number 10
1986

SAVE THE MIDWIVES

CONTENTS

your letters....

Dear Editor,

Male Midwives: Thanks for asking for the feelings of members on this issue. Personally I would not like to see males trained in midwifery.
Having a male midwife attend me at my birth would just shatter me, because he - as a male - would represent so much of what I am against, in this particular field. I would feel most insecure and even threatened.
I hope you will vote against this proposal for the sake of the distance we have come from the male domination in obstetrics.

Yours sincerely,
G.M. Aiken (Mrs)

Dear Save the Midwives,

I oppose the Save the Midwives policy of not accepting men as midwives, a policy of which I was not aware untill it was mentioned in the last newsletter.
Because of their conditioning and the present male domination of the health system men may, on average, hold more closely to the pathological model of childbirth and be less sensitive to the needs of a woman in labour. But to put a blanket veto on all men seems to me a very clumsy method of adressing this problem - and also counterproductive, as it excludes those men who do not fit this generalisation. I find grossly insulting the implication that no man is capable of acting in the best interests of a woman in labour and no doubt many potentially good midwives would be lost by this policy. If my GP was barred from obstetrics merely because of his sex no political arguement could justify the loss of his skills to the many women in this area who rely on him for caring non-interventive delivery of their babies.
More important than the exclusion of males is the need to change the emphasis of midwifery training so that birth can be experienced as the natural process that it is. Empathy and a realisation of the emotional needs of a woman in labour would develop more readily when attending GP deliveries in small hospitals and home deliveries than in the high-tech surroundings of a large hospital.

Yours faithfully,
Meg Davidson.

Dear Judy,

Please accept this cheque as a donation toward the good work that the association does. Riverside Community strongly believes in the right of women to have choices in childbirth and have been responsible for me to be able to continue my career as a domiciliary midwife without worrying about making a realistic living wage.
So our regards and best wishes for your important work in supporting midwives.

Bronwen Pelvin on behalf of the Community.

S.T.M's extends their warmest thanks to the Riverside Community for their generous donation of $200.00.

R. Nicholson Newsletter Convenor.

Dear Editor,

I have had the privilege of working with, and participating in the training of, male midwives in third world countries and New Zealand. Save the Midwives, by discriminating against their membership of the organisation is, in my view, showing unwarranted discrimination against men. Should your policy remain unchanged I will withdraw my membership in support of the male members of the profession.

Yours sincerely,
Jo Mawdsley
Midwife.

Dear Madam,

I wish to add my support to Male Midwives becoming members of this association. I think there are 2 Male Midwives practising in New Zealand at present, both whom trained in the U.K. I personally have employed one for 4½ years in a clinical setting with nothing but praise for the highly professional caring attitude of this gentleman well liked by his clients. I really enjoy your magazine and the many excellent articles.

Name witheld on request.

A BOOK REVIEW....

RECOVERY AFTER CAESAREAN
produced by the Auckland Caesaren Support Group.

This booklet was compiled by the Auckland Caesarean Support Group (Inc), a group of mothers who all experienced birth by caesarean section. They were concerned at the lack of support and information available for caesarean parents so they set up their group with the following aims:

1 To provide emotional and practical support to caesarean families immediately after the birth and later if required, e.g. in subsequent pregnancies.The support is provided through telephone conversations, home and hospital visits, and regular informal discussion meetings where mothers can get together and talk about their experiences.

2 To provide information and promote education about caesarean birth. A library of relevant literature is being set up and pamphlets produced on such topics as the above-mentioned one, vaginal delivery after a previous section, and antenatal information for all prospective parents to consider about caesarean births.

This 12-page booklet has been prepared with suggestions based on medical advice and women's own experiences and covers areas such as physical effects of caesarean birth, recovery exercises, breastfeeding, bonding, going home, and emotional side-effects.

Valid reading for all prospective parents;a must for those women and their families who have recently had a caesarean section and for those with conditions which may indicate a caesarean delivery; and enlightening reading for midwives, doctors and other health professionals who work with women undergoing caesareans.

CONTACT PHONE NUMBERS : Auckland Philippa Rodgers 598 441
Judy Fredriksen 564 205
Pip Williams 546 670

...written by Ruth Nicholson.

NEWS & EVENTS

* OBSTETRIC REGULATIONS 1986.

The new obstetric regulations have some horrific connotations for midwives, mothers, and babies. Excerpts include:

"'Domiciliary practice' means the carrying out of obstetric nursing... by a registered midwife or a registered nurse approved to carry out obstetric nursing under Section 110 of the Social Security Act 1964."

"In every obstetric unit there shall be a registered midwife being a person who is also a registered general obstetric nurse or registered comprehensive nurse on duty at all times."
The mind boggles! One midwife per obstetric unit! Who is going to give expert quality care to labouring women? House surgeons? Enrolled nurses? Registered nurses? Who is going to staff post natal and ante-natal wards?

"In every maternity unit there shall be a registered midwife being a person who is an RGON or an RCN on duty at all times."
Once again leaving enrolled nurses and registered nurses to play the part of midwives!

"'Registered nurse' means a person who is both an RGON and a registered midwife or a person who is both an RCN and a registered midwife."
So, are we no longer going to be called midwives? Is the direct-entry midwife the only real midwife left? Will this further limit our already limited sphere of midwifery practice?

WHAT CAN YOU DO about the Obstetric Regulations?

Write and tell the Minister of Health, Dr Bassett, what you think. Send a copy of your letter to your M.P. Write to the Director-General of Health, Dr G Salmond, telling him what you think. Do it Now!

Dr M Bassett
Minister of Health
Parliament Buildings
Wellington.

Dr G Salmond
Director-General of Health
Health Department
P O Box 5013
Wellington.

* DOMICILIARY MIDWIVES PAY

The great news here is that their pay has been increased by 50% to $270.00 per case! This is the fist step in an increase in pay that will ensure that planned home birth becomes an option available to all New Zealand women, according to the Minister of Health , Dr Bassett. Write to the Minister telling him what this increase for the midwives means to you, and to home birth.

* SUZANNE ARMS RETURNS

to New Zealand in November. She will be giving public and private lectures in Auckland - more news from Maternity Action's newsletter convenor, Lynda Williams, 16 McEntee Rd., Waitakere. Send an s.a.e.

* SAVE THE MIDWIVES MEETINGS

August 4, November 3, February 10 (1987), 24 Ashton Rd., Ak., 8 p.m.

MIDWIFERY TRAINING - conclusion (see 2 previous issues for parts I and 2)

In response to the meeting held at the end of 1985 as a result of an official complaint laid by Midwifery students regarding the poor quality of their training, with Auckland student midwives representitives, A.T.I's Assistant Director Ian Turner, H.O.D. of Nursing Yvonne Shadbolt and a representitive from Save the Midwives an "Ad Hoc Advisory Committee Maternal and Child Health Nursing" was set up.Nurse/midwife tutors and nurse tutors/administrators of the course formed the bulk of the committee with student midwives being invited guests. The first meeting took place in February and discussed the revised format for the "1986 Midwifery Clinical Option of the Advanced Diploma in Nursing (ADN) Course."

A thoroughly comprehensive and detailed course outline for the Midwifery Clinical Option 1986 had been prepared (a copy to each midwife and tutor) and included well defined theoretical and clinical objectives for the 4 areas of childbearing - antenatal, intrapartum, postpartum and neonatal. Evaluation plans and assessment criteria were also included.

Specific dates when students should have reached the expected standard of clinical competence and due dates for exams, assignments and client follow through assignments are also specified so students know what is expected of them and can plan their work well in advance.

Nursing Concils requirements for registration as laid out in the document "Standards and Criteria for the Registration of Midwives who enter a N.Z. A.D.N. course from 1985" are also included in the course outline - once again to enable students to know what is required of them.

Other changes include more clinical experience overall than in 1985 - 3 days more in the antenatal wards and neonatal units, 2 days in Delivery Suite and 6 more days in the Antenatal clinic (every little bit helps!).

The engagement of an experienced, recently practising midwife (who was tutoring the obstetric component of the Comprehensive course in 1985) will ensure consistent tutor coverage for the clinical areas, that there are enough midwives available to mark the test papers of students (last year non midwives were marking some parts of them) and that a timetable of the terms midwifery programme be available at the beginning of every term.

There is to be more domicillary input with one of the three client follow through case studies being a planned home delivery if the student wishes. The student attends the antenatal classes with the client run by the A.H.B. A. and in doing so receives a more balanced outlook on childbirth - the remainder of their experience being undertaken in Auckland obstetric base hospitals.

The above changes are all positive and an improvement on the 1985 course content. The 1986 student midwives are reasonably happy with the way Term I has progressed though are still frustrated by the lack of midwifery theory and clinical experience. Term I mostly comprised of A.D.N. work.
This cannot be changed however unless midwifery is removed from the A.D.N. and installed as a seperate course on its own. Only then, would the students get a broader outlook on midwifery as more time would be able to be spent out in the community, with domicilary midwives and in smaller maternity hospitals where emphasis is on normal childbirth not requiring interventionist obstetric practices.

RUTH NICHOLSON

REPRINTED FROM THE LATEST BULLETIN OF THE NEW ZEALAND WOMEN'S HEALTH COMMITTEE

With Compliments P O Box 5147 Wellington

Women's Health Committee

New Zealand Board of Health

MIDWIFERY: A DISCUSSION PAPER

INTRODUCTION

This paper has been prepared by the Women's Health Committee and draws together the views expressed in submissions made to the Committee. The Committee was established in 1985 to advise the Board of Health on matters relating to policy on the health of all New Zealand women, in particular to identify current and future needs in the area of women's health and to establish priorities within these. Rather than itself determining the priorities the Women's Health Committee called for submissions. More than 250 submissions identifying 1600 issues were received. A preliminary analysis of these submissions was published late last year in the first Bulletin released by the Committee.

This paper examines one area or topic in more detail by focussing on those submissions which discussed midwifery. The views and ideas expressed are those of the submission writers, and are not necessarily those of the Committee or its members. The members of the Committee regard the sharing of information and ideas as one of their major functions - sharing information both with those who made the submissions and those involved in policy and decision making. For this reason this summary of submissions on midwifery has been prepared to share the differing perceptions and points of view expressed in the submissions and to encourage further discussion and debate about these issues.

MIDWIFERY SUBMISSIONS

In all, 32 submissions (13% of the total) made some reference to midwifery. 17 submissions made only passing reference to midwives, while the remaining 14 raised several issues or gave a wider overview. The great majority of the submissions are concerned with domiciliary midwives rather than with hospital based midwives. The main reason given for the improvement of a domiciliary service is to safeguard the provision of home birth. Issues such as female birth attendants, continuity of care throughout the pregnancy and low levels of technical intervention in the birth process figure highly.

1 The Role of the Midwife

In the majority of the submissions the midwife was envisaged as the prime health care provider during pregnancy and birth. Most groups were convinced that a midwife was competent to oversee the entire process of birth and delivery in most cases. Thus, one group suggested that a research project to compare the birth outcomes of low risk mothers by "midwife only care" and "specialist obstetric care" (140) would support the assertion of midwife competency. Only one group suggested that midwives should perform deliveries without the presence of a GP.

Some submissions stressed that a midwife is ideally placed to provide antenatal care, especially for home birth mothers and women who had chosen an early discharge from hospital. There was some support for the concept of a "woman's right to a midwife up to 14 days post-partum".

A number of submissions stressed that midwives were in the unique position of being able to provide ongoing continuity of care (88). Because of this, it was felt that a midwife could provide more personal involvement and contact than, for instance, a Plunket nurse (81). One woman in a rural area narrated her period of antenatal care and the experience of having been seen by 10 different practitioners during her pregnancy. While this may be an extreme case, continuity of care is obviously an issue of importance to many women.

MIDWIFERY SUBMISSIONS

109	Individual - Dunedin	81
112	Rotorua Parents Centre, Rotorua	86
114	Whangarei Women's Resource Centre, Whangarei	88
126	NZEI Matauka	98
130	NZNA, Canterbury	107
131	Wellington Women's Refuge, Wellington	Individual - Christchurch
		Individual - Palmerston North
		Christchurch Women's Refuge, Christchurch
		Dunedin Parents Centre, Dunedin North
		NZE Berikori/Kano & Thames, Auckland
		24 NZ Women's Health Network, Tauranga
		43 South Pacific College of Natural Therapeutics NZ Inc, Auckland
		45 Oamaru Women's Group, Oamaru
		51 Patients' Rights, Christchurch
		75 NZNA - National Midwives Section, Dunedin

A number of the submissions commented on the decline in status generally of midwifery. This was attributed in some cases to factors such as "male specialists clinging to their control" (51) of the birth process. Some submissions stated that midwives are "care givers who can offer alternatives to the medical model of childbirth". We see midwifery as the major source of alternative care (86). Thus the call for increased numbers of midwives is related in some cases to a rejection of routine technical intervention in birth. Midwifery is also supported as a female profession which ministers to women and which can provide important role models. Finally, according to one submission, midwives are valuable because they concentrate as much on the health of the woman, as the health of the baby (81).

2 Remuneration and Facilities

A large number of the submissions expressed great concern at the shortage of midwives in New Zealand. This shortage had implications such as inadequate midwifery servicing of community health centres (73), a threatened domiciliary service (161) and the increasing threat to home birth as a viable option for women (174). Many submissions stressed that this shortage would continue and worsen unless changes were made to present training systems and payment for services was increased.

The low level of payment for domiciliary midwives was the most frequently mentioned topic in this set of submissions. Several women pointed out that under the present system there was in fact a financial dis-incentive to do domiciliary work. One group suggested that a midwife with a full caseload of 50-60 births a year at present would earn approximately $10,000 (86). This same group was the only one which indicated what they considered adequate levels of payment. They suggested reimbursement of a standard equivalent to a hospital charge nurse midwife; a flat rate per caseload of $350 or a salary system.

A number of submissions also believed that the list of equipment which domiciliary midwives were presently required to own was prohibitively large. It was suggested that some equipment should be provided by the government.

3 Training

A considerable number of the submissions also raised the question of the content of midwifery training. Many comments were to the effect that present training programmes needed to be retained, and a number of changes were suggested. The NZNA Midwives Section, for example, traced the low numbers of training midwives to the fact that there is no reciprocity with other countries and that once the qualification is gained no further advanced courses are available. According to this group, the present system which requires both completion of registration and an advanced diploma is too time consuming.

A number of submissions called for specialised training to continue but believed that direct entry (ie, with no previous nursing qualifications) was desirable (99). One midwives lobby group suggested changes including: instituting a greater practical component; extension of the course from 8 to 18 months; some mandatory domiciliary work and removal of the training from the Advanced Diploma of Nursing.

FUTURE ACTIVITIES

The Women's Health Committee has begun to work on a number of the issues raised in this paper. Recommendations and suggestions are being, and will be, taken up with the appropriate organisations, eg, Department of Health, Department of Education, Hospital Boards, etc. Interested groups will be asked to support changes. In addition, a full report will be prepared for the Board of Health and the Minister. The members would appreciate hearing any feedback from you and learning of further recommendations or suggestions

137	Individual - Auckland	165	Wellington Home Birth Assn, Wellington	185	Individual - Wellington
139	Wellington NZNA, Wellington	170	WEL Southland, Invercargill	193	Southland NZNA, Invercargill
140	Save the Midwives Assn, Auckland	171	Napier NZNA, Napier	203	Federation of NZ Parents Centres, Wellington
143	Wanganui Women's Network, Wanganui	174	Individual - Nelson	235	Anonymous
161	Individual - Tokaha	181	Individual - Nelson South	236	Results of Dunedin Public Meeting.

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THE MIDWIVES' DILEMMA

JUDITH A. DAVIS, Nursing Supervisor, Delivery Ward, King Edward Memorial Hospital for Women, Subiaco, Western Australia

ON THIS DAY of the Conference, when we are focusing on "choices of practice", I have been asked to address the topic of the midwives' dilemma.

Recently, at the College of Nursing Australia Conference in Adelaide, Jill Hamilton, in her paper titled "Nursing and the Scientific Revolution", challenged the growing trend of specialisation within nursing when she said, "In an age where medical specialisation is an established fact, nursing, too, has unfortunately been led to specialising along the precise lines of the medical specialist. There are now ostomy nurses, intensivist nurses, renal nurses, orthopaedic nurses, midwifery nurses and so on. Some specialist nurses have not questioned the effect on the profession at large of the divisive practice of their separation into distinct autonomous special interest groups outside the mainstream of organised nursing". What she said has a great deal of relevance to midwives and I have picked up that gauntlet and will attempt to address her very pertinent comments.

I have divided my remarks on this subject of midwifery practice into three parts: Our dilemma in defining the parameters of our practice; Our dilemma in our relationship with our obstetric colleagues; And, thirdly, our dilemma in developing and caring for ourselves personally and professionally.

THE PARAMETERS OF PRACTICE

On reading the literature of midwives practising from Malaysia to Milwaukee, Perth to Peru and Hull to Hawaii, it is apparent that in many parts of the world the role of the midwife is in a state of flux and challenge.

Within some countries and cultures the traditional role of the midwife *is* still the accepted role. For instance the *Dai* of India and the *bidan Kampung* of Malaysia typify the traditional, the culturally acceptable, the "spirit" of midwifery in their countries.

Similarly, in Holland the midwife seems secure in her role, with the evidence of how safe and successful home birth can be with infant mortality and morbidity figures that statistically support that claim ...

But in those places where problems of role definition do exist the situations are diverse and complicated. In some instances it is we who are the aggressors. In North America the nurse-midwife is moving into the virtually unchallenged territory of a male-dominated arena of obstetric practice, and in developing countries it is the traditional birth attendant who is meeting the onslaught of the trained midwife.

Conversely, we have the obstetrician moving into our areas of expertise more often and more rigorously and in other areas of the US the "lay" or "spiritual" midwife puts claim to a philosophy of care that is not only holistic but is more in tune to the ethos of midwifery, and that presents a significant challenge to our practice.

In Britain the midwife is increasingly coming in from the cold of district practice to join the rest of us in GP clinics or hospital environments. It is here, within the walls of safety, security, statistics and the sterility of approach, that most of us practise our art. It is also within the confinement of these same walls that the dilemma and pain experienced by the midwife are perhaps most obvious.

Confronted with Conflicts

In Australia last year [1983], at a National Midwives' Association Conference in Canberra, the theme was "The Art, Science and Spirit of Midwifery"; it was this theme that clarified for me the ethos and dimensions of our practice and profession. For if midwifery were practised only as art and science then our dilemma and our pain would not be so real, nor would our profession demand such attention and agonising as it does. It is because we have components in our practice that are affective and emotionally based that we are confronted with conflicts, and that does not vary anywhere in the world, whether it be Delhi, Dallas, Denpasar or Darwin. It is at this point that Jill Hamilton and others could justly ask us why we think we are so different. Why *are* we so different from the general trained nurse? Why *do* we defend the midwife title and role so jealously? Why is our practice any more special than that of the intensive care nurse and all the knowledge and expertise she has, with the opportunity of accepting a high degree of responsibility for her practice? Or the oncology nurse who tunes into the fine balance of drug therapy and therapeutic listening and care? Then there is the gerontologist, with her mind on the importance of supporting the dignity of the individual inside a body and mind no longer able to accept that responsibility, and doing it with loving and constant concern. The community nurse, who takes on a whole family unit, with all the implicit and explicit problems that that presents, respecting the individual and his needs but with due cognisance of his symbiotic relationship with that family and the need to maintain an equilibrium. What do we have, or think we have, in our practice that demands so much of our attention in defining and defending?

I suppose that most of us would immediately react with the comment that our attention is on the care of two individuals—mother and baby. Furthermore, and more importantly, there is the fact that one of those individuals is initially the unborn baby; the vulnerable, unprotected

and defenceless being who needs the advocacy and protection of our care. That statement should not then imply that the care is steeped in emotional responses, indeed, that would be highly inappropriate . . . what I would most like to convey is the complexity of the care of that mother and fetus.

For the interaction or symbiosis of the care is an integral part of the problem and approach. To illustrate this point, may I say that at no other time in the history of fertility has there been so much focus on the fetus. Not only is his/her mere conception and implantation loaded with more moral, legal and ethical issues than ever before (and I do not intend to pursue that further here) but its sex, growth and development, well-being or otherwise, can all be measured and monitored with relative ease. The midwives' knowledge base relating to those procedures must be sound and logical.

The effects of the mother's nutrition, drug intake and general health habits will determine the fetus's outcome. The fetus has no voice, nor a will to convey views about the handling of its arrival into the world and the degree of activity that that arrival should engender. It cannot object to an inadequate blood or nutritional supply, nor to the insult of nicotine or narcotics.

The long-standing argument about viability, mode of delivery and degree of management is perennial and complex. Often the volume of information that is given to the parents becomes clouded with their own psycho-emotional state and their often intense need for the fetus to survive at any cost. Expectations of the parents are mixed with those of the professionals responsible for their care, and often these factors are diametrically opposed.

Personal and Professional Views

We need to sort out our own personal and professional views about the complexities of *in vitro* fertilisation, artificial insemination and other issues so that we do not impose our own values on others. We then have a responsibility to be the voice in terms of providing appropriate and balanced information about health and how that relates to the fetus, remaining mindful of the cultural, social and religious views of parents and balancing them against safe and appropriate birthing plans.

Parenting in Western countries has become a premium experience. Only 2.2 babies nationally for fertile couples and demographers tell us that will decrease in time. Because of that, the quality of the experience has, and is, undergoing quite a revolutionary process. Klaus and Kennell, Enkin and others have shown us the importance of bonding, of inter-personal involvement, of family-centred approaches. Not only husbands and coaches but siblings and relatives are involved and involving themselves in this birthing process. Kitzinger preaches orgasms, warm feelings and skin contact, and we are all now well versed in the virtues of soft lights, soft music and the soft approach.

There is a parallel to be drawn on Maslow's hierarchy between those of us practising in Western countries and our sisters in developing countries. In these latter countries day-to-day living is based very much at the lower levels of Maslow's hierarchy of needs, revolving around sheer survival, food, shelter and protection. This applies similarly to the issues of childbirth. That is if the baby survives at all, then one can be considered fortunate indeed . . . to do so without trauma to either mother or baby is nothing short of miraculous.

Low-key expectations

So there these mothers sit, with their very low-key expectations—and where are our expectant women? Somewhere at the top of that hierarchy self-esteem and self-actualisation are not uncommon goals, for within our fertile women are the older, more professional, high achievers, who want to do as well at their childbearing as they have done with their academia or their other pursuits. If childbirth is not within their control, does not measure up to their needs, results in an outcome that is unacceptable, then they feel they have failed.

When some of us completed our midwifery programmes we came away with no thoughts about the psychological traumas that the birthing process or our rigidity in the postnatal period had produced. We had never really thought about postnatal depression, the need for caesarean section support groups and the likelihood of mothers of twins needing to meet and talk, postnatal follow-up of families in groups, and the short- and long-term effects of still-born or neonatal deaths. Does that mean that these problems did not exist then, or that we were not aware of them, or that suddenly people are voicing their discontent and concern? A mixture of all of these things I am sure. And why do we have this birthing/parenting revolution? Is it a response to the very effective way in which we suppressed people's freedom of choice in the past? It is a natural phenomenon of social change that the pendulum should swing so far in the other direction from birth, and the preparation of it, being very private, to it being participated in, filmed, photographed and taped. It would be sad indeed if we were playing only lip service to these issues without giving them some real thought and attention.

Educational Programmes

Having said that, we need to look critically at where our educational programmes place their emphasis. It is obvious with the complex issues I have outlined, and with the knowledge of the broadness and depth of the moral, legal, social and cultural issues, that it would be inappropriate if our programmes produced a midwife whose only real competencies centred around cardiotocographs and their interpretation, care of epidurals, setting up for intra-uterine pressure and central venous pressure and intravenous therapy. For caring, empathy, loving concern and compassion are indeed natural and necessary mixers with good clinical skills to make a midwife. It may well be argued that they are ingredients for any health care professional, and that is true, but in midwifery they are not just necessary but a crucial combination.

It may well be that therein lies the dilemma and, for

many of us, the pain of arriving at the core of our practice.

Several facts are self-evident:

1. There is a need to look critically at the philosophies and content of midwifery programmes.
2. Midwifery and its practice needs a broadly-based programme with the learner supernumerary.
3. If we believe that the "spirit" of our practice is implicit, then we need to develop appropriate strategies in selection, education and evaluation of both students and midwives to encompass that affective behaviour.

Disquieting Revolution

Where have we, as midwives and women, stood while all this revolution was going on around us? Sad to say that many of us reacted rather than acted when change was obviously not only necessary but long overdue. The impetus came from our clients, not from our own critical assessment of our practice and its inherent routine and ritual. We have, in fact, been undergoing our own quiet and disquieting revolution, for we are, for the most part, women *and midwives*, and as women we have been pursuing the same self-awareness and self-actualisation as the women in our care. Maybe that is why we have become willing and capable buffers and advocates of their move from subservience into an independence we are also pursuing. As professional women we are making a painful journey out of a time that has labelled us as second-class citizens who have needed to prove our credibility and worth, into a society that has increasingly given value to high technology, the pursuit of scientific discovery and achievement. Simultaneously, it has given little value to warmth, caring and compassion. Women, to survive in the competitiveness of the work ethic, have often had to become slicker, quicker and smarter than men. Is that where the basic mistake has been for us? That we have not seen that those softer qualities are of an equal importance and that their value cannot, and need not, be measured in the same way. Nonetheless, we as a profession have continued to play that game and devalue ourselves over and over again, until many of us actually believe that we are of no real consequence and that subservience is our role.

Subservience is *not* our role, as pointed out by Lesley Barclay when summarising her work available at that time (1983) on the practice of midwives in Australia; "those of us who have remained in midwifery have become experts at taking a secondary or subservient role. That this is only a superficial view and not our actual role is emerging clearly in my present work". She went on to say, "we have the option of gracefully accepting the decline into impotence that has already begun or we can become more vocal, independent and throw off the social camouflage that successfully hides our worth and importance. We could reassert our expertness in normal midwifery and make this explicit".

RELATIONSHIP WITH OBSTETRIC COLLEAGUES

It matters not too much whether where we are or are not with obstetricians in a conflict based on sexual or professional grounds. The fact is that we do have a continual dilemma in defining, maintaining and rationalising that relationship. It is a dynamic and powerful *en face* in which both professions continually find themselves. The roles and skills of the midwife and the obstetrician overlap and are continually interchanging, being challenged and forever under scrutiny. We midwives jealously guard our control of those women in our care to the point of excluding the doctor easy access. On the other hand, we put high demands on the doctor's involvement. We expect good, sound, clinical knowledge delivered in a warm way. We demand excellence in the obstetrician's delivery skills but a right to voice our own opinion about the mode of delivery. The obstetrician should be readily available for all deliveries and emergencies but without inhibiting our control; involvement with his patient but not so much that we become redundant. No wonder the obstetricians cannot win—and we will not compromise. I would be more guilty than most of you in this room of adopting an assertive and usually aggressive stance with them. The questions are then ... At what level within our joint professional bodies do we meet? How do we draw acceptable lines and areas of responsibility? How do we convince our own profession and obstetricians that what we have to offer is a great deal of expertise in the care of the normal pregnancy and labour which could be put to good use in numerous situations? That this should complement rather than challenge their practice and give us more satisfaction in our professional activities?

The brevity of these comments should not be interpreted as a measure of their lack of importance but rather as a measure of my impotence in finding a solution.

CARING FOR OURSELVES

The final, and by no means the least important, comments I want to make, have to do with how we care for ourselves professionally and personally. If we truly believe Klaus and Kennell when they say that bonding between mother and baby is "a unique relationship between two people that is specific and endures through time . . ." then we have a formidable task in midwifery to produce midwives who are committed to an ethos of excellence of practice, mixed with compassion, tenderness and intelligence, and, having done that, to "let them grow". Midwifery, as any other branch of nursing, has its growth stunted by the hierarchical framework of bureaucracy. A framework which stifles development, kills innovation and devalues its members. Our profession will continue to remain growth retarded without: enough space to grow ... sufficient nurturing and care ... the appropriate cognisance of its needs, which are dynamic and diverse. While nursing, and midwifery in particular, fails to recognise its own value and its need to have a united and trusting relationship then we will not attract the care givers we need, we will not retain the ones we have and we will burn out and gradually destroy the "spirit" which I believe is the nucleus of our practice.

Aristotle, who lived and died between the years 384 and

322 BC, found enough time in his day to write down what he saw as our role . . . *a midwife should be of middle-age, neither too old or too young and of good habit of body, not subject to disease, fears or sudden fright, nor are the qualifications assigned to a good surgeon improper for a midwife: viz. a lady's hand, a hawk's eye and a lion's heart. She ought to be sober and chaste and not subject to passion but bountiful and compassionate and of even temper, cheerful and pleasant. A midwife is the most necessary and honourable office being a helper of nature.*

I wonder how well we, any of us, fit into that description?

Change & Challenge

I know that in the pace and pressure of our busy days we often don't have a chance to reflect on our real value and on *our* needs ... we contribute a great deal of our personal selves to the care of those families in our charge and to the creation of the best possible milieu for families to birth and midwives to grow. There is a depth of commitment and pursuit of excellence of our practice that leaves many of us with little personal reserve. There are feelings of sadness, frustration and impotence from midwives who are right in the centre of the powerful scenario of change and challenge. There are high rates of turn-over and burn-out amongst our profession. It is appropriate, then, at a conference such as this, to give one another some of the warmth we may have missed out on ... to reaffirm our worth ... to recharge our batteries and to go back for another round, feeling stronger, safer and more assured than when we came. For, *we are unique and special and a most precious commodity,* and we should never lose sight of that fact.

Acknowledgement
I am indebted to Ruth Lubic, Director, New York Maternity Centre, USA, who, on a visit to the Centre, recharged my batteries and left me with a new faith and belief in midwifery and in how far we can really go, and feeling that anything is possible if only we try and believe. She validated the need in all of us to support and be supportive and to take the time to talk about our hopes and aspirations. Finally, she gave me a re-affirmation of our uniqueness of practice.

Note: *The author, Judith Davis, is now a Lecturer at the School of Nursing, Western Australian College of Advanced Education, Nedlands.*

Thanks to Clare Hutchinson (Waikato) for sending this article in.

Domiciliary Midwives Pay

THE AUCKLAND DOMICILIARY MIDWIVES AND THEIR ACCOUNTANT, ALLISON LIVINGSTONE, HAVE RECENTLY BROKEN DOWN THEIR INCOMES IN DETAIL TO WORK OUT EXACTLY THEIR EXPENSES, HOURS WORKED AND EARNINGS. DOMICILIARY MIDWIVES ARE SELF-EMPLOYED BUT HAVE A CONTRACT WITH THE HEALTH DEPARTMENT WHO PAYS THEM A MATERNITY BENEFIT ON A FEE-FOR-SERVICE BASIS.

THIS INCOME WAS WORKED OUT ON A HEAVY CASE LOAD THAT AVERAGED OUT TO 6 CASES A MONTH. (I.E. 72 PER YEAR). FOR EACH CASE THE MIDWIFE IS PAID $180. X 72 = $12,960/YR. TIME INVOLVED FOR EACH CASE IS 48 HOURS, (3 ANTENATAL VISITS, LABOUR, AND 12 POSTNATAL VISITS, TRAVELLING TIME - ON AVERAGE 20 MINS. EACH WAY, DELIVERING/COLLECTING EQUIPMENT FOR STERILIZING, SPECIMENS, LAB REPORTS, POSTING ETC.) COVER IS PROVIDED 24 HOURS A DAY, 7 DAYS A WEEK, 52 WEEKS A YEAR. HOLIDAYS, SICKNESS, UNSOCIAL HOURS OR MATERNITY LEAVE ARE NOT INCLUDED IN PAYMENTS - THESE AND DAYS OFF RESULT IN LOSS OF EARNINGS TO THE MIDWIFE. HAVING NO PAID LEAVE THEY ARE FORCED TO WORK CONTINUOUSLY TO PROVIDE COVER AND INCOME.

THIS INCOME TRANSLATES TO $3.75 BEFORE EXPENSES.

DOMICILIARY FEES.		12,960	
LESS COST OF SERVICES			
-EQUIPMENT COSTS:			
DISPOSABLE EQUIPMENT AND SUPPLIES	2,225		
DEPRECIATION ON PLANT AND EQUIP.	351		
HIRE CHARGES	360	2,936	
-GENERAL BUSINESS OVERHEADS.		2,385	
TOTAL COSTS		5,321	
NET INCOME BEFORE TAX.			7,639

48HRS. X 72 (CASES) = 3456HRS/YR. : $7639/3456HRS = $2.22/ HR. !

(HOSPITAL CHARGE NURSE CURRENTLY EARNING $26,500/YR - INCLUDES SICK PAY, MATERNITY LEAVE ETC. - 40HRS X 49WKS = $13.52/HR)

MOTOR VEHICLE EXPENSES ARE PAID AT PUBLIC SERVICE RATES IN RELATION TO THE 16 PAID VISITS ONLY, SOMETIMES MORE VISITS ARE REQUIRED BUT ARE NOT REMUNERATED. MAINTENANCE OF A RELIABLE VEHICLE IS ESSENTIAL AT ALL TIMES TO PROVIDE 24 HOUR COVER. ON THIS INCOME NONE OF THE MIDWIVES CAN AFFORD TO OWN OR OPERATE GOOD VEHICLES. PUBLIC HEALTH NURSES AND OTHER HOME VISITORS ARE PROVIDED WITH TRANSPORT. MIDWIVES HAVE TO RELY ON OTHER FAMILY VEHICLES AS BACK-UP OR OCCASIONALLY RESORT TO HIRE...

A STATION WAGON OR LARGE SALOON IS REQUIRED SO THAT EQUIPMENT IS ON HAND AT ALL TIMES. MIDWIVES PROVIDE ALL THEIR OWN EQUIPMENT AND DISPOSABLE ITEMS, THESE ARE FREELY AVAILABLE TO WOMEN DELIVERING IN HOSPITAL.

HOWEVER.... AT THE RECENT HOME BIRTH ASSOCIATION CONFERENCE IN PALMESTON NORTH A NEGOTIATING COMMITTEE WAS FORMED AND IT WAS DECIDED TO HIRE A PROFESSIONAL NEGOTIATOR, RON TROTT, TO PRESENT OUR CASE. IT IS HOPED THAT SUPPORT FOR THIS MOVE WILL COME FROM THE MEMBERS OF THE H.B.A. AT SAY, $5 EACH. WE ARE PRESSING FOR AN INCREASE OF $900 PER CASE ($20/HR FOR WORK WHILE USING EQUIPMENT AND $15/HR FOR TRAVEL.)

REALISTIC REMUNERATION WOULD ENCOURAGE MORE MIDWIVES INTO DOMICILIARY PRACTICE, MAKE HOME BIRTH MORE READILY AVAILABLE TO THOSE WHO WANT IT AND BE CHEAPER FOR THE TAX PAYER IN THE LONG RUN.

YOU CAN HELP ! FOR MORE INFORMATION ON THESE NEGOTIATIONS CONTACT A MEMBER OF THE NEGOTIATING COMMITTEE.

AUCKLAND : ALLISON LIVINGSTONE. 17 MATAPANA RD., PALM BEACH, WAIHEKE. PH. WAIHEKE 8557.
JOAN DONLEY. 3 HENDON AVE., MT. ALBERT. PH 887759.

WELLINGTON: MADELINE GOODA. 92 ALICE ST. MT. VICTORIA. PH.842628.
JENNY JOHNSTON. 1 CARDALL ST. NEWTON. PH. 898255

NELSON: BRONWYN PELVIN. RIVERSIDE COMMUNITY. R.D.2 UPPER MOUTERE. NELSON. PH LOWER MOUTERE 807.

MANY THANKS TO ALLISON AND ALL THOSE WHO HAVE PUT SO MUCH EFFORT INTO THIS.

Veronika Muller.

WANTED

Domiciliary midwife to work in Whangarei Area.
Supportive doctors, back up equipment and a strong network of home birth support available.
For further information -
Ph. Germaine Nicklin - Whangarei 480224
or write to Judi Strid - P.O.Box 183 Ruakaka Northland

CHEMICALS CAUSE IMPOTENCE -

Impotence, infertility, birth defects and childhood cancer can be caused by exposure to a wide range of common chemicals, pesticides, and drugs, according to a trade union study sponsored by the Equal Opportunities Commission. This report found that men are just as likely as women to suffer reproductive disorders when they are exposed to chemical hazards. For example, children born to fathers who work with petrol and other hydrocarbons run a significantly higher risk of developing childhood cancers. Reproductive hazards to women have received wider publicity but this report warns that not enough is being done to protect women in the pharmaceutical industry and the health service.

(Guardian , Jan.18,1986 on "Reproductive Hazards of Work," A:C. Fletcher, Equal Opportunities Commission and ASTMS.)

OUR SUBMISSION TO THE HEALTH BENEFITS REVIEW COMMITTEE

EPISIOTOMY VS TEARS: PAIN ON HEALING

Postnatal perineal discomfort is greater following episiotomy than if the structures are allowed to tear or the perineum is intact. A questionnaire to mothers in Queen's Medical Centre, Nottingham, compared the levels of discomfort between patients. Mothers were given the questionnaire on their first and fifth postnatal day (450 given, 319 returned).

On the fifth day, 76.2% of mothers with intact perineums had no pain, while 12.9% of those who had an episiotomy complained of very severe pain. Asked if perineal pain was the most severe problem after delivery, 46.4% of mothers who had an episiotomy and a normal vaginal delivery said it was. This compared with 27.8% of women who had vaginal or perineal, or labial tears and 9.7% of women with intact perineums.

Mothers were asked to draw the position on a diagram of where they thought they had been cut and how long it was. They were also asked what structures they thought were involved. Most underestimated the extent of the structures involved.

(Cater, Nursing Mirror, 2 May 1984)

SAVE THE MIDWIVES

24 ASHTON RD, MT EDEN, AUCKLAND NEW ZEALAND

1. MIDWIFERY

1.1.1. We support the retention of the Benefit paid to domiciliary midwives under the authority of the Department of Health.
We do not support transfer of employment of such midwives to the local Hospital Boards.The emphasis with home birth is on normality, on health, and the appropriate employer of health workers is the Health Department, as is the case with public health nurses.

1.1.2. We support the retention of a Benefit paid to domiciliary midwives -

a)homebirth midwifery provides high job satisfaction, thus ensuring good retention of trained personnel.

b)home births, in our estimation, cost the State approximately one-third that of an uncomplicated hospital birth.This is a low cost option, the safety of which has been well established, that should be much more widely available to New Zealanders.

c)women who have given birth at home have a much lower rate of postnatal depression than in the general population, and are consequently less of a financial strain on other aspects of the health service - general practitioners, Plunket nurses, counsellors etc.

d)the psychological benefits of home birth are considerable- these are difficult to judge quantitatively but are no less important for that. Satisfaction with the birth experience is of major importance to many mothers in the subsequent development of the relationship with their child - we believe that a woman who has a good birth experience will find it easier to mother her children well.
The satisfaction of home birth parents with the service provided to them is very high.

We are happy to provide data to support our statements if requested.

2.1.1. We believe that domiciliary midwives should be financially reimbursed on an equal level with hospital employed Charge Nurses, since the experience necessary, and responsibility accepted, are equal.

2.1.2 We are currently preparing a submission to the Women's Health Committee of the Board of Health on a fee structure for home birth midwives. The Women's Health Committee is currently preparing policy recommendations for the Department, and the Minister, on Midwifery, and we would suggest that the Health Benefits Review Committee also take into account comments made to and by this group on the subject of benefits payable to midwives.

*We are happy to forward a copy of our Fee Structure for Domiciliary Midwives if requested.

SAVE THE MIDWIVES

2. GENERAL PRACTITIONER OBSTETRICS

24 ASHTON RD, MT EDEN, AUCKLAND
NEW ZEALAND

2.1.1. We support the retention of a maternity benefit payable to general practitioner obstetricians.It is desirable that general practitioners provide medical cover for normal births, while specialist obstetricians provide medical cover for abnormal births.General practitioners thus need to remain a financially competitive option to specialists, and in order for this to be so the maternity benefit should be adjusted annually from 1986 to account for inflation.

2.1.2. We believe that general practitioners should be one of the groups permitted to authorise the home help scheme- see section 3.

SAVE THE MIDWIVES

24 ASHTON RD, MT EDEN, AUCKLAND
NEW ZEALAND

3. HOME HELP SCHEME.

3.1.1 Home help should be available to all women postnatally for a period of one month, extendable to 3 months in exceptional circumstances such as after a Caesarean section, a multiple birth or where there are three or more children under the age of five.

3.1.2 Many women today lack family support when they most desperately need it - immediately after the birth of a baby. It is highly likely these days that grand-mothers/sisters/friends etc are in paid employment, at least part time, and are thus unable to provide this type of assistance.

3.1.3 Many women who would consider a home birth do not in fact go ahead because of the lack of support in the immediate post partum period.Our estimate of the cost of a home birth is that it is approximately one/third that of a hospital birth with no compli-cations, and this low-cost option is being lost to us because of the unavailability of home help.

3.1.4 We believe that this scheme should be operated on the approval of a general practitioner OR a public health nurse OR a domiciliary midwife OR a Plunket nurse. We are strongly opposed to any one group, such as Plunket, being given a monopoly on this.

3.2.1 We suggest that the scheme could be operated in a manner similar to the one offerred nationally by the IHC - example overleaf.

3.2.2. A Home Help Scheme is operated nationally by the IHC to assist the parents of handicapped children. Assistance is available for a maximum of six hours a week and is paid at market rates, currently $6.00 per hour.

3.2.3. The parent finds her own home help person, who is then approved by the IHC social worker assigned to the parent. In the case of post-partum home help, the approving agency could be the mother's G.P., domicilliary midwife, public health nurse, or plunket nurse, whoever the mother has chosen as her primary health care giver.

3.2.4. The homehelp person is self-employed and thus taxation becomes a matter between her/him and the Inland Revenue Department. The IHC is not involved.

3.2.5 Home help is available initially for a period of three months, and is renewable on the advice of the social worker. In the case of post partum home help, we suggest an initial one month, renewable to three months in exceptional circumstances (see 3.1.1.)

SAVE THE MIDWIVES

24 ASHTON RD. MT EDEN, AUCKLAND
NEW ZEALAND

4. SPECIALIST OBSTETRICS

4.1.1. Specialist obstetricians currently recieve a benefit for both obstetrically normal and obstetrically abnormal births. We are opposed tp the provision of a benefit to specialist obstetricians for normal births, that is, those births anticipated to be uncomplicated which do eventuate as uncomplicated.

4.1.2. Specialist obstetricians should recover their costs in full from the parents in thesecases. We do not agree that the State should subsidised specialist medical care for potentially and actually normal births.

4.1.3. In cases where a potentially normal case develops complications requiring the care of a specialist, application should be made to the Medical Officer of Health stating indications for specialist cover in order for a benefit to be paid.

4.1.4. We support the provision of free specialist care for parents who have sound obstetric reasons for requiring it.

4.2.1 The trend among specialist obstetricians to decide who needs specialist cover and then to charge them for it concerns us. In Auckland the Obstetric Standards Review Committee has decided that a women who has had a previous Caesarean section should see a Consultant for a subsequent pregnancy.Only one visit may be necessary, with the specialist agreeing that the G.P. can continue to provide medical cover, but if the woman wants to see an obstetrician of her own choice she is required to pay him or herfor the visit. We believe that the Benefit should be restructured so that women can see a specialist of their own choice without incurring personal cost; i.e. the specialist should not be able to charge a fee in addition to receiving a Benefit in these cases.

Midwives are on the move!

Throughout the Western world midwives are struggling to regain their autonomy, and some very positive and exciting developments have resulted.

1) In British Columbia, Canada, an underground midwifery school graduated its first class in September 1985, and came out of the closet. Fillippa Lutenburg, president of the International Confederation of Midwives was one of the panel of examiners! Fillippa praised 'the high standard and quality of learning the students had done under the supervision of a handful of dedicated, visionary teachers'. The midwifery school was organised and supported by the Midwifery Task Force (MTF) and the Midwives Association of B.C. (MABC). This is a direct entry school. During their academic year the students were required to be primary attendants at 50 births and to attend 50 more. They will now seek apprenticeships with qualified midwives in other countries. (Maternal Health News, Dec 1985, vol 10, no 4. Contact P.O. BOx 46563, Station G, Vancouver, B.C. V6R 4G8)

2) On the other side of Canada, in Ontario, midwifery has been legalised. This resulted from recommendations made by a inquest jury into the neonatal death of a homebirth baby. Midwifery will now be recognised as a part of the health care system. A task force (which does not include any midwives) is to report back within a year on whether or not midwives can become a self-regulating profession. In Canada doctors maintain the exclusive right to deliver babies and midwives can be charged with practising medicine without a license. Ontario is the first province to legalise midwifery. Contacts: Midwifery Task Force, Ontario, P.O. Box 489, Station "T", Toronto M6B 9Z9; Association of Ontario Midwives, P.O. Box 85, Station C, Toronto M6J 3M7.

3) In U.K. an Independent Midwives Association was founded in July 1985. Its members work outside the Health Service as practitioners in their own right. IMA members work mainly with women having home births. One of these IMA midwives, Melody Weig writes, 'most people are not aware that midwives are able to take full responsibility for the care of child-bearing women, with or without medical cover. We consult with other health practitioners as necessary'. Enquiries: IMA, 65 Mount Rd, Streatham, London, SW16, 2LP.

Finally,

4) In April 1985 the World Health Organisation in a statement on 'Appropriate Technology for Birth' says:

> 'The training of professional midwives or birth attendants should be encouraged. Care during pregnancy, birth and afterwards should be the duty of this profession'.

Hurrah! Hurrah! Hurrah!

Joan Donley.

WHO CARES ABOUT BIRTH!

APPROPRIATE TECHNOLOGY FOR BIRTH

In April, the European regional office of the World Health Organisation, the Pan American Health Organisation, and the WHO regional office of the Americas held a conference on appropriate technology for birth. The conference, held in Fortaleza, Brazil, was attended by over 50 participants representing midwifery, obstetrics, paediatrics, epidemiology, sociology, psychology, economics, health administration and mothers. Careful review of the knowledge of birth technology led to unanimous adoption of the recommendations which follow. WHO believes these recommendations to be relevant to perinatal services worldwide.

Every woman has the right to proper prenatal care and she has a central role in all aspects of this care, including participation in the planning, carrying out and evaluation of the care. Social, emotional and psychological factors are fundamental in understanding how to provide proper prenatal care. Birth is a natural and normal process but even "no risk" pregnancies can give rise to complications. Sometimes intervention is required to obtain the best result. In order that the following recomendations are viable, the thorough transformation of the structure of health services is required together with modification of staff attitudes and the redistribution of human and physical resources.

* GENERAL RECOMMENDATIONS INCLUDE

Health ministries shoul establish specific policies regarding appropriate birth technology for the private and nationalised health services.

The whole community should be informed of the various proceedures in birth care, so as to enable each woman to choose the type of birth care she prefers.

Countries should carry out joint surveys to evaluate birth care technologies.

Women's mutual aid groups offer valuable social support and a unique opportunity to share information about birth.

The mother and her family should be encouraged to practise self-care in the perinatal period and develop the understanding of when and what help is required to improve the conditions of pregnancy, birth and afterwards.

Informal perinatal care systems (including traditional birth attendants) must coexist with the official system and a collaborative approach must be maintained for the benefit of the mother . Such relations, when established in parallel, can be highly effective.

Information on birth practices in different hospitals, such as rates of caesarean section, should be available to the public.

The training of professional midwives or birth attendants should be encouraged. Care during normal pregnancy, birth and afterwards should be the duty of this profession.

The training of health professionals should include communication techniques in order to promote sensitive exchange of information between members of the health team and the pregnant woman and her family.

* SPECIFIC RECOMMENDATIONS INCLUDE

The wellbeing of the new mother must be ensured through free access of a chosen member of her family during birth and through the postnatal period. In addition the health team must provide emotional support.

Immediate breastfeeding should be encouraged even before the mother leaves the delivery room.

The healthy newborn must remain with the mother whenever possible. Observation of the newborn does not justify separation from the mother.

Countries with some of the lowest perinatal mortality rates in the world have caesarian rates of less than 10%. There is no justification for any region to have a rate higher than 10-15%.

Women who give birth in an institution must retain their right to decide about clothing (hers and her baby's), food, disposal of the placenta and other culturally significant practices

The induction of labour should be reserved for specific medical indications. No region should have rates of induced labour higher than 10%.

There is no indication for shaving pubic hair nor for an enema before delivery.

There is no evidence that caesarean section is required after a previous caesarean section birth. Vaginal deliveries after a caesarean should normally be encouraged wherever emergency surgical intervention is available.

There is no evidence that routine fetal monitoring has a positive effect on the outcome of pregnancy. Electronic foetal monitoring should be carried out only in carefully selected cases related to high perinatal mortality rates and where labour is induced. Research should investigate the selection of women who might benefit from foetal monitoring. Meanwhile, national health services should refrain from purchasing new equipment.

It is recommended that the foetal heart be monitored through ascultation during the first stage of labour and more often during expulsion.

It is not recommended that the pregnant woman be placed in a dorsal lithotomy posistion during labour and delivery. Walking should be encouraged during labour and each woman must freely decide which posistion to adopt during delivery.

The perineum should be protected whenever possible. Systematic use of episiotomy is not justified.

Artificial early rupture of the membranes as a routine process is not justified.

During delivery the routine administration of analgesic or anaesthetic drugs (not specifically required to correct or prevent any complication) should be avoided.

Further investigation should evaluate the minimum special clothing required for those attending birth and the newborn.

* IMPLEMENTATION OF RECOMMENDATIONS INCLUDES

The above recommendations acknowledge differences between different regions and countries. Implementation must be adapted to these special situations.

Obstetric care that criticises technological birth care and respects the emotional, psychological and social aspects of birth should be encouraged.

Government agencies, universities, scientific societies and other interested groups should be able to influence the excessive and unjustified use of caesarean section by exploring and publicising its negative effects on mother and infant.

The results of technology assessment should be widely disseminated in order to change the behaviour of professionals and the attitudes of the general public.

Goverments should consider the development of regulations to permit the use of new birth technologies only after adequate evaluation.

National and regional conferences on birth to include health providers, health authorities, users, womens groups and the media should be promoted.

WHO and PAHO should designate a year during which attention is focused on promoting better birth.

THE LANCET, AUGUST 24, 1985.

ANOTHER BOOK REVIEW....

Save the Midwife Joan Donley
Auckland: New Womens Press 1986

"Given support and patience, 85% of women can give birth normally and naturally. They don't need the routine intervention backed up by high technology that is common practice in large hospitals today."
In this book well known Auckland midwife Joan Donely who believes the guardian of natural childbirth is the midwife explores what has happened to midwives and midwifery in New Zealand this century. She traces the takeover of childbirth by doctors armed with forceps and sedation - and their relentless undermining of the status of the midwife so that now the very survival of her profession is at stake.
Joan thoroughly researched her topic and although maintains a sense of humour throughout provides stimulating and thought provoking material, challenging even the most established doctrines of the "powerful elite" in the field of childbirth. Well worth $20.00 to everyone with an interest in this field.

Ruth Nicholson.

Recognizing Congenital Heart Defects

by Janet Kingsepp

From ASSOCIATION OF TEXAS MIDWIVES NEWSLETTER
Winter, 1984, Vol. IV, No. 1
P.O. Box 584, Hawkins, Texas 75765

Most babies born with congenital heart defects are full term and at a glance may appear healthy. The heart is created between the fifth and eighth weeks of embryonic life. Statistics show that 25% of infants born with cardiac disease have other congenital defects, but three-fourths of these are not severe. The midwife may be the first to detect an abnormality during the newborn exam or follow up visits. To check for heart disease, you must first have a good stethescope. Some authorities recommend short (10-15 inch), thick tubing. Be sure the ear pieces fit comfortably. The stethescope should have a heavy bell-and-diaphragm end. Both parts are needed for listening to the heart.

In making the assessment, be sure to have a quiet atmosphere so that you can hear well. The baby should be lying on its back. Place the diaphragm end of the stethescope between the ribs directly under the baby's left nipple. Listen closely to the higher-pitched sounds, then use the bell end to hear the lower-pitched sounds. Count the pulse for a full minute, listening for regularity as well as rate. Also, feel for pulses in the groin and inside the elbows. Is there a difference between these pulses and the apical (over-the-heart) rate? Are the groin pulses weak or absent?

Now touch the skin over the heart - both front and back - and feel the beat. A "thrill" produces a feeling of vibration or buzzing. This would also indicate possible heart problems.

Remember also to check the umbilical cord for number of vessels. A cord having only two vessels could indicate cardiovascular defects.

Murmurs are not always present in a baby with a deadly heart condition. Murmurs themselves are common, but only about 10% are associated with congenital defects. Those appearing in the first days of life usually show left to right shunts or semilunar stenosis. Murmurs can be heard as an extra sound: a sticking, clicking, or swishing quality between or after the usual lubb-dubb.

Since murmurs and listening alone cannot determine the condition of the heart, you will also be observing for cyanosis and signs of congestive heart failure.

Cyanosis is defined by Tabers Cyclopedic Medical Dictionary as a: "Slightly bluish, grayish, slatelike, or dark purple discoloration of the skin due to presence of abnormal amounts of reduced hemoglobin in the blood." Two-thirds of infants with cardiac disease show cyanosis. Be sure to check the lips, gums (mucous membranes), nailbeds and ears. Checking the mucous membranes in the darker-skinned oriental, hispanic and black babies is especially important in looking for cyanosis.

Any cyanosis lasting more than three hours after birth should be suspect. Observe for cyanosis in good light, the best being daylight. Watch the baby when crying, feeding, or during a bowel movement. Cyanosis may worsen with activity or only appear at these times. Other things that may give the baby a bluish cast to its skin might be a very high hematocrit, or a subnormal temperature. Cyanosis from a respiratory problem will be alleviated with the administration of oxygen. A good guide for deciding the cause of cyanosis is that if the problem is respiratory distress, the baby will get pinker when crying, and with a heart problem he or she will get bluer. Those defects showing cyanosis are: transposition of the great arteries, tetrology of Fallot, hypoplastic left heart syndrome, atresia of the pulmonary or tricuspid valves, severe pulmonic stenosis and total anomalous pulmonary venous return.

In the first weeks of life, feeding difficulties may alert you to the possibility of heart defects. These range from refusal to suck to vomiting, choking, or fatigue (taking a long time to finish a feeding).

Noncyanotic defects in infants often appear with signs of congestive heart failure (CHF). Symptoms are: tachypnea (over 50 respirations per minute at rest), dyspnea (chest retractions, grunting, flaring nostrils), and tachycardia (over 150 beats per minute). Diaphoresis (sweating) may be seen, especially with activity. Edema around the face and eyes and/or an enlarged liver may be late signs of CHF. The most frequent causes of CHF in the neonatal period are: hypoplastic left heart syndrome, coarctation of the aorta, ventricular septal defect (VSD), transposition of the great arteries, and patent ductus arteriosis (PDA

If you feel the baby needs to be seen by a physician, don't waste time -- and don't beat around the bush about what you think may be happening. If it turns out that the baby is perfectly normal, the physician could only credit you with being cautious. Be sure you have copies of your records/charts ready as well as a tube of cord or maternal blood, if possible. Oxygen by mask may be helpful during a transport, but the main thing to remember is to keep the baby warm. The best position for the baby will be a semi-upright position, and a standard infant seat may be useful. A very cyanotic baby should be placed in the knee-chest position. Lie the baby on its stomach and tuck the knees under the buttocks with his/her face turned to the side.

Let the baby rest while awaiting medical examination. Postpone feedings. If the baby seems really hungry, offer clear fluids.

The parents' needs are crucial at this time. Allow them to touch the baby when possible. Explain your findings to them. Point out the poor color or the breathing difficulties, but also point out the child's "normal" and attractive features. The baby may require extensive surgery at a large hospital or may be admitted for observation and medical (drug) treatment.

If, indeed, the baby will admitted to the hospital, informed, written consent is needed for admittance and procedures. Any questions remaining after the doctor's explanation can be directed to the nurses that will be involved in the baby's care.

New techniques using circulatory arrest with hypothermia to cool the body make by-pass surgery possible on newborns to age three months.

Dr. Paul A. Ebert, one of the best-known pediatric cardiovascular surgeons in the country has stated that the long-term results of this type of surgery are better now because of early diagnosis and correction before damage occurs from the defects.

Friedberg, Charles K., Diseases of the Heart, 3rd Ed. W.B. Saunders Co., Philadelphia, c. 1966, p. 1190.

The Merck Manual, Thirteenth Edition, p. 982.

Shor, Vivian A., "Congenital Cardiac Defects," American Journal of Nursing, February, 1978, p. 256.

Visich, Mary Ann, "Assessing Heart Sounds," Nursing 81, November, p. 72.

Young, Patty, "Tiny Tasks," Baylor Medicine, January, 1984, p. 3.

SAVE THE MIDWIVES

24 ASHTON RD, MT EDEN, AUCKLAND
NEW ZEALAND

NEWS FROM OUR ORGANISATION

* Save The Midwives is having a membership campaign drive. This is the first time that we have actively sought new members; until now midwives and parents have simply heard about us by word of mouth. Midwife Veronika Muller has designed a poster to be displayed in public places such as hospitals, Plunket rooms, doctors'' waiting rooms, libraries, Citizens Advice Bureaux, supermarkets, women's centres, church notice boards, staff lunch rooms, community houses and halls.

  We have sent each member two copies of the poster. Please make an effort to put these up - we need our members, to be effective, and we must be effective to retain midwifery as a profession in New Zealand. We have a very good track record for achieving change, and we can do even better with a larger membership to draw skills and resources from.

* We have sent in submissions to the Health Benefits Review (see inside) and to the Nursing Review.

* We are presently working on a plan to introduce a Midwifery Clinic as part of the service offered to Auckland mothers. This would provide antenatal care and delivery by midwives, in conjunction with G.P.'s. This plan is in its very early stages - more on this in the next issue.

* We have formed a Direct-Entry or Specialist Midwife Task Force. A member from Kaitaia, Micky Harrower, is heading the task force and is currently surveying Specialist Midwifery training programs overseas. She will report on progress in the next newsletter.

* We have donated $50.00 towards the costs of member Lynda Williams, who is going to Chicago in July to attend the International Childbirth Education Conference. The same amount has been sent to midwife Jenny Woodley, who is attending the conference too. Midwives from Middlemore Hospital have raised $1600.00 towards Jenny's costs!

SAVE THE MIDWIVES ASSOCIATION

Secretary: Judy Larkin, 24 Ashton Rd., Mt Eden, Ak 3.
Subscriptions Secretary: Lynda Schroeder, 19 Awa St., Miramar, Wntn.
Newsletter Convenor: Ruth Nicholson, 11 Morrin Rd., Ellerslie, Ak.
Newsletter Collective: Veronika Muller, Sally Morison, Jenni-Churton, Ruth Nicholson, Judy Larkin.
Specialist Midwife Tak Force: headed by Micky Harrower.

SAVE THE MIDWIVES ASSOCIATION SUBSCRIPTION FORM
please post to Lynda Schroeder, 19 Awa St, Miramar, Wellington.

Name:_____ Address:_____

_____ Phone:_____

Midwife?____ Mother?_____ Other?_____

NEW?_____ RENEW?_____ Annual Sub(Your Choice) $4___ $6___ $10___

Australia $NZ 10_____ International $NZ 15_____ Receipt reqd?__

I can help with_____