NEW ZEALAND HOMEBIRTH ASSOCIATION

P . O . Box 7093, Wellesley St, Auckland

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AUCKLAND BRANCH NEWSLETTER - NO. 10

THE RECENT SOCIAL EVENT AND OTHER THINGS.

On Saturday 19th January approximately fifty people came to Cascade Springs for a picnic. The event was so enjoyable, the position so idyllic, and, particularly with the help of Jill and Greg Wittmer's horse, the children so entertained, that unless someone presents a better venue, it was decided to make Cascade Springs (near Kauri Park, on the way to Bethells for those of you who did not come) the regular HBA picnic spot.

But to come to the central issue: Fifty people out of the total current financial membership of approximately 150 is not bad at all. Fifty people out of the total possi membership (i.e. all those people who have joined the HBA since its inception, say abo 450 people) is pathetically small.

It seemed, moreover, that very few members at the picnic who did not already know each other took the opportunity for a conversation. Children of course, preclude seriou and extended discussion, and in fact children, the whole cause of an organisation such as ours, are simultaneously the very reason for its weakness. Homebirth for most membe is a vital issue when expectant parents. Once the birth is over, the time- and energy-consuming task of child rearing begins, and while a person's philosophical commitment to homebirth may still be high, their active, even financial involvement wanes and in many cases, disappears completely. The issue of membership fees is an example of this. If people joined for longer than merely the period around pregnancy and birth, the HBA would have a vastly greater membership and be correspondingly wealthier.

Birth is the beginning, but it is only the beginning. Involvement in the HBA around th period is easy. Involvement after this time is hard. It is abundantly clear that long-term membership, financial or active, is essential in developing a strong HBA.

There are, thankfully, a few people whose commitment to homebirth is greater than mere the immediately personal. These are people who see homebirth as a political issue, i.e who regard a move away from the hospital-doctor-patient complex and the move towards personal responsibility and self-reliance as not only the sanest way to go for the hea and welfare of the individual child and its family, but also see this as a direction that will result in an improvement in society generally.

By the May A.G.M. we will have come to the end of our 3rd year. Although some gains have been made they are slight in comparison with those yet needing to be made. Gains as basic as a comparative pay structure for domiciliary midwives so they no longer hav to live on the brink of poverty($6-7,000p.a. see page one); increasing general practitioners support for home birth so that those G.P. s who do support us are no longer treated like scoundrels by their ignorant and fearful colleagues; the creation of prop domiciliary training within the midwifery training system so that N.Z. trained midwive may be given the opportunity to produce a truly natural birth for a change; and so on.

Being realistic, let's predict what would happen to homebirth if the HBA declines, falters and dies. It would take at least 10 years, if not twice that, before we could return to the same position, shaky though it is, that we hold now. The opponents of homebirth would be increasingly strengthened by such a decline, and all those persons who are vacillating between the two positions would have no alternative but to believe in the rubbishy propaganda that homebirth is dangerous, because there would be no homeb

The HBA is in danger of decline. It needs more members, it needs more committed membe it needs more money. Please do something to help.

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****** A RECORD NOT TO BE REPEATED: **** JOAN DONLEY HAS DELIVERED EIGHT BABIES IN TEN DAYS. WE NEED MORE MIDWIVES NOW. **********

THE NORTH SHORE SUPPORT GROUP IS AN EXAMPLE TO US ALL !! **********

Pauline Proud sent us the following programme to show how they manage to keep going so successfully:

> The support group will phone you a few days before each meeting to give details and venue. Your support group contact no: is 453 489 (Pauline Proud) and 4789 418 (Cathi Sadler).
>
> The meetings will commence about 7.30 p.m. and will take the form of informal discussions. We recommend the expectant mother's partner attend, or a support person; We also extend an open invitation to anyone who is interested.
>
> The midwife likes to attend each meeting. This is an opportunity to get to know the midwife attending your birth. We ask for a donation of 50 cents per meeting to help us provide books, leaflets and cover postage expenses, we hope to extend our library.

MEETINGS:

1. PREPARATION FOR YOUR 'BIRTHDAY'

   A discussion of practical and emotional preparation for delivery at home. Experienced home birth fathers are invited to lead this discussion, to describe their support before, during and after the birth.

2. THE BIRTH PROCESS

   The midwife talks about the importance of diet during pregnancy, and avoidance of drugs, alcohol and tobacco. She also describes normal pregnancy and labour and aspects of safety.

3. METHODS OF COPING WITH LABOUR AND DELIVERY

   Exercise and breathing techniques, featuring talks by a Lamaze instructor, but including Yoga and other methods. Courses of various kinds are available on the Shore - if this meeting does not come around early in your pregnancy and you wish to join antenatal classes (e.g. Parent Centre, Lamaze) phone your support group for details.

4. AFTER THE BIRTH

   A discussion of the needs of the family in the days and weeks after the birth; the contribution of the midwife at this time, the importance of breastfeeding and contraception. Speakers are invited from La Leche League.

INFORMAL COFFEE MORNING - This is a chance to generate interest and share experiences. Bring along your curious friends, children and babies. Plate optional.

The information available, and the enthusiasm generated at the group meetings help prospective parents prepare calmly and confidently for the birth. We hope you enjoy them.

N.B. The thoughts and opinions expressed by the speakers are their own and not necessarily those of the Home Birth Association.

****** NOTE THESE DATES ! **********

*Coffee morning, Highbury House - Wednesday 11th February.
*Evening meetings at 7.30pm:
Tuesdays 3.3.81 Methods of coping with labour and delivery
7.4.81 After the birth
5.5.81 Preparation for your 'birthday'
2.6.81 The birth process
As the venue changes, please ring Pauline 453 489 or Cathi 4789 418 for info.

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PATIENTS' RIGHTS : DO YOU KNOW THEM?

Barbara McFarlane (Secretary of the Homebirth Association, and the major half of our Legal Department) has provided a précis of the chapter on 'Hospital Patients' in The New Zealand Civil Rights Handbook, an excellent and thought-provoking book by Tim McBride. This is the 1980 edition and the price is $15.50.

It is useful to have this to hand not only for our own information, but also to show others who may not be so conscious of their personal rights, particularly with regard to the medical profession.

1. The Introduction to this chapter, page 207, states "Traditionally, little attentio has been given to the legal rights of hospital patients. When people are ill, thei first priority is to regain their health. While in hospital, many patients simply accept that the 'Health Department', 'hospital', or 'Doctor' knows best. Under these circumstances, they often give up rights which in other situations they migh vigorously assert. As a result, hospital patients have come to be regarded as possessing few rights, little dignity, and no status".

2. Admission: Admission forms require detailed personal information. Every patient should receive a copy of the 'Hospital Patients' Code of Rights and Obligations' which has been prepared by the Auckland Hospital Board and is available in a number of languages. The Board may direct you to attend a particula hospital.
   Discharge: Patients are free to leave when they choose. Patients wishing to leave without the permission of the medical staff are usually required to sign a form absolving the hospital of any legal responsibility. (The form should be amend ed by the patient to absolve the hospital only from injurious effects which follow from early discharge.)

3. Consent: To be a valid consent for treatment the following requirements mu be observed: (a) The consent must be free and voluntary. No restraint. Consent obtained by compulsion or fraudulent misrepresentation is invalid. Consent under sedation may be challeng eable.
   (b) The patient must be given sufficient information to make an informed choice. The amount of information required to satisfy this will depend on the condition and state of mind of the patient.
   (c) A general consent must not be so wide as to be meaningless. T usual consent form, 'I hereby give consent to any operative treatment considered necessary by the surgeon in charge of the case...' is far too wide. (Do not hesita to negotiate and amend forms.)
   (d) The consent of a guardian is required for medical or surgical procedures on those under 16 years.
   Consent is not necessary for emergency blood transfusions; a blood test after a motor vehicle accident does not require consent; both partners are required to consent to artificial insemination and the hospitals usually require this for sterilisation, though this requirement is of doubtful validity.
   In New Zealand the Accident Compensation Act 1972 precludes any civil proceedings in reality actions for failure to obtain necessary or valid consents have only the remedy of criminal proceedings for assault which is not recommended except in the most extreme circumstances.

4. Confidentiality: The Code of Medical Ethics imposes absolute secrecy on all patient confidences. The New Zealand law however recognises privilege only where the confidence is made to the physician or surgeon in his official capacity, and is not subject to criminal proceedings or for a criminal purpose. The privilege does not apply to psychologists, social workers (or, it would seem, domicil iary midwives). The Evidence Amendment Bill may rectify some of these problems. Disclosure of medical information, except of a general kind to relatives and the press etc. is prohibited without the patient's consent except in the case of legal proceedings. The Health Amendment Bill contains provisions on computer secrecy etc.
   There is no general legal right of access by a patient to his/her medical records which are the property of the hospital. Unless an order for discovery is issued by the Court, the hospital has no legal obligation to give the patient access to the record.

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5. Complaints: (a) If there is dissatisfaction with the quality of service received from a doctor, his/her fee or behaviour, the matter should first be discussed with the doctor. If this is unsatisfactory or the matter is too serious then a formal complaint should be made to the Disciplinary Committee of the N.Z. Medical Association. The Association prints a pamphlet 'Complaints about the Medical Services - What to do if something goes wrong' and gives the following advice: Write to the General Secretary, The N.Z. Medical Assoc., P.O.Box 156, Wellington. Set out simply the nature of the complaint and ask for it to be passed the disciplinary committee. Be sure to include your full name and address, name of the doctor, correct date and time of day when the consultation took place. Enclose the account if the matter refers to a fee charged, and have the doctor personally sign it. S/he is obliged by law to do this. Your complaint re a fee must reach the Association within the month after you receive the account. You can't be forced to pay until the enquiry has been completed. The procedure takes time, so be patient.

If the Committee finds professional misconduct then it may censure the doctor or fine him. If the conduct is felt to have been disgraceful conduct in a professional respect then the matter is referred to the Medical Council who have powers to remove the doctor from the medical register, suspend her/him from practice, fine, censure, or order payment of costs. A lesser charge of 'conduct unbecoming to a doctor' may be referred to a Divisional Disciplinary Committee for investigation.

(b) If the complaint concerns the quality of nursing care or the condition of the ward, the Charge Nurse or Sister of the Ward should be informed. If the complaint relates to the member of a particular department, then the Head of the Department should be advised.

Complaints may also be made to the Medical Superintendent if the matter involves hospital administration or the conduct of staff. The District Office of the Dept of Health deals with complaints concerning over-charging, abuse of the medical benefits scheme, conditions in private hospitals, but not professional misconduct. Formal complaints against nurses may be made to the Registrar of Nurses appointed by the Nursing Council.
The Ombudsmen deal with matters of administration not of professional misjudgement but have investigated whether patients received sufficient information before consenting to treatment and whether access should be given to the patient's own records.

6. Civil and Criminal Proceedings: Section 61 of the Crimes Act protects doctors from criminal liability where they perform with reasonable care and skill any surgical operation where the operation is for the patient's benefit. The Accident Compensation Act 1972 precludes civil proceedings for personal injury by accident which expressly includes'medical or surgical misadventure'.

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********** NEWS FROM OTHER CENTRES **********

The Dunedin Branch of the Home Birth Association has sent us a copy of their newsletter and seem to be doing amazingly well in spite of having no domiciliary midwife at all; they report that they were on their regional news television programme last year (for grand three minutes), and that they have been speaking at several obstetric seminars in Dunedin, making their voices heard in professional places. Also, we hear that the number of doctors in Dunedin "prepared to consider home births" has doubled to two!!

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HOMEBIRTH AT NAMBASSA

Ina May Gaskin, author of'Spiritual Midwifery', was one of a panel of people (Kiet Moonen, domiciliary midwife; Helen Brew, producer of 'Birth With R.D.Laing'; John Nealie, Waimauku G.P.; and Rukmini Venkataiah,consumer) which offered a 2-hour symposium covering many aspects of homebirth - both political and personal-to about 500 people. This was extremely well received, and Kiet and her husband were clever enough to record all of it, plus Ina May's talk - highlights of these will be serialised in successive newsletters. Kiet reports that Ina May, whom she has held in awe for so long, was totally different from what she expected "I thought she'd be incredibly high-powered, but she's just a tremendously good midwife who loves people. She's totally untrained officially, all her training is through reading and practical experience." Kiet ran the HB stall for 2½ days totally unaided...Were YOU at Nambassa???

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The following code of rights and responsibilities was drawn up in 1978 by the N.Z. Nurses Association:

PATIENTS' CODE OF RIGHTS

The following is a list of the rights every person has as a consumer within the health services:

1 The right to be treated with reasonable skill and care by professionally qualified personnel.
2 The right to know the identity and professional status of all persons providing health services and the role each of these persons is to play in the health care programme.
3 The right to full information about, and access to, free health care services whenever and wherever such facilities are available.
4 The right to prompt attention, especially in an emergency situation.
5 The right to be treated with respect and dignity and to be afforded privacy during discussion and treatment.
6 The right to have an interpreter where English is not understood.
7 The right to observe cultural, ethnic, and religious practices and customs if able to be reasonably accommodated by the health care facility.
8 The right to wear whatever clothing is desired with consideration for others, unless special clothing is required for specific examinations and treatments.
9 The right to confidentiality in respect of all communication (verbal and written) between health care personnel and the person concerned. However, hospital authorities may be required to give some information to Government departments.
10 The right, if hospitalised, to have reasonable contact with persons outside the hospital or institution by means of visitors of choice and by ready access to the telephone.
11 The right to have close friends or relatives stay 24 hours a day with children, terminally ill and critically ill patients, providing in the case of critically ill patients it is not medically contra-indicated.
12 The right to receive full information (in layman's terms) about his/her health or illness, the proposed course of treatment, any risks attendant on such treatment, the outcome and prognosis.
13 The right to participate in decisions regarding his/her health care programme.
14 The right to clear, complete, and accurate information about the nature and purpose of any proposed examination, test, treatment, or procedure and whether this is for research, education, or treatment purposes before being asked to consent.
15 The right to refuse to undergo any test, examination, treatment, or procedure unless the type imposed by tute. Such refusal should not in itself render a pat liable to be discharged from hospital.
16 The right of access to and interpretation of all informa contained in his/her medical records.
17 The right to have arrrangements made for subseq health care and prior notification of a person of his choice before being discharged from a health care facil
18 The right to leave a health care facility before comple of treatment, but he/she may be expected to sign a st ment releasing the facility and its staff from any fur responsibility.
19 The right to have his/her directions for terminal care spected, providing an illegal act is not involved.

If any of the foregoing rights are disregarded, he/she has right to bring this to the attention of the relevant authori

PATIENTS' CODE OF RESPONSIBILITY

A consumer within the health services, as well as rights, the following responsibilities:

1 To inform appropriate health personnel if unable to keep appointment.
2 To acquaint himself with, and abide by, the rules and re lations of the health care facility.
3 To be completely frank and honest with health person about health, current medications and treatments, previ illnesses and treatments, and family history of illness w questioned.
4 To ask for clarification or further explanation of anyth not understood.
5 To co-operate honestly with treatment agreed upon.
6 To respect the privacy of other patients and to keep confidence any information gained about them.
7 To respect other patients' observations of religious, c tural, and ethnic practices.
8 To show consideration to other patients in regard to no levels, lighting, smoking, and conduct of visitors.
9 To advise the appropriate authority of any complaint.

How these rights and responsibilities could be legall plemented is an open question. Some rights could possib made legally enforceable in the courts. Other rights might w enforced by, for example, a specially appointed patients budsman working within a particular hospital but completely pendent of the hospital administration. Such an official co called simply the complaints officer or, perhaps, the patients cate.

********** IN THE NEWS **********

The latest contortion of a maternity hospital: Making hospital like home?...

(a) with architecture: Recently the N.Z.Herald printed a short news item about an imminent development at Britain's famous maternity hospital, Queen Charlotte's, in London: A "special family viewing room", where relatives can watch births, is to be se up. The room will be made to look as much like a bedroom at home as possible (whose bedroom!!?) - "the whole idea is to make it feel like home". Also, the births will be "natural" without monitoring or any other equipment being used, they say.

(b) with the company: New Scientist magazine (Sept 1980) reported a study of women in a maternity hospital in Guatemala City. The study compared the deliveries of 20 women who had a companion with them, and 20 who were left alone with medical staff during their deliveries. They found that labour was on average shorter for the women with a friend present; and that that group had a lower incidence of labour complicati also, the mothers with a companion spent more time stroking, smiling and talking to th newborn babes.

No doubt this sort of "scientific" study will be used as evidence for the need for a 'birth companion' in hospitals, and, with the shining example of Queen Charlotte's, women will soon be allowed to have their babies in a home away from home. What can on say? It all sounds a bit too much like the wolf in expensive lambswool clothing...

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CAMPAIGN AGAINST DEPO PROVERA

A "WONDER-DRUG", A MANUFACTURER'S MONEY-MAKER, AND A DANGER TO WOMEN

A campaign against Depo Provera has been formed in New Zealand. Depo Provera (D.P.) is given as an injection every three months to prevent pregnancy.
D.P. is banned for general contraceptive use in the USA, Britain, Australia, Canada, and Sweden. It is, however, used in over 70 countries - most are 'developing nations' and New Zealand is one of them. In N.Z, it is estimated that approx. 40,000 women are receiving D.P. and it is subject to no controls other than that it is available on prescription.
The Effects of Depo:Although D.P. is extremely effective in preventing pregnancy (95-98% effective), it can have other 'side effects', and is linked with serious dangers:

In animal and human studies it has been associated with cancer of the breast and cervix; it has been associated with increased incidence of malformation in foetuses in women already pregnant when given the drug; it has been shown to cause longterm infertility and possibly permanent sterility in some women after they have stopped using it; it frequently causes severe depression, and has been found to have other effects such as weight gain, mood changes, loss of sex drive, hair loss, acne and headaches; it is also passed on in breast milk at the same level of concentration as is found in the mother's blood stream. Therefore, the baby receives an orally active dose of the hormone. This interferes with the immunoglobulins in breast milk.

The Campaign Against Depo (C.A.D.) has several aims, which include:

1. Stopping the current New Zealand contraceptive study funded by the US manufacturers of D.P., Upjohn. This study, already underway, will involve 12,000 women, 3,000 of whom will be using Depo.
2. Collecting information on D.P. use in N.Z. - to date the use of Depo has not been monitored here (except for some very limited information collected by the Committee on Adverse Drug Reactions).
3. Informing women and health professionals of the facts about Depo, instead of leavi the information dissemination to the makers of the drug who have, of course, a vested interest in its widespread use.
4. Supporting and promoting safe, effective contraception and freely available abortion where it is needed.

What you can do:

* Form a C.A.D. group in your area and link up with national C.A.D.
* Collect information of D.P. use in your area and send it to the campaign.
* Distribute leaflets to women in your area to inform them of the dangers associated with D.P. usage.
* Pressure the Minister of Health and your local M.P. to have D.P. banned and the Upj study stopped.
* Raise money or donate money to C.A.D. towards printing multi-language leaflets on barrier contraception which is safe to use and most effective contraception when th user is fully informed of the correct way to use it.

Write to: Campaign Against Depo,
12 Hayward Road, Papatoetoe, Auckland.

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NATIONAL SPOKESPERSON FINALLY GETS INTO PRINT:

In accordance with HBA policy to use anything relevant for publicity, the following piece, which was reduced (somewhat incorrectly) from two foolscap pages presented radio and newspapers, appeared in the Auckland Star 30/12/80.

Home births 'at risk'

Closing the Howick and Helensville obstetric hospitals could threaten the growing move to home births, the Home Birth Society believes.

(The chief executive of the Auckland Hospital Board, Mr Les Corkery, had said this might have to be done following a further cut in the board's budget.)

Dr Derryn Cooper, speaking for the society, said the closure of small maternity hospitals increased the risk of home delivery in outlying areas.

In an emergency, the woman and baby would have to be transferred farther to the larger base hospitals.

She said a recent survey in West Auckland showed 10 times more people wanted home births than were able to have them, because of the limited services available.

Parents who opted for home birth were saving the country considerable amounts of money, she said. A home birth cost $140, and a hospital birth cost about $700.

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'NEW DOCTOR'

An Australian radical doctors' magazine, called New Doctor, has recently had some interesting articles on pregnancy and childbirth:

FOETAL MONITORING

Judith Lumley, writing about foetal monitoring, showed that the evidence for the positi effects (preventing perinatal deaths from oxygen deficit) of monitoring foetal hear rate and foetal scalp blood during birth, is unclear. Research reports are contradictor in their findings: some showing a fall in perinatal mortality, others showing a measurable extra hazard to both mother and infant, and some showing no differences in controlled experiments using intravaginal foetal monitoring procedures.
The author concludes that " the foetal monitoring story is in microcosm the story of th whole obstetric decade. It includes the powerful professional urge towards'scientific management'; the commercial and other pressures first to acquire and then, increasingly to use expensive equipment; the devaluing of clinical skills; the philosophy of, that which is good for 10% of women should be given to 100%, to be on the safe side; the gre debate between 'intensive care' and 'back to nature' views of birth...As with other debated procedures, it is unfortunate that the available evidence cannot settle the questions once and for all".

CHILDBIRTH: A CULTURAL RITUAL

In an interesting article which links anthropology and obstetric care, Pia Brous suggests a rationale for the continuation of practices in obstetrics which are of dubious value (eg : The supine position of labour, which has been described as " optimal for intervention" , and least effective for labour and delivery" and the pubic shave, which has been shown to be of no hygenic value.) . She suggests that these practices may serve the function of cultural rituals; and that these rituals are consistent with the values of the nineteenth century during which modern obstetric care arose. She also suggests that "the form such rituals take in obstetrics reflects the culture's attitudes towards women, reproduction and medicine"...
She states: "In our culture the lack of certainty of the outcome of birth, and the danger of giving birth, or of being born, are emphasised by the significance placed on the unexpected emergency./
"Segregation of the pregnant woman occurs when she is separated from her home environme and from most of her family and friends for the birth, after which she is permitted to return home. This culture's attitudes towards women and medicine in obstetrics are indicated by childbirth being highly medicalised; by the woman being a passive recipient of her medical care; and by her being addressed by hospital staff as if she were a chil and often a naughty one at that.
"The obstetric education of medical students involves their training in the expectation of danger, and the appropriate rituals. Obstetric complications and emergencies are much emphasised... Purity, order and hygiene are important. Gloving, gowning, masking, capping and draping are taught carefully in the delivery room. In fact, even today, in some teaching hospitals in the state of Victoria, medical students wear total white from head to foot for their entire undergraduate obstetric training, whether in the labour ward, lecture theatre or cafeteria."

Brous suggests that these practices may relate as much to the purity/pollution rites of childbirth in"primitive"societies, as to issues of scientific indication.

She concludes that "the appropriateness of obstetric cultural rituals is being challenged, because of the many changes in attitudes towards women, consumer autonomy, and the medical establishment".

CLASS IS A DANGER TO HEALTH AND LIFE

** In addition, Brous makes the important point that although obstetrics is safer now than in the nineteenth and early twentieth centuries, women in low socioeconomic classes suffer the highest rates of perinatal mortality and foetal damage . Obstetric risk factors such as smoking, alcoholism, poor weight gain in pregnancy and scanty antenatal care, as well as low levels of certain vitamins in maternal blood, are cited as being more common in this group.
Also, Brous states, many complications of pregnancy and labour coexist with life situations which have the characteristics of a high level of life stress, and few psychological supports. This configuration is more commonly found amongst women of lower socioeconomic class.
To conclude this section of her paper, Brous says: " When issues of survival no longer predominate, other needs and issues arise. It is not surprising that the middle and uppe classes predominate amongst those interested in childbirth alternatives..."

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'New Doctor' continued...

LAMBS TO THE SLAUGHTER

Lisolette Muhlen and Lena Nordholm write about technology and drugs in childbirth, reporting on a questionnaire study of 139 middleclass Sydney mothers with babies under twelve months old.
In their sample (a"few"of whom had homebirths, although they did no separate analysis for this group) they found a very high use of induction and caeserean section, well beyond an accepted high-risk expectation, when there was no reason for a bias towards high risk in the sample.
Inductions represented 33% of the total sample, spontaneous births 55% and caesarean sections 12%. Thus 45% of respondents experienced active intervention in their childbirt
There was also a high use of pain relieving drugs (about 75%), the episiotomy rate was high (72%) and the resulting wound still painful during intercourse three months and longer after the birth in 15% of the cases. Most mothers gave birth on their backs, whic has been shown to be an unsatisfactory posture for giving birth. (92%).
However, the authors state that "despite these findings, in general mothers are satisfie with the treatment they get from doctors and nurses in hospital, and do not demonstrate a strong desire to break away from the hospital as a place to give birth."

Maybe these words give some comfort to the medics? The authors do not speculate as to why the majority of mothers were satisfied : we could suggest, of course, that most women have been taught to EXPECT medical intervention and pain and discomfort during birth (as well as being taught to be 'nice' and 'co-operative'etc), and therefore, having had their expectations fulfilled, it does not occur to them to feel dissatisfied.

THE OBSTETRIC DIALECTIC

In an editorial, New Doctor identifies the "two polarised groups", "the medical professionals" and "some groups of women",in the "obstetric dialectic", and cautiously insists that obstetric consumers "should be able to benefit from the positive contribution which each side offers."
However, the editor is careful to point out that the factors governing pregnancy and la are so complex and varied that identifying the positive contribution of each side of the dialectic is hard - because the "establishment of causal relationships from observational data is, in practice, extremely difficult."

(But it seems that the dialectic is based not so much on establishing "causal relationships", but rather on issues of power and control...)

New Doctor's editorial also reveals that SOME doctors are now 'discovering' something th women have understood for a long time - in that the "significance of psychological aspects of pregnancy and childbirth are just beginning to be appreciated." !

(It will be interesting to see how such 'new' information will be interpreted and acted on by the medical professionals' side of the'dialectic'!!)

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