midwives' wage negotiations: analysis of options and suggestions', Paper written for DMS, March 1982, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

74 Auckland Branch MSIS, NZNA, 'Minutes of meeting', 7 March 1981, Joan Donley Personal papers, 'Midwives Section: Minutes 1980 - 1989, Missives 1984'.

75 Glenn Harris to Lynne McLean, Letter, 5 October 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

76 Chris Voaden, 'Report of the first meeting of the national Association of NZ domiciliary midwives', c. 1982, 'Papers re Domiciliary Midwives Society of NZ', (MS95/20 15) and Joan Donley, 'Domiciliary Midwives' wage negotiations: analysis of options and suggestions', Paper written for DMS, March 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

midwives had resulted in a large pay rise following the coal miners' strike of support.⁷⁷ However the Society's request to the FoL⁷⁸ met with an offer to work towards possible resolution with NZNA, warning that resolution of difficulties would not be an automatic consequence of affiliation.⁷⁹

The self-employed status of the DM prevented NZNA, Combined State Unions (CSU), New Zealand Nurses Industrial Union of Workers (commonly called the Nurses Union) and New Zealand Public Services Association (PSA) from negotiating on their behalf.⁸⁰ More importantly, at each turn, NZNA would ultimately be the negotiating body for the DMs. The CSU, acting as a 'watch dog' in matters which affected member groups, was a group for employed workers. Its decision-making was by consensus though matters which affected only one service, in this case, domiciliary midwifery, would be negotiated by the individual organisation - NZNA. The Nurses Union represented employed nurses in the private sector, though not the self-employed. While this organisation appeared at first glance to be the logical body to represent the DMs, Shona Carey, NZNA Executive Director, was also both National Secretary of the Nurses Union and the Hospital Services Representative on the CSU Executive.⁸¹ The PSA, a group representing state servants, needed a very clear majority for members of any group wanting membership and representation. There was also a need to elect delegates and participate in decision-making. The major part of member's income needed to come from the state.⁸² The PSA already negotiated for NZNA so affiliation to this group would only differentiate DMs as a separate category of 'nurse' within NZNA.⁸³

The DMs actioned the resolve of the 1981 HBA Conference to form their own organisation separate from NZNA so as to present a unified and effective, rather than individual, voice.⁸⁴ Meeting first on 31 October 1981,⁸⁵ the Domiciliary Midwives

77 Joan Donley to Lyn McLean, Letter, 27 October 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

78 Lynne McLean to K. Douglas, Secretary, FoL, Letter, 13 April 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

79 K.G. Douglas to Lynne McLean, Letter, 17 June 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

80 Lynne McLean to DTI, Letter, 6 December 1982, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

81 Joan Donley, 'Domiciliary Midwives' wage negotiations: analysis of options and suggestions', Paper, March 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

82 Karolin Peter, Field Officer, NZPSA, to Lyn McLean, Letter, 27 March 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

83 Joan Donley to Lyn McLean, Letter, 27 October 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

84 Lynne McLean to Roslyn Livingstone, Letter, 13 July 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

Association would, as previously evidenced, become successfully incorporated as the DMS on 29 March 1982.

A voice of their own

Six midwives attended that first meeting - Joan Donley, Bronwen Pelvin, Lynne McLean, Ursula Helem, Fiona Barnett of Palmerston North and Chris Voaden of Nelson.⁸⁶ The level of remuneration dominated the agenda. Lynne had already started corresponding with Dr Phillips, Director of Clinical Services in the DoH, by early October 1981. Her request for a review of fees followed hospital colleagues gaining wage and salary increases, as well as a 5% General Wage Order in June 1981 and periodic cost-of-living adjustments⁸⁷ - funds DMs were not entitled to because, as self-employed midwives, they were not classified as state servants.⁸⁸ Despite it having been a year since the DMs' last increase,⁸⁹ Dr Phillips reported the Benefit would be reviewed later in the year.⁹⁰

The DMS wrote directly to the MoH, A.G. Malcolm, to initiate discussions personally.⁹¹ The DMS informed him it had no way to participate in the discussion to improve the level of the MSB through existing mechanisms. Mindful of the pending MSC report, which I discuss later in the thesis, it directly linked adequate remuneration as an essential to maintaining a high professional standard.⁹² The DMS requested a meeting. The Minister deferred this meeting for six weeks until after release of the MSC Report and following government indication of whether it could afford to increase some health benefits. He gave no assurance of any increases being approved.⁹³ Following six weeks

85 Chris Voaden, 'Report of the first meeting of the national Association of NZ domiciliary midwives', c. 1982, Joan Donley Personal papers, 'Papers re Domiciliary Midwives Society of NZ', (MS95/20 15).

86 Ibid.

87 Lynne McLean to Dr J.S. Phillips, Letter, 11 October 1981, DMS, 'Correspondence, re Maternity Benefits, DM/S00 4/18'.

88 Joan Donley, 'Domiciliary Midwives' wage negotiations: analysis of options and suggestions', Paper, March 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

89 Lynne McLean to Dr J.S. Phillips, Letter, 11 October 1981, DMS, 'Correspondence, re Maternity Benefits, DM/S00 4/18'.

90 Dr J.S. Phillips to Lyn McLean, Letter, 15 October 1981, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

91 Chris Voaden, 'Report of the first meeting of the national Association of NZ domiciliary midwives', c. 1982, Joan Donley Personal papers, 'Papers re Domiciliary Midwives Society of NZ', (MS95/20 15).

92 Jennifer Sage and Lynne McLean to A.G. Malcolm, MoH, Letter, 3 March 1982, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

deferral and another request by the DMS to meet with him,⁹⁴ a meeting date of 16 July 1982 was set, following his return to New Zealand.⁹⁵

Henrietta Kemp, the National Lobbying Coordinator and National Newsletter Editor for the HBA, accompanied Lynne to the meeting as moral support and note taker. The Minister, raising the issue of NZNA as the appropriate arbitrator for DMSs, was made aware of the DM's reluctance for this and the unsuitability of NZNA. In the half hour meeting with the Minister, Lynne and Henrietta were informed of a 17% increase, which, unbeknown to them, had been approved by the Cabinet Committee on expenditure on 5 April 1982.⁹⁶ The meeting continued with Dr Phillips following the Minister's departure with discussion on issues relating to visits, payments, further policy, applications and suggestions for the following year.⁹⁷

Within a fortnight of being informed of the 17% increase, a price freeze of twelve months was introduced⁹⁸ and Cabinet withheld the increase as it did for other health services benefits. Despite the Department's sympathy towards a request to waive the freeze for the DMS on the grounds of hardship,⁹⁹ this did not happen. The price freeze, anticipated to be lifted in April 1983, would continue into the second half of 1984.¹⁰⁰

The DMS made application to the Department of Trade and Industry (DTI) for an exemption from the price freeze in December 1982,¹⁰¹ informing the Director that correspondence with Dr Phillips had started in early October 1981. It stated that as correspondence with the MoH had "brought a negative result and correspondence", the

93 A.G. Malcolm to Jennifer Sage and Lynne McLean, Letter, 19 March 1982, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

94 Lynne McLean and Jennifer Sage to A.G. Malcolm, Letter, 17 May 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

95 J.R. Burns, Private Secretary, Office of the Ministry of Health, to Lynne McLean and Jennifer Sage, Letter, 26 May 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

96 L.J. Castle, Ombudsman to Gillian McNicoll, Secretary, DMS, Letter, 25 May 1984, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

97 Lynne McLean to DMS members, Letter, 19 July 1982, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

98 The Maternity Benefits Tribunal 1985, 'Decision of the Tribunal', 11 November 1985, NZNA, 'Midwives 1981-1989, 65/9/5', p. 4.

99 L.J. Castle to Gillian McNicoll, Letter, 25 May 1984, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

100 The Maternity Benefits Tribunal 1985, 'Decision of the Tribunal', 11 November 1985, NZNA, 'Midwives 1981-1989, 65/9/5', p. 4.

101 Lynne McLean to DTI, Letter, 6 December 1982, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18' and Lynne McLean to DMS members, Letter, 29 November 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

promised increase did not happen as the freeze was already in force with the midwives remunerated at the rates set on 1 October 1980, despite their best efforts.¹⁰²

A favourable response to the application of the validity of the DMS' case was received and DTI recommended to the DoH that the increase be approved.¹⁰³ It cited the need for a reliable car to be run on a small income that had not increased "for quite some time" and that parity between hospital and DMs had deteriorated markedly in the last ten years.¹⁰⁴ While the DoH supported this,¹⁰⁵ Lynne's enquiry to Dr Phillips in February 1983¹⁰⁶ brought the response that Government "has already made public its determination to hold fast to the general spirit of the price freeze in the interests of the population in general".¹⁰⁷ The midwives were forced to await the Minister's consideration of the justifiability of the increase. If he so determined, then Cabinet would make the final decision.¹⁰⁸ No approval to increase the fees was given.

The Auckland HBA wrote to the Parliamentary Commissioner for Investigations in Auckland questioning whether the MoH's given reasons for the low rates of the MSB "are proper decisions based on our interpretations of the relevant Acts", given that the reason for the lack of DMs was economic.¹⁰⁹ Passed on to the Ombudsman in Wellington, his sole response was to question the HBA's role in writing on behalf of DMs.¹¹⁰ Gillian McNicoll, now DMS Secretary, informed the Ombudsman of the HBA's role in seeking improvement to the Benefit and asked him to proceed with their complaint.¹¹¹ The Ombudsman, requesting a DoH report on the complaint, was advised that the benefit payments made to

102 Lynne McLean to DTI, Letter, 15 November 1982, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

103 R.K. Hynds, DTI to Lynne McLean, Letter, 22 March 1983, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18' and Lynne McLean to Dr J. Phillips, Letter, 8 February 1983, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

104 Lynne McLean to DMS members, Letter, 23 February 1983, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

105 Ibid.

106 Lynne McLean to Dr J. Phillips Letter, 8 February 1983, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

107 Dr J. Phillips to Lynne McLean, Letter, 18 February 1983, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

108 Lynne McLean to DMS members, Letter, 23 February 1983, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

109 Barbara Macfarlane, NZHBA to Parliamentary Commissioner for Investigations, Letter, 10 November 1983, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

110 L.J. Castle to B. Mcfarlane, Letter, 2 December 1983, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

111 Gillian McNicoll to L.J. Castle, Letter, 19 February 1984, DMS, '1984 Correspondence, DMS/00 4/4'.

DMs were regarded as a wage rather than a fee for service.¹¹² The Ombudsman, not authorized to investigate decisions of Cabinet, found no grounds for criticizing the DoH.¹¹³ The DMS had no option but to wait out the price freeze until it ended.

While the 17% fee increase would finally be effective from 1 July 1984, DMs had already experienced a petrol price increase, and another was on the way by June.¹¹⁴ There was an immediate call for feedback about new negotiations, which Bronwen, as new DMS secretary, would undertake.¹¹⁵ Further application for urgent review was made to the new Labour Government in July 1984.¹¹⁶

The HBA lobbied the new MoH, Dr Michael Bassett, that a 100% increase should occur in the fees payable to DMs, to correct the “grossly inadequate” remuneration for the eight years training and practice required of a DM.¹¹⁷ Elaborating on the lack of parity with hospital midwives, both the DMS and HBA proposed a \$350.00 per case payment¹¹⁸ with the Society reiterating it was committed to not charging women a private fee for their service. It hoped that the special nature of domiciliary midwifery and the competence and professionalism of the midwives would be recognised by the MoH with a yearly income of \$21,000, that being directly comparable to the salary of a maternity ward Charge Nurse.¹¹⁹

While agreeing that there were non-recoverable costs and that the fees were inadequate for full-time employment, the Minister did not see the appropriateness of comparing the fees paid to DMs with the salaries of hospital nurses. Fees were paid for particular services and were not salary-related. Agreeing that some improvement was

112 L.J. Castle to Gillian McNicoll, Letter, 28 March 1984, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

113 L.J. Castle to Gillian McNicoll, Letter, 25 May 1984, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

114 Gill Williams to Bronwen Pelvin, Letter, c. June 1984, DMS, ‘1984 Correspondence, DMS/00 4/4’.

115 Bronwen Pelvin to DMS members, Letter, 13 August 1984, DMS, ‘1984 Correspondence, DMS/00 4/4’.

116 Bronwen Pelvin to Alison Hendley, DoH, Letter, 23 July 1984, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

117 It was a commonly held view that to become a midwife one had to undertake three years training as a nurse followed by two years practice prior to undertaking midwifery training. Following the six to twelve month programme to register as a midwife, a further two years was recommended before commencing domiciliary practice.

118 Home Birth Association of New Zealand to MoH, Submission, c.1984, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

119 Bronwen Pelvin, Secretary DMS to Dr Michael Bassett, MoH, Letter, 5 March 1985, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

necessary,¹²⁰ he determined increases equalling a 7.55% increase, effective from 1 April 1985.¹²¹ This did little to draw the MSB remuneration towards the 55% more income that hospital-employed colleagues earned.

However, there would be some heartening evidence of the potential for change by 1986, as I now explain.

A dawning understanding

The Labour Party's policy on women in 1984 had committed to supporting the planned home birth option and, therefore, the domiciliary midwifery service.¹²² The change to a Labour government had seen the establishment of the Women's Health Committee in 1985. Its role was to advise the MoH on matters relating to health policy for all New Zealand women. Calling for submissions to determine priorities, it received more than 250 submissions identifying 1,600 issues. Thirteen percent of these made some reference to midwifery. The great majority expressed concerns about domiciliary midwifery, namely, safeguarding provision of the service and the continuing, worsening shortage of DMs. Both these things were linked as being primarily dependant on an increased payment for the service (and changes to training systems). The financial disincentive to practise domiciliary midwifery was stressed and assistance was sought from government to equip the DM,¹²³ something which had been called for since the 1st National HBA Conference in May 1980.¹²⁴

The Committee also received 246 submissions on maternal health issues and, of those mentioning home birth, there was unanimous support for home birth to be a viable birth option.¹²⁵ It determined to work on a number of the issues identified and take them up with the appropriate organizations.¹²⁶

120 Dr Michael Bassett to Bronwen Pelvin, Letter, 19 April 1985, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

121 Dr J.S. Phillips to Bronwen Pelvin, Letter, 20 June 1985, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

122 Labour Party, 'Women's Policy 1984', Health, cited in Home Birth Association of New Zealand to MoH, Submission, c.1984, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

123 Committee on Women's Health, 'Midwifery'.

124 'National Conference', July 1980, Joan Donley Personal papers, MS95/20 1.

125 Committee on Women's Health, 'Maternal health issues: a discussion paper', 1986.

126 Committee on Women's Health, 'Midwifery'.

However as obstetric care (sic) in hospitals was available and adequately provided in the view of the Acting MoH, Russell Marshall, the urgency of the DM's plight was still not universally recognised in April 1986.¹²⁷ As the Member of Parliament (MP) for Te Atatu in 1983, Dr Bassett had criticised the MoH's "rather parsimonious attitude to the payment of domiciliary midwives" as indication that fears were "soundly based" that home birth was not intended to be an available option.¹²⁸ Yet, as the MoH in 1986, Dr Bassett's 'magnanimous gesture' of a 50% MSB increase,¹²⁹ though welcomed by the DMs, proved far from adequate – so eroded was the income of the DM in 1986.¹³⁰

A full Health Benefits Review had not been undertaken since 1974¹³¹ and it was recognised that the Benefit needed further examination. The Health Benefits Review Committee would expose the inequalities of payments for DMs in their continuing considerably lesser remuneration than midwifery colleagues in hospital who worked shorter hours in the "better-supported hospital environment".¹³²

However, the immediate ongoing financial crisis would not be automatically remedied. An urgent request to the Minister for a Benefit increase of 100% in April 1987¹³³ was met by a 44% increase from 1 August 1987.¹³⁴ The Minister would see this increase as generous in comparison to that offered other health service providers (7%).¹³⁵

HBAs had agreed at their 1986 National Conference to finance a professional negotiator to assist with further MSB negotiations.¹³⁶ It donated the remainder of its funds

127 Russell Marshall, Acting MoH to Allison Livingstone, Letter, 29 April 1986, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

128 Dr Bassett, M.P., Te Atatu, 'Nurses Amendment Bill: Report of Health and Welfare Committee', New Zealand Parliamentary Debates, 13 December 1983, Volume 455, p. 4824.

129 Michael Bassett, MoH to Bronwen Pelvin, Letter, 14 July 1986, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

130 Bronwen Pelvin, 'Press release', 5 July 1986, DMS, '1986 Correspondence, DMS/00 4/6'.

131 The Maternity Benefits Tribunal 1985, 'Decision of the Tribunal', 11 November 1985, NZNA, 'Midwives 1981-1989, 65/9/5', p. 6

132 Health Benefits Review Committee, *Choices*, pp. 55 and 121.

133 Bronwen Pelvin, Secretary, DMS to Honourable Michael Bassett, Minister of Health, telegram, 8 April 1987, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

134 K.E. Swann, Acting Manager, Medicines and Benefits, 'Department of Health Circular Memorandum', No 1987/12, June 1987, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

135 Michael Bassett, Minister of Health to Bronwen Pelvin, Letter, 16 June 1987, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

136 Joan Donley, *Herstory*, p. 37.

(\$407.62),¹³⁷ swelling the proceeds of the Negotiating Donation Box put out at the launch of Joan's book, *Save the Midwife*, which collected \$23.45¹³⁸. From these small beginnings industrial advocates (Trott Grovehills and Associates) would be joined by the negotiating team of Joan and Allison Livingstone to continue the fight for improvements from late 1987¹³⁹ through until at least the end of 1989¹⁴⁰ in this altered environment.

Concluding remarks

While minor increases in the MSB would be gained over the years, parity (at least) with hospital midwives would not be achieved until following the Nurses Amendment Act 1990. At this point, the MSB applicable to GPs became accessible to DMs,¹⁴¹ an action that would relieve the financial burden of practice that increasingly affected the midwives from at least the early 1970s. That the DM was the 'poor sister' to the hospital-employed midwife until 1990 has been illustrated in the reflections of both the midwives of the study and the archival story. Prior to the 1985 Maternity Benefits Review, at each turn, the DMs were thwarted in trying to resolve their financial crises – beginning with an uncommitted arbitrating organisation (NZNA), which had made clear its opposition to home birth and self-employed DMs. During those vital years from the mid 1970s and through the 1980s when the demand for home birth services was growing, the DM lived at a below subsistence level of income and their numbers remained low.

Penalised by a price freeze which prevented access to an approved increase to the MSB for over two years, the financial oppression and penury of the DMs would have minimal influence on successive MoHs. The Right Honourable A.G. Malcolm ignored the DM's efforts to achieve pay parity with their hospital colleagues and did not expect DMs to earn their total income from home birth practice.¹⁴² While this was true for GPs who also treated medical and surgical patients, it was indeed the only source of income for a DM.

137 Lois Ollivier to Bronwen Pelvin, Letter, 24 June 1986, DMS, '1986 Correspondence, DMS/00 4/6'.

138 Joan Donley to Bronwen Pelvin, Letter, 20 June 1986, DMS, '1986 Correspondence, DMS/00 4/6'.

139 Kelly Grovehills, 'Report prepared for the Home Birth Association Conference, Whangamata, 8-10 May 1987', DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

140 Bronwen Pelvin to Allison Livingstone and Kelly Grovehills, Letter, 10 December 1989, DMS, 'Correspondence, re Maternity Benefits, DMS/00 4/18'.

141 For information on midwifery parity of income with GPs gained following the Nurses Amendment Act 1990, see, Department of Health, Health Benefits Letter No. 1, 1 November 1990, DMS, 'Correspondence, re Maternity Benefits, DMS00 4/18'.

142 A.G. Malcolm to Mrs R. Blomfield, Letter, 5 April 1983, DMS, '1983 Correspondence, DMS/00 4/3'.

The twenty-four hour, seven days a week on-call nature of the work made it difficult, if not impossible, for a midwife with a full caseload to be available for other employment. As Acting MoH, Russell Marshall, as mentioned previously, would not see that retaining the home birth option was a priority. Finally, as the next MoH, Dr Michael Bassett began to address the level of MSB but this was a protracted exercise which took another four years after the Maternity Benefits Review Team identified the reason for the DMs' plight - that "the present pattern of state subsidies to maternity services is by no means neutral in the way it treats different providers and is in need of review".¹⁴³ As the Team elaborated:

*...domiciliary midwives offer a service which is frowned upon by a large section of the medical community who consider home birth as an unsafe, second-best option which is best discouraged. The low rates of pay may not be entirely unrelated to this attitude.*¹⁴⁴

Only then would the campaign for parity of income with hospital midwifery colleagues start to show moderate success.

As inadequate as the MSB rate was, attempts were made to use it as a means to control DMs.¹⁴⁵ For example, the Christchurch MOH and PPHN wanted payment withheld if a midwife booked women for home birth prior to receiving confirmation of referral from the GP¹⁴⁶ or if, prior to seeking new permission, the DM accepted a woman living beyond the specified area of cover.¹⁴⁷ This means of control was thwarted only because the benefit was a 'patient' benefit – the woman's entitlement, rather than that of the midwife.¹⁴⁸

The comparisons between GPs and hospital-employed midwives' incomes and that of DMs illustrated the financially downhill spiral that continued for the DMs from the early 1970s until at least 1987. The reflections of Jenny, Carolyn, Anne, Sian and Bronwen bear witness to the financial hardship suffered in order to practice. Though Dr RA Barker,

143 Health Benefits Review Committee, *Choices*, p. 121.

144 *Ibid.*, p. 56.

145 'Paper IV, Legislation, comments and recommendations', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

146 W.A. Malpress, MOH and Mrs R. Selby, PPHN, Christchurch, to Head Office, Memo, 18 June 1981, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

147 Adele Birbeck to Lynne McLean, Letter, 26 January 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

148 G.R. Boyd, Assistant Director, Division of Clinical Services, DoH to MoH, Christchurch, Memo, 3 July 1981, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

Chairman of the MSC, wondered if domiciliary midwifery was “economically unattractive”,¹⁴⁹ the DMs knew intimately that it was neither attractive nor sustainable as some stopped home birth practice and others took up other temporary employment to stabilise their financial positions.

There was little support to address their plight from NZNA and MSIS as exemplified in NZNA’s minimal negotiating efforts and the defeat of the 1981 remit at the MSIS meeting to address the issue. The DMS linked this low income as having a direct bearing on ensuring the maintenance of standards in maternity services¹⁵⁰ (which I discuss later in the thesis).

The DMS, made ‘official’ in 1981 with the opening of a bank account and donation of a letterhead, was incorporated in June 1982.¹⁵¹ Only then would DMs begin to have an effective negotiating voice – one which would become contractually recognised by the MoH¹⁵² as the appropriate MSB negotiator for DMs.

Woven throughout this chapter has been the ever present support of the women (and men) of the HBAs and HBSGs throughout New Zealand, as well as individual home birth consumers. Their support included providing food parcels, firewood and repairs to the midwife’s car, house and plumbing. Financially, they assisted DMs with shifting locations, donations, letterhead and a negotiating fund. They also assisted with writing submissions, accounting and MSB negotiations - information which the MoH, DoH and the Ministry of Women’s Affairs would acknowledge as very informative and having been previously unavailable.¹⁵³ This would prove crucial in the move towards parity of income with hospital-employed midwives. All these groups, individuals and their activities were to ensure that the home birth option became viable by ensuring continued practice of the DM, and were fundamental in sustaining domiciliary midwives.

149 Roy Burke, ‘Midwifery scheme to be reviewed’, *The Times*, 4 August 1979, p. 3.

150 Jennifer Sage, Chairperson, DMS and Lynne McLean, Secretary DMS to A.G. Malcolm, MoH, Letter, 3 March 1982, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

151 Department of Justice, ‘Certificate of Incorporation’, 9 June 1982, DMS, ‘Documents of Incorporation, DMS/00 1’.

152 ‘Terms and conditions, for approved midwives and Registered Nurses providing domiciliary maternity services’, Contract, 30 July 1987, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

153 Russell Marshall, Acting MoH to Allison Livingstone, Letter, 29 April 1986, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’; J. Crawford, for Director, Division of Clinical Service to A.M. Livingstone, Letter, 1 May 1986, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’; Ann Hercus, Ministry of Women’s Affairs, to Allison M. Livingstone, Letter, 20 May 1986, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

By September 1987 there was a new climate of uncertainty as Government determined there would be a transition from Hospital Boards to Area Health Boards. With it came the possibility that funding for DMs (and the overseeing of their contracts) could devolve from the DoH and be regionalised under the Area Health Boards.¹⁵⁴ While this may have provided a better income it offered a new challenge - as Lynne McLean phrased it in 1982 when the DoH first mooted the service be controlled by Area Health Boards - “to ensure that autonomy is not cancelled out along with overdrafts”.¹⁵⁵ That this was indeed a possibility following the MSC review of domiciliary midwifery is discussed in the next chapter.

154 Jennie Nicol, Senior Advisory Officer, Women, Children and Family Health Programme to Bronwen Pelvin, Secretary, DMS, 10 September 1987, DMS, ‘Correspondence, re Maternity Benefits, DMS/00 4/18’.

155 Lynne McLean to members of DMS, Letter, 29 November 1982, DMS, ‘1982 Correspondence, DMS/00 4/2’.

CHAPTER 5: DOMICILIARY MIDWIFERY UNDER THE MICROSCOPE

I established earlier in the thesis that supervision of the contracted domiciliary midwife was a legal obligation of the MOH of each health district under Section 58 of the Nurses Act 1977. The MOH's supervision related to "safeguarding the health of the patient". As such, he¹ supervised the midwife's practice, specifically relating to preventing the occurrence or spread of infection, but he had no jurisdiction over the birthing environment - the woman's home. A MOH (or any Deputy Medical Officer) had no authority to delegate his responsibility to the PPHN and, equally, the latter had no authority to make decisions under Section 58 of the Act.² However, the PPHN would be the MOH's nominee in interviewing the DM, administering her claims and inspecting her notes, equipment and premises. This role was commonly perceived by the DoH and domiciliary midwives as 'supervision'.

The Department had difficulty determining exactly what the supervisory obligation entailed and how it should be fulfilled. The 'no set policy' created considerable variation in the practice of supervision throughout New Zealand.³ As Carolyn Young reflected – "they didn't know what to do with us".⁴ As the first of the new wave of midwives to apply for a contract in the 1970s Carolyn felt the DoH was "a little taken aback to have new blood" as it had been hoped that "this 'nasty' [home birth] business would go away".⁵

I have shown earlier in the thesis how, rather than going away, home birth numbers were increasing each year. The DoH viewed home birth women as "anti-establishment" and not willing to have 'supervision' during the childbirth experience. While some Public Health Nurses managed "to infiltrate", resistance from women to their involvement was

1 The use of the word 'he' indicates the pre-dominance of men as Medical Officers of Health during 1974-1986.

2 'Paper IV, Legislation, comments and recommendations', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

3 DMS Minutes, 4 May 1984, DMS, 'DMS meetings, DMS/00 2/1'.

4 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, p. 5.

5 Ibid.

evident.⁶ Without the ability to force compliance on women, supervision of DMs was the only mechanism to influence home birth. I examine that supervision in this chapter and discuss the review of domiciliary midwifery which the MSC undertook from 1978-1982. I discuss how this review brought out into the open the attitudes of the obstetric, nursing and midwifery professions – attitudes that would be influential in determining legislative changes to increase the MOH's powers to suspend a DM from practice.

With the legislative requirement that DMs accept women for home birth only if they were supervised by medical practitioners, the GP was an integral part of the home birth service, which I detail later. This chapter closes with an examination of the best available evidence of the time that was made available to the MSC during its review.

I begin by detailing the DoH and DMs experiences of supervision.

Suits, shiny blouses and handbags

Gaining a contract

Though a seemingly simple process, as I explained in Chapter 3, there was considerable variation throughout the country around the ease, or otherwise, of gaining a contract. This could be a simple notification from the DoH following an application that a contract had been granted, as in the case of Denise Black of Central Otago. When Denise applied to the Wellington DoH, her application was successful without interview, equipment check, backup arrangements or investigation.⁷ Equally, it could be an informal meeting to make sure the midwife was aware of the statutory and administrative requirements, as my own experience with the Hamilton PPHN proved – but even this varied amongst midwives under this DHO. For example, Corrie Van der Hulst, responding to the newly formed Thames-Hauraki Plains HBA's need for a DM, planned to establish domiciliary practice in Thames. This same Hamilton PPHN was “very discouraging”⁸ - a reception which

6 'Paper III', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

7 Denise Black to Joan Donley, Letter, 28 June 1982, Personal papers, Joan Donley, 'Correspondence', MS93/7 2. Denise was pregnant at the time and not planning to practice immediately but was setting the contract up for the future.

8 Corrie Van der Hulst to Lyn McLean, Letter, 29 February 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

recognised the long standing and continued opposition of the Thames obstetrician towards home birth,⁹ as will become more evident later.

Conversely, an application could result in an interview between the PPHN and midwife with discussion around 'suitable cases' and previous practice experience, as occurred when Bronwen gave notice of her intention to commence domiciliary practice in Nelson.¹⁰ Sent a questionnaire, Bronwen was asked to meet with the PPHN, bring her practice certificates and a recent nursing (sic) reference, and they would "discuss the service" Bronwen planned to provide.¹¹

Day to day supervision

Varied approaches also extended to DMs' ongoing relationships with PPHNs. Jenny's experience when commencing domiciliary practice in Hamilton replicated my own in that the PPHN took a hands-off but supportive approach. Jenny took the opportunity which was offered to discuss issues with the PPHN with whom she would regularly phone or meet. Though the meetings were formal, Jenny felt this Hamilton PPHN was supportive of domiciliary midwifery practice and this was mirrored with her shift to Wellington, as she explains:

I always felt reasonably supported, it didn't feel like punitive or really checking up on you – they were – but it didn't feel like in a bad way and I know if anything bad ever happened, they were really supportive. I know when I moved to Wellington I had a stillbirth...I thought, well, I've got to tell the Principle Public Health Nurse...I rang up and said this is the story – this baby died...and they were just really supportive.¹²

Sian, having worked in Great Britain, was not challenged by the role of the Auckland PPHN. The latter's supervision was minimal compared to what she had been used to:

9 C.S. Harison, Gynaecologist and Obstetrician to Colleagues, Letter, 2 May 1986, Anne Sharplin Personal papers; Elizabeth Allen, MOH, Hamilton to Lorraine Dickson, PPHN, Hamilton, Letter, 7 May 1986, Anne Sharplin Personal papers; G.M. Tye, Thames Valley HBA to Standing Committee on Women's Health, Ministry of Women's Affairs and Women's Health Section, DoH, Submission, c. 1986, Anne Sharplin Personal papers.

10 Bronwen Pelvin to Director, Division of Nursing, DoH, Letter, 8 June 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

11 Miss M.J. Russ, PPHN, Nelson to Bronwen Pelvin, Letter, 18 July 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

12 Catch-up: Maggie Banks with Jenny Johnston, 23 August 2004, p. 3.

*...I know that the first home birth that I went to, I knew that there was an opportunity or it seemed very different to home birth in Britain, you know, there wasn't this overarching supervision of midwives. There wasn't the Supervisor of Midwives. There weren't all of the regulations that were involved in having to do it a particular way...*¹³

However, a PPHN who saw it was her role to provide tight supervision on the suitability of both the home environment and 'case' selection made it awkward for the DM. From the beginning, the Nelson PPHN had given indication of the tight reign applied to DMs and this continued with her insistence on visiting each woman Bronwen cared for - to check on the suitability and safety of the home. The PPHN filled in 'Appendix C', which Bronwen, dubbing it "the nosey sheet", presumed recorded notes on the woman's and her home's suitability and safety. Bronwen would then be advised as to whether the criteria were met, along with a murmured threat from the PPHN about "losing her licence" if Bronwen accepted women who were 'unsuitable' to meet the criteria.¹⁴ Lynne McLean had initially experienced this same checking of the woman's home by the Wellington PPHN. However, it had quickly fallen by the wayside, being 'delegated' to Lynne.¹⁵

A tight reign, reflective of Bronwen's problems, was also experienced by Gill Williams of Tauranga from the Rotorua PPHN. This included the PPHN's insistence that she wear a uniform, which was seen as a sign of professionalism.¹⁶ Unlike Bronwen's problems, these would soon resolve when Henrietta Kemp, the National Secretary of the HBA, wrote of Gill's problems to Sally Shaw, the Supervisor of District Nursing at the DoH Head Office,¹⁷ and the retirement of the PPHN soon after.¹⁸

Even within the same geographical region of Auckland, Carolyn in Takapuna had close supervision with yearly inspections while Joan and Irene Hogan, both in the Auckland DHO, had minimal supervision with equipment inspection only once in four years. But the PPHN of Takapuna not only wanted to randomly inspect the homes of

13 Catch-up: Maggie Banks with Sian Burgess, 7 January 2005, p. 8.

14 Bronwen Pelvin to Ursula Helem, Lyn McLean and Joan Donley, Letter, 14 December 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

15 Lyn McLean to Bronwen Pelvin, Letter, 21 December 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

16 Joan Donley, 'Report of meeting', 28 March 1982, DMS, 'DMS meetings, DMS/00 2'.

17 DMS Minutes, 28 March 1982, DMS, 'DMS meetings, DMS/00 2'.

18 DMS Minutes, 17 October 1982, DMS, 'DMS meetings, DMS/00 2'.

women for whom Carolyn cared – she also proposed attending a birth. This latter plan was thwarted by Carolyn asserting the PPHN had no right to do so unless she was invited into the home by its owner.¹⁹

Initially Christchurch's Ursula Helem had reported "very little interference" from the DoH "apart from two inspections and the odd letter regarding complaints from disgruntled obstetricians".²⁰ However, within three years, the Christchurch PPHN made a point of accompanying her to each woman's antenatal visit, again, to inspect the home - the main focus of the PPHN's interest being the house's toilet. Ursula found that in order to be able to have a 'real' antenatal visit she needed to make a second unfunded visit on her own.²¹

Intrusive supervision placed DMs in an awkward position with women planning home births. Bronwen saw any decision on 'suitability' was her own role and the PPHN's actions prevented her from conducting her midwifery practice on her own responsibility.²² Equally, the DMs saw no role for anyone to pass judgement on the woman's home. Rather, if a home was suitable to return to with a new baby following a hospital birth then it was also a satisfactory place in which to give birth.²³

Lynne discussed these restrictive interpretations of supervision that some DMs experienced in other areas with the Wellington PPHN. Such was the support that Lynne received, the PPHN committed to discussing the matter at the 1979 PPHN Conference where home birth, particularly Appendix C, was on the agenda.²⁴ However, in not filling in 'the nosey sheet', Bronwen would continue to have these problems with the PPHN until at least 1986 as the PPHN felt she had "a 'moral responsibility' ...to ensure that each homebirth [adhered] to the 'standards' ...of safe practice".²⁵

19 Joan Donley to Bronwen Pelvin, Letter, 20 December 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

20 Ursula Helem to Bronwen Pelvin, Letter, 31 January 1979, DMS, 'B.L. Pelvin, DMS/00 16/1'.

21 Joan Donley, 'Report of meeting', 28 March 1982, DMS, 'DMS meetings, DMS/00 2'.

22 Bronwen Pelvin to Ursula Helem, Lyn McLean and Joan Donley, Letter, 14 December 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

23 Joan Donley, 'Report of meeting', 28 March 1982, DMS, 'DMS meetings, DMS/00 2/1'.

24 Lyn McLean to Bronwen Pelvin, Letter, 8 February 1979, DMS, 'B.L. Pelvin, DMS/00 16/1'.

25 Bronwen Pelvin to Joan Donley, Letter, 25 June 1986, DMS, '1986 Correspondence, DMS/00 4/6'.

Carolyn's relationship with the PPHN had quickly soured in what were yearly reviews. Carolyn felt her different lifestyle fascinated the PPHN. The inspections followed a familiar format:

[The PPHN] would come out with people from the Health Department in suits and shiny blouses and handbags and they would all come out to inspect me...do a yearly interview, and ask me the same stupid trick question, every year, you know...I could almost say 'and now we're going to ask you know'...The trick question was something about rectal temperatures on babies and I would say, well, I don't actually take rectal temperatures on babies, and she would say, good, because you're not meant to without a special thermometer - and every year.²⁶

Practising in other health districts

The DM was required to notify the MOH of each health district in which she intended to practise if she wished to access the MSB, despite already being contracted in another. A midwife practising in Auckland, for example, could be under the three health districts of South Auckland, Auckland and Takapuna, each with its own MOH, and each requiring a new permission.

Wanting to enter a different health district provided challenges for Carolyn and a woman for whom she cared. Carolyn was normally under the supervision of the MOH from the Takapuna DHO. However she wished to care for a client whom she knew well from a previous attendance, but the woman had subsequently moved to South Auckland. Carolyn notified the South Auckland MOH of her intention to provide services there. Carolyn picks up the story:

... the Medical Officer of Health wanted to interview me to allow me to come into his area to do a birth and it got right up my nose - wanted to see all my equipment. He knew nothing about it and I had two little kids and I drove over - and it was pouring with rain - and I walked in and I put my car keys on the desk and I said - my things are out in the boot. If you want to inspect them, go and get them, bring them in. So we didn't get off on a good

26 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, p. 6.

*footing and he was talking about case-loading, wanted to know what my caseloads were and I didn't need him to tell me if I was busy or not. So he refused to allow me to come into the area.*²⁷

This refusal of permission was not accepted by the woman. She and her partner complained to the Ombudsman whose role was (is) to independently investigate complaints raised against government organisations or agencies, and his or her accountability was (is) to Parliament. Carolyn explained to the Ombudsman during her interview with him that the problem was a personal rather than a professional problem and the MOH's decision was overturned, enabling Carolyn to attend her client and be paid for it.

Delay in granting permission for the midwife to attend women in different health districts could result in last minute efforts and expensive remedies. Carolyn gave an example of trying to arrange with the PPHN for Carolyn to attend a woman on Great Barrier Island. There was considerable delay and still no word of a decision. Carolyn continues:

*I remember one time ringing and saying - well, have you made your mind up because the woman's in labour. She's not going to leave the island and unless you approve of me going out there she's going to have her baby on her own because of you. So then it was - oh well, you'd better go, and I said, you've left it so late, I'll have to charter a plane now - so I did.*²⁸

While Carolyn found it tiring, she related how the "politicking and fighting" with PPHNs and MOHs was necessary - to ensure home birth women got what they wanted.²⁹

Seeking strategies to deal with problems from the DoH would initiate networking nationally from Bronwen in 1978. She sought advice from Ursula, Lynne and Joan about her ongoing problems with the Nelson PPHN.³⁰ While networking would become formalised into the DMS, this early contact enabled strategies to 'work the system' to be shared amongst the DMs before the start of the Society.

27 Ibid., pp. 5-6.

28 Ibid., p. 8.

29 Ibid., p. 6.

30 Bronwen Pelvin to Ursula Helem, Lyn McLean and Joan Donley, Letter, 14 December 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

Working the system

Though the very literal interpretation of supervision of the PPHN in Bronwen's district appeared accurate, the obstruction Bronwen experienced was interpreted by Lynne as reflecting the PPHN's opposition to home birth. To deal with the intrusion of the PPHN into women's homes, a strategy of non-compliance in notifying intended home births was discussed. Bronwen's attention was drawn to the fact that the PPHN could not keep a copy of the Register without Bronwen's help.³¹ The practice of not notifying the PPHN of intended home births in Auckland meant the first notice the DOH received was the Notification of Foetal Birth (H671).³² However, Lynne warned, a DM had the responsibility to have the Register of Patients (Form A) available for inspection by the PPHN. Notably, Lynne offered, despite the PPHN's 'murmured threats', the DoH's ability to suspend practice was only in the event of a DM acting 'irresponsibly'.³³

Bronwen had tried resolving the situation but with little success. She would gradually change her former stance of open cooperation as a result of this oppressive supervision. As she explained to Joan:

[The PPHN] maintains that she takes some responsibility for my practice and has to give her permission for the home birth to take place and also that I have to notify of cases, that is, whenever I enter a new lady on my register I must tell her and then she'll give me the stationery I require, conveniently kept in a cupboard in her office so I have to approach her personally for it... When I first started practice, I was prepared to co-operate with the Health Department but in view of this woman's hope of 'control' over my practice, I'm rapidly changing my ideas to eventually becoming as non-co-operative and obstructive as she is!!! My plan now is to approach the Medical Officer of Health personally who I know is not prepared to deal with [domiciliary midwifery], hence his passing the buck to the [PPHN] but I have to try. After that, if no success with him, then a stiff legal letter outlining my only responsibilities to the Department, that is,

31 Lyn McLean to Bronwen Pelvin, Letter, 21 December 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

32 Joan Donley to Bronwen Pelvin, Letter, 20 December 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

33 Lyn McLean to Bronwen Pelvin, Letter, 21 December 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

*uniforms, equipment, register and clinical records whenever they want to see them.*³⁴

Bronwen sought a legal opinion on the Obstetric Regulations.³⁵ This confirmed her opinion that the Department had no right to be involved in the day to day administration of a DM's practice nor in the professional decisions made relating to clients. The only role of supervision was to ensure that the DM practised within the terms of the contract, the Regulations and the Act. Moreover, Bronwen was advised "it is significant that the Department's right to suspend you from practice is limited to one very specific provision, and that relating to the spread of diseases."³⁶ The DoH was made aware of this opinion³⁷ which confirmed that which it had sought in 1978, as evidenced previously.

As the trouble persisted Bronwen put the suggestion of non-compliance into practice. Within a few months Bronwen was asked by the PPHN why there was no doctor at the birth and why the Department had not been notified of the women's booking when it had occurred in April, citing the Department's need for Appendix A "to have information available to satisfy medical and nursing critics".³⁸ Bronwen responded that she would fill in Appendix A for the PPHN at her own official antenatal visit when the woman was approximately 32-34 weeks pregnant and send it to the PPHN. Bronwen provided her records to date, her Register and current practising certificate which the PPHN requested. Noticeably, Bronwen invited queries only about her records or Register.³⁹

As previously mentioned, from 1971-1990, the DM was legally unable to provide home birth services unless the woman had engaged a GP to provide overarching supervision of the childbirth experience. To ensure compliance with this, the DoH would only authorise

34 Bronwen Pelvin to Joan Donley, Letter, 2 February 1979, Joan Donley Personal papers, 'Correspondence', MS93/7 2.

35 Bronwen Pelvin to Ursula Helem, Lyn McLean and Joan Donley, Letter, 14 December 1978, DMS, 'B.L. Pelvin, DMS/00 16/1'.

36 J.A. Dogue, Hunter, Smith & Co, Barristers and Solicitors to Bronwen Pelvin, Letter, 2 February 1979, DMS, 'B.L. Pelvin, DMS/00 16/1'.

37 'Paper II', in Department of Heath, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

38 Miss M.J. Russ, PPHN to Bronwen Pelvin, Letter, 2 July 1979, DMS, 'B.L. Pelvin, DMS/00 16/1'.

39 Bronwen Pelvin to Miss Russ, Letter, 4 July 1979, DMS, 'B.L. Pelvin, DMS/00 16/1'.

payment to the DM “where a doctor has indicated that he is in charge of the patient throughout and is in agreement with proposed, private domiciliary service”.⁴⁰

The lack of GPs willing to support home birth women was a perennial problem except in Auckland which boasted thirty-five GPs by May 1979.⁴¹ There was only one GP who would attend home births in Dunedin⁴² and Terryll Muir of Invercargill reported she had three home births planned but lacked a willing doctor.⁴³ Anne Sharplin related how women could not get GP support in Thames even though they had previously home birthed in another area.⁴⁴ Hamilton’s Thelma Fell reported some women had to cancel their planned home births because of the lack of GP co-operation as once their practices had built up they went out of obstetrics.⁴⁵ Thelma also reported “the main cause of the Doctors lack of cooperation around the Waikato” was the lack of a backup service.⁴⁶ Almost unanimous anti home birth attitudes of Hospital Boards and health professionals, which I discuss later, influenced this lack of support for home births by GPs in general.

R.K. Pears, the Regional Co-ordinator of the Family Medicine Programme in Christchurch determined GPs needed to be open-minded to facilitate a dispassionate discussion of birthing options with each woman, pointing out the advantages and disadvantages of home birth.⁴⁷ But, in general, open-mindedness of GPs to home birth was not the reality. In 1978 NZNA surveyed the forty doctors practising obstetrics at Queen Mary and Mosgiel Maternity hospitals. Of the half who responded, 80% (n=16) would not support women to home birth and the remaining four would do so only because “care at home is better than no care at all”. Home birth was viewed as contrary to good care which resulted in higher mortality and morbidity rates. The hospital’s labour ward and baby care units were seen as appropriate facilities where all labours could be monitored, while the

40 Head Office letter, 18 February 1977, in ‘Paper IV, Legislation, comments and recommendations’, in Department of Health, ‘Self-employed midwives (domiciliary): the Department’s responsibilities’, Paper, March 1979, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

41 Joan Donley, *Herstory*, p. 5.

42 Adele Birbeck to Lyn McLean, Letter, 26 January 1982, DMS, ‘1982 Correspondence, DMS/00 4/2’.

43 Terryll Muir to Bronwen Pelvin, Letter, 18 September 1985, DMS, ‘1985 Correspondence, DMS/00 4/5’.

44 Anne Sharplin to Bronwen Pelvin, Letter, September 1986, DMS, ‘1986 Correspondence, DMS/00 4/6’.

45 Thelma Fell to Lyn McLean, Letter, 28 May 1981, DMS, ‘1981 Correspondence, DMS/00 4/1’.

46 Thelma Fell to Lyn McLean, Letter, 5 October 1981, DMS, ‘1981 Correspondence, DMS/00 4/1’.

47 R.K. Pears, Regional Co-ordinator Family Medicine Programme, Christchurch, ‘The responsibility of the family doctor in domiciliary midwifery’, Submission, 26 August 1980, DoH, ‘Board of Health – Maternity Services Committee, 1980-1981’, ABQU 632 W4415, 29/21 (53013).

‘isolation’ from hospital practice would result in ‘slipping’ standards. Home birth was viewed by one medical practitioner as a form of child abuse. Another opined that the decision as to where to birth was no different to the consideration of where teeth should be extracted – it should not occur at home. Others would not support home birth as it was inadequately remunerated.⁴⁸

While Bronwen reported most of the GPs who attended home births had “no idea how to function with a midwife as opposed to an obstetric nurse”, those who frequently attended home births understood the difference of working with a domiciliary midwife,⁴⁹ as I now discuss.

With and without the home birth doctors

Jenny worked pre-dominantly with two GPs in Wellington. One in particular recognised her skills, as she exemplified:

[The GP] used to say to me years before [the law changed in 1990]...I don't know why I come, you should be doing this on your own by now you know...there's no need for me to be here, you should be doing this without me...He was acknowledging the fact that he was not needed and that his skills were not needed, which was great really.⁵⁰

Sometimes the midwife was actively sought out by the GP. One Palmerston North GP did this to Bronwen when she lived in the area. One of his clients had birthed at home without professional attendance with her first baby. The woman was again determined not to go to hospital for her second labour. The GP wanted the woman to be attended by a midwife so he asked Bronwen to visit the couple, which she did. After getting to know Bronwen, the woman called her when she was in labour and Bronwen attended.⁵¹ Similarly, when Bronwen shifted to Nelson, she was welcomed by a GP whose clients wished to birth at home, as she explains:

48 B.D. Henderson, Secretary, Otago Branch, NZNA, ‘A questionnaire to doctors’, 10 March 1978 in ‘Appendix C’, MSC meeting papers, 8 November 1978, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

49 Bronwen Pelvin to Joan Donley, Letter, 25 June 1986, DMS, ‘1986 Correspondence, DMS/00 4/6’.

50 Catch-up: Maggie Banks with Jenny Johnston, 23 August 2004, pp. 20-21.

51 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 11.

I had this fabulous guy, CC. And [he] was a GP who came from a farming background...a dairy farm...and had trained initially to be something like a biochemist...and so he understood nature...What had happened in Nelson is that people were having their babies at home and he was known as a supportive doctor so had clients who were having babies at home that he felt enormously responsible for and he'd have to go to these births. So as soon as he saw me, it was like he grabbed me and thought, yes, yes, yes, a midwife, great.⁵²

While those GPs who did willingly support home birth were fundamental to the service, it was, however, always the GP who controlled who could birth at home and women having first babies were not usually supported.⁵³ There was an expectation that the DM would do as she was told which did not necessarily happen if the DM did not agree with the GP and, as a consequence, the DM would not work with the GP again.⁵⁴

At times, the GP's agreement to support a home birth was withdrawn after pressure was brought to bear on him or her (and the midwife) from anti home birth obstetricians. This meant that women had no other choice if they wanted to birth at home than be attended by lay midwives.⁵⁵

To counteract the low numbers of GPs supporting home birth, the DMs presented GPs with their statistical information in the hope that more would be encouraged to support home birth but, as Bronwen found, they remained "incredibly cautious and incredibly unconvinced".⁵⁶ The problem of diminishing support worsened. In 1986 Bronwen reported GPs continued to have a lack of understanding of home birth and were "very stuck in their 'responsibility' role [seeing] their presence as crucial to the proceedings".⁵⁷ By 1987 the mood of the DMs was despondent as many reported the lack of GP support. Carole Collins from Palmerston North, New Plymouth's Lynley MacFarland, Jane Marshall from

52 Ibid., p. 14.

53 Catch-up: Maggie Banks with Jenny Johnston, 23 August 2004, p. 16.

54 Catch-up: Maggie Banks with Gillian Wastell, 2 November 2004, p. 8.

55 Geraldine Homes to Home Birth Folk, Letter, 4 February 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

56 Bronwen [Pelvin] to Lyn [McLean], Letter, 6 July 1981, DMS, '1981 Correspondence, DMS/00 4/1'.

57 Bronwen Pelvin to Joan Donley, Letter, 5 August 1986, DMS, '1986 Correspondence, DMS/00 4/6'.

Napier/Hastings, Mary Garner from Kapiti, Bronwen and Anne all reported diminishing or no support from GPs for some of the areas they covered.⁵⁸

Ursula Helem had continued to book women for home birth irrespective of the lack of GP support and supervision from the late 1970s. The Christchurch MOH and PPHN requested advice from the DoH in 1981, complaining:

*In spite of our not inconsiderable efforts, she continues to accept patients for home delivery prior to the patient's first visit to the general practitioner. This is often without a routine referral note from the general practitioners. This midwife appears to disregard the guidelines as printed in the advisory notes to the Obstetric Regulations 1975 as well as verbal advice from us.*⁵⁹

The Department responded by pointing out that it was an offence to carry out obstetric nursing where the GP had not taken responsibility for the case and the responsibility for selection was with the GP. If a midwife did this without that, she was open to prosecution and she should be advised of this.⁶⁰

It was expected that the domiciliary midwife “should make every effort to reinforce the doctor’s opinion and encourage the patient to follow the doctor’s advice”⁶¹ and this included advising well women to birth in hospital if the GP so determined.

By 1988 Bronwen had practised as a domiciliary midwife for ten years. During this time she had increasing difficulty in being able to access GPs to assume legal responsibility for women birthing at home as those in her area were particularly susceptible to pressure from the anti home birth obstetricians. Not content to refuse to support women at home where no medical practitioner could be secured, Bronwen made a decision to support a woman to birth at home without a ‘responsible’ medical practitioner. As Bronwen wrote to Joan in 1988:

Have finally run out of doctors for covering one area – Richmond, Brightwater and surrounds. Went to our MOH and told him that these

58 ‘Minutes from the Annual Midwives Meeting, Home Birth Conference, Whangamata, May 1987’, in *The Domiciliary Midwives Newsletter*, 4 (July 1987), pp. 16-17, ‘The Domiciliary Midwives Newsletter, DMS/00 6’.

59 W.A. Malpress, MOH and Mrs R Selby, PPHN, Christchurch to Head Office, Memo, 18 June 1981, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

60 G.R. Boyd, Assistant Director, Division of Clinical Services, DoH to MoH, Christchurch, Memo, 3 July 1981, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

61 New Zealand Maternity Services Committee, *Mother*, p. 24.

*women would be having their babies at home and they would call me and I would go and that it would happen from time to time. He was most unperturbed (being trained in Scotland etc etc) and came across relatively supportive.*⁶²

This action would predispose her to potential censure and prosecution from Nursing Council if a complaint was made. She chose not to take this action surreptitiously but instead discussed the lack of willing GPs not only with the MOH, as above, but also the PPHN, a lawyer and an obstetrician. While each of these people was sympathetic to her situation none felt able to give the necessary legal back-up.⁶³

While this would have been lawful in the context of an emergency, planning this ahead of time was not. Bronwen went ahead with her decision and supported a woman birthing at home without a GP, as she wrote of the following:

*It wasn't an emergency. We could have said it was. We could have cooked up a story about early labour care, going to hospital to have the baby and being discharged once the birth was over. But we decided not to do that. The woman decided to stay at home. I decided to attend her. We decided to leave a doctor out of the picture entirely.*⁶⁴

Since she was aware of the consequences, there was no surprise for Bronwen when she was summoned to meet with the MOH in what proved to be an assertive encounter:

*I remember being called in [to the Department of Health] with my friend Heather, because I always took a support person, and off I went with Heather from the Home Birth Association. The first thing they tried to do was to separate us. They separated us. Neither of us would speak. 'No, no, no, I'm not having this conversation. I need Heather in the room'. So anyway and that's when we were grilled by the Medical Officer of Health.*⁶⁵

62 Bronwen Pelvin to Joan Donley, Letter, 14 June 1988, Joan Donley Personal papers, 'Papers re Domiciliary Midwives Society of NZ', MS95/20 15.

63 Ibid.

64 Bronwen Pelvin. 'A New Zealand midwife's Tale', *The Domiciliary Midwives Newsletter*, 6 (1988), p. 9, 'The Domiciliary Midwives Newsletter, DMS/00 6'.

65 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 15.

Bronwen was warned that she must not do this again. If she attended a home birth without the woman having a GP undertake responsibility for the woman's care, her contract was likely to be terminated.⁶⁶ Rather than being repentant about her decision to breach the law, Bronwen would invite other midwives of the DMS through *The Domiciliary Midwives Newsletter* to act collectively. She wrote as follows:

*In the meantime, I'm out here on a limb. I've done it and so far, the sky hasn't fallen in. Maybe more of us will do it – I like to think so. I wonder what would happen if we all did it – just didn't bother about doctors and attended women anyway. It's an appealing thought. So you can join me if you like, out here on this branch that's the independent, autonomous midwifery profession.*⁶⁷

It is possible that Bronwen's deliberate act may have been more tolerated by the DoH in December 1988 than it would have been earlier. Consumers had started their lobby for midwifery autonomy earlier that year;⁶⁸ there were the beginnings of recognition that the status of midwives could change in the future⁶⁹ and the sustained efforts of the 'Save the Midwives' organisation⁷⁰ following the Nurses Amendment Act 1983 had increased the profile of midwifery in the community. However, from 1978-1982 DM attendance at home births without medical practitioners – something which occurred in 75% of all home births in one unidentified health district in 1978⁷¹ - would be amongst the prompts for the MSC to review domiciliary midwifery.

66 J.S. Roxborough, MOH, Nelson, to Bronwen Pelvin, Letter, 9 December 1988, Joan Donley Personal papers, 'Papers re Domiciliary Midwives Society of NZ', MS95/20 15.

67 Bronwen Pelvin, 'Midwife's tale', p. 11.

68 For an example of this, see David Caygill, MoH to Lynda Williams, Letter, 12 August 1988, DMS, '1988 Correspondence, DMS 00 4/8'.

69 Judy Keall, MP for Glenfield, Speech, 5 August 1988, National Midwives Conference, Auckland, DMS, '1988 Correspondence, DMS 00 4/8'.

70 'Save the Midwives' was formed by Judy Larkin following the Nurses Amendment Act 1983. It aimed to support and promote midwifery as an independent profession, and to support direct-entry midwifery education, domiciliary midwifery and the right of parents to informed choice in all aspects relating to childbirth..

71 'Paper IV, Legislation, comments and recommendations', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

In February 1980, the Board of Health would call for submissions on domiciliary midwifery through the Hospital Boards Association circular letter,⁷² press statements and by direct approach to interested parties.⁷³ I now discuss these responses except for the MSIS submission ‘Policy Statement on Home Confinement’⁷⁴ which I analyse separately in the next chapter.

A landslide of sectional opinion

Of the forty-five submissions received,⁷⁵ opposition to domiciliary midwifery and home birth from the medical and nursing profession was overwhelming. The only support for the service as essential came from the West Coast Hospital Board and the Nurses Society of New Zealand (NSNZ), the latter opining that home birth should remain a choice.⁷⁶ Most Hospital Boards wanted Early Discharge schemes introduced as this was seen as a viable way to discourage women from birthing at home.⁷⁷

While the South Canterbury and Thames Hospital Boards opposed home birth outright⁷⁸, the Obstetric Advisor to the Thames Hospital Board, submitted that the service should not be officially recognised or encouraged “at the taxpayer’s expense”.⁷⁹ Similarly, the Southland Obstetrical and Gynaecological Society was vocal in its opposition to the

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- 72 G.A. Nind, Deputy Chief Executive, South Canterbury Hospital Board to MSC, Submission, 4 March 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).
 - 73 R.A. Barker to MoH, Memorandum, 31 July 1980, DoH, ‘Board of Health – Maternity Services Committee, 1980-1981’, ABQU 632 W4415, 29/21 (53013).
 - 74 Midwives and Obstetric Nurses Section, NZNA, ‘Policy Statement on Home Confinement’, February 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).
 - 75 ‘List of submissions’, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139). Margaret Guthrie noted 49 submissions were received, see, Margaret Guthrie, Deputy Director, Division of Hospitals, ‘Report of the Board of Health Maternity Services Committee: The Mother and Baby at Home: The Early Days’, 11 July 1983, DoH, ‘Board of Health – Maternity Services Committee, 1983-1984’, ABQU 632 W4415, 29/21 (57881).
 - 76 B.P. Jackson, Chief Executive, West Coast Hospital Board to MSC, Submission, 29 February 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139) and Nurses Society of New Zealand to MSC, Submission, c.1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).
 - 77 J.S. Phillips to MSC, 17 April 1980, DoH, ‘Board of Health – Maternity Services Committee, 1979-1980’, ABQU 632 W4415, 29/21 (50925).
 - 78 G.A. Nind, Deputy Chief Executive, South Canterbury Hospital Board to MSC, Submission, 4 March 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139) and C.S. Harison, Obstetric Advisor, Thames Hospital Board to MSC, Submission, 11 June 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).
 - 79 C.S. Harison, Obstetric Advisor, Thames Hospital Board to MSC, Submission, 11 June 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

DoH paying midwives to attend home births.⁸⁰ Palmerston North, Waikato and Christchurch Women's Hospitals did not want to provide home birth services⁸¹ or flying squads for emergency transfers⁸² as they were concerned that this would wrongfully indicate to women that the Boards approved of home birth. Simply undertaking the review worried St Georges Private Hospital in Christchurch because the increased profile of home birth could raise the number of women birthing at home. It feared the review may be interpreted as the Department's "apparent approval" of the option.⁸³ In the same vein, the Medical Superintendent of Palmerston North Hospital was concerned that an "explosion of demand" may occur to outstrip the Board's resources.⁸⁴

The Chief Executive of Waipawa Hospital Board feared that an expanded home birth service would reduce the experience of staff and therefore the skill base of small hospitals.⁸⁵ The viability of small units in the Wairarapa Hospital Board area, already threatened by a midwife shortage, meant GPs had trouble maintaining caseloads because of the falling birth rate and the increasing transfer rate of women and babies to specialist services.⁸⁶

The National Council of Women, with its dominant medical and nursing presence in its Standing Committee on Health, submitted that "the very existence of domiciliary midwifery services is a controversial subject, with many of the medical profession strongly opposed to such a service on the grounds of danger to the mother and child." It took the opportunity to impose conditions where hospital birth "should be obligatory" and strategies

80 Southland Division, Obstetrical and Gynaecological Society to MSC, Submission, 15 May 1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

81 A.G. Poynter, Medical Superintendent, Palmerston North Hospital to MSC, Submission, 28 February 1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139); Chief Executive, Waikato Hospital Board to MSC, Submission, 15 April 1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139) and Christchurch Women's Hospital to MSC, Submission, c.1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

82 Christchurch Women's Hospital to MSC, Submission, c.1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

83 St Georges Private Hospital to MSC, Submission, 2 April 1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

84 A.G. Poynter, Medical Superintendent, Palmerston North Hospital to MSC, Submission, 28 February 1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

85 W.A. Gillespie, Chief Executive, Waipawa Hospital Board to Maternity Services Committee, Submission, 25 March 1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

86 Wairarapa Hospital Board to MSC, Submission, c.1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

to ensure “the lowest socio-economic groups...and those of lower intelligence” did not escape “the net”.⁸⁷

Birth at home was seen as a “retrograde step”⁸⁸ catering for “the extremely wealthy or the unintelligent poor”⁸⁹ in the presence of an adequate hospital maternity service. The New Zealand Medical Association (NZMA) wanted the DoH to counter the demand and growth of home birth by a publicity campaign to advise the public of the disadvantages of home birth.⁹⁰

Overwhelmingly, these opinions affirmed the 1937 Committee of Inquiry’s recommendation that the maternity service in New Zealand be a hospital-based service.⁹¹

Lynne McLean’s personal submission to the MSC could not have more accurately assessed the process of inquiry and predicted the responses or have been more poignant as to the need for objectivity. Of these matters she submitted:

*Lay people and medical and nursing professionals have difficulty in discussing domiciliary midwifery objectively. Rather, as with abortion, it is debated at an emotive and personal level...most people, especially nursing, midwifery, and medical personnel, are grossly ill-informed about planned home confinement, and indeed it is possible that not one member of the Committee has seen a prepared home birth as it is in New Zealand. It is therefore important that the people making decisions for the future, on behalf of parents and domiciliary midwives, avail themselves of the facts concerning planned home birth in this country, and that decisions are not based on hearsay, personal feelings, or other countries’ situations.*⁹²

87 National Council of Women of New Zealand to MSC, Submission, 15 February 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

88 R.D. Moffat, Executive Officer, Otago Hospital Board to MSC, Submission, 25 March 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

89 C.S. Harison, Obstetric Advisor, Thames Hospital Board to MSC, Submission, 11 June 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

90 New Zealand Medical Association to MSC, Submission, February 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

91 New Zealand Board of Health, *Report*, p. 18.

92 Lyn McLean to MSC, Submission, 23 June 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

Having discussed the powerful rhetoric of health professionals, I now examine the statistical information available from the national data collection and the evidence made available to the MSC from the HBAs. I begin by discussing the difficulty the MSC had in distinguishing the difference between what the HBAs and DMs knew as ‘planned home birth’ as opposed to out-of-hospital birth, and the significance of this difference.

Rhetoric versus evidence

Planned home birth was promoted by domiciliary midwives and the HBAs from at least 1974 and 1978 respectively, as appropriate only for those women who were well, received professional health care throughout the childbirth continuum, had known caregivers, were well nourished, non-smoking and whose babies were at term. Conversely, unplanned out-of-hospital birth could occur when a woman had no antenatal care, was poorly nourished and had a pregnancy complicated by health issues and socio-economic factors. Further, unplanned out-of-hospital birth could occur en route to hospital in taxis, private cars or at home with no or unskilled attendants.

The information to distinguish between planned home birth and unplanned out-of-hospital birth was not available from the National Health Statistics Centre (NHSC) data collection.⁹³ Instead all out-of-hospital birth data was tabulated together - planned or unplanned ‘accident’, and planned home birth. Out-of-hospital births without professional attendants could only be picked from the Registrar of Births⁹⁴ and were known in 1979 to have occurred, at least, in Hamilton, New Plymouth, Christchurch, Nelson and Dunedin.⁹⁵

NHSC data indicated two maternal deaths during 1972-1976. (Table 5.1). Both deaths occurred in women who birthed without a domiciliary midwife (or medical

93 ‘Appendix 1 - Statistic data’, in Department of Health, ‘Self-employed midwives (domiciliary): the Department’s responsibilities’, Paper, March 1979, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

94 ‘Statistics in domiciliary practice’, c. 1979, DoH, ‘Board of Health – Maternity Services Committee, 1979-1980’, ABQU 632 W4550, 29/21 (50925).

95 J.L. Wright, Professor of Obstetrics and Gynaecology, Medical School, University of Otago to MSC, Letter, 12 October 1979, DoH, ‘Board of Health – Maternity Services Committee, 1979-1980’, ABQU 632 W4550, 29/21 (50925); ‘Statistics in domiciliary practice’, c. 1979, DoH, ‘Board of Health – Maternity Services Committee, 1979-1980’, ABQU 632 W4550, 29/21 (50925) and Department of Health, ‘Paper II’, in ‘Self-employed midwives (domiciliary): the Department’s responsibilities’, March 1979, Paper, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

practitioner) in attendance - one woman not knowing she was pregnant and the other having had no antenatal care as well as an unattended birth.⁹⁶

Table 5.1 Maternal, foetal and neonatal death of out-of-hospital births, 1972-1976

Years	Maternal Death	Late Foetal Death	Neonatal Death
1972 - 1976	2	-	-
1976	-	2	8

Data source: 'Appendix 1 - Statistic data', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

The data also showed ten late foetal or neonatal deaths⁹⁷ following out-of-hospital births during 1976, as in Table 5.1. Five of the eight babies who died following birth were less than thirty-six weeks gestation and were, therefore, unlikely to have been planned home births at the time of labour due to being preterm. The gestations of two babies were not reported and no information was available as to whether or not the place of birth was planned for one further baby at thirty-nine weeks gestation. Two late foetal deaths at home were also reported in 1976, one having died prior to the onset of labour.⁹⁸

Poor quality data on out-of-hospital births was a problem shared by other countries. For example, in Oregon, USA most home births were not reported because of the negative attitudes from health professionals and health authorities that were experienced by mothers (and fathers). Home births that were reported were often those which were problematic and therefore, involved medical practitioners or hospitals. Some couples chose not to register their babies because of the “harassment they may receive from health officials”, as they

96 'Appendix 1 - Statistic data', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

97 A 'late foetal death' is defined as the death of an unborn baby of 28 weeks gestation or more prior to his or her birth. An 'early' neonatal death is the death of a live-born baby within seven days after birth while a 'late' neonatal death is one which occurs after a live birth and following the first week after his or her birth but before 28 completed days after birth. The NHSC data did not differentiate between the two categories but grouped the deaths of all babies following live birth as 'neonatal deaths'. For further information on definitions of foetal and newborn deaths, see <http://www.nzhis.govt.nz/stats/fetal/glossary.html>, retrieved 26 July 2006.

98 'Appendix 1 - Statistic data', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

were “scolded, upbraided and questioned rudely”. Any data that was available could not be used to look at health or nutritional status, antenatal care or professional attendance.⁹⁹

Considerable evidence was made available to the MSC by the Auckland branch of the HBA and birth activists as the MSC started its review of domiciliary midwifery. This included statistical studies of matched comparisons of women birthing at home and in hospital, as well as critiques of the impact of unnecessary but routine obstetric interventions during childbirth.¹⁰⁰ These papers, reports and book chapters were written by widely accepted world authorities on home birth, including such authors as Dr Lewis E. Mehl, a leader in home birth research from the 1970s; Dr G.J. Kloosterman, former President of the Federation of International Gynaecologists and Obstetricians and the ‘godfather’ of home birth in the Netherlands, and Dr David Stewart, a geophysicist and specialist in medical statistics and expert witness on obstetric practice and medical care who consulted for government agencies and the United States Congress,¹⁰¹ as well as epidemiologists, medical sociologists and other medical practitioners.

Dutch evidence distinguished a 1974 perinatal mortality rate (PMR) of 4.2 per 1,000 births for 85,000 home births from a PMR of 23 per 1,000 hospital births. The PMR of home birth from the Netherlands had dropped from 14.0 per 1,000 in 1960 to 4.2 per 1,000 in 1974, indicating that the falling PMR was not due to increasing hospitalisation. Professor Kloosterman’s study flagged up that when the PMR for babies of women birthing in Dutch cities was compared – one with a 50% home birth rate, the other with almost an absence of home births, the former had the lower PMR. By 1975 the national PMR in the Netherlands in a population where 50% of women birthed at home was 13.5 babies per 1,000.¹⁰² While international comparisons of PMR can be problematic due to different definitions of perinatal mortality, in New Zealand, with its almost 100% hospital

99 David Stewart and Lewis E. Mehl, ‘A rebuttal to negative home birth statistics cited by ACOG’ in Lee Stewart and David Stewart, *21st Century Obstetrics Now! Volume 1*, NAPSAC, Marble Hill, MO, 2nd edn., 1978, pp. 27-29.

100 For a full list of references made available to the MSC by the Auckland Branch of the NZHBA, see NZHBA to George Gair, MoH, Letter and reference list, 9 October 1979, DoH, ‘Board of Health – Maternity Services Committee, 1979-1980’, ABQU 632 W4550, 29/21 (50925).

101 David Stewart, *The Five Standards for Safe Childbearing*, NAPSAC International, Marble Hill, Missouri, 1981, pp. 418-420 and 426.

102 G.J. Kloosterman, ‘The Dutch system of home-birth’, in S. Kitzinger and J.A. Davies, *The Place of Birth*, Oxford Medical Publications, Oxford, 1978.

birthing rate, the PMR was 16.5 per 1,000 in the same year.¹⁰³ (See Table 5.2). This trend for a lower PMR at home than in hospital birthing was replicated in England and Wales suggesting home birth was as safe in those countries as in the Netherlands.¹⁰⁴

Table 5.2 Perinatal mortality rate, births per thousand, 1960, 1974 and 1975

	1960 per 1,000	1974 per 1,000	1975 Per, 1000
Home Births only (Netherlands)	14.0	4.2	
Hospital births only (Netherlands)		23.0	
Combined 50% home birth & 50% hospital birth (Netherlands)			13.5
New Zealand			16.5

Data source: G.J. Kloosterman, 'The Dutch system of home-birth', in S. Kitzinger and J.A. Davies, *The Place of Birth*, Oxford Medical Publications, Oxford, 1978 and New Zealand Health Statistics "Mortality and Demographic Data, 1975" and "Hospital Management Data, Part III Statistics and Payments 1977" cited in Auckland Branch of the New Zealand Home Birth Association to Maternity Services Committee, Submission, 23 September 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

In 1979 the Auckland Branch of HBA analysed the first 500 home births during 1974-1979 of six midwives, four of whom resided in Auckland (Carolyn Young, Joan Donley, Irene Hogan and Gillian McNichol) and one each in Christchurch (Ursula Helem) and Wellington (Lynne McLean). These midwives worked within HBAs or HBSGs and, as the Auckland HBA stated, "brought to their profession an approach to birth that is radically different to the one used in hospitals and taught in technical institutes".¹⁰⁵ While these statistics are not directly comparable to the hospital birthing population, the HBA statistics showed a remarkable level of non-interventionist birth when considered against the national norm of the mid to late 1970s, as shown in Table 5.3.

103 N.Z. Health Statistics, 'Mortality and Demographic Data, 1975' and 'Hospital Management Data, Part III Statistics and Payments 1977', in Auckland Branch of the NZHBA, Submission, 23 September 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

104 M. Tew, 'The case against hospital deliveries: the statistical evidence', in S. Kitzinger and J.A. Davies, *Place*.

105 Auckland Branch, NZHBA, Submission, 23 September 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

Table 5.3 Comparison between planned home birth and hospital data, 1975-1979

Intervention	New Zealand Hospital Births * %	New Zealand Home Births # % (n = 500)
Episiotomy	>70.0	2.5
Surgical Induction of Labour	>15.0	0.0
Sedation	No data	7.5
Syntocinon augmentation of labour	>25.0	No data
Forceps deliveries	>10.0	<1.0
3 rd or 4 th degree lacerations	10.0	0.0
Caesarean section	>8.0	No data
Post partum haemorrhage	10.0	<1.0
Retained placenta	5.0	<1.0

Source data: * New Zealand Health Statistics, “Mortality and Demographic Data, 1975” and “Hospital Management Data, Part III Statistics and Payments 1977” cited in following submission ; # Auckland Branch of the New Zealand Home Birth Association to Maternity Services Committee, Submission, 23 September 1979, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

Of these 500 births, two babies were stillborn in hospital following transfer from home during labour, one of whom had a lethal congenital abnormality.¹⁰⁶ This equated to a PMR of 4 per 1,000 at a time (1975) when, as stated previously, the PMR rate for all babies born in New Zealand was 16.5 per 1,000.¹⁰⁷

This and other evidence-based information, including the annual statistics for each DM’s practice kept by each DHO,¹⁰⁸ could have been valuable to the MSC in its review of the safety of the domiciliary midwifery service. But none of this information would be reflected in its 1982 report, *Mother and Baby at Home: The Early Days*,¹⁰⁹ nor tempered its recommendations which would culminate in legislative changes to the Nurses Amendment Act 1983 to ‘better manage’ supervision of the domiciliary midwife.

106 This baby had anencephaly, that is, the vault of the baby’s skull and the cerebrum (brain) was absent.

107 Auckland Branch, NZHBA, Submission, 23 September 1979, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

108 Department of Health, ‘Self-employed midwives (domiciliary): the Department’s responsibilities’, Paper, March 1979, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

109 New Zealand Maternity Services Committee, *Mother*.

Concluding comments

While the GP was legally integral to the home birth service, the DoH wanted to tighten up surveillance of his or her oversight of, and agreement with the woman birthing at home. It believed that some GPs were signing their names to provide supervision but not carrying out responsibility for this.¹¹⁰ Where the DMs worked with supportive GPs their professional relationships generally worked well. Many areas throughout New Zealand lacked GP support for home birth but in Auckland there had been significant support from numerous GPs for over a decade from at least the mid 1970s. However, Auckland DMs' relationships with home birth doctors would start to deteriorate in 1990 as changes to the Nurses Act 1977 to restore midwifery autonomy looked imminent. These same previously pro home birth GPs now talked about the dangers of home birth as their incomes and role would be affected by DMs 'going it alone'.¹¹¹

It was this same rhetoric of safety that each professional group used to couch their opposition to home birth during the MSC review of domiciliary midwifery during 1978-1982. However, my scrutiny in this chapter has exposed the underlying reason - self interest that home birth services would impact negatively both on the numbers of births available for GPs in small hospitals, and called for services that the larger obstetric hospitals were not prepared to provide.

The DoH had an expectation that the DM would reinforce the GP's opinion and encourage women to follow the doctor's advice, as previously evidenced. If the midwife did not accept the GP's advice to transfer to hospital, he or she was advised to inform both the Medical Superintendent of the base hospital and the MOH of this fact.¹¹² However, when women's opportunity for support to birth at home was curtailed by the lack of GP support, some DMs chose to provide the home birth service without the required medical oversight. To counter this illegal action, the DoH considered withholding the meagre MSB

110 'Paper II', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879) and W.A. Malpress, MOH and Mrs R Selby, PPHN, Christchurch to Head Office, Memo, 18 June 1981, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

111 J. Donley, 'Auckland Domiciliary Midwives' Report – Jan 1-31 Dec 1989', Letter, April 1990, Sian Burgess Personal papers, Box 40.

112 M. McKerr, 'The responsibility of General Practitioners', DoH, 'Board of Health – Maternity Services Committee, 1980-1981', ABQU 632 W4415, 29/21 (53013).

from the DM and the midwives were warned that their contracts with the MoH could be terminated.

I have explained in this chapter how supervision was problematic for the DoH and the DM alike. In exploring who could provide that supervision,¹¹³ the DoH determined that under S. 110 (1) of the Social Security Act 1964, the conditions approved by the MoH could include the contract being held by a Hospital Board and the DM could be supervised by the obstetric unit.¹¹⁴ This was the resolution to the problem PPHNs desired¹¹⁵ as, often not being midwives themselves, they lacked the expertise to assess midwifery practice.¹¹⁶

None of the MSC members recommended birth at home. Rather, as stated by the Committee, “quite the opposite”.¹¹⁷ The press release that accompanied the MSC report, *Mother and Baby at Home: The Early Days*,¹¹⁸ when sent to the MoH, would begin – “A report opposing the practice of home births but containing recommendations to reduce risk when they do take place.”¹¹⁹ The penultimate sentence of the press release would read “the Maternity Services Committee have carried out a very thorough survey of trends in birth practices and their effects on maternal and neonatal mortality.”¹²⁰

I have, in this chapter, examined that ‘very thorough survey’ and discussed the data on home birth in New Zealand that informed the Committee. Both failed to show that domiciliary midwifery practice in New Zealand posed risk to women (and babies) during home birth – to use the Committee’s phrase – ‘quite the opposite’. However, the MoH sought support from the Caucus Committee on Health for legislative changes “affecting

113 R.A. Barker, Memo, c. 1981, DoH, ‘Board of Health – Maternity Services Committee, 1980-1981’, ABQU 632 W4415, 29/21 (53013).

114 O. Smuts-Kennedy, Office Solicitor, DoH, ‘Contracts with domiciliary midwives’, 31 March 1981, DoH, ‘Board of Health – Maternity Services Committee, 1980-1981’, ABQU 632 W4415, 29/21 (53013).

115 New Zealand Board of Health, *Mother*, p. 22.

116 ‘Paper I, Comments on present maternity services’, in Department of Health, ‘Self-employed midwives (domiciliary): the Department’s responsibilities’, Paper, March 1979, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

117 ‘Mother and baby at home – the early days: a report of the Maternity Services Committee of the Board of Health’, Draft report, 14 April 1981, p. 7, DoH, ‘Board of Health – Maternity Services Committee, 1980-1981’, ABQU 632 W4415, 29/21 (53013).

118 New Zealand Maternity Services Committee, *Mother*.

119 ‘Report on mother and baby at home released’, Draft press release, in R.A. Baker, Chairman, MSC to MoH, Letter, 26 January 1983, DoH, ‘Board of Health – Maternity Services Committee, 1982-1983’, ABQU 632 W4415, 29/21 (54816).

120 Ibid.

home births and domiciliary midwives”.¹²¹ These were introduced into Parliament as the Nurses Amendment Bill 1983 on 1 September. In his introduction the MoH noted the “more important changes” related to nursing education programmes; the obligation on a medical practitioner to notify the Nursing Council of a nurse’s or midwife’s diagnosed or suspected mental or physical disability and finally, increased power to the MOH to suspend “a nurse carrying out obstetric nursing” – that is, a domiciliary midwife providing home birth services – if he suspected her to be practising in an unhygienic manner.¹²²

The role the NZNA and MSIS played in the MSC review which resulted in the above outcome is examined in the next chapter.

121 A.G. Malcolm, MoH, to Caucus Committee on Health, ‘Report of the Maternity Services Committee of the Board of Health: The Mother and Baby at Home: The Early Days’, Memorandum, c.1982, DoH, ‘Board of Health – Maternity Services Committee, 1983-1984’, ABQU 632 W4415, 29/21 (57881).

122 A.G. Malcolm, MoH, ‘Nurses Amendment Bill: Introduction’, *New Zealand Parliamentary Debates*, 452, (September 1983), p. 2005.

CHAPTER 6: CAPES, COLLUSION AND CONTROL

In 1988 at the Midwives Special Interest Section Conference Joan Donley would present a paper which related the antiquity of difference between midwifery and nursing. She wrote:

Ever since Eve ate that apple midwifery has been distinct from nursing. While nursing and midwifery are two branches of the same strong tree of caring, midwifery grew out of the age-old covenant between women, while nursing developed from caring for the sick and wounded in convents, on the battlefield, in poor houses and finally in hospitals under the dominance of doctors.¹

In this chapter I examine the obstetric nursing position which NZNA promoted as appropriate to the midwife. This position would determine the content of the ‘Policy Statement on Home Confinement’² which, as previously mentioned, MSIS sent to MSC in 1980 in response to the Committee’s call for submissions on domiciliary midwifery. This policy has received little attention from midwifery commentators and academics, perhaps because its only publication was as an appendix to the *Policy Statement on Maternal and Infant Nursing*³ ratified at the 1981 NZNA Conference. While the latter policy would apply to midwives in general, the ‘Policy Statement on Home Confinement’ would have wide-ranging implications for DMs which I discuss in this chapter. I detail the growing awareness of NZNA and MSIS to domiciliary midwifery from 1973-1979 that prompted development of the policy, and examine NZNA’s engagement with NZMA on home birth issues.

I preface this now with discussion about NZNA’s ability to influence nursing and midwifery following the Nurses Act 1971 before introducing the Midwives and Obstetric Nurses Special Interest Section of NZNA.

1 Joan Donley, ‘Moas’, p. 23.

2 Midwives and Obstetric Nurses Section, NZNA, ‘Policy Statement on Home Confinement’, February 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

3 NZNA, *Policy*.

The voice of nursing and midwifery - NZNA

The New Zealand Registered Nurses Association (NZRNA), as NZNA was named in 1932-1971,⁴ had experienced a diminished ability to influence nursing following the Nurses Act 1971. This altered the position it had enjoyed for the previous forty-six years. The Act disbanded the Nurses and Midwives Registration Board (NMRB) which had existed from 1925, constituting instead, the NCNZ with its purpose of providing for “the registration and control of nurses”.⁵ Prior to this, NZRNA had been influential in NMRB functions of setting nursing and midwifery training courses for registration, approving hospitals or institutions which provided the courses, appointing examiners, arranging and conducting examinations, issuing certificates to successful examination candidates, authorising registration, as well as anything within the scope of its authority to effectively administer the Nurses and Midwives Registration Act 1925 and its amendments.⁶

With NMRB’s disbanding, the strong links that had continued through the 1960s with senior nurse leaders often holding key positions on the regulatory body, the DoH and the policy committees of NZNRA,⁷ would change. Renamed the New Zealand Nurses Association in 1971,⁸ the Association would find its “political influence in strategic nursing and health policy decisions at governmental level”⁹ disappeared. Moreover, when education programmes were transferred from hospitals to the tertiary education sector,¹⁰ the “enormous status and power in the system”¹¹ that senior hospital nurses – Matrons, later renamed Principal Nurses – had as heads of both the nursing service and school of nursing was challenged. Kathryn Adams, in her PhD thesis on nursing history, notes

4 Margaret Gibson Smith and Yvonne T. Shadbolt, *Objects and Outcomes. New Zealand Nurses’ Association 1909-1983*, New Zealand Nurses Association, Wellington, 1984, p.vi.

5 Pamela J. Wood and Elaine Papps, *Safety to Practise: Reflections of Chairpersons of the Nursing Council of New Zealand 1971-2001*, The Nursing Council of New Zealand, Wellington, 2001, p. 9.

6 Mary Lambie, *Historical Development of Nursing in New Zealand 1840-1950*, Wellington, Department of Health, 1953, p. 17.

7 Barbara Gay Williams, ‘The primacy of the nurse in New Zealand 1960s-1990s. Attitudes, beliefs and responses over time’, PhD thesis, Victoria University of Wellington, Wellington, 2000, p. 136.

8 Margaret Gibson Smith and Yvonne T. Shadbolt, *Objects*, p. vi.

9 Faye Kathryn Adams, ‘A postmodern/poststructural exploration of the discursive formation of professional nursing in New Zealand 1840-2000’, PhD thesis, Victoria University of Wellington, Wellington, 2003, p. 235.

10 For more on this, see Sally Pairman, ‘From autonomy and back again: educating midwives across a century. Part 1’, *New Zealand College of Midwives Journal*, 33, 2005, pp. 6-10 and Sally Pairman, ‘From autonomy and back again: educating midwives across a century. Part 2’, *New Zealand College of Midwives Journal*, 34, 2006, pp. 11-15.

11 Yvonne Shadbolt, cited in Faye Kathryn Adams, ‘Postmodern’, p. 254.

NZNA went from having a 'top down' to a 'bottom up' process as the organisation became "restricted to nursing educational policy making and to setting standards for nursing [and midwifery] education and practice".¹²

One senior midwife who not only maintained most of her status and power but who increased this in the new environment was Anne Nightingale. Anne had been in charge of midwifery education at Auckland's St Helens Hospital during 1967-1972 and was Principal Nurse there during 1972-1990. She would also be NCNZ Chairperson from 1975-1984.¹³ Simultaneously she was NZNA Auckland Branch President¹⁴ and a Committee member of MSIS Auckland Branch at its beginning in August 1972.¹⁵ Remembered as "midwifery personified"¹⁶ by Nancy Neilson, an NCNZ member from 1981-1987,¹⁷ Anne in her multifarious roles proved to be a major spearhead in initiating investigation into domiciliary midwifery, as I evidence shortly.

In 1971, Beatrice Salmon, a New Zealand nurse academic, identified in her address¹⁸ at a nursing education seminar that the prevailing attitudes and values in New Zealand nursing were detrimental to the promotion of new ideas and change. She urged NZNA to substantially increase the number of nurses below forty years of age in its committees. Bringing "a fresh approach, unencumbered by previous deliberations and decisions" was a necessity to counteract the fact that "nurses are inclined to be conservative and are not known as brash innovators".¹⁹

The conservative attitudes and inability to respond to demands for change that Beatrice recognised in NZNA were also evident in MSIS, as I explain following introduction of MSIS.

12 Faye Kathryn Adams, 'Postmodern', p. 235.

13 Pamela J. Wood and Elaine Papps, *Safety*, pp. 39-40.

14 *Ibid.*, p. 40.

15 MSIS Auckland Branch, 'Annual report and balance sheet, 1972/73', MSIS, 'Annual reports', Box 1.

16 Pamela J. Wood and Elaine Papps, *Safety*, p. 69.

17 *Ibid.*, p. 56.

18 E. Beatrice Salmon, 'Anabasis', pp. 67-71.

19 *Ibid.*, p. 70.

Midwives and Obstetric Nurses Special Interest Section of NZNA

NZRNA had rejected formation of Special Interest Sections within its membership which was suggested from time to time, though some informal ones did establish from the early 1960s with members retaining membership to NZNRA.²⁰ One such group, the first Midwives Section,²¹ had formed in Wellington in 1969 with Maureen Lawton, then a Supervisor at Wellington Women's Hospital, elected as its first Chairperson.²² However, a resolution passed at the 1971 NZNA Conference formalised Special Interest Sections²³ and the National MSIS was established and approved by NZNA that same year.²⁴ Numbering 300 members by August 1973,²⁵ this grew to 651 by 1984 with eight regional branches²⁶ as shown in Table 6.4. By 1986 it had ten branches and a membership of 611.²⁷

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- 20 'NZNA: structure and function 1909-1983', in Margaret Gibson Smith and Yvonne T. Shadbolt, *Objects*, p. 14.
- 21 An Obstetrical Nurses Special Interest Section was set up in 1935 by Dr Ewart of the Obstetrical Society, in, Joan Donley, *Save*, pp. 101 and 181.
- 22 Maureen Lawton, 'Report on 19th International Confederation of Midwives held in Brighton (UK) from September 13th-19th 1981', in 'Midwifery Quarterly', March 1982, Joan Donley Personal papers, 'Midwives Section: Minutes 1980-1989, *Missives* 1984', p. 1.
- 23 Alison M. Pitts, 'Nursing services', in Margaret Gibson Smith and Yvonne T. Shadbolt, *Objects*, p.58.
- 24 Maureen Lawton, 'Report on 19th International Confederation of Midwives held in Brighton (UK) from September 13th-19th 1981', in 'Midwifery Quarterly', March 1982, Joan Donley, Personal papers, 'Midwives Section: Minutes 1980-1989, *Missives* 1984', p. 1.
- 25 MSIS Auckland Branch Committee meeting, Minutes, 28 August 1973, MSIS, 'Minutes of Committee meetings', Box 1.
- 26 Ann McQueen, MSIS National Chairperson, 'Annual Report 1983/84', MSIS, 'NZNA Midwives Section, Chairman's file, 1983-1987', Box 4.
- 27 MSIS National Committee, 'Annual Report 1986-1987', MSIS, 'NZNA Midwives Section, Chairman's file, 1983-1987', Box 4.

Table 6.1 Regional membership of Midwives and Obstetric Nurses Special Interest Section of NZNA, 1973 and 1984

Region	1973	1984
Northland	18	47
Auckland	81	157
Waikato	70	86
Eastern and Central North Island	-	78
Wellington, Nelson and Marlborough	83	112
Canterbury and West Coast	30	65
Otago	-	68
Southland	18	38*
TOTALS	300	651

Sources: MSIS Auckland Branch Committee meeting, Minutes, 28 August 1973, MSIS, 'Minutes of Committee meetings', Box 1 and Ann McQueen, MSIS National Chairperson, 'Annual Report 1983/84', MSIS, 'NZNA Midwives Section, Chairman's file, 1983-1987', Box 4.

* Approximate number

MSIS embraced obstetric nursing in both its name²⁸ and objectives, the latter established as follows:

*to bring into accord Midwives and others engaged in Obstetric Nursing in New Zealand; to ensure the promotion and maintenance of the best standards of Midwifery Practice and Education in New Zealand [and] to promote and uphold the purposes of the International Confederation of Midwives.*²⁹

28 The founding name of NZNA 'Special Interest Section (Incorporated), Midwives' would change in 1974 to NZNA 'Midwives and Obstetric Nurses Special Interest Section'. This was to broaden the membership to nurses who were interested in or practising obstetric nursing, see Miss P.A. Dunkley, MSIS Chairman, 'Annual report', 8 September 1973 and MSIS Auckland meeting, Minutes, 4 May 1974, MSIS, 'Minutes of Branch meetings', Box 1 and 'Special Interest Sections', *The New Zealand Nursing Journal*, 72, 8 (August 1979), p. 28.

It was agreed in 1976 that this unwieldy name could be changed to 'Midwifery Section' but its final name, NZNA Midwives and Obstetric Nurses Section, would stand from May 1980. MSIS Auckland Branch meeting, Minutes, 6 March 1976 and 22 May 1980, MSIS, 'Minutes of Branch meetings', Box 1.

29 'Special Interest Sections', p. 28.

The NZNA hierarchy with its apex of “top nurse administrators”,³⁰ and at the bottom “the graduate nurse”,³¹ was replicated in MSIS.³² Principal and Assistant Principal Nurses, Supervisors and Charge Nurses of large obstetric hospitals and midwifery tutors were Chairpersons throughout the country. These members also filled the working parties that developed policy on domiciliary midwifery and home birth services,³³ maternal and infant nursing³⁴ and midwifery education.³⁵

So where did the midwives of the DMS fit into the above organisations?

Domiciliary midwives in NZNA and MSIS

Midwives of DMS had varying contact with these two groups. Only Lynne McLean was active in NZNA³⁶ from at least 1978 though she was not a member of MSIS. Lynne would be nominated as a resource person for the 1981 *Policy Statement on Maternal and Infant Nursing* but, as will be discussed later, would have minimal influence on policy development.

Sue Lennox attended MSIS meetings from 1976 onwards in both Palmerston North and Wellington. While home birth was discussed in 1976, Sue was drawn to find out more about it, rather than supporting the opposition to home birth,³⁷ which I explain later. Jenny Johnston became involved in MSIS in the mid to late 1980s when midwifery policy was redeveloped but otherwise had little contact during the study period.³⁸ Gillian Wastell belonged to neither NZNA nor MSIS until she returned to hospital employment in 1984. As she explained:

30 New Zealand Nurses Association, *Policy*, p. 19.

31 *Ibid.*

32 My own (one) experience of attending a Midwives Section meeting in the late 1980s reflected this same hierarchical structure in the seating arrangements and the right to speak.

33 Midwives and Obstetric Nurses Section, NZNA, ‘Policy Statement on Home Confinement’, February 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

34 NZNA, *Policy*.

35 MSIS, ‘Report of the Working Party looking into education for the role, scope and sphere of practice of the midwife in New Zealand’, April 1984, MSIS, ‘Midwives education’, Box 6.

36 NZNA National Executive meeting, Minutes, 17-18 August 1978, NZNA, Unnamed file, 25/5/5.

37 Catch-up: Maggie Banks with Sue Lennox, 3 December 2004, pp. 2, 5 and 10.

38 Catch-up: Maggie Banks with Jenny Johnston, 23 August 2004, p. 8.

*The only reason I belonged to that [NZNA] was because of the negotiating for income and work conditions. I never belonged to it thinking that they gave me nourishment in terms of a midwife. It wasn't for professional reasons at all...[and MSIS] was still too much in the sense that the hospital midwives were anti-home birth.*³⁹

It appears Joan Donley started attending MSIS meetings from January 1981, following being invited to a special meeting as part of a HBA delegation.⁴⁰ A regular attendee from then, she offered herself for the Committee of MSIS Auckland Branch in late 1985.⁴¹ With her successful election she attended meetings as a Committee member from this point. The reception when Joan first attended MSIS meetings was one of cool indifference during which members would neither look at nor speak to her. However, following the Nurses Act 1983, she would begin to be treated cordially as midwives began to recognise that her analysis of NZNA's control of midwifery, which I elaborate on later, had been accurate.⁴²

Despite low numbers of DMs and limited contact with them NZNA and MSIS would become increasingly aware of domiciliary midwifery within two years of the Section's formation, as I now detail.

Domiciliary midwifery comes into view

As mentioned earlier in the thesis, the BoH's 1937 prediction that home birth numbers would drop progressively had been realised. In 1972, that number was sixteen - less than one third than the previous year, and the drop continued in 1973 to the all time low of thirteen.

Vera Ellis-Crowther, then seventy-three years old,⁴³ continued to attend home births in Auckland in the absence of other DMs to take over from her.⁴⁴ It appears likely

39 Catch-up: Maggie Banks with Gillian Wastell, 2 November 2004, pp. 4-5.

40 MSIS Auckland Branch Committee meeting, Minutes, 28 January 1981, MSIS, 'Minutes of Committee meetings', Box 1. It was usual to record only names of members offering apologies rather than those present. Joan Donley's archives hold consecutive MSIS minutes from January 1981.

41 MSIS, 'Voting paper', October 1985, MSIS, 'Minutes of Branch meetings', Box 1.

42 Personal communication: Joan Donley to Maggie Banks, 17 October 2001.

43 Joan Donley, *Herstory*, p.18.

that Vera's continued practice at this age provided impetus for MSIS discussion on home birth at its National Committee meeting in August 1973. Anne Nightingale, then Principal Nurse of St Helens Hospital in Auckland and NZNA Branch President, prepared a Conference remit for the following year requiring a minimum standard for domiciliary midwifery practice.⁴⁵ Once passed at the 1974 Conference, the remit was sent to the Director-General of Health (DGoH) with the request that DMs be required to have a special licence issued, and renewed at stipulated intervals. Renewal would be dependant on the midwife attending approved refresher courses and achieving a satisfactory standard of practice.⁴⁶

Shirley Bohm, then Director of Nursing (DoN), discussed the remit with the Department's professional staff. But as the number of DMs practising outside the district nursing services was so few, and as there was a "relative absence of complaints [legislation would be] using a sledge-hammer to kill an ant".⁴⁷ If NZNA had evidence that there was cause for complaint, Shirley advised, this could be taken up with local MOHs who had the ability to exercise control under Section 56 of the Nurses Act 1971.⁴⁸

The H.Mt. 20 Regulations⁴⁹, no longer in use in November 1974,⁵⁰ were soon to be replaced by drafted Obstetric Regulations under the Nurses Act 1971. These, Shirley assured MSIS, would ensure DM supervision by two medical practitioners as all women, including those at home, would have a doctor present at birth.⁵¹

The DoN posed questions as to who would approve refresher courses, what a satisfactory standard of practice was and whether there would be a right of appeal against refusal of licence⁵² - questions, some of which formed the framework that NZNA would later use to develop policy.

44 Personal communication: Joan Donley to Maggie Banks, 17 October 2001.

45 MSIS Auckland Branch Committee meeting, Minutes, 28 August 1973, MSIS, 'Minutes of Committee meetings', Box 1.

46 Shirley M. Bohm, Director, Division of Nursing, DoH to Miss Burton, NZNA National Secretary, Letter, 29 May 1974, MSIS, 'Midwives Section Correspondence, 1972-1989', Box 2.

47 Ibid.

48 Ibid.

49 Department of Health, *General Principles*, 1960.

50 NZNA National Executive meeting, Minutes, 27-28 November 1974, NZNA, Unnamed file, 25/5/5.

51 Shirley M. Bohm to Miss Burton, Letter, 29 May 1974, MSIS, 'Midwives Section Correspondence, 1972-1989', Box 2.

52 Ibid.

Invited to comment on this reply,⁵³ MSIS was dissatisfied with it and determined to discuss the issue again at local and national levels. It wanted NCNZ to set standards for continuing practice, commenting “because there have been no complaints does not mean there hasn’t been cause for some”.⁵⁴ MSIS remained concerned that demand for home birth would increase⁵⁵ as while Vera would stop practising in 1974, Carolyn was now attending home births⁵⁶ and within a few months, both Joan in Auckland and Ursula in Christchurch had commenced domiciliary practice.

The ‘home birth issue’ waited until the Association’s AGM in April 1975 as MSIS responded to an increasing demand for Early Discharge services. It anticipated this would counter demand for home birth – an option which MSIS neither suggested nor supported. It wanted to ensure that, firstly, any Early Discharge service which was developed would be provided by midwives rather than nurses and, secondly, that midwives would have a liaison with maternity hospitals.⁵⁷

Domiciliary midwifery was again raised before NZNA in 1976, this time by NCNZ,⁵⁸ the Chairperson of which was now Anne Nightingale. It informed NZNA that a free domiciliary midwifery service was being advertised by two Christchurch midwives.⁵⁹ Ursula had distributed information to GPs and chemists about the service she and a colleague provided. Chemists had been chosen because pregnant women obtained iron supplements from chemists who, the DMs thought, could tell women about the service. GPs had also been given forms so they could distribute them to pregnant women when they came for antenatal care.⁶⁰ The matter had been drawn to the attention of the local MOH by several Christchurch obstetricians who objected to the availability of a home birth service being advertised.⁶¹

53 Miss Suzanne Burrell, NZNA Assistant Secretary to Miss McAleer, MSIS Auckland Branch Secretary, Letter, 3 July 1974, MSIS, ‘Midwives Section Correspondence, 1972-1989’, Box 2.

54 MSIS Auckland Branch meeting, Minutes, 3 August 1974, MSIS, ‘Minutes of Branch meetings’, Box 1.

55 Ibid.

56 Joan Donley, *Herstory*, p.18.

57 NZNA, Annual General Meeting, Minutes, 8-11 April 1975, NZNA, Unnamed file, 10/75/9.

58 NZNA National Executive meeting, Minutes, 25-26 November 1976, NZNA, Unnamed file, 25/5/5.

59 Ibid.

60 Personal communication: Ursula Helem to Maggie Banks, 11 February 2002.

61 NZNA National Executive meeting, Minutes, 25-26 November 1976, NZNA, Unnamed file, 25/5/5.

The ‘highly improper’ way in which the Christchurch midwives advertised irked NZNA and it questioned the midwives’ ethics. NZNA also determined that the leaflet was misleading because the care available varied between health districts and it perceived discrepancies between what was on the advertisement and that which should actually be provided.

Neither NZNA nor the MOH were able to intervene in the advertising and had no authority to censor the work but the Executive determined to show its displeasure to the midwife. It informed the DGoH that various MOHs were interpreting the regulations differently and referred the matter to MSC so the apparent loophole could be remedied to prevent repetition.⁶²

The Maternity Services Committee wanted to know if NZNA had disciplined the midwives but, as mentioned previously, it had no ability to formally do this.⁶³ Instead, when Ursula questioned the ambiguity of the offending leaflet, the Executive responded by specifically detailing issues and advising both midwives that their membership to NZNA could be withdrawn for “ethical misconduct due to misleading advertising”.⁶⁴

Advertising would again arise in 1978 during NZNA’s discussions with the New Zealand Medical Association, this time regarding Wellington DMs. Again, NZNA intended to reproach the midwives⁶⁵ but their inability to censure the behaviour continued.⁶⁶ Shona Carey would write to Lynne McLean that advertising by professionals was considered unethical.⁶⁷ The Executive chose to take no further action when Lynne responded defending domiciliary midwifery.⁶⁸

Margaret Bazley, now DoN, had assured the Executive subsequent to its November 1976 meeting, that any future domiciliary midwifery service in Christchurch would be

62 Ibid.

63 NZNA National Executive meeting, Minutes, 30-31 March 1977, NZNA, Unnamed file, 25/5/5.

64 NZNA National Executive meeting, Minutes, 11 February 1977, NZNA, Unnamed file, 25/5/5 and NZNA National Executive meeting, Minutes, 30-31 March 1977, NZNA, Unnamed file, 25/5/5.

65 NZNA and New Zealand Medical Association meeting, Report, 1 March 1978, NZNA, Unnamed files, 25/5/1 and 15/7/9.

66 Margaret Bazley, Joy Motley and Shona Carey meeting, Report, 7 March 1978, NZNA, Unnamed file, 30/3/3.

67 NZNA National Executive meeting, Minutes, 27-28 April 1978, NZNA, Unnamed file, 25/5/5.

68 NZNA National Executive meeting, Minutes, 15-16 June 1978, NZNA, Unnamed file, 25/5/5.

provided through the Nurse Maude District Nursing Association.⁶⁹ Moreover, no midwife would be paid the MSB unless a medical practitioner recommended it.⁷⁰

But the continued ability for a midwife to provide domiciliary services under DoH contract appeared to surprise the Executive in late 1976.⁷¹ This continued arrangement existed because when St Helens Hospitals were transferred from the State to Hospital Boards in 1969, home birth numbers were so low that DM contracts had been overlooked and remained with the DoH.⁷² The Executive informed NCNZ that it had no policy on home birth but the matter would likely be discussed at its 1977 Conference.⁷³

Maureen Lawton, then Charge Tutor at St Helens Hospital in Wellington in 1977, had reported back on home birth in Britain in the *New Zealand Nursing Journal*⁷⁴ the month prior to Conference. She had previously worked in the domiciliary scene in Great Britain and during a midwifery education study tour she had discussed home birth with British Maternal and Child Health Services. Health professionals in Great Britain surmised that as women were having fewer babies than previously, babies should be a “high quality [and] if equal opportunity is to be given to all for safe confinement, then domiciliary midwifery must be phased out”.⁷⁵ She returned home convinced that to succeed in discouraging women from home birth individualised care and Early Discharge with follow up services were essential.⁷⁶

Domiciliary midwifery was discussed at length at NZNA’s February 1977 Executive meeting. It determined more information was needed on both the demand for and problems associated with home birth. It canvassed MSIS and NZNA Branches through its March ‘Branch Circular’⁷⁷ and the *New Zealand Nursing Journal*⁷⁸ and notified MSC of its activity.⁷⁹

69 For more information on this, see Eve A. Stonehouse, *In the Name of Nurse Maude: A History of the Nurse Maude District Nursing Association*, Whitcombe and Tombs, Christchurch, 1972.

70 NZNA National Executive meeting, Minutes, 25-26 November 1976, NZNA, Unnamed file, 25/5/5.

71 Ibid.

72 Judy Keall, MP for Glenfield, ‘Speech for the opening of National Midwives Conference Auckland, Friday 5 August 1988, Jackie Gunn Personal papers.

73 NZNA National Executive meeting, Minutes, 25-26 November 1976, NZNA, Unnamed file, 25/5/5.

74 Maureen Lawton, ‘Reporting on midwifery’, *The New Zealand Nursing Journal*, 70, 3 (March 1977), pp. 19-22.

75 *Ibid.*, p. 21.

76 *Ibid.*

77 NZNA, ‘Branch Circular 4/1977’, 22 March 1977, NZNA, ‘Branch Circulars’, 20/3/2.

Within five months of the 1977 Conference, NZNA would be forced to acknowledge demand for home birth was clearly evident. While Auckland MSIS did not feel that less than 2% of women who formed the ‘vocal minority’ warranted a big research project, it agreed to have open discussion on home birth at its next study day.⁸⁰ Workshops to discuss the question were held by Wellington, Blenheim and Nelson Branches. Whangarei, Palmerston North and Hutt Valley Branches undertook ‘exercises’ and discovered both the demand and that there were women in the community planning to have their babies at home, irrespective of the presence, or otherwise, of “adequate back up facilities”.⁸¹

Following discussion at the MSIS National meeting during the 1978 NZNA Conference, the group made a clear statement they did not support home birth.⁸² While there had been little support for home birth amongst NZNA midwives in 1977,⁸³ by early 1979 MSIS documented its “stated policy that [MSIS] rejects totally any move toward home delivery”.⁸⁴

Emphatically, NZNA Executive did not support the service provided by self-employed DMs. If any domiciliary service occurred, NZNA wanted it provided through existing community nursing services⁸⁵ to ensure control over standards of practice and care quality⁸⁶ as this was “in the interest of continuity and [the] status of midwives”.⁸⁷ It informed MSC of its concerns in September 1977,⁸⁸ which were duly noted.⁸⁹ When the

78 NZNA National Executive meeting, Minutes, 11 February 1977, NZNA, Unnamed file, 25/5/5.

79 Shona Carey to Dr Barker, Letter, 27 September 1977, DoH, ‘Board of Health – Maternity Services Committee, 1982’, ABQU 632 W4415, 29/21 (54019).

80 MSIS Auckland Branch Committee meeting, Minutes, 25 March, 1977, MSIS, ‘Minutes of Committee meetings’, Box 1.

81 Shona Carey to Dr Barker, Letter, 27 September 1977, DoH, ‘Board of Health – Maternity Services Committee, 1982’, ABQU 632 W4415, 29/21 (54019).

82 NZNA, Annual General Meeting, Minutes, 5-7 April 1978, NZNA, Unnamed file, 25/5/5.

83 Shona Carey to Dr Barker, Letter, 27 September 1977, DoH, ‘Board of Health – Maternity Services Committee, 1982’, ABQU 632 W4415, 29/21 (54019).

84 G.E. Stimpson, MSIS Secretary, Open letter, 12 March 1979, MSIS, ‘Midwives Section Correspondence, 1972-1989’, Box 2.

85 NZNA National Executive meeting, Minutes, 22-23 September 1977, NZNA, Unnamed file, 25/5/5 and R. Dickie, Director, Division of Hospitals, DoH to Dr Barker, Letter, 27 June 1978, DoH, ‘Board of Health – Maternity Services Committee, 1982’, ABQU 632 W4415, 29/21 (54019).

86 NZNA National Executive meeting, Minutes, 22-23 September 1977, NZNA, Unnamed file, 25/5/5.

87 Maternity Services Committee, ‘Early discharge of mother and baby’, 28 June 1979 DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

88 Shona Carey to Dr Barker, Letter, 27 September 1977, DoH, ‘Board of Health – Maternity Services Committee, 1982’, ABQU 632 W4415, 29/21 (54019).

DoH examined this suggestion the following year, it saw no legal bar to the hospital nursing service doing this.⁹⁰ Meanwhile, MSC invited the Association to research the counter measure - Early Discharge,⁹¹ which the MSIS Otago Branch agreed to undertake,⁹² and results would be sent to MSC.⁹³

In March 1978, the Canterbury/West Coast MSIS Branch informed NZNA of its concerns about increasing numbers of home births in the region, citing the lack of a flying squad and distances between base hospitals as posing danger to mother and baby. Branch Chairperson Margaret McGowan reported that a Christchurch midwife had attended a home birth where the woman had a Syntocinon infusion at home without a medical practitioner. Margaret wanted health authorities to be lobbied to direct their effort and monies towards hospital birth and Early Discharge. Midwives in her area believed this to be in the best interests of mother and baby as DMs not attached to hospitals posed a “grave danger” that would see increasing perinatal mortality and morbidity rates for baby and mother.⁹⁴

Having already drawn similar concerns from the Wellington area to the attention of MSC and NZMA, Shona Carey intended to lobby the MoH⁹⁵ and repeated her request to the Department⁹⁶ that criteria enabling domiciliary midwifery practice be reviewed.⁹⁷

The matter had now become pressing. As shown previously in Table 3.5, home birth numbers were increasing and DM numbers had more than doubled from five in 1977 to eleven by the end of 1978. Consumer demand for home birth had become organised with the 1978 establishment of HBA and lobbying the Minister for increased DM

89 'Paper V, Alternative ways of providing maternity services', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

90 R Dickie, Director, Division of Hospitals, DoH to Dr Barker, Letter, 27 June 1978, DoH, 'Board of Health – Maternity Services Committee, 1982', ABQU 632 W4415, 29/21 (54019).

91 NZNA National Executive meeting, Minutes, 22-23 September 1977, NZNA, Unnamed file, 25/5/5.

92 NZNA National Executive meeting, Minutes, 14-15 February 1978, NZNA, Unnamed file, 25/5/5.

93 NZNA National Executive meeting, Minutes, 15-16 June 1978, NZNA, Unnamed file, 25/5/5.

94 Margaret McGowan to Shona Carey, Letter, 15 March 1978, NZNA, 'SIS Midwives Section, Canterbury/West Coast', 65/9/3.

95 Shona Carey to M.A. McGowan, Letter, 30 March 1978, NZNA, 'SIS Midwives Section, Canterbury/West Coast', 65/9/3.

96 NZNA National Executive meeting, Minutes, 14-15 February 1978, NZNA, Unnamed file, 25/5/5.

97 Shona Carey to M.A. McGowan, Letter, 30 March 1978, NZNA, 'SIS Midwives Section, Canterbury/West Coast', 65/9/3.

remuneration to ensure her viability had begun within the year.⁹⁸ Forewarned by this, NZNA had to develop policy on home birth and domiciliary midwifery. Though urgent in itself, it wanted to counter literature that HBA had sent to the Minister suggesting that domiciliary midwifery could be provided by midwives who were not nurses, that is, Direct Entry midwives.⁹⁹ It was also timely as NZNA was redrafting its community health paper¹⁰⁰ and the DGoH had indicated the Department's concern with home birth and MSC's beginning review.¹⁰¹ The Executive was forced into "reluctant acceptance of a fait accompli"¹⁰² that home birth was gaining strength that "no amount of opposition will stem".¹⁰³

The strategy for control

NZNA informed the MoH that New Zealand trained midwives did not have the skills necessary for domiciliary practice. It requested information about the level of home births over the last two years, requirements of the DM, including her education, what fees existed and the level of payment.¹⁰⁴ When NZNA met with the Minister in early July 1979, he indicated the requested information was being drafted,¹⁰⁵ the lengthy reply of which was discussed at the Executive's July meeting.¹⁰⁶

NZNA determined to "publicly express its extreme concern that domiciliary midwives are not necessarily subject to adequate supervision or control and do not have ongoing educational programmes".¹⁰⁷ This last concern would be part of the general wide-ranging debate on updating midwifery education programmes which existed from 1972.¹⁰⁸

98 NZNA National Executive meeting, Minutes, 17-18 May 1979, NZNA, Unnamed file, 25/5/5.

99 'New Zealand Home Birth Association – letter of Minister of Health. Excerpts from minutes of meeting held on July 19 and 20, 1979', *New Zealand Nursing Journal*, 72, 9, (September 1979), p. 12.

100 New Zealand Nurses Association, *Report on Community Health Nursing in New Zealand*, Wellington, 1980

101 NZNA National Executive meeting, Minutes, 13-14 September 1979, NZNA, Unnamed file, 25/5/5.

102 'Home confinement', in NZNA, *Policy*, p. iv.

103 *Ibid.*, p. ii.

104 NZNA National Executive meeting, Minutes, 17-18 May 1979, NZNA, Unnamed file, 25/5/5.

105 NZNA, 'Report of meeting with Minister of Health', 3 July 1979, NZNA, 'Minister of Health', 30/4/2.

106 NZNA National Executive meeting, Minutes, 19-20 July 1979, NZNA, Unnamed file, 25/5/5.

107 *Ibid.*

108 For more information on this, see Sally Pairman, 'From, 1' and 'From, 2'.

NZNA couched this public announcement as “examining the position”, intimating that it intended resolving an “unwieldy” structure which existed for midwives wanting to set up domiciliary practice. It also flagged up inadequacies in supervision of DMs and a lack of on-going training,¹⁰⁹ and issued a press release to the same effect in late August.¹¹⁰ It published notice of its intention along with its concerns about standards of practice and consumer safety in the September 1979 *New Zealand Nursing Journal*.¹¹¹

After considering approaching MSIS, the Executive determined it would not canvass midwifery opinion but would instead discuss the matter with NZMA.¹¹²

The New Zealand Nurses Association and the New Zealand Medical Association

NZNA met regularly with NZMA. From at least March 1977 members of the Executive (Joy Motley and Margaret Lythgoe, respectively present and past NZNA Presidents¹¹³ and Shona Carey) had put out feelers as to how NZMA viewed growing home birth numbers. NZMA’s interest was tweaked as the Wellington Clinical School required 1,000 ‘deliveries’ for medical students from Hutt Hospital, which diminished those available for GPs, and home birth could further diminish those numbers. NZMA wanted investigation into regional services and was reassured that NZNA was assessing home birth demand.¹¹⁴

NZNA kept the topic alive in 1978 by raising the issue of home birth advertising at its March meeting with NZMA.¹¹⁵ It would invigorate debate in October 1979 by discussing its concerns about increasing home birth numbers, and the education and practice of domiciliary midwives. NZMA, not aware of any disquiet amongst doctors about increasing home birth numbers, agreed to canvas its members for any problems in its ‘News and Views’ publication. NZMA floated the idea that NZNA could implement

109 Roy Burke, ‘Midwifery scheme to be reviewed’, *The Times*, 4 August 1979, p. 3, DoH, ‘Board of Health – Maternity Services Committee, 1982’, ABQU 632 W4415, 29/21 (54019).

110 ‘Executive Director’s Report’, 7 September 1979, NZNA, ‘Executive Director Report, 1979-1989’, 25/5/17.

111 ‘New Zealand Home Birth Association – letter’, p. 12.

112 NZNA National Executive meeting, Minutes, 19-20 July 1979, NZNA, Unnamed file, 25/5/5.

113 Margaret Gibson Smith and Yvonne T. Shadbolt, *Objects*, p. 166.

114 NZNA and New Zealand Medical Association meeting, Report, 15 March 1977, NZNA, Unnamed file, 25/5/5.

115 NZNA and New Zealand Medical Association meeting, Report, 1 March 1978, NZNA, Unnamed files, 25/5/1 and 15/7/9.

similar review criteria to that which Obstetric Standards Review Committees (OSRCs) were gradually implementing for doctors.¹¹⁶

Minutes excerpts of the Executive's July meeting were published in the *New Zealand Nursing Journal* as per usual. These recorded the decision not to consult with midwives who "might have a vested interest in maintaining the status quo".¹¹⁷ So what was the response from MSIS and domiciliary midwives on the Executive's engagement with NZMA while it avoided consultation with its own membership?

Midwifery affronted

Ignoring the expertise of domiciliary midwives and MSIS was interpreted as "insulting and judgemental".¹¹⁸ Gillian White, National President of the latter group, announced a lack of confidence in NZNA's leadership¹¹⁹ and there was a call by Margaret McGowan for midwives to set up their own professional organization,¹²⁰ which echoed a call in a Wellington newspaper the preceding year.¹²¹ Bronwen and Lynne both voiced the lack of support received from NZNA in 'Letters to the Editor',¹²² seeing that NZNA was an organization which benefited hospital obstetric nurses rather than DMs.¹²³

NZNA would later argue that it had always intended to canvass MSIS opinion. It responded to criticism by determining that in the future it would not publish excerpts of its Committee meetings, rather, only sub-headings and a reference to the amount of discussion which had occurred.¹²⁴ This resolution was later rescinded as publishing the minutes would become pointless.¹²⁵

116 NZNA and New Zealand Medical Association meeting, Report, 1 November 1979, NZNA Unnamed file, 15/7/9.

117 'Excerpts from minutes of meeting held on July 19 and 20, 1979', *New Zealand Nursing Journal*, 72, 9, (September 1979), p. 12.

118 Gillian White, 'Letters'.

119 Ibid.

120 M.A. McGowan, 'Letters'.

121 NZNA National Executive meeting, Minutes, 17-18 August 1978, NZNA, Unnamed file, 25/5/5.

122 Lyn McLean, 'Letters to the Editor', *New Zealand Nursing Journal*, 72, 11, (November 1979), p. 32 and Bronwen Pelvin, 'Letters'.

123 Lyn McLean, 'Letters'.

124 NZNA National Executive meeting, Minutes, 29-30 November 1979, NZNA, Unnamed file, 25/5/5.

125 NZNA National Executive meeting, Minutes, 7-8 February 1980, NZNA, Unnamed file, 25/5/5.

Despite dissention, NZNA would move swiftly into action and develop policy. Jackie Gunn, had “some sense of reporting back” from MSIS members who were also NZNA Executive members during her time as Branch Chairperson in 1980. However, she does not remember the 1980 ‘Policy Statement on Home Confinement’ being discussed at MSIS meetings which, she reflected, probably meant it was not. Jackie summarised the usual route that information came to MSIS from NZNA as being “ ‘fell off the back of a truck’ sort of ways. People had to actively seek it out. They had to actively acquire it.” This may have been cost-based or reflected the difficulty of copying in days prior to readily available photocopiers. As Jackie explained:

It was harder for the information to circulate so people had a lot of power if they actually had a document... You could actually withhold information quite easily just not saying you had a document... I don't think the NZNA actually deliberately said we will not give the midwives this. I think that people just failed to pass on documents... but I also know that we didn't get the information directly. We had to seek it out, had to find who had it, demand copies of things.¹²⁶

MSIS comments on midwifery which had been sought the previous year¹²⁷ were tabled at the February 1980 meeting. Joy Motley and members of MSIS National Committee were tasked with collating Branch comments, finishing the ‘Policy Statement on Home Confinement’,¹²⁸ and sending it to the MSC the following week.¹²⁹

The ‘Policy Statement on Home Confinement’

The policy prescribed the experience required prior to commencing domiciliary practice, the midwife’s practice assessment and her educational needs. It also prescribed the environments where that experience was to occur and the people who would evaluate her practice. Two years continuous clinical experience in all areas of midwifery in an obstetric

126 Personal communication: Jackie Gunn to Maggie Banks, 3 November 2004.

127 NZNA National Executive meeting, Minutes, 16 February 1979, NZNA, Unnamed file, 25/5/5.

128 Midwives and Obstetric Nurses Section, NZNA, ‘Policy Statement on Home Confinement’, February 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

129 NZNA National Executive meeting, Minutes, 7-8 February 1980, NZNA, Unnamed file, 25/5/5.

hospital was pre-requisite.¹³⁰ This would later be specified as six months in an antenatal clinic; one year in delivery suite and six months in a postnatal area, and included experience in neonatal intensive care or a special care nursery.¹³¹ Further, ongoing reinforcement of the ‘special’ skills needed for labour and birth was to occur in obstetric units as some of the annual minimum of fifteen normal births was to occur there.¹³² And yet those experiences, as I discussed in Chapter 3, had not prepared midwives for domiciliary practice as each had to learn a new set of skills to support women at home. As DMs acknowledged when they developed their own Standards of Practice in 1988,¹³³ it was community-based practice which offered the best learning.

The Policy demanded “excellent”¹³⁴ standards of practice for DMs while those of their hospital counterparts needed to be only “minimum requirements”.¹³⁵ Though the hospital midwife’s practice was not assessed annually by an obstetrician, the policy determined that DM practice would be evaluated yearly by a midwife and obstetrician from the local obstetric hospital.¹³⁶ I will further address the attitudes of hospital nurses and midwives towards DMs in the next chapter but I have already shown that obstetricians were adamantly opposed to domiciliary midwifery. With only one obstetrician in Auckland sympathetic to home birth, review by obstetricians would be “nothing less than an attempt at a de facto shutdown of the home birth option”.¹³⁷

DMs were to access lectures and clinical teaching in local obstetric unit in-service programmes¹³⁸ – again run by the very people who did not support domiciliary midwifery.

130 Midwives and Obstetric Nurses Section, NZNA, ‘Policy Statement on Home Confinement’, February 1980, p. 2, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

131 NZNA, *Policy*, p. 18.

132 Midwives and Obstetric Nurses Section, NZNA, ‘Policy Statement on Home Confinement’, February 1980, p. 3, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

133 ‘Domiciliary Midwives Standards’, Paper, 1988, DMS, ‘Domiciliary Midwives standards Review, DMS/00 10’.

134 ‘Home Confinement’, in NZNA, *Policy*, p. iii.

135 NZNA, *Policy*, p. 18.

136 *Ibid.*

137 Auckland Branch of the New Zealand Home Birth Association to Maternity Services Committee, Submission, 23 September 1979, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

138 ‘Home Confinement’, in NZNA, *Policy*, p. iii.

While the DoH reported some obstetric units provided programmes,¹³⁹ these proved impossible to access. For example, Pat Fuller wanted to undertake a refresher course in Christchurch Women's Hospital in 1981 prior to commencing domiciliary practice. She was informed by the Principal Nurse that refreshers were not run as a routine except for pre-employment. An exception would not be made because offering this to a DM "could be seen as contrary to the policy of the North Canterbury Hospital Board which promotes hospital deliveries".¹⁴⁰ Invited to take up any further discussion with the Chief Nurse,¹⁴¹ Pat pursued the request. It would later become apparent that despite having received assurance that the matter would be forwarded to the Hospital Board for consideration,¹⁴² a decision to withhold Pat's request from the Board had been made by four Canterbury Principal Nurses who "did not wish to encourage home births".¹⁴³

This policy was submitted to MSC in February 1980 in the name of the Midwives and Obstetric Nurses Special Interest Section of NZNA (Incorporated) prior to ratification by the membership. Once in the hands of MSC it provided the blueprint which Professor R.J. Seddon and Maureen Laws, two MSC members, used to draft pre-requisite experience for DMs and ongoing annual review.¹⁴⁴

The policy was sent to at least MSIS Auckland Branch, without covering letter or explanation, and was received without comment.¹⁴⁵ It otherwise remained unavailable to the membership until January 1981 when it was reproduced minus its 'Summary' and 'Summaries of views' on both Early Discharge and Branch Submissions.¹⁴⁶ It was then

139 'Paper IV, Legislation, comments and recommendations', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

140 H.R. Henshaw, Principal Nurse, Christchurch Women's Hospital to P Fuller, Letter, 15 March 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

141 Ibid.

142 Lynne McLean to Shona Carey, Letter, 30 March 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

143 Handwritten note on back of H.R. Henshaw, Principal Nurse, Christchurch Women's Hospital to P Fuller, Letter, 15 March 1982, DMS, '1982 Correspondence, DMS/00 4/2'.

144 Professor R.J. Seddon to M.G. Robinson, Secretary, MSC, Letter, 29 September 1980, DoH, 'Board of Health – Maternity Services Committee, 1980-1981', ABQU 632 W4415, 29/21 (53013).

145 MSIS Auckland Branch Committee meeting, Minutes, 28 February 1980, MSIS, 'Minutes of Committee meetings', Box 1.

146 Midwives and Obstetric Nurses Section, NZNA, 'Policy Statement on Home Confinement', February 1980, pp. 5-7, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139).

appended to the 'Proposed Policy Statement on Maternal and Infant Nursing'¹⁴⁷ for ratification at the 1981 NZNA Conference, this latter document having been written by the Ad Hoc Maternal and Infant Health Committee established in February 1980.

Once again, these Committee members were all either Charge Nurses, Supervisors, Nurse Advisors or the Assistant DoN and none practised domiciliary midwifery.¹⁴⁸ While Lynne McLean was noted as a resource person to the Ad Hoc Committee,¹⁴⁹ her expertise was not called upon to any depth though Margaret McGowan as National MSIS President may have taken up some of the DMs' concerns. The ToR were drawn up by the Executive¹⁵⁰ and the Committee met approximately monthly¹⁵¹ tabling their report in September¹⁵². The Policy and its accompanying document, 'Current Issues in Midwifery Practice', was discussed at the next Executive meeting where it was decided to incorporate the recommendations of the issues paper into the document which needed to be available for discussion at the November Executive meeting. Maureen Laws, also a member of the Ad Hoc Committee, wanted to have the policy available for MSC's next meeting as it had discovered discrepancies between the Obstetric Regulations 1975 and the Nurses Act 1977, and it was discussing existing policies related to Early Discharge. NZNA wanted to have input into MSC discussions but it stated the policy would not be available by February as it needed to be ratified at Conference in April 1981.¹⁵³

At the November 1980 meeting the Ad Hoc Committee labelled this new policy a 'draft'.¹⁵⁴ It was submitted for Executive approval at its early December meeting.

147 NZNA, 'Proposed Policy Statement on Maternal and Infant Nursing', January 1981, Joan Donley Personal papers, 'NZNA 1981 Policy Statement'.

148 Joy Motley, Maureen Laws, Shona Taylor, Sister Mary Patricia Clark and Margaret McGowan were members of the Ad Hoc Committee.

149 NZNA National Executive meeting, Minutes, 7-8 February 1980, NZNA, Unnamed file, 25/5/5.

150 Ibid.

151 Shona Carey, 'Executive Director's Report' 29 April 1980 and 7 July 1980, NZNA, 'Executive Director's Report', 25/5/17.

152 NZNA National Executive meeting, Minutes, 4-5 September 1980, NZNA, Unnamed file, 25/5/5.

153 NZNA National Executive meeting, Minutes, 21-22 October 1980, NZNA, Unnamed file, 25/5/5.

154 New Zealand Nurses Association, 'Report of a meeting of the Maternal and Infant Health Ad Hoc Committee', 10 November, 1980, p. 2, NZNA, 'Maternal and Infant Health Ad Hoc Committee, 1980-1987', 25/5/31

Following minor amendments¹⁵⁵ four copies of the 'Proposed Policy Statement on Maternal and Infant Nursing'¹⁵⁶ were sent to each Branch in late January for comments.¹⁵⁷

Auckland's NZNA Advisory Committee and sixteen midwives discussed the document on 11 February 1981¹⁵⁸ with Joan Donley attending as a DM representative. It agreed that domiciliary midwifery needed reviewing and restructuring so DMs could maintain their skills and receive adequate remuneration. However, from the start, the meeting determined the document title was misleading. While supportive of the need for definition and regulation of independent practice, the appended 'Policy Statement on Home Confinement' required substantially more discussion, restructuring and clarification before it became policy. It was viewed as a 'discussion' or 'current position' paper and the meeting concentrated on the recommendations,¹⁵⁹ accepting only ten of the twenty-four outright and a further five with qualification. Notably, it also wanted to ensure all midwives had continual updating of skills, not just DMs.¹⁶⁰

At Conference it was the last item on the AGM agenda and a motion to defer it till the following day was lost.¹⁶¹ Many speakers felt the policy should not be accepted as it was and the Auckland region's motion to have further regional debate and defer ratification until the following year was supported by many Branches¹⁶² and by MSIS National Committee.¹⁶³ But the "urgent need for such a policy statement from the profession" was stressed by the DoN and the motion to accept the Policy was carried¹⁶⁴ by a majority of Branches.¹⁶⁵ While the Ad Hoc Committee agreed to examine comments and

155 NZNA National Executive meeting, Minutes, 4-5 December 1980, NZNA, Unnamed file, 25/5/5.

156 NZNA, 'Proposed Policy Statement on Maternal and Infant Nursing', January 1981, Joan Donley, Personal papers, 'NZNA 1981 Policy Statement'.

157 'Branch Circular 1/1981', 20 January 1981, NZNA, Unnamed file, 20/3/2

158 MSIS Auckland Branch meeting, Minutes, 7 March 1981, p. 3, Joan Donley Personal papers, 'Midwives Section: Minutes 1980 - 1989, *Missives* 1984'.

159 Gloria M Shute, NZNA Auckland Branch Secretary to Miss Carey, Letter, 18 March 1981, NZNA, 'Maternal and Infant Health Ad Hoc Committee, 1980-1987', 25/5/31.

160 Gloria Shute, 'Summary of discussion on Proposed policy paper of maternal and infant health', 11 February 1981, Report, Joan Donley Personal papers, 'NZNA 1981 Policy Statement'.

161 NZNA, Annual General Meeting, Minutes, 1-3 April 1981, NZNA, Unnamed file, 10/81/5.

162 Ibid., and MSIS Auckland Branch meeting, Minutes, 13 May 1981, Joan Donley Personal papers, 'Midwives Section: Minutes 1980-1989, *Missives* 1984'.

163 MSIS Auckland Branch meeting, Minutes, 13 May 1981, Joan Donley Personal papers, 'Midwives Section: Minutes 1980-1989, *Missives* 1984'.

164 NZNA, Annual General Meeting, Minutes, 1-3 April 1981, NZNA, Unnamed file, 10/81/5.

165 MSIS Auckland Branch meeting, Minutes, 13 May 1981, Joan Donley Personal papers, 'Midwives Section: Minutes 1980-1989, *Missives* 1984'.

suggestions which could be incorporated, the document remained unaltered¹⁶⁶ with only “one or two factual amendments” prior to its publication.¹⁶⁷

The following day a remit was passed urging the Minister to formulate policy that encompassed recommendations of the ‘Policy Statement on Home Confinement’ – namely, that all DMs should receive payment commensurate with their professional status, and that all intending DMs have a minimum of two years continuous, approved clinical post-registration experience immediately prior to undertaking domiciliary practice; approved on-going educational and professional refresher courses; and, annual evaluation by an approved midwife and obstetrician. This remit was amended by deleting the words ‘and obstetrician’ from the practitioners who would evaluate the DM’s practice.¹⁶⁸ As Joan Donley noted, the passing of this remit subsequent to adoption of the document superseded the policy.¹⁶⁹ She would later question whether NZNA informed MSC of the opposition to obstetricians evaluating DMs’ practice by the Conference majority, stressing:

*This is a crucial point, because the entire planned organisational structure to eliminate domiciliary midwives hinges upon their being transferred to hospital boards with their contracts assessed by OSRC, to which token midwives have already been appointed.*¹⁷⁰

But the published *Policy Statement on Maternal and Infant Nursing* retained the obstetrician as an evaluator of the DM’s practice.¹⁷¹ Even if this amendment had occurred and MSC had been notified of it, this would have come at least fourteen months after MSIS proposed obstetrician evaluation in its submission to MSC. The recommendation stood uncorrected, and MSC would recommend that DMs be evaluated by OSRCs.¹⁷²

166 NZNA, Annual General Meeting, Minutes, 1-3 April 1981, NZNA, Unnamed file, 10/81/5.

167 NZNA, ‘Branch Circular 6/1981’, 14 April 1981, NZNA, Unnamed file, 30/3/2.

168 NZNA, Annual General Meeting, Minutes, 1-3 April 1981, NZNA, Unnamed file, 10/81/5.

169 ‘Re: Mother and Baby at home – the early days’, Paper prepared for Domiciliary Midwives for MSIS meeting, 25 June 1983, Joan Donley Personal papers, ‘Papers re Domiciliary Midwives Society of NZ’, MS95/20 15.

170 Ibid.

171 ‘Home confinement’, in NZNA, *Policy*, p. iii.

172 MSC, *Mother*, pp. 6 and 24-25.

The obstetric nursing cape

From at least the 1970s midwifery was defined by NZNA as “one aspect of nursing”¹⁷³ and “but one facet of maternal and infant nursing”¹⁷⁴. Determined a nursing sub-speciality, a deep knowledge and understanding of nursing were prerequisites to ‘specialising’ as a midwife.¹⁷⁵ Once trained, the midwife was commonly referred to by NZNA as a nurse providing obstetric nursing services.¹⁷⁶ Reference to her as a ‘midwife’ was noticeable only in relation to the definition or scope of practice of a midwife, or domiciliary midwifery.¹⁷⁷ While the title ‘midwife’ was excluded from the newly established NCNZ in 1971, NZNA with its various names had never embraced the title, succinctly reflecting midwifery’s assimilated position within nursing during the study period. The midwife had been renamed a ‘nurse’ within legislation, policy statements and job title. The issue of midwifery identity as separate from nursing would not receive significant attention from midwives in New Zealand until 1980, building in 1983 to “a real sense of desperation”¹⁷⁸ to preserve the midwifery role.

The midwife was not seen as providing the totality of the maternity service, albeit under supervision of a medical practitioner. She was a member of an “integrated health service”¹⁷⁹ - a service based on women giving birth in hospital. The midwife’s role was complementary to other health professionals, for example, GPs, obstetricians, paediatricians, and nurses within neonatal and child health specialties such as the Plunket¹⁸⁰ service.

With the midwife in the subservient role of ‘the nurse’, NZNA focused on preventing duplication of skills. In valuing the midwife’s role most as that of a health educator and counsellor co-coordinating care,¹⁸¹ NZNA accepted that it was the midwife rather than the medical practitioner who needed to reduce his or her scope of practice. Yet

173 NZNA, *Policy*, p. 12.

174 *Ibid.*, p. 14.

175 *Ibid.*, p. 12.

176 *Ibid.*, pp. 20-25 and 27-30.

177 *Ibid.*, pp. 19 and ‘Home confinement’, in NZNA, *Policy*, pp. ii-iii.

178 Personal communication: Jackie Gunn to Maggie Banks, 3 November 2004.

179 NZNA, *Policy*, p. 19.

180 The Plunket Society provides Well Child services such as health and development checks for babies and family support.

181 NZNA, *Policy*, p. 19.

DMs working throughout the continuum of pregnancy, labour and birth and the postnatal period fulfilled the full scope of the midwife's practice.

NZNA aimed for nurses to be recognized as “a powerful professional group” and to be innovative and advocating changes in maternity services.¹⁸² But the small group of midwives who had seized their full measure of power, practising innovatively and as effective change agents - domiciliary midwives - were obstructed, ostracized and their expertise ignored,¹⁸³ being referred to by NZNA as the “relatively small group of vociferous advocates of home confinement”.¹⁸⁴

NZNA's strategy to restrict the growth of home birth and increase surveillance of domiciliary midwifery relied on maintaining a doctor-led, hospital-based service. It recommended that risk status of women was assessed by obstetricians and DMs come under control of Chief Nursing Officers of local Hospital Boards who would delegate supervision responsibility to Principal Nurses.¹⁸⁵

However, DMS midwives identified strongly with midwifery, not obstetric nursing. Lynne McLean flagged up oppression of the midwifery identity in both hospitals and NZNA. In responding to NZNA's intention to stipulate the education of DMs without consulting midwives she questioned, “is it really the DMs who need the educating, or is it the hospital obstetric nurses [midwives] who have been blinded by their male ‘superiors’ as to what birth is really all about?”.¹⁸⁶

Anne Sharplin had no desire to be a nurse and searched out midwifery schools providing Direct Entry midwifery programmes. Despite being penniless, she travelled to Great Britain to undertake training which was unavailable in New Zealand. She believed this path was differently focused than midwifery training after nursing registration. She illustrated this with the following story of working with a student midwife who was a Registered Nurse when she herself was in Direct Entry midwifery training in Great Britain:

182 *Ibid.*, p. 20.

183 E.M.E. Odinet, ‘Domiciliary Midwives’, *New Zealand Nursing Journal*, 73, 1 (January 1980), p. 15 and Bronwen Pelvin, ‘Letters to the Editor’, *New Zealand Nursing Journal*, 72, 12, (December, 1979), p. 21 and Lyn McLean, ‘Letters to the Editor’, *New Zealand Nursing Journal*, 72, 11 (November 1979), p. 31

184 ‘Home confinement’, in NZNA, *Policy*, p. i.

185 Midwives and Obstetric Nurses Section, NZNA, ‘Policy Statement on Home Confinement’, February 1980, p. 7, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

186 Lyn McLean, ‘Letters’, p. 32.

One of the first women I was helping in labour - and nurses were doing the midwifery as well but in a shorter time. So there was this nurse student midwife...and me and...the woman was needing some help and I remember getting a flannel and wiping her head and I remember watching the nurse student going and taking her pulse and blood pressure and I was thinking, why is she doing that? That's not helping, and you know, it appeared that what I was doing did help.¹⁸⁷

As I have previously discussed, Bronwen's story of PPHN supervision exemplified a continual tussle to protect her right to conduct midwifery practice on her own responsibility rather than within a nursing hierarchical framework. Jennie Nichol, a senior advisory officer for the DoH, would identify in her 1987 study on domiciliary midwifery that ensuring autonomy of practice and protecting "the right to use their professional judgement"¹⁸⁸ was highly valued by DMs in general. This judgement centred on the role of supporting women's abilities and right to birth well. To conclude, Bronwen would present this position with resounding clarity and simplicity in her address to the 1988 HBA Conference when she stated:

Midwives...have a responsibility to stand up in any society, in any community, for the normal functioning of having babies, not obstetrics...and we have a responsibility to women in our society to believe that they can do it and we have to say that again and again and again...¹⁸⁹

Concluding remarks

In this chapter I have detailed NZNA's and MSIS' inspection of domiciliary midwifery as DM numbers began to rise. Repetitiously, as with medical practitioners and Hospital Boards, there was a lack of evidence that domiciliary midwifery resulted in poorer outcomes. But the nursing and midwifery professions did not support home birth and strategically aligned themselves with medicine to achieve 100% hospitalisation during childbirth. MSIS' "absence of positive sanctions against those who condone and support

187 Catch-up: Maggie Banks with Anne Sharplin, 24 October 2004, p. 4.

188 Jennie Nicol, *Choice, Part I*, p. 14.

189 Bronwen Pelvin, 'Panel Discussion', *Report on National Home Birth Conference*, Wellington, 1988, Hamilton.

the trend”¹⁹⁰ towards home birth was remedied by developing strict criteria as to the experience needed prior to commencing domiciliary practice, and an annual gauntlet of review by an obstetrician and midwife from the obstetric hospital. Those intended to undertake this practice review, issue (or withhold) a certificate of professional competence and assess her educational needs, were the very people who spearheaded much of the hostility towards her - the senior midwife and obstetrician of the hospital. It was a foregone conclusion that MSC would recommend that the same committee set up to review the doctor’s maternity practice (OSRC) would also review the DM’s practice.¹⁹¹

MSIS’ home birth policy was instrumental in setting the tenor of results for the Maternity Services Committee’s review of domiciliary midwifery from 1979-1982 which culminated in the 1982 *Mother and Baby at Home: The Early Days*.¹⁹² This report, so undermining and threatening for both DMs and the home birth movement, created an uncertain future for DMs. It was ‘the last straw’ for Lynne McLean and she ceased practice early in the year following its publication. Her colleague in the Hutt Valley had already ceased domiciliary practice when the report came out and Lynne felt increasing professional isolation.¹⁹³

While NZNA stated that “the health services, nursing included, exist for the benefit of the consumer”¹⁹⁴ this was only if nursing agreed with the choice the consumer made. NZNA and MSIS saw it was the role of nursing (and medicine) to judge the safety of the requests made by the woman and her family,¹⁹⁴ that is, protect the baby from his or her mother and indeed the woman from herself.¹⁹⁵ Using the words “fanatical enough”¹⁹⁶ (my emphasis) to describe a woman who may plan to birth at home when “real threats” to her or her baby’s well being existed, indicates that any woman birthing at home was indeed fanatical. The only wise choice a ‘normal’ woman would make would be to birth in hospital.

190 ‘Home confinement’, in NZNA, *Policy*, p. ii.

191 NZNA, *Policy*, p. 22.

192 New Zealand Board of Health, *Mother*.

193 *The Dominion*, 25 February 1983.

194 NZNA, *Policy*, p. 23.

195 ‘Home confinement’, in NZNA, *Policy*, p. ii.

196 *Ibid.*, p. i.

MSIS and NZNA promoted Early Discharge schemes with community midwives, nappy services and home help as preferable.¹⁹⁷ However, to satisfy an increasing consumer demand for humanitarian maternity services, there would need to be attitudinal changes from hospital nurses, midwives and medical practitioners, both issues of which I discuss in the following chapter.

¹⁹⁷ 'Policy statement on maternal and infant nursing', *New Zealand Nursing Journal*, 74, 9 (September 1981), p. 16.

CHAPTER 7: AMAZING DISGRACE

In 1960, MSC had been established to advise the MoH on all matters pertaining to pregnant women and their babies. Within four years MSC found it was unable to provide that advice as there was insufficient data on numbers of specialists, GPs, the types of anaesthetics used and the services provided in smaller hospitals, as well as the availability of services. From November 1968 to November 1972 two members of MSC visited 160 of the country's maternity or obstetric hospitals¹ following which MSC felt confident it had a "valid picture" of obstetric services during 1969-1974.²

The Committee surmised that New Zealand's maternity service was "far from satisfactory" with marked regional variations in the standard of care³ and many hospital boards "failed to provide satisfactory human relations in obstetrics".⁴ This echoed many of the concerns that the Christchurch Psychological Society and Parents Centre New Zealand had expressed from the late 1940s and 1950s respectively.⁵ In this penultimate chapter I discuss how consumers and women's health activists continued to raise these concerns from the early 1970s. I also examine hospital maternity services from 1969-1982 and medical, nursing and midwifery attitudes which gave rise to the growing demand for a 'humanised' hospital maternity service and a viable home birth service. Many DMs in the study were trained amid these 'unsatisfactory services'. They also transferred labouring women to these environments for services in the course of planned home births if additional care was needed. I explore these experiences, as well how 'being' a DM impacted on her if the DM required hospital services during her own birthing experiences.

I continue this chapter now with the 1976 findings of the MSC's review before examining those beyond the review until 1982 – the latter time chosen because this coincided with the period which finalised the MSC review of domiciliary midwifery.

1 The only hospital not visited was Chatham Islands Hospital.

2 New Zealand Maternity Services Committee, *Maternity*, pp. 3-8.

3 *Ibid.*, p.84.

4 *Ibid.*, p.75.

5 M. Bevan-Brown and Enid F. Cook, 'The psychology of childbirth', in M. Bevan-Brown, *The Sources of Love and Fear*, Christchurch Psychological Society, Christchurch, 1947, pp. 102-126 and Mary Dobbie, *The Trouble with Women: The Story of Parents Centre New Zealand*, Cape Catley, Queen Charlotte Sound, 1990.

Maternity services in New Zealand, 1969-1982

The MSC review demonstrated non-standard definitions of perinatal death and as to what a 'maternity bed' meant and how bed occupancy was assessed throughout the country. There were wide-ranging variations in the quality and quantity of record keeping in labour by doctors, and the availability of information on women's antenatal care and health histories, equipment, staffing levels and maternity care practices.⁶

Few GPs attended ongoing education courses, a situation mirrored amongst the midwifery workforce.⁷ Many differing and outdated practices in caring for women and babies were evident, ranging from individually variable use and type of drugs used in labour, whether that be the doctor's choices between ergometrine or syntocinon, the timing of its administration to the woman (at crowning of the baby, with birth of the anterior shoulder or after the birth) and the administration or withholding of vitamin K to the newborn.⁸

A lack of equipment for newborn resuscitation was endemic - equipment determined by the sub-committee as necessary in normal newborn care as it recommended that every baby should have endo-tracheal suctioning and ventilation of the lungs in the first few minutes after birth.⁹ Intravenous fluids were used frequently in labour, as were 'active techniques' introduced from the early 1960s, such as, rupturing the foetal membranes and the use of obstetric forceps, reputedly to reduce risk to the baby and "to shorten the second stage for the present and future comfort of the mother".¹⁰ As a result of these techniques, more babies were placed in incubators in special care nurseries and, therefore, separated from mothers than prior to the strategy.¹¹

Rooming the newborn baby in with his mother, even in the absence of interventions during birth, was seldom practised as there was resistance to this by staff of most hospitals. Few nurses and midwives understood the principles of demand feeding and a strict four hourly feeding regime continued to exist in some hospitals, both large and small. Instead

6 New Zealand Maternity Services Committee, *Maternity*, p. 7.

7 *Ibid.*, pp. 84-85.

8 *Ibid.*, pp. 10-11.

9 *Ibid.*, pp. 60-63.

10 *Ibid.*, p. 29.

11 *Ibid.*, p. 76.

the baby was delivered from the nursery to his mother at appointed times during the day and returned to the nursery following feeding. He remained in the nursery at night, sometimes unwatched as staff members were not always in attendance. In one hospital, staff were not present unless there was someone in labour.¹² The poor design of some of the modern hospitals compounded the problem of isolation of the baby, his cries unheard, as the nursery was at the other end of the hospital to where his mother resided.¹³ In at least one hospital mothers were forbidden to enter the nursery¹⁴ and, in another, the nursery was completely soundproofed to prevent the baby's cries from being heard in the rest of the hospital.¹⁵ The return of the baby to his mother in the morning was often on a 'multiple trolley', along with many other babies. Breastfeeding advice was conflicting and mothers could be discharged home without ever having cared for their infants overnight and, therefore, were unable to determine what infant demands would be at home.¹⁶

Inflexible visiting hours postnatally meant access to women and newborn babies was made difficult for partners, their children and families. Husbands were refused entry to the labour room in some hospitals¹⁷ and in others, for example, Waitakere Hospital, husbands were allowed entry to the labour room only after the Matron had interviewed them to satisfy herself that "they were up to scratch to go into the birthing room with the woman".¹⁸

These 'far from satisfactory' hospital maternity services resulted in marked regional variation in the standard of care while poor attitudes of staff meant entrenched and out of date practices often took considerable time to show change. Even when serious concerns were raised by the Committee, as exemplified in the case of one Wellington hospital where conditions were found to be "totally unacceptable", change had not occurred by a subsequent visit three years later.¹⁹

12 *Ibid.*, pp. 79-80.

13 *Ibid.*, p. 13.

14 *Ibid.*, pp. 55 and 79.

15 *Ibid.*, p. 55.

16 *Ibid.*, pp. 79-80.

17 *Ibid.*, pp. 77 and 79.

18 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, p. 3.

19 New Zealand Maternity Services Committee, *Maternity*, p. 7.

Escalating and variable intervention rates throughout the country meant maternal morbidity rates increased and were area dependant. For example, while the 1971 national obstetric forceps delivery rate was 11.5%, Otago and South Otago Hospital Boards' rates were, respectively, 18.8% and 23.8% in the same year.²⁰ In 1977, one year following publication of the MSC report, returned survey data from 74% (n=127) of women who birthed in Dunedin's Queen Mary Hospital in a one month period in 1977 showed a 30% forceps delivery rate – half of which were low forceps commonly used to shorten the time the mother spent in pushing out her baby. Active management of labour care meant 38% of women had their labours induced or augmented, of which one in four complained they did not have adequate explanation of the procedure. Fifteen percent of the women given pain relief had it without their consent.²¹

Such was the morbidity for babies in the Dunedin survey that 34% experienced physical or health problems, of which at least 18% were admitted to the Special Care Baby Unit. Of breastfeeding babies, only 38% had been put to the breast in the first hour after birth and 47% of mothers experienced lactation problems. The common practice of supplementary infant feeding meant at least three quarters of all babies were fed artificial milk formulae. Seventy-five percent of women had to wait to return home before they could demand breastfeed their babies, 27% being unable to do so in hospital because of hospital routines. Conflicting advice on breastfeeding from multiple caregivers was frequent, resulting in 30% of women unhappy with information they received.²²

This same pattern of interventionist birth practices was evident in Auckland. In 1978 the West Auckland Community Health Group surveyed 205 West Auckland women, which represented 43% of West Auckland's women birthing. It identified that 28.3% of the surveyed women reported some complication during birth²³ with this rate increasing to 49% for women having their first babies.²⁴ Overall, only 55.9 % of the responding women who birthed at Auckland's St Helens Hospital achieved a 'normal' birth.²⁵ The need for

20 *Ibid.*, p. 29-30.

21 L.J. Hood, JE Clarkson, P.T. Shannon and G.H. Neill, 'Dunedin Maternity Survey', October 1978, DoH, 'Board of Health – Maternity Services Committee, 1982', ABQU 632 W4415, 29/21 (54019).

22 *Ibid.*

23 West Auckland Community Health Group, *When I had my Baby - Women's Perspectives on Maternity Services for West Auckland*, West Auckland Community Health Group, Auckland, 1980, p. 27.

24 *Ibid.*, p. 49.

25 *Ibid.*, p. 50.

more information was evident, including that concerning prevalent medical procedures and the choices of where and how to give birth. Women were clear in expressing a need for “less institutionalism and more control placed in their hands”.²⁶

That ‘institutionalism’ with its routine care was illustrated by Bronwen Pelvin in her description of the in-labour admission procedure during her midwifery training at Christchurch Women’s Hospital in 1976, as follows:

I was told to go in and give a woman Pethidine in the prep room, because everybody got Pethidine - whether they needed it or not was entirely irrelevant. I walked in and the woman was completely distressed, and of course, you never questioned what you were told, and this little Australian midwife sort of virtually passed in the corridor ‘Nurse Pelvin give the woman in Prep Room One a hundred milligrams of Pethidine , here it is, go and give it, I’m going to the toilet’ and so I walked in and here’s this woman, obviously in an advanced stage of labour, and I thought – shit, I can’t question [the midwife] - so I gave [the woman] the Pethidine and oh, I had to give her an enema - shave and enema - so I gave her that and there was an enrolled nurse or an obstetric nurse there as well, checking her clothes - that whole system thing that you came in, you had your clothes checked off, you had your shave and your enema, whatever drugs they were giving to you and then you were in the labour ward – then you’d been admitted.²⁷

While the consumer movement asked for change, three years later another study of 195 women to determine whether antenatal education improved maternal morbidity in Auckland’s St Helens Hospital, showed intervention rates were continuing their trajectory. Women giving birth for the first time experienced operative or surgical deliveries at the rate of 63.07%. Of the seventy-two first time mothers (39.9%) who birthed ‘normally’, it is unknown how many of them experienced narcotic and anaesthetic administration. The 308 administrations of narcotics, inhalation, local, regional and/or general anaesthetics as

²⁶ *Ibid.*, pp. 52-53.

²⁷ Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 8.

shown in Table 7.1 occurred at the rate of 1.57 per woman. Of the group studied, 32.3 % (n=63) expressed disappointment with their births.²⁸

Table 7.1 Rates of intervention for 195 women having first babies in St Helens Hospital, Auckland, December 1981- January 1982

Intervention type	No.	%
LSCS	44	22.56
Keilland's forceps	10	5.12
Other forceps	18	9.23
Ventouse extraction	51	26.15
General anaesthesia	21	10.76
Epidural anaesthesia	90	46.15
Pethidine	105	53.84
Nitrous oxide	46	23.58
Local anaesthesia	46	23.58

Data source: Tania R. Gunn, Ann Fisher, Peter Lloyd and Stephanie O'Donnell, 'Antenatal education: does it improve the quality of labour and delivery?' *New Zealand Medical Journal*, (26 January 1983), pp. 51-53.

Rather than being isolated, intervention was increasingly applied to the majority of births. As one commentator opined, birth should have been 'normal' in 90% of cases.²⁹ The cultural warping of childbirth that Doris Haire reported in her classic publication of the same name³⁰ applied equally to New Zealand as the inappropriate and extensive use of technology³¹ during childbirth turned a potentially physiological life event into a series of medical procedures. Despite this (or perhaps because of it), by 1983 the Caesarean section rate was increasing at a far greater rate than the perinatal mortality rate was reducing.³²

28 Tania R. Gunn, Ann Fisher, Peter Lloyd and Stephanie O'Donnell, 'Antenatal education: does it improve the quality of labour and delivery?', *New Zealand Medical Journal*, (26 January 1983), pp. 51-53.

29 J. Henderson to Dr Barker, Letter, 5 May 1983, DoH, 'Board of Health – Maternity Services Committee, 1983-1984', ABQU 632 W4415, 29/21 (57881).

30 Doris Haire, *Cultural Warping*.

31 For information on appropriate technology during childbirth, see World Health Organisation, 'Appropriate'.

32 A.J. Henderson, 'Letter to the editor', *New Zealand Medical Journal*, 9 March 1983, p. 185.

The growing consumer voice

Having initially ignored the issue of childbirth in favour of “areas that count”,³³ by 1973 the women’s movement in Great Britain began to focus on maternity as an area of control for women³⁴ while that of the United States of America raised the question ‘are you safer with a midwife?’.³⁵ This question was picked up by Wellington health activist³⁶ and midwife Maureen Marshall the following year as the women’s movement in New Zealand began to address maternity issues. While valuing the role of midwives in childbirth, Maureen challenged midwives to “change their attitudes...from a hospital/sickness orientation and...play a large part in humanising maternity services”³⁷ in what were “depersonalising places of sickness”.³⁸ At the 1977 United Women’s Convention, delegates were urged to consider themselves ‘consumers’ rather than clients or patients, and to learn about the power of being such and use the following rights that the description implied:

*The right to demand value for money, a concern with costs, wastage and the quality of the service, the right to complain and question, the right to know about the services we are utilising, just as we expect these rights when we engage a television repairman or plumber.*³⁹

The home birth option would be at the forefront of the Conference’s attention. It focused on the woman’s right to choose the place of birth, how she would birth and who should be present. Recommendations were made for a family-centred maternity service⁴⁰ and a Pregnant Patient’s Bill of Rights.⁴¹

33 Suzanne Arms, ‘Why women must be in control of childbirth and feminine health services’, in Lee Stewart and David Stewart, *21st Century Obstetrics Now! Volume 1*, NAPSAC, Marble Hill, MO, 2nd edn., 1978, pp. 75-76. The ‘areas that count’ were those that earned money and produced work as the movement aimed first and foremost for equality.

34 Mary Stewart, *Pregnancy*, p. 3.

35 Shirley Streshinsky, ‘Are you safer with a midwife?’ *Ms*, 11, 4 (1973) pp. 24-26.

36 Christine Dann, *Up From Under: Women and Liberation in New Zealand 1970-1985*, Allen & Unwin, Wellington, 1985, p. 83.

37 Maureen Marshall, ‘Women as Healers’ in *Women ’74: Proceedings of the University Extension Seminar*, 14-15 September 1974, Hamilton, University of Waikato, 1975, p. 96.

38 *Ibid.*, p. 94.

39 Toni Church, ‘Towards the future’, in *Changes*, p. 32.

40 *Ibid.*, p. 28.

41 *Ibid.*

By 1978, the demand for home birth existed in Auckland, Whakatane, Wellington, Nelson, Christchurch and Dunedin, though it was only available in Auckland and Christchurch. There was already an action group in Christchurch by 1977 and what would become the HBA was planned to be formed in Auckland.⁴² This was to be instrumental in both informing women that home birth was a safe and legal alternative to hospital birth,⁴³ and ensuring domiciliary midwifery was viable, as I have explained previously.

The health activist lobby did not go unnoticed by MSC.

Humanising the hospitals

Aware of both the growing consumer demand for a humane approach to childbirth and the deep dissatisfaction many women felt with their hospital childbirth experiences, MSC's 1976 report acknowledged the need for 'humanising' the obstetric service,⁴⁴ a need also identified in other developed countries.⁴⁵

However, the number of overcrowded, congested public outpatient clinics which lacked privacy and helpful clerical staff that the report identified was anticipated to rise.⁴⁶ MSC would later identify a need for continuity of medical care and coordination of ante-natal services to prevent fragmentation and overlap.⁴⁷ Maternity professionals in hospitals were urged to look at the reasons for ante-natal and post-natal non attendance and to involve voluntary community groups and other professionals.⁴⁸ While some facilities were described as "difficult, overcrowded and unsuitable conditions with outdated facilities",⁴⁹ rather than safeguarding the traditional role of hospital care, maternity professionals were encouraged to "move out of...sterile sanctuaries [and] fill the wide gaps" that existed in

42 *Ibid.*, p. 29.

43 *Ibid.*

44 New Zealand Maternity Services Committee, *Maternity*, pp. 76-80.

45 House of Commons, *Second Report from the Social Services Committee on Perinatal and Neonatal Mortality*, HMSO, 19 June 1980, p. 160. The Committee identified "cattle-market conditions" in overcrowded antenatal clinics.

46 New Zealand Maternity Services Committee, *Maternity*, pp. 76-80.

47 'Changing human relationships in obstetrics', in MSC meeting, Minutes, 8th November 1978', DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

48 *Ibid.*

49 'Appendix B' in MSC meeting, Minutes, 8th November 1978', DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

ante-natal and post-natal care.⁵⁰ Obstetricians and midwives were urged to adopt a “tolerant approach”, tailoring responses and advice according to the particular needs of each individual woman and baby.⁵¹ MSC summarised:

*Judging by pressure for home deliveries, etc, it would appear there is a considerable group in our society whose needs are not being met by our present system...the inflexibility of many institutions and those within them have created many of the problems. Excuses such as the type of structure in which the patients are cared for, lack of facilities and equipment, shortages of staff are just some of those often put forward by staff, but these are usually used when people are unable to change and meet new challenges.*⁵²

While prettying up of delivery suites with warm colours and wallpaper, attractive curtains, soft lights and sweet music was promoted, the “greatest area of abrasion”⁵³ centred around natural childbirth as promoted by French obstetrician Frédérick Leboyer. This required the baby to be welcomed in a calm, quiet and gentle manner by his parents and attendants, with warm water for his immediate bathing after birth⁵⁴ as opposed to the ‘active techniques’ that would become known as ‘active management of labour’ with planned surgical induction, augmentation with syntocinon drips and epidural anaesthesia. The labouring woman did not need to be confined to bed, nor forced to have medication against her wishes. Similarly avoiding excessive pharyngeal suctioning of the newborn baby meant the mother could immediately hold her baby which would remain with her.⁵⁵

MSC formalised the changes necessary to humanise maternity hospitals and called for action in its 1979 policy document *Obstetrics and the Winds of Change*.⁵⁶ The policy was welcomed by those medical practitioners who, along with Parents Centre New

50 Ibid.

51 ‘Changing human relationships in obstetrics’, in MSC meeting, Minutes, 8th November 1978’, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

52 ‘Appendix B’ in MSC meeting, Minutes, 8th November 1978’, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

53 ‘Changing human relationships in obstetrics’, in MSC meeting, Minutes, 8th November 1978’, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

54 For more information on this, see Frédérick Leboyer, *Birth without Violence*, Mandarin, London, (revised edn.), 1991.

55 ‘Changing human relationships in obstetrics’, in MSC meeting, Minutes, 8th November 1978’, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

56 R.A. Barker, *Obstetrics*.

Zealand, had ‘battled’ for years with little progress to create women-centred spaces in hospitals.⁵⁷ It was lauded as “a masterly effort” which encouraged care in public hospitals that could equal that of the best private hospitals, despite not being able to choose their own doctor.⁵⁸ However, warning also came that nothing would change because of “very rigid, ultra conservative [consulting obstetricians who were] resistant to any reasonable suggestion for change”.⁵⁹ Moreover, MSC was warned no change would happen until medical and nursing staff treated normal labour as physical and psychological processes. Until then, impersonal hospital staff, lack of continuity of health professional, unnecessary use of machinery, forceps and surgery would continue to cause tension and inhibition of normal labour.⁶⁰

Those ‘very rigid and ultra conservative’ attitudes were not long in being forthcoming from prominent obstetricians. Auckland obstetrician Dr HP Dunn reported all others he had spoken to resented the policy, elaborating:

*In the long and unhappy relationship between the Department and obstetricians this is one of the worst blows they have suffered. It may be a ‘policy statement’ of the Committee but it will be difficult to coerce obstetricians into complying with it...the endorsement of lay participation to an extreme degree will lead to a renewed campaign by radical groups to dominate midwifery...It has succeeded only because the pressure in favour of it are so strong and determined. When cameras and mirrors are introduced so that the bemused couple can gaze at the external genital organs, the atmosphere in the labour and delivery rooms becomes like a circus. It is inimical to a calm assessment of a difficult obstetric problem; and it makes teaching of junior staff impossible.*⁶¹

57 Dr P.F.M. Chambers to Dr R.A. Barker, Letter, 3 December 1979, DoH, ‘Board of Health – Maternity Services Committee, 1979-1980’, ABQU 632 W4415, 29/21 (50925) and Dr A.J. Henderson to Dr Barker, Letter, 16 November 1979, DoH, ‘Board of Health – Maternity Services Committee, 1979-1980’, ABQU 632 W4415, 29/21 (50925).

58 Professor P.J. Scott to R.A. Barker, Letter, 15 November 1979, DoH, ‘Board of Health – Maternity Services Committee, 1979-1980’, ABQU 632 W4415, 29/21 (50925).

59 Dr P.F.M. Chambers to Dr R.A. Barker, Letter, 3 December 1979, DoH, ‘Board of Health – Maternity Services Committee, 1979-1980’, ABQU 632 W4415, 29/21 (50925).

60 Dr A.J. Henderson to Dr Barker, Letter, 16 November 1979, DoH, ‘Board of Health – Maternity Services Committee, 1979-1980’, ABQU 632 W4415, 29/21 (50925).

61 H.P. Dunn to MSC, Letter, 17 December 1979, DoH, ‘Board of Health – Maternity Services Committee, 1979-1980’, ABQU 632 W4415, 29/21 (50925).

Advocacy for family involvement was judged as “an extension of current ‘permissive’ mores [that give] evidence of serious sexual malaise”, while the presence at birth of husbands or partners reflected “the vulgarity of modern taste”. Dr Dunn was concerned how obstetricians would cope with obstetric emergencies “while the couple are engaged in an embarrassing demonstration of affection which is more appropriate to the boudoir than a public place...”. He reported that the role of obstetrics was “to preserve the safety of mother and child [and] if the patients are made happy or psychologically fulfilled, this is of secondary importance.” Between 20-50% of the women he saw in hospital clinics were unmarried, and thus, he opined, “even the most avant garde obstetrician would hardly call these deliveries moments of triumph”. He feared that inclusion of family would make obstetricians medico-legally vulnerable as lay involvement would lead to increased charges of negligence because ‘lay participation’ equated to “lay persecution” in practice. Dr Dunn did not see the document represented “true women” and he would not change his practices “to oblige the intimidating minority rather than serving the sensible majority”.⁶²

Dr AG Cummings, Chairman of the Palmerston North Hospital Board shared his opposition to family involvement in the public press and the Hospital Boards Association magazine, as follows:

*The labour room is no place for a circus nor a spectacle for all in sundry...the mind boggles at the thought of a confinement ‘en famille’; mother being embarrassed at not being able to conceal her distress, father doing his best to comfort her, teenagers chewing furiously to cover embarrassment, the little ones open-mouthed, wide-eyed and terrified, their fish and chips forgotten in their hands, and the youngest whimpering in a corner where he has fouled both his pants and the floor.*⁶³

Rigid and conservative attitudes of nurses and midwives lacking in humanity were also evidenced throughout the study in the domiciliary midwives’ her-stories and archival material. Before I discuss this, some explanation of the nursing ethos of the time is necessary.

62 Ibid.

63 New Zealand Press Association, ‘Labour room no place for family.’ *Nelson Evening Mail*. 5 June 1980.

The nursing ethos of the study period

Beatrice Salmon described the background to the nursing ethos of at least the 1970s and early 1980s when in 1971 she wrote of nursing legacy:

*The roots of 20th century nursing lie in the army and the church, both authoritarian organisations requiring subordination of the individual to fixed rules and regulations, and demanding considerable dedication. Both organisations are closely related to what one modern sociologist calls total institutions which have similar forms of induction processes in which the new recruit is stripped of their personal identity, humiliated and made to feel guilty and more unworthy than others in the institution. Once people accept their inferiority and unworthiness, the structure of a new relationship is easy...The individual is gradually re-shaped by the institution and those who are outstanding in their conformity are given rewards.*⁶⁴

Beatrice opined that in the early 1970s hospitals continued to have some of the characteristics of ‘total institutions’ where the “self-sacrificing and somewhat self-righteous nurse flourished. She staked out a claim, won security by identifying with an institution and gained satisfaction from maintaining the rules”.⁶⁵

The nurse, reciting the Nightingale Pledge that she took on graduation to loyally aid the doctor in his work,⁶⁶ received the Five Pointed Star medal - its red, white and blue colours representing loyalty “to self, patients, hospital, doctors and all in authority”.⁶⁷ Her Pledge sealed the experience of an education process that did its “best to destroy individuality and to produce the same attitudes and behaviour in all students”.⁶⁸

Bronwen’s experience during her nursing training from 1970-1973 exemplifies the lengths that the educational system went to in order to strip away personal identity and ensure maintenance of rules. She related the following:

64 E. Beatrice Salmon, ‘Anabasis’, pp. 67-68.

65 Ibid., p. 68.

66 Margaret Brown, Diana Masters and Barbara Smith, *Nurses of Auckland: The History of the General Nursing Programme in the Auckland School of Nursing*, 2nd edn., Margaret Brown, Diana Masters and Barbara Smith, Auckland, 1998, p. 85.

67 Ibid., p. 33.

68 E. Beatrice Salmon, ‘Anabasis’, p. 68.

By that second year I really hated all the regimentation. Of course it was the Woodstock era and I was very drawn to peace and love and music and all that. People thought I was a bit weird and I started dressing in hippie-type clothes, you know, long skirts and tie dyed calico - things that I'd made myself and all that and in my third year of training - of course the way the training was done you had block study courses then you worked, had block study courses, then you worked - and so, because I had adopted this very strange dress that nobody approved of, I was actually made to wear my uniform to the study days, you know, because I was just 'beyond the pail' ...⁶⁹

The effectiveness of the destruction of individuality through the uniform code continued beyond the student period, as evidenced in Carolyn Young's experience. She had worked in Waitakere Hospital for a number of years working her way up to becoming the Charge Nurse (sic) of Delivery Suite before starting domiciliary practice. A doctor whom she had worked alongside in the hospital for several years did not recognise her once she dressed in her own clothes rather than the hospital uniform denoting her rank.⁷⁰

However, rather than destroying her identity Bronwen spoke out for her right to be an individual and took action to maintain it:

I was already starting on the fringe-dweller road you know the person who doesn't quite fit and I was absolutely determined, I was very stubborn and very opinionated and dogmatic about things, as you are at that age, and then eventually I managed to negotiate that I didn't have to wear my uniform to study days. It was just so ridiculous but I wasn't going to let anyone tell me what I could and couldn't wear, you know, and I'd bloody well wear my uniform if they wouldn't let me wear my clothes that I wanted to...⁷¹

As mentioned in the previous chapter, the prevailing attitudes and values in New Zealand nursing did not foster the promotion of new ideas and change. While Beatrice

69 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 4.

70 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, p. 14.

71 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 4.

Salmon had urged a 'fresh approach' to counter conservatism,⁷² she also spoke pointedly to the need for nursing to move forward and to identify its own service and professional development in 1981.

However, blocking mechanisms could be instituted to make it difficult to participate in professional development. Equally, there could be retributive measures taken against those who asserted the right to professional development. Carolyn related her experience of this when she had been a member of staff at Waitakere Hospital and was attending University on her days off:

I had a major run-in with the matron because I wanted time off to go to classes, which she was blocking me from doing. I realized I could have actually had leave all the way through to have done the study I was doing, so I bypassed her and went up to the head and they sent an edict down to her that I was to be granted this study leave. So she knew I loved working in the birthing unit and that postnatal work, as was done then, bored me shitless, so she put me on the postnatal ward. So I went in and resigned.⁷³

Carolyn's resignation ultimately paved her way into domiciliary practice but she was not content to simply walk away from this conflict and determined to address the bullying culture of the Matron at Waitakere Hospital once she had ceased employment. Carolyn continues:

I left and then I wrote a letter in to the Matron-in-Chief and asked for an interview and went in to see her and I basically told her how things worked at that hospital and - at one of the courses I had Yvonne Shadbolt... and she had fired me up, she was a nurse too. So every time Matron-in-Chief stood up to get rid of me I'd say 'I haven't finished yet' and I'd say a little more.⁷⁴

It was almost as if Carolyn had pre-empted Beatrice's caution that would appear five years later in the latter's editorial for the *New Zealand Nursing Journal* in which she wrote the following:

72 E. Beatrice Salmon, 'Anabasis', p. 70.

73 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, pp. 2-3.

74 Ibid.

*We cannot afford to tolerate one group of nurses downgrading or belittling another; each must be able to hear what the other is saying. Minds closed to new ideas, or old ideas in new combinations, are totally unacceptable under any circumstances in the late twentieth century...*⁷⁵

But, as I have evidenced in this and the last chapters, a conservative nursing and midwifery culture existed throughout the study period and it was this culture that at least Carolyn, Joan, Gillian, Jenny and Bronwen had been immersed in during their midwifery training, and prior to undertaking domiciliary practice. Sian, Anne and Sue practised in this same culture once registered as midwives.

I now examine Sue Lennox's experience of midwifery training in Australia, by way of comparison, before relating DMs' experiences of midwifery studentship and as midwives working in hospitals prior to domiciliary practice.

Domiciliary midwives during midwifery training and hospital employment

Sue described her 1971 midwifery training experiences in Perth as "ghastly". The only experience of natural childbirth during this time was shared with her entire class of thirty students who were all called in to witness a very determined woman giving birth naturally to her baby. While Sue found this "extraordinary" experience affected her emotionally, natural childbirth was far from the norm of her student experience. Working in a hospital focused on active management of labour meant she almost always cared for women having inductions of labour and Syntocinon infusions. Rather than learning midwifery skills, she learned to hold down male babies for circumcision and the delaying tactics to ensure four hourly infant feeding, such as stuffing bottle teats full of cotton wool for babies to suck on. Her strongest memories illustrated a profound lack of humanitarianism in a hospital where the professor was famous for his research on neonates, purported to increase neonatal survival rates. Sue, like other staff members at the hospital, gathered his experimental data unbeknown to parents.⁷⁶ Sue continues the story of this experience:

75 E. Beatrice Salmon, 'The heart of the matter', in Pat Carroll, Alice Fieldhouse and Sally Shaw, eds., *A Profession in Transition: Issues in Nursing in New Zealand over Two Decades, 1961-1981*, The C.L. Bailey Nursing Education Trust, Wellington, 1982, p.152.

76 Unethical research on pregnant women and their babies was also undertaken in New Zealand during, at least, 1963 and 1979. Examples of this are trials on prolonged pregnancy and vaginal swabbing of newborns to examine congenital erosions. See Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at

*[I remember] sitting in neonatal units with twenty-six week babies who were not going to be surviving but the mothers didn't know that and they were coming in from home with their thirty [millilitres] of breast milk and we would take these babies off respirators for half an hour every sort of three, four hours...see how long it took before they went blue and then put [the babies] back on again.*⁷⁷

It would not be until Sue came to New Zealand as a Registered Midwife and met women who wanted natural childbirth that she would begin “to develop some notion of women being supported to do what they wanted”.⁷⁸ Until Sue experienced home birth with Joan, she would retain common midwifery training myths, for example, that complementary formula feeding from birth was essential for brain development.⁷⁹

Carolyn, Joan and Gillian had all undertaken midwifery training at St Helens Hospital in Auckland. Carolyn reflected the following of what she described as “the pressure cooker” experience:

*I suppose, even in that level of training, [I] was thinking this is just a nonsense...I felt that the maternity hospital was like a sausage machine that was out of control and I felt as a future midwife the very best thing I could do was stand on street corners handing out contraception.*⁸⁰

Midwifery education during the study period taught the midwife skills for a highly technological approach to birth which was then applied to the low technological or ‘cottage’ hospital setting, as Carolyn described:

*I came back to Waitakere and was, as much as you can be in a Level 0 hospital, was now into the high tech stuff - so was into putting in the drips, was into good pain relief and had it all sussed.*⁸¹

National Women's Hospital and into Other Matters, *The Report of the Cervical Cancer Inquiry 1988*, Government Printing Office, Auckland, 1988, pp. 140-142 and 147-148.

77 Catch-up: Maggie Banks with Sue Lennox, 3 December 2004, p. 1

78 Ibid., p. 2.

79 Ibid., p. 3.

80 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, p. 2.

81 Ibid.

Both Sian and Bronwen had established themselves while working in the hospitals as midwives who would support women who planned natural childbirth and, as such, Sian experienced a degree of isolation by this stand:

I could see I was very different to them...and there were a lot of very religious women there who were punitive and right wing and I didn't like what they did and I didn't like how they were with women and I knew that I was different. So when... 'difficult' women or women who were seen to be alternative came in, they would say - oh Sian could look after them - so I'd certainly put myself in a bit of a box already.⁸²

However, Bronwen, in reflecting on herself as 'being different', did not find this situation isolating. She worked in Palmerston North Hospital as a new midwife in late 1977 before the "new swept-up obstetrician" introduced active labour techniques into the hospital. In general, the labours were not managed during her time there. Bronwen worked with "a real old-time midwife" who taught her many things. While she worked happily with hospital staff she was identified by herself and others as "the midwife who was sort of out of the square because I was the one who kept bringing things like *Spiritual Midwifery* to work". However, she "just fitted the system that they had" without difficulty.⁸³

So what support, or otherwise, did DMs receive in hospitals when they transferred women in from planned home births, and how were they supported in their own birthing choices?

Domiciliary midwives in hospital

Some support for domiciliary midwives did exist within the obstetric hospitals in the form of assistance with linen and disposable supplies.⁸⁴ For example, the Wellington Hospital Board issued the DM with 'delivery bundles' if the planned home birthed was 'cleared' by

82 Catch-up: Maggie Banks with Sian Burgess, 7 January 2005, p. 5.

83 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 10.

84 'Appendix 2 - Equipment', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

the PPHN at the District Health Office⁸⁵ and the Hokianga Hospital Principal Nurse allowed the local DM to replenish stocks from the hospital.⁸⁶ Jennie Nicol in her investigation of home birth and domiciliary midwifery recorded one particular (unnamed) hospital where the obstetrician, GPs and DM had good relationships which impacted positively on home birth women.⁸⁷ Equally, hospital midwives could be supportive of the DM⁸⁸ as Jenny Johnston experienced when she shifted to Wellington. Two senior hospital midwives welcomed her socially and supported her professionally by acting as her replacement for antenatal classes if she was at a birth.⁸⁹

But a supportive relationship could not routinely be relied on. Rather, it was dependant on which Team and staff was present on the day.⁹⁰ Bronwen encapsulated the person-dependant nature of the support for the domiciliary midwife:

[In that] era, because you were persona non grata in the hospital, you handed over and you stayed there and supported [the woman] through the experience and that was good. Occasionally that worked out fine in the sense that if there was a nice midwife on, or if they'd gone down the other end and oops, somebody's baby came out [and] you just caught the baby.⁹¹

I have previously mentioned that a 'Pregnant Patient's Bill of Rights' was advocated in the early 1970s by New Zealand women's health activists. The Federation of New Zealand Parents' Centres and all branches of National Council of Women would endorse 'The Pregnant Patient's Bill of Rights' developed in the United States of America in the 1970s.⁹² This elaborated the woman's right to participate in decision-making during her own and her unborn baby's maternity health care and included the right to choose those who would support her during labour and birth.⁹³ While this Bill received most vocal

85 'Paper II', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

86 Liz to Bronwen Pelvin, Letter, 27 July 1986, DMS, '1986 Correspondence, DMS/00 4/6'.

87 Jennie Nicol, *Part I*, p. 10.

88 Jennie Nicol, *A Choice of Birthing. Part II: Hospital Birth*, Department of Health, Wellington, 1989, p. 21.

89 Catch-up: Maggie Banks with Jenny Johnston, 23 August 2004, p. 8.

90 Jennie Nicol, *Choice, Part I*, p. 8 and Jennie Nicol, *Choice, Part II*, p. 20.

91 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 12.

92 'The Pregnant Patient's Bill of Rights', in June Connor to Secretary, MSC, Letter attachment, 25 September 1980, DoH, 'Board of Health – Maternity Services Committee, 1980-1981', ABQU 632 W4415, 29/21 (53013).

93 Ibid.

opposition from consultant obstetricians,⁹⁴ there was variable support from hospital midwives of the woman's right to have her chosen support people with her in hospital. The DM could be welcomed as one of the woman's companions,⁹⁵ or conversely, she could be ordered to leave the area.⁹⁶ Carolyn related transferring a woman from home to hospital during a protracted labour. The woman was very distressed at needing to go to hospital and, as a result, was very upset when she, Carolyn and Joan arrived at Auckland's St Helens Hospital. Carolyn continues:

We got greeted at the door - really poor reception - so much so that the partner we had to sort of take outside and sit down and say – look, just keep it together and calm yourself and know what we've dealt with isn't how it should be, but see past that to being supportive with your baby arriving.

The woman didn't want me to leave her and hung onto me. I walked with her from the admitting door into the birthing room. I wasn't allowed to go in with her, was then basically told I had to get out, so I left her at that point with her kind of sobbing – it was just awful. It was just a really distress[ing] situation...I spent ten minutes walking from the door to the birthing room with a woman weeping asking me not to leave and when the staff were responding to me in the way that they were.⁹⁷

This hostility towards DMs spilled over into the midwife's own birthing. Sian Burgess planned to birth at home with her first child, Emily. Coming from a family where home birth was the norm, she made no secret of the intended birth place when working in Auckland's St Helens Hospital prior to birthing:

I was a nice English midwife and they liked me and so they all knew, I hadn't kept [it a secret]... I came in quite naïvely and said, oh I'm having my baby at home. So every day I did hear lots of negative stories about, oh

94 Dr P.F.M. Chambers to Dr RA Barker, Letter, 3 December 1979, DoH, 'Board of Health – Maternity Services Committee, 1979-1980', ABQU 632 W4415, 29/21 (50925).

95 Mrs E. Davis, Principal Nurse, National Women's Hospital, to Delivery Suite Staff, National Women's Hospital, 14 August 1987, Memo, Sian Burgess Personal papers.

96 Jennie Nicol *Choice, Part I*, p. 9.

97 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, pp.11-12.

*those domiciliary midwives are not like midwives from England you know they're really bad and...*⁹⁸

Unlike a nurse colleague also pregnant and planning to birth at home, Sian did not know 'the rules'. These necessitated keeping the place of birth a secret, as her colleague did by telling staff she planned to birth in National Women's Hospital. As Sian would stress – "because she [her nurse colleague] knew the rules".⁹⁹

Carolyn attributed her stance as "a bit of a renegade" as one which would impact negatively on her the first time she herself came into labour. Her baby had assumed a breech presentation in late pregnancy and she feared birthing in hospital rather than at home with Joan in attendance as she had planned:

*I knew when I had my first birth child, I knew that the hospitals were waiting for me to come in and I knew that if I transferred in life probably would not have been happy. Fortunately, I didn't have to...he turned at the end. Yeah, I had my plan and I wasn't sure if Joan would be able to come in with me or not, but I was thinking whatever I do, if they've got me on a table, I've got to be able to get off the table and get my baby off the [resuscitation] trolley before they do anything and so I went into labour thinking - I hope I can birth at home...*¹⁰⁰

Conflict between staff and DMs was not resolved with collegial discussion to find mutually agreeable solutions. Rather, a hierarchal approach of reporting the DM to the Medical Superintendent was used. Continuing with Carolyn's story on page 186 of the woman in protracted labour transferred to St Helens Hospital and Carolyn having been banned to the waiting room. She was later reported to the Medical Superintendent as having "interfered with treatment". This resulted in an 'order' to go and see him. Carolyn related the following of this experience which ultimately resolved well:

Joan and I just kept putting him off. He would say come up and I thought, you have no authority over me, so I would let him set up this appointment and then I would ring in and say - sorry I've got someone in labour - which I didn't have. The phone calls were so rude - but after about three times of

98 Catch-up: Maggie Banks with Sian Burgess, 7 January 2005, p. 5.

99 Ibid., p. 5.

100 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, p. 13.

*having people in labour then I finally got some kind of civil treatment...and it was then - would you please, if it's convenient, keep this appointment...and [I] went up and said - this is the way it was... He'd been told a totally different version by the staff and when I said, well this is what really happened, I think he was quite appalled at it. And I said - how can I interfere with the treatment when I spent ten minutes walking from the door to the birthing room with a woman weeping asking me not to leave and when the staff were responding to me in the way that they were?*¹⁰¹

Rarely supported in transfer to hospital with a collegial response and empathy for the woman unable to remain at home, the midwife could be challenged, belittled and undermined by being told that her assessments were “not up to scratch”.¹⁰² Sian Burgess would summarise the common experience of at least the Auckland DMs in relation to collegial support when she stated the following:

*Who was the enemy was clearly midwives...the hospital midwives who made your life hell, where you were treated like a back street abortionist, to quote Joan, when you went in there with women. And who you got enormous support from was the GPs who you worked with, and it was great.*¹⁰³

I have related in the previous chapter that, from at least 1977, NZNA would call on the DGoH to initiate Early Discharge schemes with domiciliary midwifery care offered through the existing Community Health services.¹⁰⁴ MSC and the medical profession would join this call in the hope that demand for home birth would lessen.¹⁰⁵ I now examine the feasibility of this proffered alternative.

101 Ibid., p. 12.

102 Ibid.

103 Catch-up: Maggie Banks with Sian Burgess, 7 January 2005, p. 13.

104 NZNA, Annual General Meeting, Minutes, 20-22 April 1977, NZNO, Unnamed file, 10.

105 Maternity Services Committee, 'Early discharge of mother and baby' Paper, 28 June 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879); Secretary, Royal College of Obstetricians and Gynaecologists to MSC, Submission, 18 March 1980, DoH, 'Board of Health – Maternity Services Committee, 1978-1981', ABQU 632 W4550, 29/21 (53139); J.S. Phillips, Chairman, Medical Services Advisory Committee to Secretary, MSC, 17 April 1980, DoH, 'Board of Health – Maternity Services Committee, 1979-1980', ABQU 632 W4415, 29/21 (50925).

Early Discharge schemes

Early Discharge was promoted as the ‘best of both worlds’ option. Women could come to “properly equipped hospitals”,¹⁰⁶ give birth and be discharged within forty-eight hours with postnatal care provided by the District Nursing service. However, of twenty-four Hospital Boards, only one (Waikato) had a policy of Early Discharge though it sometimes occurred from St Helens Hospital in Auckland following a home birth transfer.¹⁰⁷

GPs were the people who had most opportunity to promote Early Discharge because of their contact with women in the antenatal period. Yet NZNA’s survey of the forty doctors who practised obstetrics at Queen Mary and Mosgiel Maternity Hospitals that I mentioned in an earlier chapter, indicated Early Discharge was poorly supported by GPs. Of the twenty who responded to the survey, most GPs saw women with first babies as not suitable for the scheme. A “pre-assessment of the home environment and an adequate standard of housing” were criteria to be investigated before women could access the option¹⁰⁸ – criteria women did not have to fulfil with usual discharge from hospital after birth.

Sue Lennox set up an Early Discharge scheme in 1981 in Lower Hutt caring for women who were discharged from the local hospital. She was drawn to do so following her time with Joan Donley in Auckland which proved to be her “hook into midwifery”. Sue began to value being a midwife as she became engaged with women’s empowerment. As Sue explained – “I could actually do something...that was actually really useful and worth doing...It was about seeing women being independent in the community...about self-determination and independence really, I guess”.¹⁰⁹ Sue’s Early Discharge scheme was utilised by the hospital, as follows:

Because I did the Early Discharge the hospital said, well, you follow up the stillbirths, and I said yea, thinking it would be once in a blue moon. Well, it

106 H.H. McCrostie, President, NZOGS to R.A. Barker, Letter, 19 June 1978, DoH, ‘Board of Health – Maternity Services Committee, 1982’, ABQU 632 W4415, 29/21 (54019).

107 Clare Scanlon, Assistant Advisory Officer, Division of Nursing, to Director of Nursing, ‘Post natal maternity services’, Report, c.1978, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879)

108 B.D. Henderson, Secretary, Otago Branch, NZNA, ‘A questionnaire to doctors’, Report, 10 March 1978 in ‘Appendix C’, MSC meeting papers, 8 November 1978, DoH, ‘Board of Health – Maternity Services Committee, 1978-1979’, ABQU 632 W4550, 29/21 (49879).

109 Catch-up: Maggie Banks with Sue Lennox, 3 December 2004, p. 2

*was once a fortnight. And women who adopted out so I followed them up as well...and I was working in the hospital a couple of times a week and then they would call me in to look after those particular women when they were in labour as part of the hospital work, so that those women would have me follow them up afterwards so they had some continuity across that spectrum.*¹¹⁰

However, Sue keenly felt the lack of support for Early Discharge. After nineteen months of providing the service, she compiled her results sending them to the Hospital Board. Such was the lack of interest from the Board, her submission was never acknowledged.¹¹¹

Moreover, Early Discharge required an acceptance of women's wishes which seldom existed amongst the hospital services, as previously discussed. Sian would experience firsthand the antagonistic and resistant attitudes of hospital staff towards Early Discharge. While she had planned to birth at home with her first child, the unavailability of her midwife forced her to birth in hospital. Sian continues narration of the incident, finishing with intimating the gossip that ensued:

*I...came straight home and was badly treated afterwards. They were pissed off with me that I left the hospital straight away and the story was that I'd been this nice English midwife and the minute I gave birth I turned into this mad home birth person and that my mental health was definitely in question – you know, I discharged myself as soon as the baby was born - and the matron...came around and saw me at home and the baby was “very jaundiced” and I “wasn't prepared to come back into the hospital...and you know that Rhonda Jackson, (Rhonda Evans then), was visiting her and you know... they turned her mind it did...”.*¹¹²

Thus, Early Discharge would have no effect on the ability of the woman to control her decision making. This required an attitudinal change, but as I have shown throughout the thesis, the willingness of which, while flagged up by the MSC and welcomed by the occasional health professional, was far from evident in the greater numbers of health professionals in the hospital environments.

110 Ibid., p. 11.

111 Ibid., p. 5.

112 Catch-up: Maggie Banks with Sian Burgess, 7 January 2005, p. 4.

Concluding remarks

Karen Poutasi, in her President's lecture for the Royal Congress of Obstetricians and Gynaecologists, would reflect in 1988 that the consumer, by wanting to change the rules of health care, had given obstetrics and gynaecology "the Pearl Harbour of the challenge".¹¹³ Suggesting that dissatisfaction with health care which had neither consumer input nor consent was a recent phenomenon ignored the last four decades of education, lobbying and concern of women (and men) in New Zealand. Expressions of concern about the science of obstetrics being focused on the 'mechanics' of labour to the detriment of the individual woman (and baby) had started with the Christchurch Psychological Society in 1947.¹¹⁴ Karen's comments indicated little had changed in the mindset of medical practitioners in the intervening years. From at least the late 1960s women experienced negative and indifferent hospital staff attitudes towards their own and their babies' care, conflicting medical opinion about length of hospital stay, inability to choose who was present during labour, and lack of co-operation with simple requests, such as having the baby handed to them immediately or to assume a de facto name in hospital - all prevalent and reoccurring concerns.¹¹⁵ When women chose to birth at home, the choice was described as "lunacy and colossal self-indulgence"¹¹⁶ while those women transferring to hospital during labour from planned home birth were described as "the 'maddest' of women",¹¹⁷ the latter comment of which was also opined to me by a Waikato obstetrician when I informed him of my intention to commence domiciliary midwifery in 1989.

This same 'Pearl Harbour of challenge' was given to those nurses and midwives in hospitals who saw themselves as pivotal in deciding who should or should not be present during birthing and what services were appropriate that the consumer demanded. Beatrice's imperative of a zero tolerance to nurses 'belittling and degrading' each other

113 Karen Poutasi, 'Women's health care', 1988 President's lecture for the Congress of the Royal College of Obstetricians and Gynaecologists, Paper, March 1988, p. 4, DMS, 'Articles (Journal) – Publications, DMS/00 15/2'.

114 M. Bevan-Brown, *Sources*, p. 6.

115 'Paper I, Comments on present maternity services', in Department of Health, 'Self-employed midwives (domiciliary): the Department's responsibilities', Paper, March 1979, DoH, 'Board of Health – Maternity Services Committee, 1978-1979', ABQU 632 W4550, 29/21 (49879).

116 Jennie Nicol, *Choice, Part I*, p. 8.

117 *Ibid.*

which constituted aspects of what would become known as ‘horizontal violence’,¹¹⁸ was seldom demonstrated in the experiences of midwives of the DMS.

Providing Early Discharge schemes (or ‘alternative’ birth facilities) promised none of the changes that were needed to make the facilities, and the care received in them, more humane. The response to the BoH’s Policy document, *Obstetrics and the Winds of Change*, showed entrenched attitudes as to who controlled birth, and triggered the overt resistance to change from many health professionals.

My own experiences, as detailed earlier in the thesis, and observations in 1989 were that any changes that had occurred in the hospitals were mainly cosmetic. While the environment might have been painted and comfortable beds installed, the change needed in the attitudes of midwives, nurses, general practitioners and specialists was accepted more by some than others. This same variability was observed equally by Jennie Nicol in her parallel investigation of hospital services in 1989.¹¹⁹

DMS generally only had contact with obstetric hospitals when women required additional services after transferring to hospital from planned home birth. I have detailed in this chapter how this proved to be the time of most vulnerability for both the women of home birth - the labouring woman and the domiciliary midwife.

I conclude the main body of the thesis with the next chapter as I draw together the strands of this and Chapters 3-6 in which I have given voice and visibility to domiciliary midwives and the DMS.

118 Leap, N., ‘Making sense of ‘horizontal violence’ in midwifery’, *British Journal of Midwifery*, 5, 11 (November 1997), p. 689.

119 Jennie Nicol, *Choice, Part II*, p. 24.

CHAPTER 8: THESIS-MOON, AND BEYOND

Following labour and birth at home, the baby is almost always greeted with a sense of relief following the transition from pregnant woman on the brink of labour to the woman (mother) with her baby safe, sound, and in arms. As the woman seeks her baby's eyes, face, hands, feet and everything in between, the universal door of openness to labour and birth, flung wide open in the last moments, hours or days of labour, begins to close. In the ensuing hours a new transition begins. She has journeyed to the baby-moon - a time when she is driven to develop intimate knowing of her baby.

In the first chapter of the thesis I explained how I came to this study through the consequences of practising as a domiciliary midwife starting in 1989. Having experienced first hand the lack of support that existed for home birth amongst many colleagues, I wanted to find out why this was so. I therefore set out to explore the herstorical background in New Zealand for this, and what informed health professionals other than DMs about the position they took. As I searched I found there was minimal available evidence in the New Zealand literature to answer these questions, but found an abundance within the archival material I re-searched and the hers-stories told to me.

I have in Chapters 3-7 'flung the door wide open' to my investigation of domiciliary midwifery and revealed archival and oral her-stories of DMS midwives. During my investigation, I have also entered the spaces of the New Zealand Nurses Association and its Midwives Special Interest Section, the Department of Health and the Maternity Services Committee of the New Zealand Board of Health, and have intensively examined the various administrative sources which recorded each group's investigation of domiciliary midwifery. This investigation is now behind me.

This chapter of the thesis draws together the knowing that I came to of the personal mandate - the self-delegated authority - to practise midwifery by domiciliary midwives of the DMS during 1974-1986. Thus, in part, this chapter records the thesis-moon. I elaborate this in 'The Cardigan Brigade's choice to stand' - the midwives of the DMS so named because of their response to being urged by a speaker at the 1988 MSIS National Conference to abandon their woolly cardigans with deference to more corporate clothing

reflecting a Professional Image. This recommendation would invoke a knitting flurry by DMs of brightly coloured, fluffy woollens to distinguish themselves as domiciliary midwives rather than ‘respectable’ Professionals, an activity that resulted in them being dubbed the Cardigan Brigade.¹

My penultimate consideration in this chapter is of the significant contributions this thesis makes to the body of midwifery knowledge before I conclude both chapter and thesis with my reflections on the re-search process.

The Cardigan Brigade’s choice to stand

The primary reason for the Domiciliary Midwives Society’s inception was to overcome the impediment of substandard remuneration that proved a powerful obstacle to midwives being able to sustain domiciliary midwifery. The MoH saw NZNA as the appropriate body to negotiate for increases in the Maternity Benefits Schedule payable to midwives. Yet the DMS, aware of the undercurrent of professional opposition to home birth, could not rely on NZNA to advocate for an income that would ensure viability of the domiciliary midwifery service. The act of informing the MoH that the Society would negotiate on behalf of domiciliary midwives and that it wished to be informed of all submissions made by NZNA on behalf of midwives speaks to the authority that this handful of women claimed to ensure control over their right to practise as (domiciliary) midwives. That they achieved this lofty goal was evidenced by DoH recognition of the DMS as the arbitrating authority in the new DM Contract of 1987.

However, the DMS also provided a forum for networking, and sharing experiences and strategies for political action, such as setting their own standards of practice and lobbying for improvements to maternity services.

The exclusivity of the group, suggestive of a ‘clique’ with its power to marginalise others if seen as different or as a threat, was acknowledged by members.² The Society did serve as “a power base for individuals to gain control and resist change imposed from outside”³ – a recognised trait of a clique. However, the membership was open to all

1 Catch-up: Maggie Banks with Sue Lennox, 3 December 2004, p. 12.

2 ‘Report of Meeting of Domiciliary Midwives Association (DMS), 28.3.82, at Palmerston North’, DMS, ‘DMS meetings, DMS/00 2/1’.

3 Gerald A. Farrell, ‘Tall poppies’, p. 29.

midwives working throughout the continuum of home birth. This exclusive nature was necessary until more midwives showed awareness and support for natural childbirth⁴ and this restricted membership ensured a safe forum amongst like-minded others. To paraphrase Sian's comments on page 82, the safe and supportive environment of the DMS was essential to enable a high level of disclosure in the short and infrequent times that DMs met together.

I have shown how midwives of the MSIS commonly worked in conservative and hierarchal structures in environments that lacked innovative strategies for care. Under the umbrella of hospital hierarchies, midwifery practice was conducted as determined by the medical practitioner, nurse or midwife with the most authority. I have also evidenced the dysfunction that existed in maternity services within hospitals in practices that the consumer identified as not being with-woman, that is, supportive of the woman's right to determine her own labour and birth choices. As Jennie Nicol's investigation of hospital birth in 1989 would find, many hospital-employed midwives expressed their frequent feelings of being powerless to prevent unnecessary medical intervention⁵ - a powerlessness voiced internationally by midwives in various arenas.⁶

Stephen Leyshon, in his paper intended to stimulate debate on empowering practitioners, cites autonomy as "the capacity to think, decide, and act on the basis of such thought and decision freely and independently without...let or hindrance".⁷ However, throughout the thesis I have shown the DM was subjected to considerable 'let and hindrance'. She was dependant on NZNA to negotiate a sustainable income for domiciliary midwifery yet NZNA supported neither home birth nor the service provided by the self-employed midwife. The degree to which the DM could use her professional judgement

4 'Report of Meeting of Domiciliary Midwives Association (DMS), 28.3.82, at Palmerston North', DMS, 'DMS meetings, DMS/00 2/1'.

5 Jennie Nicol, *Choice, Part II*, p. 21.

6 Jennifer Fenwick, Janice Butt, Jill Downie, Leanne Monterosso and Jennifer Wood, 'Priorities for midwifery research in Perth, Western Australia: A Delphi study', *International Journal of Nursing Practice*, 12, 2 (2006), p. 90; M. Kirkham, 'Culture', p. x; Cecily M. Begley, ' "Great fleas have little fleas": Irish student midwives' views of the hierarchy in midwifery', *Journal of Advanced Nursing*, 38, 3 (2002), pp. 3134-314; Linda Ball, Penny Curtis and Mavis Kirkham, 'Why do midwives leave?', *Midwifery Matters*, 96 (2006), p. 9; M. Kirkham and H. Stapleton, 'Midwives' support needs as childbirth changes', *Journal of Advanced Nursing*, 30, 3 (September 1999), p.467; Caroline Flint, 'On the brink' in Sheila Kitzinger, *Midwife Challenge*, p. 31.

7 Stephen Leyshon, 'Empowering practitioners: an unrealistic expectation of nursing education?', *Journal of Advanced Nursing*, 40, 4 (2002), p. 468.

could be hampered by an individual PPHN's interpretation of supervision. The MOH could affect the midwife's ability to claim the MSB if he withheld permission to enter a particular health district and the obstetrician could be influential in the support (or lack of it) that the DM received in a particular area. The Midwives Special Interest Section and NZNA determined the appropriate skill base, ongoing education, review process and those who would review the DM. And finally amongst the let and hindrance present, the DM's ability to exercise choice was limited within the constraints of legislation that had diminished her previous legal ability to act independently from medical practitioners, with considerable consequences to her if illegal actions were taken.

The domiciliary midwife's solitary stand in realising her own power began with the act of becoming a self-employed midwife in an unsupported branch of midwifery when all but a handful of midwives were employed by, and worked within hospitals. This realisation of her own power could be something of which she already had conscious knowledge prior to becoming a midwife, as Bronwen exemplified in asserting her identity in the clothing she wore to 'study block' during her nursing training. Equally, Anne recounted her experience of taking a stand as to where she stood in the world as a fifth form student at her Catholic boarding school. She related the following of a visit to her school by members of the anti-abortion group, Society for the Protection of the Unborn Child:

...They showed a film of discarded fetuses and it was horrific. And then afterwards the woman stood up and said - now, just put your names here and I've got thirty new members for our organisation. I stood up and said - no you've only got twenty-nine. And the thing is...I actually am anti-abortion...my values and my ethics and my sense of spirituality is not to abort fetuses. So even though my gut instinct back as a fifteen year old girl was that the woman was right, it wasn't right to abort fetuses, I didn't like being taken for granted in the mob that I was going to be part of that organisation.⁸

8 Catch-up: Maggie Banks with Anne Sharplin, 24 October 2004, p. 19.

As Anne and Bronwen both illustrated, the ability to exercise choice, which is a common interpretation of autonomy when applied to individuals,⁹ existed amongst other components determined of autonomy - “the power to make and act upon decisions”.¹⁰ Katherine Pollard’s analysis of the literature identified ‘associated characteristics of autonomy’ which can be expressed by autonomous individuals as:

*determining the sphere of activity under one’s control, having the right and capacity to make and act upon choices and decisions in this sphere, having this right acknowledged by others affected by or involved in the decision [and] taking responsibility for decisions made.*¹¹

However, the ability to act assertively that is implicit within these characteristics has been identified as problematic in the institutionalised workplace. In Fiona Timmins’ and Catherine McCabe’s examination of Irish midwives’ (and nurses’) assertive behaviours, they found that, along with medical staff, midwifery and nursing managers in the hierarchical team structures within hospitals are a major barrier to the assertive behaviour of midwives (and nurses). While midwives were less likely to use assertive skills with doctors than they were with colleagues of their own profession, negative responses were identified as a major barrier to assertive behaviours.¹²

Lack of assertive behaviour can give rise to “complex and devious ways” midwives seek change without offering apparent challenge to the prevailing culture of childbirth, as Mavis Kirkham and Helen Stapleton related in their study of midwives within the United Kingdom’s National Health Service. In deflecting interventions midwives enact “doing good by stealth” through their midwifery activities. While this may be beneficial in individual circumstances Mavis and Helen highlighted that “concealment prevented concerted action leading to major change”.¹³

Midwives of the DMS demonstrated a conscious awareness of the midwifery responsibility to participate openly and effectively in the with-woman relationship. This

9 Valerie E.M. Fleming, ‘Autonomous or automatons? An exploration through history of the concept of autonomy in midwifery in Scotland and New Zealand’, *Nursing Ethics*, 5, 1 (1998), p. 44.

10 Katherine Pollard, ‘Searching’, p. 113.

11 Ibid., p. 115.

12 Fiona Timmins and Catherine McCabe, ‘Nurses’ and midwives’ assertive behaviour in the workplace’, *Journal of Advanced Nursing*, 51, 1 (2005), p. 43.

13 M. Kirkham and H. Stapleton, ‘Midwives’, p.467.

conscious awareness was frequently followed by overt action and taking responsibility for the consequences of this action, despite predominantly hostile collegial feedback from other than DMs. Impingements on the ability to conduct and be responsible for their own practice was remedied by, for example, the actions Carolyn, Bronwen and Ursula took. The later two did not follow ‘the rules’ in notifying the PPHN of the women they booked for home birth. Carolyn did not tolerate the overzealous inquiry into her practice by the MOH when she wished to attend a birth out of her usual health district. And there was nothing ‘stealthy’ about Bronwen’s supporting women to home birth when GP support could not be accessed. Openly discussing this with those who were likely to initiate disciplinary proceedings – the MOH, the Medical Superintendent of the hospital and the PPHN – she was addressing the widespread and increasing problem of diminishing GP support for home birth in the late 1980s. As she saw it she had a legal, professional and moral responsibility to ensure home birth women were not birthing unattended. Sure of her ground on these issues she tried to provoke a response from the DoH that could be turned to advantage for home birth women and domiciliary midwives, as she explains:

I said that I have a responsibility to attend these women...I was absolutely certain that that’s how I stood and I was actually desperate for the Department of Health to take me on, because I thought I had a really good argument, and it would have been very good publicity, you see...The difference between me and anybody else was that I talked about it. I made it public and that was sort of like an important thing for me to do that, to actually stand up for what was right...¹⁴

This same conscious awareness leading to overt action amongst DMs was seen with regard to NZNA’s dicta of 1980 and 1981 in introducing controls on domiciliary midwifery practice. The DMs recognised that standards of practice were “primarily a political issue and have more to do with ensuring obstetric power than with the welfare of mothers and babies”.¹⁵ Basing their own Domiciliary Midwives Standards¹⁶ on the InterNational Association of Parents and Professionals for Safe Alternatives in Childbirth’s

14 Catch-up: Maggie Banks with Bronwen Pelvin, 12 September 2004, p. 15.

15 ‘What are standards?’, Paper prepared for meeting to discuss standards of practice, ca. 1985/1986, Sian Burgess Personal papers, Box 40.

16 ‘Report of Meeting of Domiciliary Midwives Association (DMS), 28.3.82, at Palmerston North’, DMS, ‘DMS meetings, DMS/00 2/1’.

Five Standards for Safe Childbearing,¹⁷ the Society couched these as suggestions to the midwife as the home birth consumer was seen as having the “ultimate power to set and enforce standards”.¹⁸

Significant in my re-search was the conduct of MSC’s and NZNA’s investigations of domiciliary midwifery that revealed there was no evidence that care provided by domiciliary midwives during planned home births resulted in poorer outcomes for women or their babies. But there was considerable evidence of the sectional opinion from the maternity professional lobby that home birth should not be provided, and even that DMs should not be paid for the services they provided.¹⁹ The ‘evidence’ that counted in these forums was obstetric, nursing and midwifery rhetoric that birth at home was unsafe. Moreover, the hospital was seen by these opponents of home birth as the only place where worthwhile learning could occur.

Home birth midwifery experience, however, proved pivotal in challenging many midwives’ understandings about childbirth and the care that was appropriate during this time. Midwives of the DMS knew that ongoing education programmes based on hospital obstetrics did not benefit them and pointed out that “that after obstetric competence, the main [domiciliary midwife] requirements are for dedication and concern for women – attributes not necessarily acquired within the hospital system”.²⁰ Instead, they valued community born and woman-led knowledge development which included having given birth themselves.

The home birth consumer was fundamental to domiciliary midwives developing midwifery skills and furthering knowledge development. At the beginning of practice the consumer’s knowledge was frequently more diverse and more health orientated than the knowledge that midwives brought with them from midwifery training and hospital practice. It was the mutuality of goals that I experienced with my commencement of

17 David Stewart, *Five Standards*. These standards were structured as Good Nutrition, Skilful Midwifery, Natural Childbirth, Home Birth and Breastfeeding.

18 ‘Domiciliary Midwives Standards’, Paper, 1988, DMS, ‘Domiciliary Midwives Standards Review, DMS/00 10’.

19 C.S. Harison, Obstetric Advisor, Thames Hospital Board to MSC, Submission, 11 June 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139), and Southland Division, Obstetrical and Gynaecological Society to MSC, Submission, 15 May 1980, DoH, ‘Board of Health – Maternity Services Committee, 1978-1981’, ABQU 632 W4550, 29/21 (53139).

20 Auckland Domiciliary Midwives, ‘Submission to Maternity Services Committee of the Board of Health’, 22 February 1981, DMS, ‘1981 Correspondence, DMS/00 4/1’.

domiciliary midwifery – that is, natural childbirth at home - which extended the domiciliary midwife's boundaries and type of knowledge.

The challenges of not knowing about aspects of care as Carolyn related on page 79 to the use of homeopathy and Jenny related on the same page to water birth, was met with the ability to think critically with an open mind to learn more, rather than having the DM's lack of knowledge reduce the woman's birth choices. This critical thinking would cause Carolyn to differentiate the equipment necessary for home birth and the manner in which the midwife conducted herself during home birth.

To encapsulate this evolving experience I will follow Carolyn's development and recognition of midwifery knowledge. With that first birth she attended with Vera Ellis-Crowther, Carolyn would be confronted with the difference between women birthing at home and those she normally saw in hospital 'lost at sea' as she related on page 78 of the thesis. Further she would be challenged by the woman who 'contaminated her sterile field' with her cup of tea as narrated on page 82. Carolyn would meet the challenges of her obstetric knowledge full on in moving away from hospital practices of the 1970s, such as the use of the gowns and masks that both she and Joan used at the start of domiciliary practice as they replicated the hospital at home. And she would continue to challenge that knowledge and shift her previous boundaries learned in hospital practice. Carolyn related the changing knowledge base with a story of attending a woman who took longer to push out her baby than the mandatory two hours allocated in hospital before the birth would be terminated by obstetric forceps. Carolyn continues:

I can remember standing...and I was looking at my clock and thought - oh, the two hours. We've gone past the two hours and the baby's going to be here really soon, and, what a shame that we have to transfer. And then I suddenly thought – who made that rule? Some man who's never even had a child.²¹

While Carolyn related it was a long time before she started questioning,²² she did not have the benefit of experienced DMs to guide her as Vera stopped practice when Carolyn started. Carolyn and Joan learned it together, as they went along.

21 Catch-up: Maggie Banks with Carolyn Young, 24 August 2004, p. 4.

22 Ibid.

The low numbers of DMs throughout the country meant that to begin with at least Carolyn, Bronwen, Ursula Helem and Lynne McLean practised in their separate geographical areas without domiciliary midwifery support. Bronwen, Jenny and Anne would practise later in communities where they were the only DMs for some months or years before others joined them.

In examining the position of midwives throughout the study period I have argued that the professional identity of midwifery in general was so deeply embedded in nursing as to be colonised by the latter. Loss of a separate midwifery identity meant the midwife was renamed a nurse in legislation, policy statements and job title, and midwifery was determined a sub-speciality of nursing in both education and practice. The midwife had been reinvented as an obstetric nurse or a nurse practising obstetric nursing. That NZNA should use the term midwife almost exclusively in relation to domiciliary midwives is significant in that the service was seen as the exception within nursing (midwifery). While the role of the midwife was debated within midwifery from the mid 1970s as part of the overall concerns about nursing and midwifery education, a distinct midwifery identity did not receive significant attention from midwives in general until 1983.

Midwives of the DMS came to midwifery through various paths – from a family or community culture supportive of home birth, via Direct Entry or following nursing registration. For some it was a conscious decision to be a midwife, while others did so on the instruction of the Matron in the hospital or to gain a second certificate to be more employable during overseas travel.

While domiciliary midwives were frequently isolated in terms of professional support regionally, I have shown throughout the thesis that home birth consumers were fundamentally connected and interconnected with the domiciliary midwife. This thesis attests to the wisdom of Nadine Pilley Edward's assertion that the midwife's autonomy and the woman's autonomy are linked.²³ Without the personal mandate of autonomy by midwives of the DMS during 1974-1986 as evident throughout the thesis, the autonomy of the home birth women they cared for could not have been enhanced. And conversely – the economic, political, educational and personal support provided by HBAs, HBSGs and/or

23 Nadine Pilley Edwards, *Birthing*, p. 256.

the women (and families) for whom the midwives cared, was key to the DMS midwives' ability to exist in and resist the medicalised culture of childbirth in New Zealand during the study period and to persist in their personal mandate to stand strongly and claim their space and practice as midwives.

So what is significant about this re-search?

The thesis makes four contributions to the body of midwifery knowledge, as follows.

First, the DMS archive used in this study is the largest and most comprehensive single collection of primary source material in existence relating to the domiciliary midwife in New Zealand during 1978-1997. This is the first time this collection of materials has been used. Similarly, my examination of MSIS and NZNA archival material detailing the investigation into domiciliary midwifery from 1973 which resulted in the 'Policy Statement on Home Confinement' has previously not occurred. Current midwifery herstory concentrates on the controls medicine placed on midwifery through its subordination within nursing.²⁴ This thesis evidences that the midwifery profession through its organisational structure of MSIS was fundamentally entwined with attempts to bring about the demise of self-employed domiciliary midwifery. Thus, this study makes a substantive contribution to the herstorical knowledge on domiciliary midwifery from the late 1970s until the late 1980s and provides a dissenting view of subordination of midwifery (in general) by the nursing profession in New Zealand.

Second, from the beginning I established this re-search as a midwifery activity consistent with the practice of a home birth midwife. I also established that the philosophical underpinnings, process and method used in this study are fundamental to the identity of a home birth midwife. The philosophical underpinnings, process and method of this study are a 'decolonising methodology' which provides an important stepping stone to break down academically determined barriers in midwifery re-search practice and to assist midwifery knowledge development. Thus, evocation of the with-woman spirit in the re-search process makes a substantive and original contribution to the ways in which midwifery (and women's) knowledge can be informed, gathered, analysed and expressed that is congruent with home birth midwifery practice in New Zealand.

24 Evan Willis, *Medical*; Elaine Papps and Mark Olssen, *Doctoring*, Jean Donnison, *Medical* and Joan Donley, *Save*.

Third, 'horizontal violence' is continually and increasingly reported in the literature as a widespread and ongoing problem within maternity services in both New Zealand and internationally.²⁵ It exists and proliferates in midwifery (and nursing) "because it helps to demonstrate the hierarchical structures and preserves the status quo"²⁶ and it negatively influences the retention of midwives.²⁷ The thesis shows that anti home birth sentiment existed during the study period to a degree that overwhelmed the ability of many medical, nursing and midwifery professionals to act in a collegial manner. Domiciliary midwives experienced insults and derogatory remarks, spreading of gossip or malicious rumours and acts of being shunned by their hospital colleagues. These particulars are recognised as aggressive behaviours²⁸ consistent with 'horizontal violence'. The finding of the personal mandate of autonomy of this study bears testament to Gerald Farrell's assertion that prevailing obstructive hierarchies do not need to be dismantled before horizontal violence is dealt with.²⁹ Therefore, the thesis supports evidence that midwives can act effectively in an empowered and autonomous manner despite opposing and obstructive hierarchies and 'be with-woman'.

And the fourth and final contribution this thesis makes. The international literature on domiciliary midwifery during the 20th Century is sparse, as I discussed earlier. This thesis captured what it was like for domiciliary midwives practising during 1974-1986 - a time when all but a handful of midwives practised in hospitals. This era proved to be one in which domiciliary midwives were unsupported by the vast majority of medical, nursing and midwifery colleagues and yet consumer recognition of, and support for domiciliary midwives was considerable. As with Nicky Leap's and Billie Hunter's oral history of

25 P. Curtis, L. Ball, and M. Kirkham, 'Bullying and horizontal violence: cultural or individual phenomena?' *British Journal of Midwifery*, 14, 4 (April 2006), pp. 218-21; J. Fenwick, J. Butt, J. Downie, L. Monterosso and J. Wood, 'Priorities', p. 89; C. Comisso, 'Horizontal violence and students', *Australian Midwifery News*, 5, 3 (2005), pp. 40-41; J. Robertson, 'Last word. Changing a culture of horizontal violence', *The Practising Midwife*, 7, 2 (2004), pp.40-41; Linda Ball, Penny Curtis and Mavis Kirkham, 'Why do midwives leave?', *Midwifery Matters*, 96 (2006), p. 8; Gerald A. Farrell, 'Tall poppies', pp. 26-33; Irene Calvert, 'Midwives should nurture their young not eat them', *New Zealand College of Midwives Journal*, 23 (January 2001), pp.28-29; N. Leap, 'Making sense of 'horizontal violence' in midwifery', *British Journal of Midwifery*, 5, 11 (November 1997), p. 689; Caroline Flint, 'On the brink', pp. 22 and 26.

26 Gerald A Farrell, 'Tall poppies', p. 28.

27 Linda Ball, Penny Curtis and Mavis Kirkham, 'Why', p. 8; Sheila Kitzinger, 'Sheila Kitzinger's letter from Europe: what's happening to midwives in Europe?' *Birth*, 31, 1 (2004), p.69; Marianne Teller, 'Why I left', *Midwifery Matters*, 96 (2006), available at <http://www.radmid.demon.co.uk/mtellier.htm>, retrieved 20 July 2006.

28 Gerald A. Farrell, 'Aggression', p. 503.

29 Gerald A. Farrell, 'Tall poppies', p. 27.

midwives and handywomen in pre National Health Service Britain³⁰ and June Allison's study of District Midwives of Nottingham during 1948-1972,³¹ the thesis records the financial hardship and personal costs to domiciliary midwives in their dedicated provision of home birth services. Thus, an important herstorical thread is added to the international story of midwifery in the community during 1974-1986.

I have shown throughout the thesis how domiciliary midwives embraced their personal mandate to practise midwifery when there was no legislated right of autonomous midwifery practice. Connected and interconnected with this personal mandate was the home birth consumer movement. The thesis makes visible the with-woman relationship between domiciliary midwives and home birth women, a partnership which would later become a fundamental tenet emulated by NZCOM. The midwife in New Zealand is acknowledged internationally as having a 'freedom' of practice enjoyed by few other nations and, as such, New Zealand midwifery is a world leader. This thesis tracks the domiciliary midwifery service and illustrates the forerunner to legislated autonomy of midwifery practice in 1990 and the grassroots of midwifery on which midwifery in New Zealand was built.

A photograph taken of Joan in 1993 to celebrate one hundred years of women's suffrage in New Zealand has rested on my study wall above my computer for much of the last fourteen years. Part of the photograph caption declares - "an outspoken critic of high-tech birth, Donley is a founding member of the HBA and has fought to improve the status of domiciliary midwives". Pictured holding a contented, naked baby, Joan is flagged by three erect spears of toitoi – the 'New Zealand flag' – with their plumes in full flower. In the fourteen years since the photograph was taken, the baby girl will have grown into a young woman, the flower heads will have dispersed and, sadly, since 2001, Joan's oral wit, political commentary and wisdom have not been heard. The magnitude of this loss was surpassed by Joan's death in December 2005. Joan's delivery of the herstory of maternity in New Zealand that she would tell at HBA conferences (and later those of NZCOM), and beyond, will no longer be heard. It is hoped that this finely textured analysis of domiciliary midwifery will help to retain the knowledge of that fight in which Joan and members of the DMS (and home birth women) participated, and that its recording in print will ensure it

30 Nicky Leap and Billie Hunter, *Midwife's Tale*.

31 Julia Allison, *Delivered*.

continues to be heard by a succession of midwives (and women) so they will know what came before them.

Reflections on the re-search

My primary motivation for undertaking this re-search was a personal one. It was to help me better understand the herstorical (and continuing) misunderstanding(s) perpetuated around home birth and domiciliary (home birth) midwifery. Because I was embedded in the culture of domiciliary midwifery the potential for a polemic argument could have been possible. While it is the method of historical research to check, recheck and cross check sources, this practice is familiar in home birth midwifery practice where changing circumstances can require input from different people. For example, family members or medical specialists can offer a different viewpoint which needs to be considered within the whole as to how that affects the woman. It was this examination at depth and from all viewpoints which enabled me to gain depth to the argument and which reiterated to me the fragility of a midwifery culture which does not stay connected and interconnected with the women we serve.

Prior to undertaking this study, my search into midwifery herstory had given me an understanding that midwifery was assimilated into nursing through the process of professionalisation and had come under obstetric control through hospitalisation of childbirth. While this understanding persists, I have come to deep understanding of both the embedded-ness of midwifery within nursing herstorically and the contribution to the disfranchisement of midwifery that was (is) instigated and perpetuated by midwives. For me, this has affirmed the importance of midwives being ‘with-woman’ amongst ourselves – that is, ensuring that our relationships with each other are empowering, flexible, creative and supportive.

Bringing the personal of my philosophical underpinnings which inform practice into this re-search process speaks to the fundamental politic of identifying as, and occupying a home birth (domiciliary) midwife’s space. By implication of my ‘choice to stand’ in this home birth midwife’s space, I have demonstrated (in part) my own personal identity, and the personal mandate to keep the practices of midwifery re-search and practice, in themselves, connected and interconnected.

APPENDICES

APPENDIX 1:	Information (A) about the study
APPENDIX 2:	Consent Form (A) to participate in the research project
APPENDIX 3:	Letter confirming agreement to participate in the research project
APPENDIX 4:	Information (B) about the study
APPENDIX 5a:	Schedule for release of material from the Domiciliary Midwives Society (Inc.) secretarial archive for the study (Example only)
APPENDIX 5b:	Schedule for release of material from the Domiciliary Midwives Society (Inc.) secretarial archive for the study
APPENDIX 6:	Consent form (B) to participate in the research project
APPENDIX 7:	Transcriber confidentiality form for the study
APPENDIX 8:	National application form for ethical approval of a research project
APPENDIX 9:	Letter from Waikato Ethics Committee, 7 June 2002
APPENDIX 10:	Letter to Waikato Ethics Committee, 22 January 2003

APPENDIX 1: Information (A) about the study

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui



‘Domiciliary Midwives and the Domiciliary Midwives Society’

1 January 2003

Dear

I write further to our discussion to formally invite your participation in the study I am undertaking within the PhD programme in Midwifery at Victoria University of Wellington. As you know from your work as a midwife there is no onus on you to participate in this study ~ it is purely voluntary. This study has received ethical approval from the Waikato Ethics Committee on behalf of the Auckland, Canterbury, Otago and Wellington Ethics Committees. The following information is offered for your consideration over the next week.

What does this study aim to do?

I aim to explore the experiences of domiciliary midwives prior to August 1990 and to write an herstorical account of the Domiciliary Midwives Society (DMS). This record of domiciliary midwifery, as seen through the eyes of midwives of the DMS, is an important part of midwifery herstory that needs to be readily available to student midwives, midwives, women and policy makers alike.

How come you have been asked to participate?

In October 1989, the Secretary of the Society wrote to all Health Development Units in Aotearoa/New Zealand requesting the names of domiciliary midwives who were contracted to the Minister of Health. The responses indicated there were one hundred and twenty-eight. Of these, thirty-eight were members of the DMS providing continuity of care and working in partnership with Home Birth Associations or Home Birth Support Groups

where they existed. I have selected thirteen midwives from this group who I am inviting to participate in the study and you are one of them.

What is involved?

To gather stories I would catch up with you between three and six times over a period of approximately nine months. Each session will last up to 1½ hours. During each session, which I would want to audiotape, I will guide the discussion along the themes, as discussed over page. These will be conducted in your hometown, at a place of your convenience, unless a mutually agreeable opportunity arises elsewhere. It may be that you and I also communicate by email and phone. If we talked on the phone, I may want to audiotape the conversation ~ in which case ~ I would make it very clear at the start that I wished to do so.

Each interview and/or taped phone discussion would be transcribed word for word and sent to you for reflection, verification or amendment. I will provide stamped, addressed envelopes for their return to me or we may be able to do this by email.

What sort of things will be discussed?

There are four phases to the study ~ the first two involving only two or three midwives, but all are involved in the later phases:

In the first phase I will concentrate on how and why the DMS came into being.

In the second I will focus on your background, family, events, influential people, experiences, educational path to midwifery and belief systems. This

would be to identify the key issues that shaped your interpretation of the scope of midwifery practice and what it was that led you to domiciliary practice.

In the third phase you would be asked to personally reflect on the challenges or ease of practising within the domiciliary midwife's paradigm before August 1990.

When the third phase of the study is finished, and so it flows well, I will write an individual her-story from the transcripts you have approved. This will be sent to you both in text and audio-tape format, and once again, you would need to make sure that you are happy with that story. We would meet or have contact again to discuss this.

What if you want the discussion or your part in the study to stop?

There may in the process of you telling your story be painful memories which surface. In the event of this happening I would halt the discussion and check whether you want to take time out or continue at another time. You would also be able to stop the audiotape from recording yourself, at any stage.

You will of course retain the right to entirely withdraw both yourself and your information from the study ~ without question ~ at any stage prior to me submitting the work for examination. It would only require you to let me know of that decision.

Will you have a chance to change what you said?

Yes. Each audiotape will be transcribed word for word and sent to you. You can add, delete or amend anything in the transcript that you wish to so you are comfortable with both the wording and content. You may have a copy of the tape if you wish, either to make this easier or just to keep.

If I wanted to include any of your email correspondence in my text, again, I would make sure you were agreeable to the inclusion of the specific text I wished to use and you would have the opportunity to edit your email.

Any articles sent for publication during the study would also be sent to you prior to being submitted for publication for the same reason.

What if you don't agree with my analysis of events and your story?

There is potentially a risk that you and I could have differing interpretations and analyses of events. I would see these as being resolvable within the partnership relationship through negotiation and open, honest and effective communication. If, however, we were unable to resolve this we would need to negotiate what part of your story was used and what was left out.

Will your participation remain confidential?

As you would expect, I will ensure confidentiality of information and also endeavour to protect your identity by the use of pseudonyms. However because of the politically active

and challenging profile you may have had or continue to have within the midwifery profession, you may be identifiable within the context of your story. If this is so, this may have repercussions in your personal and/or professional life and your work place.

It may also be that you wish to be identified ~ in which case a pseudonym would not be used. These are things we would need to discuss together.

I will be the only one who will hear the tapes apart from the transcribing typist who will be bound by a confidentiality agreement. The tapes will be coded to protect identity. My Supervisor will be reading and critiquing drafts of my thesis as part of the supervision process, but once again no identifying information will be passed on.

Will it cost you anything?

No ~ I pay for tapes, postage, phone calls, etc ~ and I also provide light refreshment when we catch up together!

What happens to the tapes and transcripts after the study has finished?

The audiotapes and any other material will be securely stored throughout the study period in my private study, and for a further ten years. Following this, my copy of the audiotapes will be erased. You would be able to keep your copies along with each of your interview transcripts. The 'report' will be submitted for marking in the Post Graduate School of Nursing and Midwifery at Victoria University of Wellington and deposited in the School, the main Library and in the DMS archives. Further publication and presentations that elaborate on the study will also result, of which you would also receive copies.

What needs to be done if you are happy to participate?

If you are happy to participate in this study, you can let me know when I ring on

[date to be filled in], and I will send you the Consent Form.

In the meantime, I welcome any enquiry you may have regarding this project. You are able to contact me at the address below, or if you would prefer, you can contact my supervisor Rose McEldowney, at the Graduate School of Nursing and Midwifery, Victoria University, PO Box 600, Wellington, phone 04 463 6651.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organization.

I look forward to hearing your decision.

Yours in midwifery

Maggie Banks

Home Birth Midwife

Ph: 07 856 4612; Fax: 07 856 3070; E-mail: banks@ihug.co.nz

Version 1: 20 January 2003

APPENDIX 2: Consent Form (A) to participate in the research project

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui



“Domiciliary midwives and the Domiciliary Midwives Society”

I have read and I understand the ‘Information (A) About The Study’ dated 1 January 2003. This information is for participants taking part in the study designed to explore the experiences of domiciliary midwives prior to August 1990 and to write an herstorical account of the Domiciliary Midwives Society (DMS). I have had the opportunity to discuss the study. I am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary and that I may withdraw myself, and/or any information I have provided from the study at any time prior to submission for examination and this will in no way cause penalty of any sort.

I have had time to consider whether to take part.

Choose only one box to circle yes or no and strike out the other box:

I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.

I consent to my name being used in reports on this study.	YES/NO
---	--------

I know whom to contact if I have any questions about the study.

I consent to my interviews being audio-taped.	YES/NO
---	--------

I consent to my phone calls being audio-taped. YES/NO

I wish to have a copy of all the audiotapes of my interviews. YES/NO

I wish to have a copy of further publications and presentations that will result which elaborate on this study.

YES/NO

I hereby consent to take part in this study.

Date

Signature:

Full name of Researcher: Maggie Banks

Contact Phone Number: 07 856 4612

Email: banks@ihug.co.nz

Project explained by Maggie Banks

Project role: Principal Investigator

Signature:

Date:

APPENDIX 3: Letter confirming agreement to participate in the research project

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui



‘Domiciliary Midwives and the Domiciliary Midwives Society’

DATE:

Dear

Thank you for agreeing to participate in this research project. Please find enclosed [only one to appear on form and other will be deleted]

two copies of each of two different Consent Forms

two copies of the Consent Form

for you to sign - one copy to keep and the other to be returned to me in the stamped and addressed envelope provided. Please read carefully before signing. When you have returned the signed Consent Form/Forms to me, I will contact you to arrange further contact.

Please don't hesitate to phone or email me at any time should you wish to, as below:

I look forward to our further contact.

Regards

Maggie Banks

Phone: 07 856 4612

E-mail: banks@ihug.co.nz

15 Te Awa Road, RD 3, Hamilton

APPENDIX 4: Information (B) about the study

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui



‘Domiciliary Midwives and the Domiciliary Midwives Society’

20 January 2003

Dear

I write further to our discussion to formally invite your contribution to the study I am undertaking within the PhD programme in Midwifery at Victoria University of Wellington. As you know from your work as a midwife there is no onus on you to participate in this study ~ it is purely voluntary. This study has received ethical approval from the Waikato Ethics Committee on behalf of the Auckland, Canterbury, Otago and Wellington Ethics Committees. The following information is offered for your consideration over the next week.

What does this study aim to do?

I aim to explore the experiences of domiciliary midwives prior to August 1990 and write an herstorical account of the Domiciliary Midwives Society (DMS). This will ensure that the practice reality for the domiciliary midwife prior to August 1990 is not lost and is readily available to student midwives, midwives, women, educators and policy makers alike.

How come you have been asked to participate?

You have been one of the contributors to the Secretarial Archive of the Domiciliary Midwives Society through writing letters, submitting Midwives Reports and/or practice reflections.

What is in the Secretarial Archive?

The Archive is the most comprehensive collection of herstorical material that records ‘how it was’ for the domiciliary midwife from the late 1970s to early 1990s. It is an extremely rich time capsule of the home birth midwifery identity, politics, harassment, courage and determination, not to mention the most wonderful collection of midwifery titbits. It includes submissions, minutes, midwives reports, newspaper clippings, letters and publications.

Isn't the Secretarial Archive the property of the current membership?

Yes, the Archive is ‘owned’ by the current membership of the DMS and permission to peruse it has been given by the current Secretary, Jenny Johnston.

Why am I asking your permission to use your contributions?

At times, the contribution that individuals have made to the Archive articulates deeply personal practice reflections and descriptions of the oppression, targeting of individuals by obstetric and nursing institutional hierarchies, as well as practice documentation.

These contributions were of course submitted to the Society in an atmosphere of mutual support, understanding and in strict confidentiality. The personal and professional vulnerability of the domiciliary midwife is implicit in some of these reflections and that personal vulnerability may well still be ongoing today.

The way in which the Archival story can be told while protecting the domiciliary midwives has been of major consideration to me and in my workings to date.

I see ownership of the information in the same light as that of a Childbirth Record or ‘the notes’ as we commonly call it. The paper may well be the property of the midwife but the information contained within the record is the woman’s and only she can illuminate what can be shared with others.

As the underpinnings of my practice as a midwife researcher are the same as my practice as a home birth midwife, I framed up of ethical considerations according to the Code of Ethics for midwifery practice. Therefore for me to be able to use your contribution, your informed choice and the giving of informed consent is necessary rather than just using them because they are part of the Archive.

Is this information available elsewhere?

Some information such as submissions, letters to newspapers, publications, conference proceedings etc are available in the 'public' domain, but not the personal letters, practice reflections and descriptions.

Can your identity be protected?

To write a credible herstory necessitates the ability to track sources. There are two ways to do this. The first is to credit authorship using the author's real name. The second is to allocate a pseudonym for each particular author. Both ways are acceptable, with the latter offering anonymity for you within the herstory. We would need to discuss whether you wished to use a pseudonym or your real name.

However, having said that, in 1989 there were just under forty members of the DMS. You may have been politically active and therefore have had a high profile within domiciliary midwifery. With the small number of midwives involved in the DMS, you may, despite my best efforts, including the use of a pseudonym, be identifiable within the context of the story that would be written around your contribution. If this is so, there may be repercussions in your personal and/or professional life, including your work place.

Can you withhold any single piece of information from being used but have others included?

Yes. Any information that you have authored will be listed and I will make it available for you to read. When you have made a decision about its use, then you either sign that it can be used or you can delete it from the list. I have attached an example the 'Schedule for Release' in which I have entered fictitious information so you can see how this would work. The decision as to inclusion or exclusion is entirely yours ~ there will be no questions asked as to why you request something is deleted.

What if you want to withdraw after you have said yes?

If you decide to allow your contributions to be used, I will ask you to sign a Consent Form. You will, of course, retain the right to withdraw from the study ~ again, without question ~

at any stage prior to me submitting the ‘research report’ for examination. It would only need you to let me know of this decision.

Will you have a chance to see the context in which your contribution has been used?

Yes. The text in which your contribution has been woven will be sent to you. This will include any articles submitted for publication during the study.

What if you don’t agree with my analysis of events?

Any differing interpretations or analyses of events I would see as being resolvable within the partnership relationship through negotiation and open, honest and effective communication. If this was not able to be resolved we would negotiate what gifts would be included or excluded.

Will it cost me anything?

No ~ I pay for photocopying, postage, stationery, phone calls etc.

What will happen to the Secretarial Archive after the study has finished?

The Archive remains the property of the DMS. You will be asked to classify the future availability of any document listed on the ‘Schedule for Release’ and this will be taken into consideration by the Society when the members decide where it will be permanently housed. It is currently stored in my private study.

Are you able to contribute any other relevant material for the study?

Yes! If you have any photographs, reflections or simply anything you feel would be valuable to include in this herstory, I would be very pleased to look at them.

What needs to be done if you are willing to participate?

If you are happy to participate in this study, you can let me know when I ring on
[date to be filled in].

In the meantime, I would welcome any enquiry you may have regarding this project. You are able to contact me at the address below, or if you would prefer my supervisor Rose McEldowney, at the Post Graduate School of Nursing and Midwifery, at Victoria University of Wellington, PO Box 600, Wellington, phone 04 463 6651.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organization.

I look forward to hearing your decision.

Yours in midwifery

Maggie Banks

Home Birth Midwife

Ph: 07 856 4612

Fax: 07 856 3070

E-mail: banks@ihug.co.nz

APPENDIX 5a: Schedule for release of material from the Domiciliary Midwives Society (Inc.) secretarial archive for the study (Example only)

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui



‘Domiciliary Midwives and the Domiciliary Midwives Society’

If you agree to the following material being used, please initial in the YES box OR

If you do not agree to this material being used, rule through the boxes (as illustrated below)

Date	Addressed to	Type of document	Content	Yes	Archive Catalogue No.	Future Access
03.12.84	Secretary DMS	Letter	Hospital support in getting sterile supplies	OW	DMS/00 4/4	A
21.07.83		Domiciliary Midwife's Report presented at DMS meeting	Discussion about support received in hospital	OW	DMS/00 4/3	A
04.07.88	Charlene Dickens	Letter	Complaint re Dr Slop and Nurse Gamp	OW	DMS/00 4/8	B
15.11.87	Secretary DMS	Letter	Feedback on hours spent in client care for submission re Maternity Benefits	OW	DMS/00 12	A
26.02.81	Gerty Battersby	Letter	NZNA meeting re 'Policy Statement on Home Confinement'		DMS/00 4/1	B
16.10.82		Domiciliary Midwife's Report presented at DMS meeting	Discussion of harassment by Dr Mickey and Nurse Mouse following transfer of unwell baby	OW	DMS/00 8	A

Author's Name: Olive Winterbottom

Signed:

Date:

CLASSIFICATION FOR FUTURE USE

A = Unrestricted

B = Permission required from author

APPENDIX 5b: Schedule for release of material from the Domiciliary Midwives Society (Inc.) secretarial archive for the study

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui



‘Domiciliary Midwives and the Domiciliary Midwives Society’

If you agree to the following material being used, please initial in the YES box OR

If you do not agree to this material being used, rule through the boxes, (as illustrated below)

Date	Addressed to	Type of document	Content	Yes	Archive Catalogue No.	Future Access

Author's Name:

Signed:

Date:

CLASSIFICATION FOR FUTURE USE

A = Unrestricted

B = Permission required from author

APPENDIX 6: Consent form (B) to participate in the research project

VICTORIA UNIVERSITY OF WELLINGTON

Te Whare Wananga o te Upoko o te Ika a Maui



‘Domiciliary midwives and the Domiciliary Midwives Society’

I have read and I understand the ‘Information (B) About The Study’ dated 1 February 2002. This information is for participants taking part in the study designed to explore the experiences of domiciliary midwives prior to August 1990 and to write an herstorical account of the Domiciliary Midwives Society (DMS). I have had the opportunity to discuss the study. I am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary and that I may withdraw my information from the study at any time prior to submission for examination and this will in no way cause penalty of any sort.

I have had time to consider whether to take part.

Choose only one box to circle yes or no and strike out the other box:

I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.	
---	--

I consent to my name being used in reports on this study.	YES/NO
---	--------

I know whom to contact if I have any questions about the study.

I consent to my contributions, as listed on the ‘Schedule for Release of Material from the Domiciliary Midwives Society (Inc.) Secretarial Archive’, being used in this study.

YES/NO

I wish to have a copy of further publications and presentations that will result which elaborate on this study.

YES/NO

I hereby consent to take part in this study.

Date

Signature:

Full name of Researcher: Maggie Banks

Contact Phone Number: 07 856 4612 Email: banks@ihug.co.nz

Project explained by Maggie Banks

Project role: Principal Investigator

Signature:

Date:

APPENDIX 7: Transcriber confidentiality form for the study

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui



‘Domiciliary Midwives and the Domiciliary Midwives Society’

I agree to maintain confidentiality when transcribing the participant’s audio taped interviews.

I will not disclose any information related to participants in the research project.

I understand that the only communication I have related to transcribing the audiotapes will be with the researcher, Maggie Banks.

Signed:

Name of the Transcriber:

Date:

APPENDIX 8: National application form for ethical approval of a research project

A 05/99

Page 1

PART I : BASIC INFORMATION

Protocol number and date
received (for office use only)

1. Full project title

‘The personal mandate to practise midwifery prior to 1990: A tale of domiciliary midwives and the Domiciliary Midwives Society (Inc.) of Aotearoa/New Zealand.

2. Short project title (lay title)

‘Domiciliary Midwives and the Domiciliary Midwives Society’

3. Lead Principal Investigator’s name and position

Maggie Banks ~ Home Birth Midwife

	Work ph	
07 856 4612	Home ph	
07 856 3070	Fax	
banks@ihug.co.nz	E-mail	

5. Lead investigator’s qualifications and experience in past 5 years (relevant to proposed research)

I am a registered midwife and have been in home birth practice since 1989.

The midwives and the organizational structure I intend to research involves home birth midwives and their organization ~ the Domiciliary Midwives Society. I am a member of that Society.

I am undertaking this study in the Masters programme in the Graduate School of Nursing and

Midwifery at Victoria University of Wellington.

6. Co-investigators' name(s) and position(s)

A	NIL
B	
C	
D	

7. Address of co-investigator A

N/A	Work ph	
	Home ph	
	Fax	
	E-mail	

EA 05/99

Page 2

8. Address of co-investigator B

	Work ph	
	Home ph	
	Fax	
	E-mail	

9. Address of co-investigator C

	Work ph	
	Home ph	

	Fax	
	E-mail	

10. Address of co-investigator D

	Work ph	
	Home ph	
	Fax	
	E-mail	

11. Where this is supervised work

11.1 Supervisor's name	Rose McEldowney
Position	Senior Lecturer, Nursing & Midwifery, Victoria University of Wellington
Day time phone number	04 463 6651

11.2 Signature of supervisor (where relevant)

Declaration: I take responsibility for all ethical aspects of the project

--

12. List any other New Zealand Ethics Committees to which this project has been submitted and attach their letters of approval where available

Auckland
Canterbury
Bay of Plenty
Manawatu/Whanganui
Wellington
Otago
Southland

13. I wish the protocol to be heard in a closed meeting ☐ Yes ☒ No
(If yes the reason should be given in a covering letter)

14. I request a fast track procedure ☐ Yes ☒ No

15. Proposed starting date (dd/mm/yy)	01/04/02
16. Proposed finishing date (dd/mm/yy)	30/10/05
17. Duration of project (mm/yy)	06/03
18. Proposed final report date (mm/yy)	01/06

EA 06/99

Page 3

PART II : PROJECT SUMMARY

1. Multicentre proposals

(Important: read the guidelines, Appendix 1)

	Yes	No
1.1 Is this a multicentre study? (if no, go to question 2)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1.2 Is this committee the primary ethics committee?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If **no**, name the primary ethics committee

1.3 Has the protocol been submitted to any other ethics committees ☒ ☐
in New Zealand? (If **yes**, attach copies of relevant correspondence)

1.4 Who is the lead investigator or institution in New Zealand?	Maggie Banks
1.5 List the other New Zealand centres involved, and the Principal Investigator for each centre	Whangarei Auckland Tauranga

Palmerston North Wellington Christchurch Dunedin Invercargill Maggie Banks is the Principal Investigator for each centre.
N/A

1.6 If the study is based overseas, what other countries are involved?

2. Scientific Assessment

Has this project been scientifically assessed by independent review?

	Yes	X	No
--	-----	---	----

If **yes**, by whom? (name and position) A copy of the report should also be attached

If **no**, is it intended to have the project scientifically assessed, and by whom?

N/A

3. Data and Safety Monitoring Board (DSMB)

3.1 Is the trial being reviewed by a data and safety monitoring board?

	Yes	X	No
	Sponsor		HRC

If yes, who is the funder of the DSMB?

4. Summary

Give a brief summary of the study (not more than 200 words, in lay language)

This is an herstorical study about domiciliary (home birth) midwives and the Domiciliary Midwives Society (Inc.) between c.1981-1990. The study includes researching the history of the Society using its Secretarial Archives and interviewing up to thirteen midwives who were members of that Society. The research will illuminate what it was like to be a practising domiciliary (home birth) midwife prior to the return of midwifery autonomy in 1990 and the difficulties and/or ease of practice.

PART III : PROJECT DETAILS

Scientific Basis

1. Aims of Project

1.1 What is the hypothesis/research question(s)? (state briefly)

This research project is an herstorical enquiry into domiciliary midwifery practice in Aotearoa/New Zealand prior to the 1990 Amendment to the Nurses Act, 1977. It will explore how and why the midwives of the Domiciliary Midwives Society Inc. (DMS) established and operated their Society and give voice to the experience of being a domiciliary midwife.

1.2 What are the specific aims of the project?

To study the experiences of the domiciliary midwife prior to August 1990.

To undertake an herstorical inquiry into the Domiciliary Midwives Society (Inc.).

To preserve the Secretarial Archive of the Domiciliary Midwives Society (Inc.).

2. Scientific Background of the Research

Describe the scientific basis of the project (300 words maximum) Where this space is inadequate, continue on a separate sheet of paper. *Do not* delete page breaks or renumber pages.

Joan Donley, an Auckland domiciliary midwife from 1974, has been the major contributor to the herstorical account (mid 1970s until the early 1990s) of the domiciliary midwife in New Zealand. Joan's landmark work, *Save the Midwife* (Donley, 1986) analyzed midwifery, nursing, medical and legislative events up to 1985 that led to the almost complete subsuming of midwifery into nursing. She further explored aspects of the domiciliary midwife's reality in *Herstory of the NZ Homebirth Association* (Donley, 1992), following her until 1991. Other investigators (Papps & Olssen, 1997) have focused more on midwifery in general rather than on the specific.

A unique herstorical record exists within the Secretarial Archival of the Domiciliary Midwives Society (Inc.). This Archive contains submissions, minutes, midwives reports, newspaper clippings, letters, publications and miscellaneous documents which demonstrate both the work of the domiciliary midwife and the challenges that her personal autonomy presented. While my own practice experience as a domiciliary (and now home birth) midwife helps inform this study, the

Archive captures the specific midwifery culture of the late 1970s to 1990 period, which has not been studied in the depth the Investigator intends.

While the Secretarial Archive provides a ‘closed door’ to the midwifery herstory of the time period, the ‘open door’ (Raleigh Yow, 1994, p.10) of interviews provides opportunity for the domiciliary midwives to interpret events and discuss their significance, thus achieving a ‘complete and meaningful picture’ (Josselson & Leiblich, 1993, p. xi).

In studying the lives, work and philosophical underpinnings to domiciliary practice, there are valuable lessons to be learned that can be applied to policy, practice and content of midwifery education. This project is a unique opportunity to make a significant, substantive and original contribution to the body of knowledge on midwifery herstory.

References:

Donley, J. (1986). *Save the Midwives*. Auckland: New Women’s Press.

Donley, J. (1992). *Herstory of NZ Home Birth Association*. Auckland: Author.

Josselson, R. & Lieblich, A. (Eds.). (1993). *The Narrative Study of Lives - Vol. 1*. London: Sage Publications.

Papps, E. & Olssen, M. (1997). *Doctoring Childbirth and Regulating Midwifery in New Zealand: A Foucauldian Perspective*. Palmerston North: Dunmore Press.

Raleigh Yow, V. (1994). *Recording Oral History. A practical Guide For Social Scientists*. London: Sage Publications.

EA 06/99

Page 5

3. Participants

3.1 How many participants is it intended to recruit?

Up to thirteen will be recruited for the interview phase and the remainder of the Society members will be approached about contributing their personal Archival material.

3.2 How will potential participants be identified?

The participants will be identified through the Secretarial Archive of the Domiciliary Midwives Society and through the Investigator’s knowledge of the midwives.

3.3 How will participants be recruited? (e.g.

Initial contact will be by telephone, email or in

advertisements, notices)

3.3.1 Where will potential participants be approached? (e.g. outpatient clinic) If appropriate, describe by type (e.g. students)

3.3.2 Who will make the initial approach to potential participants?

3.3.3 Is there any special relationship between the participants and the researchers? e.g. doctor/patient, student/teacher

person

Potential participants will be approached in their homes

The Principal Investigator, Maggie Banks will make the approach

The Principal Investigator has collegial relationships with most of the potential participants

3.4 Briefly describe the inclusion/ exclusion criteria and include the relevant page number(s) of the protocol or investigator's brochure

The selection criteria for potential participants in the study are that they:

Were members of the Domiciliary Midwives Society prior to August 1990;

Were contracted to the Minister of Health;

Provided a continuity of midwifery care home birth service; and,

Worked in partnership with a home birth consumer group.

In October 1989, there were 128 domiciliary midwives contracted to the Minister of Health. There are thirty-eight who fill all the above criteria.

Up to thirteen participants who were active within the Society and the midwifery profession will be selected from my own practice knowledge as well as the documentation in the Secretarial Archive.

The selection of authors of Archival material will be made according to which data the researcher wishes to use in the herstorical account of the Society.

3.5 If randomisation is used, explain how this will be done

N/A

4. Study Design

4.1 Describe the study design. Where this space is inadequate, continue on a separate sheet of paper. *Do not* delete page breaks or renumber pages.

Data will be gathered during semi-structured interviews that will be guided by the following themes:

Phase 1 The two domiciliary midwives who functioned as secretaries to the Society over extended periods and a third, instrumental in the networking that established the Society, will be interviewed. This interview will focus on the critical events that initiated formation of Domiciliary Midwives Society, processes of establishing and decision-making, networking systems and financial matters.

All participants, including those as above, will participate in the remaining phases as follows:

Phase 2 The question ‘what shaped the domiciliary midwife’s understanding of her personal autonomy?’ will guide the individual interviewing of participants. Background, family, events, influential people, experiences, educational path to midwifery, and belief systems will be explored. The key issues that shaped interpretation of the scope of midwifery practice will identify the path to domiciliary practice.

Phase 3 Each participant will contribute individually to personally reflect on the challenges or ease of practising within the domiciliary midwife’s paradigm. The question guiding this interview is ‘how was this personal autonomy applied to professional practice?’

Phase 4 Following each individual interview, a transcript will be sent for verification, elaboration and amendment. When the transcript of each interview, and its verification process is complete, a completed individual story (written by the researcher) will be sent to each participant. The final interview enables any final verification of the story and allows the interview phase to be ended.

Data will also be gathered from the Secretarial Archive of the Society to elaborate a comprehensive herstory of the Society.

4.2 How many visits/admissions of participants will this project involve? Give also an estimate of total time involved for participants.

Up to six individual interviews lasting 60-90 minutes will be conducted with each participant. It is anticipated that only five participants will have more than three interviews. Average total time involvement is anticipated to be five to six hours each over nine months.

No visits are anticipated to the Archival authors.

- 4.3 Describe any methods for obtaining information. Attach questionnaires and interview guidelines.

Data will be collected during any or all of the following means:

Semi- structured, audio-taped interviews (the preferred method);

Email contact;

Taped telephone conversations; and,

Document review and critique of the Secretarial Archive of the Domiciliary Midwives Society

The interview guidelines are elaborated in 4.1

- 4.4 Who will carry out the research procedures?

The Principal Investigator, Maggie Banks, will carry out all research procedures

- 4.5 Where will the research procedures take place?

The interviews will take place in a mutually agreeable place ~ anticipated to be the participants' homes

EA 06/99

Page 7

- 4.6 If blood, tissue or body fluid samples are to be obtained, state type, use, access to, frequency, number of samples, total volume, means of storage and labelling, length of proposed storage and method of disposal.

Not applicable

- 4.7 Will data or other information be stored for later use in a future study?

☐

Yes

☒

No

If yes, explain how

4.8 Will any samples go out of New Zealand?

☐

Yes

☒

No

If so where, and for what purpose?

5. Research Methods and Procedures

5.1 Is the method of analysis quantitative

☐

or
qualitative?

☒

(If the method of

analysis is qualitative, go to question 5.2)

If the method of analysis is **wholly or partly quantitative**, complete the following:

5.1.1 Describe the statistical method that will be used

☐

Yes

☐

No

5.1.2 Has specialist statistical advice been obtained?

If **yes**, from whom?

(A brief statistical report should be included if appropriate)

5.1.3 Give a justification for the number of research participants proposed, using appropriate power calculations.

5.1.4 What are the criteria for terminating the study?

EA 06/99

Page 8

5.2 If the method of analysis is **wholly or partly qualitative**, briefly describe the analysis. If interviews are to be used include the general areas around which they will be based. Copies of any questionnaires that will be used should be appended.

The interviews and audio-taped phone calls will be transcribed to include all words and features, e.g., long pauses, laughter, tears, sighs and so on so correct emphasis is given to each interview. Please see 4.1 for overview of semi-structured interview themes.

Analysis of the above and including any email commentary and the Archive will look for common themes and those of difference so the individual experience is apparent as well as the collective experience.

The Secretarial Archive will also be analysed to provide the contextual background which will be documented as the herstory of the Society.

6. Risks and benefits

6.1 What are the benefits to research participants of taking part?

The opportunity to reflect on their midwifery practice and the development of midwifery in New Zealand provides the participants the opportunity to contribute to the body of knowledge on midwifery herstory in Aotearoa/New Zealand.

6.2 How do the research procedures differ from standard treatment procedures?

N/A

6.3 What are the physical or psychological risks, or side effects to participants or third parties? Describe what action will be taken to minimise any such risks or side effects.

The psychological risks or side effects and measures to prevent or correct these are as follows:

- Due to the high profile and leadership in midwifery of some of the midwives they may be identifiable despite all measures to ensure non-identification precautions. This will be discussed in the initial information giving and revisited at the last catch-up to ensure they remain comfortable with the inclusion of their information. Personal Archival material will not be used unless consent is given.
- Distressing memories may surface during the interview process. The participant can stop the interview at any stage by either turning off the tape and/or stating she wishes it to stop. She can have any particular comments, discussion or information that may cause distress withdrawn up until the time of the work being submitted for examination. Should distressing incidents arise, the Investigator will initiate a follow up phone call within 48 hours to ensure she is agreeable to continuing participation.
- The researcher's analysis and interpretation of the participant's story may not be compatible with the participant's analysis and interpretation. The participants will have copies of all transcripts of interviews to verify, alter or delete comments and her own words will be used to tell her story. It will be clear in the analysis whether the words are those of the researcher or the participant. Should there be discrepancy in the interpretation, it will be negotiated as to what data will be included. Both those interviewed and those contributing Archival material will retain the right to withdraw any or all of their material from the study at any stage prior to submission for examination. The participants will be provided with the contact information of the Investigator, Supervisors and the regional Ethics Committee, should an issue arise in relation to the study, which they wish to discuss with one or the other.
- All names and identifying information of clients will be removed from the text to ensure confidentiality of client information.

6.4 What arrangements will be made for monitoring and detecting adverse outcomes?

Honest, open and effective communication within the midwifery partnership will ensure participants remain comfortable with their participation in the study.

6.5 Will any potential toxins, mutagens or teratogens be used?

☐ Yes ☒ No

If **yes**, specify and outline the justification for their use

6.6 Will any radiation or radioactive substances be used? ☐ Yes ☐ No

Note: If any form of radiation is being used please answer the following. If no, go to question 6.8

6.6.1 Under whose license is the radiation being used?

6.6.2 Has the National Radiation Laboratory (NRL) risk assessment been completed? ☐ Yes ☐ No

If **yes**, please enclose a copy of the risk assessment, and the contact name and phone number

If **no**, please explain why

6.7 What facilities/procedures and personnel are there for dealing with emergencies?

6.8 Will any drugs be administered for the purposes of this study? ☐ Yes ☐ No

If **yes** is SCOTT approval required? ☐ Yes ☐ No

Has SCOTT approval been given? (please attach) ☐ Yes ☐ No

EA 06/99

Page 10

7. Expected outcomes or impacts of research

7.1 What is the potential significance of this project for improved health care for Maori and non Maori, and for the advancement of knowledge?

a) There is an opportunity to make a significant, substantive and original contribution to the body of knowledge on midwifery herstory.

b) The unique herstorical record of the Secretarial Archive will be preserved and its permanent safekeeping will be assured (to be decided with the Domiciliary Midwives Society) at the end of the study,

7.2 What steps will be taken to disseminate the research results?

The research report will be:

- a) Lodged as a thesis in the library of Victoria University of Wellington;
- b) The Graduate School of Nursing and Midwifery at Victoria University of Wellington;
- c) Made available through publications, including peer reviewed journals; and,
- d) Results will be presented at conferences, workshops and during lectures.

EA 06/99

Page 11

PART IV: BUDGET AND USE OF RESOURCES

8. Budget

8.1 How will the project be funded?

Self funded, though application will be made for financial assistance from local organizations for transcribing and transport costs. The study is not dependant on receiving this funding. Student scholarships will be applied for where Investigator is eligible.

8.2 Does the researcher, the host department or the host institution, have any financial interest in the outcome of this research? Please give details.

8.3 Will the researcher personally receive payment according to the number of participants recruited, or a lump sum payment, or any other benefit to conduct the study? If so, please specify:

8.4 What other research studies is the lead investigator currently involved with?

9. Resource Implications

9.1 Does the study involve the use of healthcare resources?

☐

Yes

☐

No

If **yes**, please specify:

9.2 What effect will this use of resources have on waiting list times for patients ie., for diagnostic tests or for standard treatments?

10. Financial Costs and Payments to Participants

10.1 Will there be any financial cost to the participant? Give examples including travel.

EA 06/99

Page 12

10.2 Will the study drug/treatment continue to be available to the participant after the study ends?

☐

Yes

☐

No

☐

N/a

If **yes**, will there be a cost, and how will this be met?

10.3 Will any payments be made to participants or will they gain materially in other ways from participating in this project?

☐

Yes

☐

No

If **yes**, please supply details

11. Compensation for Harm Suffered by Participants

Is this a clinical trial under Accident Rehabilitation and Compensation Insurance Corporation Guidelines? (see form guidelines)

☐

Yes

☐

No

If **yes**, please answer the following:

11.1 Is the trial being carried out principally for the benefit of a manufacturer or distributor of the drug or item in respect of which the trial is taking place?

☐

Yes

☐

No

(a) If the answer to 11.1 is **yes**, please complete **Statutory Declaration Form B** and answer questions 11.2, 11.3 and 11.4

(b) If the answer to 11.1 is **no** please complete **Statutory Declaration Form A**

11.2 What type of injury/adverse consequence resulting from participation in the trial has the manufacturer or distributor undertaken to cover? (please tick the appropriate box/es)

Yes

No

- a) any injury (mental or physical)
- b) only serious or disabling injuries.
- c) only physical injuries
- d) only physical injuries resulting from the trial drug or item, but not from any other aspect of the trial
- e) physical and mental injury resulting from the trial drug or item, but not from any other aspect of the trial.

f) any other qualification (explain)

11.3 What type of compensation has the manufacturer or distributor agreed to pay? Yes No

- a) medical expenses
- b) pain and suffering
- c) loss of earnings
- d) loss of earning capacity
- e) loss of potential earnings
- f) any other financial loss or expenses
- g) funeral costs
- h) dependants' allowances

11.4 Exclusion clauses:

a) Has the manufacturer or distributor limited or excluded

liability if the injury is attributable to the negligence of

someone other than the manufacturer or distributor? (such

	Yes	No
as negligence by the investigator, research staff, the hospital or institution, or the participant).		
b) Has the manufacturer or distributor limited or excluded liability if the injury resulted from a deviation from the study protocol by someone other than the manufacturer or distributor?		
c) Is company liability limited in any other way?		
If yes, please specify		

EA 06/99

Page 13

12. Information and Consent	
<p>Consent should be obtained in writing, unless there are good reasons to the contrary. If consent is not to be obtained in writing the justification should be given and the circumstances under which consent is obtained should be recorded. Attach a copy of the information sheet and consent form.</p>	
12.1 By whom, and how, will the project be explained to potential participants?	The project will be explained by phone call or in person by the Principal Investigator.
12.2 When and where will the explanation be given?	Explanation will be given when the potential participants are approached. This will be by phone call to the potential participant's home or in person.
12.3 Will a competent interpreter be available, if required?	One week
12.4 How much time will be allowed for the potential participant to decide about taking part?	

12.5	Will the participants be capable of giving consent themselves? - if not, to whom will the project be explained and who will give consent?	YES
12.6	In what form (written, or oral) will consent be obtained? If oral consent only, state reasons.	Oral and written
12.7	Are participants in clinical trials to be provided with a card confirming their participation, medication and contact phone number of the principal investigator?	<input type="checkbox"/> <input type="checkbox"/> Not applicable
13. Confidentiality and Use of Results How will data including audio and video tapes, be handled and stored to safeguard confidentiality (both during and after completion of the research project)?		
<div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> All data will be stored during and after the study in the Principal Investigator's separate and private study and on a separate and private computer, which is not accessed by anyone else. Tapes, identified by numbering and pseudonyms, where appropriate, will be accessible to another person for transcribing purposes. Electronic copy is also protected by a firewall on a personal and private computer network. </div>		
13.2	What will be done with the raw data when the study is finished?	The Secretarial Archive will be stored in a place nominated by the DMS. Tapes will be electronically wiped and
13.3	How long will the data from the study be kept and who will be responsible for its safe keeping?	Data is to be kept for up to ten years after the study's completion. The Principal Investigator will remain
13.4	Who will have access to the raw data and/or clinical records during, or after, the study?	Data will be accessible to the Principal Investigator, a transcriber and the participants (own data only).

13.5 Describe any arrangements to make results available to participants, including whether they will be offered their audio tapes or videos.

Copies of any publications and audiotapes will be offered to

13.6 If recordings are made, will participants be offered the opportunity to edit the transcripts of the recordings?

☐
☐

No

13.7 Is it intended to inform the participant's GP of individual results of the investigations, and their participation, if the participant consents?

☐
☐

Yes

No

If **no**, outline the reasons

Not applicable

13.8 Will any restriction be placed on publication of results?

☐

Yes

☐

No

If **yes**, please supply details

EA 06/99

Page 14

14. Treaty of Waitangi

14.1 Have you read the HRC booklet, "Guidelines for Researchers on Health Research involving Maori"?

☐

Yes

☐

No

14.2 Does the proposed research project impact on Maori people

☐
☒

X

	Yes	No
in any way?		
14.3 Explain how the intended research process is consistent with the provisions of the Treaty of Waitangi		
None of the participants identify as Maori		
14.4 Identify the group(s) with whom consultation has taken place, and attach evidence of their support		
Not applicable		
14.5 Describe the consultation process that has been undertaken prior to the project's development		
Not applicable		
14.6 Describe any ongoing involvement the group consulted has in the project		
Not applicable		

EA 06/99

Page 15

14.7 Describe how information will be disseminated to participants and the group consulted at the end of the project		
<div style="border: 1px solid black; padding: 5px; width: fit-content;">Not applicable</div>		
15. Other Issues		
15.1 Are there any aspects of the research which might raise	<input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No

specific cultural issues?

If **yes**, please explain

Not applicable

15.1.1 What ethnic or cultural group(s)
does your research involve?

Describe what consultation has taken place with the group prior to the project's development

Not applicable

15.1.2 Identify the group(s) with whom consultation has taken place and attach evidence of their support

Not applicable

EA 06/99

Page 16

15.1.3 Describe any ongoing involvement the group consulted has in the project

Not applicable

15.1.4 Describe how you intend to disseminate information to participants and the group consulted at the end of the project

Not applicable

16. Ethical Issues

16.1 Describe and discuss any ethical issues arising from this project, other than those already dealt with in your answers?

Not applicable

Thank you for your assistance in helping us assess your project fully
Please now complete:
the declarations (Part V)
a drug administration form (if applicable)
an Accident Rehabilitation and Compensation Insurance Corporation form A or B

EA 06/99

Page 17

PART V: DECLARATIONS

1. Declaration by principal investigator

The information supplied in this application is, to the best of my knowledge and belief, accurate. I have considered the ethical issues involved in this research and believe that I have adequately addressed them in this application. I understand that if the protocol for this research changes in any way I must inform the Ethics Committee.

Name of Principal Investigator (please print): Maggie Banks

Signature of Principal Investigator:

Date: 15 February 2002

2. Declaration by the Head of the Department in which the principal investigator is located or appropriate dean or other senior manager **

I have read the application and it is appropriate for this research to be conducted in this department I give my consent for the application to be forwarded to the Ethics Committee.

Name and Designation (please print):

Rose McEldowney

Senior Lecturer, School of Nursing & midwifery, victoria university of wellington

Signature:

Date: 15 February 2002

Designation: supervisor

** (Note: Where the head of department is also one of the investigators, the head of department declaration must be signed by the appropriate Dean, or other senior manager.

If the application is for a student project, the supervisor should sign here).

3. Declaration by the General Manager of the health service in which the research is being undertaken (If Applicable)

I have reviewed the proposal for cost, resources, and administrative aspects and issues regarding patient participation and staff involvement. The proposal has my approval subject to the consent of the Ethics Committee.

Name of General Manager (Please Print):

N/A

Signature:

maggie banks

home birth midwife

15 Te Awa Road, R.D. 3, Hamilton, New Zealand

Ph: 64 7 856 4612 Fax: 64 7 856 3070

Email: banks@ihug.co.nz

22 January 2003

The Committee Administrator

Waikato Ethics Committee

PO Box 322

HAMILTON

Dear Juliana

Re: REF NO WAI/02/05/036

**The personal mandate to practise midwifery prior to 1990: A
tale of domiciliary midwives and the Domiciliary Midwives
Society (Inc.) of Aotearoa/New Zealand.**

In response to the Committee's letter of 7 June 2002, please note the following:

- a) I have considered the cultural issues of this project. As none of the members of the Domiciliary Midwives Society Inc. (DMS) were Maori, there are no Maori potential participants within the study.
- b) I am aware of the laws relating to privacy, confidentiality and defamation and have access to legal advice on these matters to ensure I avoid breaching any such law.
- c) The thirteen midwives have been chosen because of the roles they played in the DMS and to ensure representation from all geographical areas where domiciliary midwives practised. I have been careful to ensure there is no inherent bias in their pre-selection. As mentioned above, there were no Maori members of the DMS - thus Maori are not specifically excluded.
- d) My co-supervisor has signed the section 11.2 on page 2 of the application form as

- my supervisor is currently unavailable to do so.
- e) A variety of methods to gather data have been detailed in the proposal. All data will be used to inform the study as background material, interpretation and/or for elaboration. The data used will be that which specifically addresses the first two of the specific aims of the study – namely;
 - To study the experiences of the domiciliary midwife prior to August 1990; and,
 - To undertake an herstorical inquiry into the Domiciliary Midwives Society (Inc).
 - f) The proscribed statement on ethical approval has been added to the Information Sheets (Appendices 1 & 2).
 - g) The proscribed statement on the participants' professional organization contact has been added to the Information Sheets (Appendices 1 & 2).
 - h) Version numbers and dates have been added to all pages of Information Sheets and Consent Forms.
 - i) The proscribed statement has been added to the Consent Forms.
 - j) Contact information for local ethics committees has been deleted from the Consent Forms.
 - k) Witness signatures have been deleted from the Consent Forms.

I have attached the required number of copies (5) of the amended documents as mentioned above.

My apologies for such lateness in responding but practice necessitated me suspending this study's advance until now. I do not anticipate further delays in its undertaking.

Yours sincerely

MAGGIE BANKS

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Abbreviations

DoH Department of Health

DMS Domiciliary Midwives Society (Incorporated)

MSC Maternity Services Committee of the Board of Health

MSIS Auckland Branch of Midwives and Obstetric Nurses Special Interest Section of
 NZNA

NZNA New Zealand Nurses Association

PRIMARY SOURCES

Schedule of catch-ups

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