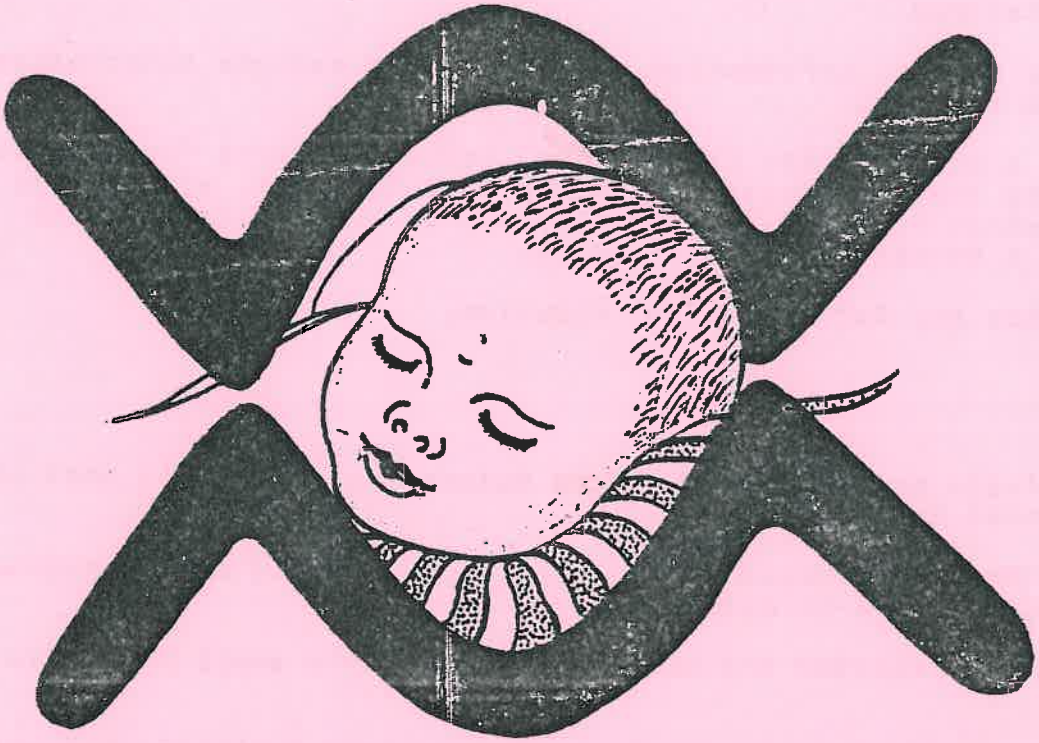
SAVE THE MIDWIVES



BUMPER DOUBLE ISSUE SUMMER '86-'87

NOS. 11 & 12

CONTENTS

save the midwives

We are a non-profit voluntary organisation currently working -

to encourage women to participate fully in their pregnancy, birth and motherhood

to share skills, information and ideas, and explore alternative patterns of care,

towards a direct-entry (specialist) training course for midwives believing that the existing midwifery course must, at the very least, be seperated from the Advanced Diploma in Nursing in order to achieve a better quality of course.

for better pay for home birth midwives.

WE HAVE

successfully opposed parts of the Nurses Amendment Bill that were detrimental to midwives

formed "Maternity Action" , a coalition of the 16 major parents and womens groups in Auckland

successfully opposed the closure of Auckland's small hospitals in 1985

made some changes to the quality of midwifery training in Auckland since the 1985 intake

WE NEED

greater membership to maintain our effectiveness as an organisation Subscribe for a friend - it's cheap compared with the changes that we are making!

more assistance with the newsletter- send articles, letters, reviews, information, suggestions, ideas on a different format for the newsletter, criticisms and even compliments to

Ruth Nicholson
Editor
Save The Midwives
11 Morrin St
Ellerslie
Auckland 5.

or phone 598 728

or

Judy Larkin
Secretary
Save The Midwives
24 Ashton Rd.,
Mt Eden
Auckland 3.

or phone 602 301.

Wellington people can contact

Lynda Schroeder
Subscriptions Secretary
Save The Midwives
27 TANERA CRES
BROOKLYN
WELLINGTON

Northland people contact Mikki Harrower
Specialist Midwifery Task Force
Fern Flat Rd.,
Peria
R D 3, Kaitaia

DO MEN REALLY HAVE A ROLE IN CHILDBIRTH?

Michel Odent, *the French obstetrician who pioneered a new approach to birth, argues – in this extract from his latest book,* Primal Health *– that labour is most natural when left entirely to women and that a male presence can adversely affect the future health of the baby*

Parents the world over ask for Odent-style births, free from unnecessary medical interference, in which fathers are welcomed as emotional and physical supporters. But Odent himself, in a seeming 180° turn, now questions the appropriateness of the father's role – and even that of the male obstetrician – in childbirth.

His controversial new theory of 'primal health' contends that everything that happens to us in the womb, at birth, and during breastfeeding will influence our basic state of health for the rest of our lives. It is then that the immune system, the hormonal system and the primitive brain are formed and reach maturity: our biological computers are programmed, determining the way we react to illness and to stress. And all the so-called 'diseases of civilisation' such as cancer, he says, can be linked to imbalances in these systems.

Yet, at precisely this moment of great vulnerability, our society interferes most – in the name of scientific progress – with the natural process. The real needs of a woman in labour should be recognised, says Odent, for the sake of her baby's future health. It is a uniquely female time, as traditional cultures understood. The mother craves intimacy – but she must feel alone. And an experienced and caring woman *(what he calls an 'authentic midwife') is often the only person who can satisfy these apparently disparate needs. By contrast, a masculine presence can block labour.*

It is not by chance that in the middle of the 20th century women suddenly need to be assisted by the baby's father during childbirth and even to share the experience with him. Before this time, either the father was excluded, as he had been in most traditional societies, or his presence was tolerated and justified by his performing practical tasks, like filling up basins of water.

This unprecedented sociological phenomenon has coincided with the concentration of births in hospital and with the evolution of the nuclear family. It has also coincided with a decline in the role of the midwife. This decline has taken different forms in different countries. But, no matter what term is used to describe it, the fact is that the midwives who have survived have become auxiliaries of doctors. Nowadays it is not possible to define the midwife's job without referring to the medical profession. Either the midwife is officially considered as an auxiliary to a doctor, or else her job is considered as that of a medical professional with limited competence. Midwives are less and less autonomous. There are fewer and fewer authentic midwives.

In most Western countries, the presence of the father at the birth has become a rule, accepted by even the most conservative maternity wards. The presence of the father reinforces the image of the nuclear family as the model, just as the nuclear family reinforces the relevance of the father at birth. It is obvious that the presence of the baby's father has become a necessity in the context of modern obstetrics. It is also part of a trend to make hospitals more human. But do men really have a place in circumstances where the priorities would be different; in circumstances where women would be able to give birth using their own hormones? The part fathers play in sharing emotions is rarely questioned. Is it always positive? To dare ask such a question is almost scandalous at a time when childbirth is thought of as something just between a couple. But, having observed thousands of couples, who come from every kind of socio-economic group, it seems that things are not as simple as people think. The kind of bond between couples and the intimacy they share can be incredibly different. The anxiety fathers feel about birth is very different from one man to another.

I have a feeling that men who had an easy birth themselves usually play a positive role in childbirth, and vice versa. Some fathers disguise their anxiety by being very active and by talking a lot. An anxious man wants to massage his wife and to control her breathing and her position. He tends to be possessive. There are sometimes latent conflicts going on inside couples and this can come out in a birth which is long and difficult. Many men, because they are men, are surprised and disturbed by the internal trip a woman makes to bring a child into the world.

Obstructive fathers

The behaviour of some men during childbirth is perhaps more akin to the behaviour of primitive men. Men like this often play a positive role. They keep themselves in the background, sometimes even outside the room, as if to protect the privacy of their childbearing wives from the world outside. Perhaps behaviour like this is not very different from how it used to

be in the primitive societies of hunter-gatherers: the men kept guard, protecting their women from the outside world and protecting the birth of their babies. Certainly, it is not very different from some animals. For example, when a baby dolphin is being born, the males stay outside the group of females, always at the ready to kill sharks.

The father's common participation has largely contributed to the role of the midwife being reduced to one of technique. Yet I am constantly reminded in daily practice of the irreplaceable role of an experienced midwife. Let me give an example. A labour is long, and does not seem to be progressing. The dilation of the cervix stays the same for several hours. The father then decides to leave the room for a short while. During his short absence, the baby is born. Because of the father's new role, it is easy to forget how positive women can be – women such as the mother or sister of the labouring woman – as long as they give birth by themselves, meaning without medical intervention.

A woman in labour needs to have a special relationship with one other person. Sometimes this means that she has to make a choice, because if there are several people present at the birth it can be counterproductive. I sometimes say that the length of the labour is in direct proportion to the number of people present!

Desire for privacy

Why is it that for thousands of years women in labour have always hidden away from men's eyes while they gave birth? No doubt they felt that their need for privacy would have been disturbed by the presence of men. Apparently the traditional needs of a woman giving birth are not the same as those of women today.

We must remember that in traditional societies women shared their daily lives, and shared intimate things with each other, such as when they were having a period. So when a woman gave birth, the presence of other women with whom she was already intimate was not felt as a disturbance. In contrast, some Western women can only find privacy alone in the bathroom. But the differences between these two groups of women are only superficial. What they share is a common need for privacy. Even if modern couples now share a kind of intimacy that was unknown before modern Western society, it is still probable that the consequences of men looking on during childbirth are not so very different now.

There are some things which a labouring woman does which she would not usually do in front of her sexual partner. For example, during childbirth a woman needs to empty her rectum. This is something she might feel comfortable doing in front of her mother. The kind of privacy which a labouring woman needs is not disturbed by the presence of an authentic midwife, someone who is a motherly woman as well as an experienced one.

THE PART FATHERS PLAY IN SHARING EMOTIONS IS RARELY QUESTIONED. IS IT ALWAYS POSITIVE? TO DARE ASK SUCH A QUESTION IS ALMOST SCANDALOUS . . .

Privacy is indeed the key word in an understanding of the needs of a woman giving birth. Privacy is what you feel when there is no social restraint. It goes with a reduction in control by the neocortex, the upper brain. The active part of the brain during childbirth is the archaic brain, the primal brain; the brain we have in common with all the other mammals. It is the primal brain which secretes all the hormones necessary for childbirth. Childbirth is an involuntary

Michel Odent with journalist Judy Graham and their 16-month-old son, Pascal – delivered by a midwife (Caroline Flint)

process, but this involuntary process can be disturbed by the activity of the neocortex. All inhibitions come from this area. Helping a woman give birth means helping her reduce the control of the neocortex, or not doing things to prevent this. It means not preventing her from cutting herself off from the outside world. Men have never been able to make the interior trip of childbirth, and that is why many of them can disturb things by their presence. Obstetrics, a medical discipline which is dominated by male doctors, has never understood the physiology of childbirth.

Sexual mystery

Another reason why it might be necessary to keep the worlds of men and women separate at this time is to maintain sexual attraction. This needs an element of mystery. At the time when men were hunter-gatherers the birth of a baby in the world of women was shrouded in mystery. Goddesses were worshipped. In the same sort of way it is possible that certain aspects of the men's world, such as hunting, fired the fantasies of women. Nowadays, in our unisex society where there is little distinction between men and women, the element of mystery has almost gone. I have been taken aback by the large number of divorces and separations among couples who shared marvellous birth experiences. On the other hand, couples where the man was not an active participant in the birth of his children seem to still have solid relationships.

The interest which a man has in a newborn baby follows a kind of chronology; it gets stronger as the baby gets older. This is not the same for a woman, who has what is called 'the primary maternal preoccupation', which is connected with profound biological changes. Perhaps there is a tendency nowadays to upset this paternal chronology. Not only are the positive effects of the father sharing the birth accepted without discussion, but some people actually teach the father to feel the baby inside the mother's tummy without waiting for him to do it spontaneously. Perhaps the main role of the father should be to protect and help the mother/baby couple, to satisfy their needs, before he establishes a direct attachment with the baby.

What I have said does not mean there is no place for the father in the birthing room. His presence is often felt to be necessary in the context of the nuclear family and hospital confinements. But it is appropriate to ask why the world of women was traditionally protected from men's sight.

For their part, men have always sought ways to give more importance to themselves in the period around childbirth. This tendency has expressed itself differently according to the different stages of history – or, more precisely, according to the different stages in the history of patriarchy. The rite of the *couvade* seems to correspond to the first stage, with the passage from matriarchy to patriarchy. *Couvade* is when the man does various things to imitate a woman giving birth. The man goes to bed, expresses pain and stops his social activities in a ritualistic way. He does this in such a way that other people devote their care to him, and offer him their congratulations. It is sometimes the man who introduces the new baby to the community. Today the *couvade* can still be found in parts of the world which are far apart from each other, such as Siberia, South America, Africa and Malaysia.

With the arrival of monotheistic religions, the power of men over women during the period around childbirth took on new forms. The Christian baptism could be interpreted as the true birth, the spiritual birth given by the religious fathers. Women are reduced to being able only to give birth biologically. Circumcision in the first eight days of life can be interpreted as the penetration by man in the world of women. Only men could originate such a cruel custom. Mothers left to themselves would be very unlikely to do that to their own baby boys.

But, of course, it is through the medical institution that men have taken control of childbirth most powerfully. The doctor has weakened the role of the midwife by making her a professional whose education he directed. Not only has medicine increased its control over childbirth itself, but during the 20th century it has also wanted to teach women how to give birth. Lamaze wrote that a woman must learn to give birth in the same way that one learns how to swim, read or write! This attitude has done a lot to contribute to the profound misunderstanding of the physiology of birth.

Today the common participation of the father seems to be the next stage in the masculinisation of the birth place, and of the feminisation of man. Although most antenatal teachers and childbirth educators are women, some of what they teach comes from male obstetricians. Some teachers even promote a method whereby the man is instructed how to coach his wife during labour and delivery. This kind of attitude has largely contributed to people holding on to the idea that a delivery can be actively helped, whereas the essential reality is that above all else a delivery should not be disturbed.

Male delivery

One must not forget the other stage in the masculinisation of childbirth – the male midwife. It is now possible for a woman giving birth to be surrounded by three men: the male midwife, the baby's father and the male doctor. Under such conditions, a woman rarely gives birth by herself. Even if she escapes a caesarian, her uterus cannot be considered to do its job properly without the help of artificial hormones, carefully administered by the professionals. All the mystery has gone. There are no goddesses any longer.

We have reached such a degree of absurdity that two questions immediately need to be asked: what chances of survival has a society got without women midwives? In other words, a society which completely denies the complementary roles of males and females. Second, is a new awareness still possible? I prefer to answer just the second question and express my optimism. All over the world, mothers feel called towards the vocation of midwifery after having had their own children. They rediscover the true role of the midwife. More and more women are searching for alternatives to conventional obstetrical birth. There are professionals who do things which are outside the law so they can abide by the body's physiological processes. Medico-legal institutions need to use more and more force to put a brake on this movement. Some midwives have been in prison. Some doctors have been disqualified because their attitude was considered 'bizarre'. There would not have been such witchhunts in various countries if this movement had been just a passing fashion. Obstetrics is the medical discipline which has contributed most to the weakening of primal health in our society. □

MEN HAVE NEVER BEEN ABLE TO MAKE THE INTERIOR TRIP OF CHILDBIRTH, AND THAT IS WHY MANY OF THEM CAN DISTURB THINGS BY THEIR PRESENCE

Taken from Primal Health, *by Michel Odent, published by Century on 10 July at £9.95.*

SENT IN BY CLARE HUTCHINSON (WAIKATO)

GOOD HOUSEKEEPING U.K. AUGUST 1986

Medical Practitioners Disciplinary Committee

All Correspondence
should be addressed
to The Secretary
P.O. Box 156

Wellington
Telephone 724-741

COMPLAINTS ABOUT MEDICAL SERVICES

WHAT TO DO IF SOMETHING GOES WRONG

There are millions of medical consultations in New Zealand every year and the vast majority pass perfectly normally.

In comparatively few cases however, a patient is dissatisfied with the service he receives, or the behaviour of the doctor, or the fee he is charged, or in some cases failure of the doctor to attend.

If this happens to you or your family you are not powerless - you can do something about it.

Talk to Your Doctor

The first and most sensible thing to do is to discuss your worry frankly with your doctor. Often it will prove to be a simple misunderstanding which can easily be cleared up.

But if you are still not satisfied, or feel you cannot approach your doctor about it, you are entitled to make a formal complaint.

Throughout New Zealand there are special committees for the investigation of complaints against doctors and for determining the fairness of medical fees and charges.

How to Lay a Complaint

It is a very simple matter to lay a complaint.

Here is what you do:

Write to: The Secretary,
Medical Practitioners Disciplinary Committee,
C/- P.O. Box 156,
WELLINGTON.

The Medical Practitioners Disciplinary Committee is a statutory body established in terms of the Medical Practitioners Act, 1968 to inquire into any formal complaint against any registered medical practitioner in New Zealand.

In the letter, simply set out your complaint as clearly as you can in your own words. Be sure to include these essential details:

- Your full name and address
- The name of the doctor
- That you wish to make a complaint
- The correct date and time of day when the consultation took place

Some people find it difficult to write such a letter. If this is a problem for you, try to find someone to help. A Minister of Religion or a Citizens' Advice Bureau will usually be happy to assist if asked.

What Happens Then?

The Chairman of the Disciplinary Committee will look into aspects of your complaint. He will invite the doctor to comment upon your complaint, allowing you the opportunity to consider the doctor's comments. If the complaint has substance, the Chairman will then determine the level of inquiry necessary, advising you of the action which is to be taken. At the completion of the formal inquiry, you will be told the result, but do not be too impatient. The Committees which make these inquiries are manned by doctors and lay people who under take this work voluntarily because they are keen to keep medical standards as high as possible. It may take time to investigate complaints thoroughly and ensure justice is done to everyone concerned.

You can be sure your rights will be protected and if your complaint is of a serious nature and a formal inquiry is held, the Committee will arrange for a solicitor to assist you.

How to Lay a Complaint about a Fee Charged

The New Zealand Medical Association has set up special committees to consider grievances about fees. You may contact the New Zealand Medical Association's local Divisional Fee Complaints Officer. The officer's name and telephone number may be obtained from either the Citizens Advice Bureau or the New Zealand Medical Association, P.O. Box 156, Wellington.

Alternatively:

You may ask the Medical Practitioners Disciplinary Committee to inquire into your complaint about the fee that is charged. To do this, you must follow the procedure as outlined above and enclose an account from the doctor setting out the services you were charged for and signed by him personally The doctor is obliged by law to supply you with this signed account on request: wrote. telephone or call at the surgery to get it.

When you are disputing an account, your complaint must reach the Medical Practitioners Disciplinary Committee no later than one month after you receive the signed account. You cannot then be forced to pay it until the inquiry is completed.

If you have any questions about these procedures, please contact either the Secretary of the Medical Practitioners Disciplinary Committee or the General Secretary of the New Zealand Medical Association at P.O. Box 156, Wellington.

Thanks to: A.R.M. Spring '86

FACE PRESENTATION

By: Ina May Gaskin

Reproduced with the kind permission of The Practicing Midwife , Spring 1985, p.11-15.

Face presentations occur about three times as often in multiparas as in primiparas. The overall rate is about 1 in 500 births, although the rate varies somewhat from place to place. Five percent of face presentations will be anencephalic babies; because the bones of the skull are absent, the face presents when labour starts with the head lying in the lower pole of the uterus.

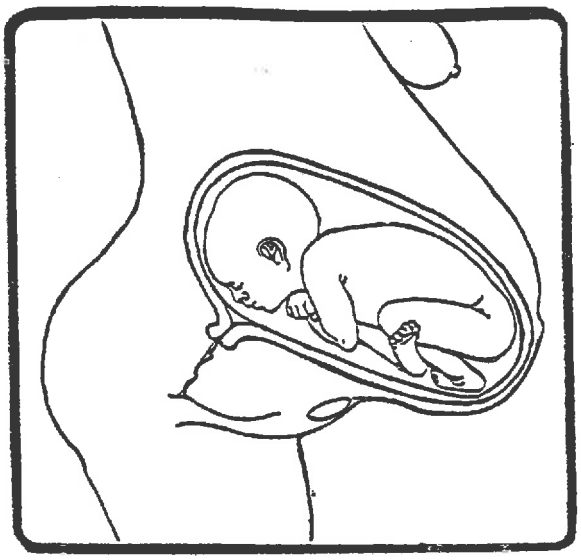
The reason for the increased incidence of face presentations in multiparas is the softening of the abdominal muscles that often takes place after childbirth. A woman with a pendulous abdomen, whose baby is in a posterior vertex presentation, may very well end up with a face presentation. The baby's bottom will tend to lean forward, and when labor begins, the baby's chin, rather than the occiput, will receive the main force from the contractions of the uterus. This is the most common cause of the face presentation.

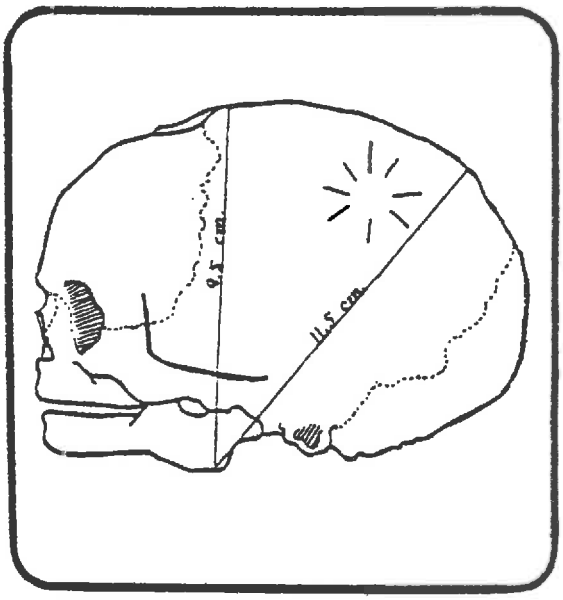
Another common cause is the woman with a contracted pelvis, whose baby's head is slightly extended at the onset of labour. During labour the baby's parietal bones get hung up on a narrow dimension of the pelvis, keeping the occiput from descending. As this happens, the head becomes even more extended. Sometimes babies in brow presentation may convert to face presentation during labour.

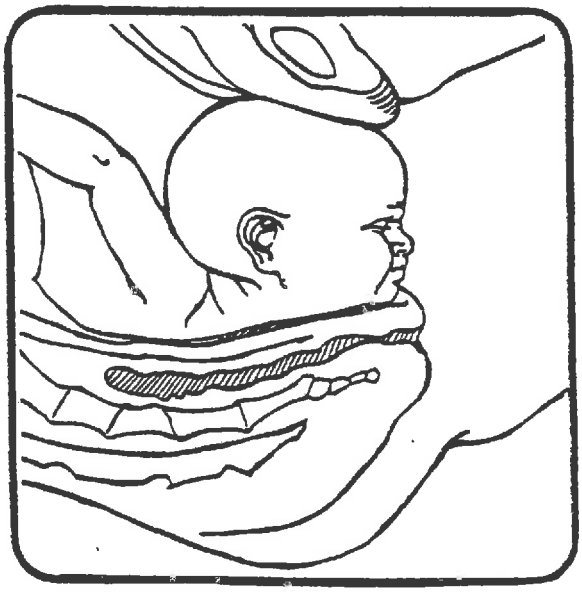
Face presentations may also be caused by tumors of the baby's neck or of the lower uterine segment or by the cord being wrapped several times around the baby's neck, causing extension of the head.

Fortunately, face presentation babies usually deliver successfully. Labour may take a little longer than when the occiput presents, but the submento-vertical diameter (11.5 cm usually, equal to the occipito-frontal diameter) is most always small enough to permit vaginal delivery.

The face presentation may not be discovered until labour has begun. A partly soft, partly firm irregular contour may be felt, which may be mistaken for a breech or an anencephalic head. The most useful landmarks are the orbital ridges, the nose, the mouth and the alveolar ridges. Care must be taken not to injure the baby's eyes during vaginal examination. Another sign of the face presentation is an S-shaped fetal outline on abdominal examination. The baby's heartbeat is easily heard, as the chest is made more prominent by the extension of the head. The chest may be mistaken for the back and the occiput for the brow. The baby's mouth may be mistaken for the anus. A more careful examination should include feeling for the gums, to distinguish the mouth from the anus. If the membranes rupture, a vaginal examination should be done to rule out prolapse of the cord.







There is no compelling reason for the use of ultrasound or X-ray, once a face presentation has been diagnosed by manual examination.

Labour usually progress uneventfully with face presentations. Some manual pressure over the pubis may help the head engage completely, once the cervix is fully dilated. The baby lying with chin posterior should rotate so that the chin is anterior at least during the second stage. If this baby fails to rotate, a cesarean section will be necessary. But most face presentations will spontaneously rotate so that the chin is anterior.

Upright positions during labour may help dilation of the cervix and descent of the head. When the baby's face is emerging, the midwife should support the perineum and hold back the baby's brow until the occiput passes over the perineum. The baby's face will be bruised and swollen for a short time after delivery. The baby should be watched carefully for a few days for oedema of the glottis, which may occur after delivery.

It is often enlightening to go back to obstetrics texts of more than one hundred years ago to see what was done with unusual presentations when obstetricians could not safely resort to caesarean sections. One well known English obstetrician-author of the mid-19th century, Playfair, wrote in THE SCIENCE AND PRACTICE OF MIDWIFERY, "The older accoucheurs had very erroneous views as to the mechanism and treatment of these cases (face presentations - ED), most of them believing that delivery was impossible by the natural efforts, and that it was necessary to intervene by version in order to effect delivery. Smellie recognised the fact that spontaneous delivery is possible, and that the chin turns forward and under the pubes; but it was not until long after his time, and chiefly after the appearance of Mme. La Chapelle's essay on the subject, that the fact that most cases could be naturally delivered was fully admitted and acted upon."

Playfair goes on to make this interesting observation about the descent of the head in face presentations:

"As a matter of fact, the chin is frequently observed in mento-posterior positions to descend so far that it is apparently endeavouring to pass the perineum before rotation occurs. At the brim the two sides of the face are on a level, but as labour advances the right cheek descends somewhat, the caput succedaneum forms on the malar bone, and, if a secondary caput succedaneum form, on the cheek."

'Birthroom' alternative for mothers

By Dr K C Hutchin, Medical Consultant

ONLY 20 of the 2,000 women who give birth daily in Britain have their babies at home.

In other developed countries the percentage of home births may be higher with an average of 30 per cent in Holland where it may be as high as 50 per cent in some parts of that country.

The birthroom, a new concept in the management of labour, is discussed in a leading article in the current issue of The Lancet.

It is pointed out that parents may feel more satisfied if the birth takes place in the familiar surroundings of their own home.

The article quotes Prof. Geoffrey Chamberlain, a consultant obstetrician at Queen Charlotte's Hospital, West London.

Unexpected hazard

While acknowledging the poor facilities available at home deliveries, Prof. Chamberlain makes a plea for giving women a more relaxed and happy time in hospitals.

Rapid intervention is needed to save the life or health of the mother or baby in about five per cent. of cases in which a hazard might not have been expected.

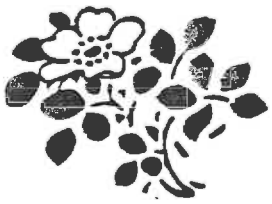
Many obstetricians believe that until a correct prediction is possible it is safer to offer expectant mothers full and comprehensive care in hospital.

The birthroom offers women comfortable and homelike surroundings close to the labour suite.

They could come there with their own community midwife under the supervision of their own general practitioner obstetrician. If all went well they could return home in hours.

But if complications arose, the adjacent hospital, staff and equipment would be available without delay. In the United States this concept is called "birthing room."

Daily Telegraph 2/9-86



Thanks to: A.R.M. spring '86

TENDER TOUCHING & SCBU

By: Elvidina Adamson-Macedo

Key Word:
Stroking - "To pass the hand softly in one direction only as a way of a caress.."
(Shorter Oxford English Dictionary).

TAC-TIC (Touching and Caressing - Tender in Caring) is the evidence that science can progress out of loving and tender caring data. One hundred and fifteen (115) newborn (Fullterm and preterm) babies were recruited from one clinic and three hospitals in London and in the home counties. From 1979 to 1983, I gave TAC-TIC programme of tactile stimulation to these babies and carefully collected data on physical growth, neurological, neurobehavioural, mental and motor development. Changes in sleep-awake activity and neurobehavioural responses during the stimulation sessions were recorded. The evidence has been encouraging: both the term and the tiny brave preterm infants benefited and they have enjoyed being systematically caressed.

TAC-TIC and its background :

Accumulated evidence over the last two decades, has indicated that infants whose birthweights are 2,500 gm or less, suffer significantly more handicaps in neurological, social, mental and motor development and functioning than full-term infants. As a contribution to these problems, and noting that 60% to 70% of infant mortality may be attributed (in the UK) to the 7% of births which are low, or very-low birthweight, a programme of tactile stimulation was advocated; this was in order both to encourage the developmental potential of premature babies, irrespective of the causes of their prematurity and to decrease the potential risk of this population to be abused and neglected.

The efficacy of this technique of tactile stimulation has been established by several means as follows:

1. excluding other forms of stimulation
2. starting on day 1, as early after birth as possible
3. employing systems of measurement with physical criteria, including sleep-awake activity, Brazelton's Neonatal Behavioural Scale, the Dubowitz and Dubowitz Neurological Assessment, and the Bayley Scales.
4. Carrying out a two and a half year follow-up study.

Scientific Evidence :

This work has provided valuable evidence towards supporting the hypothesis that very early and systematic tactile (stroking) stimulation can enhance growth and development of both the healthy full-term and the tiny (but brave) preterm newborn infant.

Full-term healthy babies: At three months, the full-term healthy babies who were stimulated (stroked) by their mothers/fathers had shown better mental development, by comparison with their non-stroked counterparts. The evidence adds to the belief that we 'healthy people' only use 10% of our respective brain, indicating need for all appropriate and hence, essential stimulation.

Pre-term babies: Before any statistics were available the first data (available to the author) were the responses of the babies themselves, (which none of the previous 22 well-known studies had taken into account). Their responses worked as a pledge for this author. As a mother, before being a researcher, I could see and feel the importance of neuro-behavioural responses such as 'skin colour,' 'hand brought to mouth,' 'change in sleep-wake activity,' 'numbers of startles,' and 'smile' amongst others.

Babies' response: The first thing the babies told me and here I also include the healthy fullterm ones, was that they discriminate between a pleasant and an unpleasant stimulus. TAC-TIC was pleasant, for instance, whereas 'blood sample' was unpleasant. In discriminating (responding differently), they were saying that they have a 'competence' and that if we give them the chance they will communicate (let us know) through their facial and body language. Yes, they were tiny little fellows, but they were willing to help us in their struggle for told me and here I also include the healthy fullterm ones, was that they discriminate between a pleasant and an unpleasant stimulus. TAC-TIC was pleasant, for instance, whereas 'blood sample' was unpleasant. In discriminating (responding differently), they were saying that they have a 'competence' and that if we give them the chance they will communicate (let us know) through their facial and body language. Yes, they were tiny little fellows, but they were willing to help us in their struggle for survival. All we researchers, parents, doctors and nurses have got to do is to open their eyes, ears and hearts to see, hear and feel them so that their needs may be fulfilled. Their capacity to respond differently will play a part in promoting their sensorimotor structures and hence make learning possible.

Babies putting on weight, sucking and grasping: After one week, it was noticeable that the stroked babies caught up their birthweight faster, they were feeding better (stronger sucking) and they were also showing stronger hand grasp reflex as compared with their counterparts, the non-stroked babies.

At the end of three weeks (end of systematic stroking) the caressed babies maintained the results above and added the beneficial effect of moving from tube feeding to bottle/breast feeding and also moving from incubator to cot earlier as compared with the non-stroked babies.

Parents were happy with their babies and looking forward to going home and indeed the caressed babies went home younger and earlier than the non-caressed ones. Babies were less irritable and easier to console.

Touching and Caressing - Tender in Caring

The acronym TAC-TIC was my husband's inspiration at three o'clock in the morning. It is pure love being suffused amongst the monitors and wires within the 'glass houses' and all the artificiality of Intensive Care Nurseries. It is communication and awareness through tender touching movements. It is an essential complement to infant care routines.

TAC-TIC Movements

There are 22 movements. Tenderness, continuity, rhythm and equilibrium are principles underlying TAC-TIC. Your touch has to be as gentle as a butterfly using your fingertips (nails cut short). One hand is always in skin contact so that the baby feels secure. Your finger tips or palm of your hand moves in a rhythm of calmness and confidence. This rhythmic tenderness is in equilibrium moreover with equal weight given to stimulation/relaxation or arousal, as against relaxing/soothing movements.

Brief procedural steps for baby lying on his/her tummy:

Do not undress your baby. Watch him/her with loving/tender care. Warm your hands and then place them very gently on baby's head (see Parents Magazine, issue No.116, Nov.'85). From head to toe, you tell your baby how much you love hom/her, communicating through the skin, the eyes, the ears and above all with the Tic-tac, tac-tic, tic-tac, TAC-TIC of your HEART. A Heart, a heart, a heart for your TENDER TOUCH, Mum, Dad, Midwives, Nurses, and Doctors. Please, do not let me develop 'touchiorkor' (touching depriviation, from 'touch + Kwashiokor').

A non-verbal discourse develops around and about his/her little body and sheds further light on them. Many human activities enhance pleasure and reduce annoyance, and this promotes learning through the 'Law of Effect.'

THE MENSAM-CORSAN INSTITUTE in London opened on 9 February 1986. One of its specialisations is the accelerated development of babies from birth, using TAC-TIC, as described above. Mothers have also experienced TAC-TIC, and all comment on its well-balanced Arousal, Relaxation and Soothing effects.

PREGNANT women have been advised by the Government to steer clear of lambing ewes. The warning is being directed particularly at the wives of sheep farmers and shepherds. Junior Health Minister Baroness Trumpington says that any woman who thinks she is pregnant and who has attended lambings or been close to sheep abortions should inform her doctor. For there is now growing recognition that sheep pose a rare but real health hazard to pregnant women—involving risks of miscarriages and serious illness.

Over the past five years there have been 10 reported cases of miscarriages caused by Chlamydia psittaci following contact with ewes in lamb, but in the Lords it has been suggested there may be more unreported cases and the Minister confirmed that following such miscarriages women suffered serious illnesses involving defects in blood coagulation, kidney and liver dysfunction and heart problems. Now the DHSS, the Ministry of Agriculture plus the Public Health Laboratory Service and the Communicable Diseases Surveillance Centre are jointly considering further research. Lady Trumpington told the Lords that health departments were closely monitoring reports of the infection. The Government, she said, was "very concerned" about recent cases.

Practical advice on warning farming families at risk is to be given to veterinary officers before the start of the next lambing season. In addition, said the Minister, doctors, particularly those in rural areas, should recognise the potential hazard to pregnant women in areas where Chlamydia infections in farm animals may be widespread. The most practical safeguard, she added, was that high standards of hygiene should be observed—"and that wherever possible pregnant women should keep away from infected flocks and ovine abortions."

Lord Walston pointed out that large numbers of farmers' wives, particularly in hill areas, helped their husbands with lambing. "Precious few, if any, know of the risk," he claimed. The Government, he said, should do all it could to warn women at risk. Calling for more research, Lord Walston said the risk to the farming community was relatively recently discovered but it was probably a long-standing disease. Lady Saltoun of Abernethy urged the Government to realise that many hill farmers were dependent upon their wives' assistance during lambing. Pressure, she said, should therefore be put on the DHSS to concentrate on preventive measures. The Health Minister replied that if one had to be near sheep the best advice was to wear protective clothing and, if possible, keep away from lambing ewes and placenta disposal.

Midwives Chronicle & Nursing Notes. Aug. '86

Birth in Alice Springs, Australia

by Doreen Carlson Doyle

Alice Springs is a rapidly growing small town community, isolated in the middle of Australia's famed Northern Territory desert. One imagines a tourist town the size of Alice (population 22,000) to be highly influenced by its transient inhabitants and media exposure. It is also true, however, that like many small, isolated communities worldwide, change is slow and suspect. The first and only traffic light was installed in 1985!

Births in Alice Springs take place in the one existing hospital located close to the centre of town and approximately a five minute drive from all residences. There is a training school for postgraduate studies in midwifery (for registered nurse candidates) and a Diploma of Obstetrics for Resident Medical Officers. The hospital was awarded accreditation as a general hospital in August 1980. Approximately 60% of hospital patients are aboriginal and these may be of several separate tribal groups. The Aboriginal Congress conducts an alternative native medical clinic that utilizes the hospital by referral.

Most highrisk patients remain in Alice for care, although 15% or more may be intermittently screened during pregnancy at major centres in Adelaside and Sydney. The hospital obstetric clinic and community health system provides free care to all. The majority of women, when eligible, still prefer private doctors with Medicare covering most of the costs incurred.

With few exceptions, the doctors practicing obstetrics are general practitioners with a diploma (six months of study) in obstetrics. Nurse-midwives supervise most labours, but account for only a fraction of actual hospital births. Due to the limited availability of "wandering" midwives and the cost incurred for transportation and such, planned homebirths occur only once or twice a year with adament medical disapproval and little or no emotional support. Women are told. and most are convinced, that homebirth is irresponsible and only highly motivated and educated women have attempted homebirth.

A recent survey revealed that most of the women giving birth at Alice Springs Hospital receive perineal preps (enemas and shaves). Approximately 80% have glucose infusions. Most practitioners surveyed advocate unrestricted nourishment and hydration "with reservation" during labor. Walking during labor is suspect by some and cited as one of the leading causes of maternal exhaustion. Auscultation and external EFM are the norm to determine fetal well-being, while internal EFM (30-45%) is routinely lauded to aid maternal mobility after membrane rupture. Women are offered nitrous oxide and pethidine (75-100 mg) for pain relief throughout labor.

Emotional prophylaxis is encouraged by the midwifery staff. Also encouraged is the presence of the husband or other support attendant. Although *all* practitioners answered the survey question "What is the *best* position for a women to give birth?" with similar answers to the effect, "Any way she wants," *in actual practice,* 97% of vaginal births are semi-supine. Episiotomy rates for primiparas are approximately 80%, multiparas, 60%. Inductions account for about 30% of all births, with postmaturity the causative factor.

Upon admittance to the hospital, women are routinely sequestered in a three or four bed room called a "staging room". Privacy is afforded by drawn curtains around the bed. Patients in various levels of first stage labor will sometimes remain in the staging room until pushing efforts are productive. At that time, women are transferred to a conventional delivery room. Staff shortages and convenience are cited for the existence of this room, despite a growing dissatisfaction among the educated consumer public.

Anesthesia for cesarean births is routinely general, done by anesthetists on call at the hospital. The cesarean birthrate is 20-22%, while the vaginal birth after cesarean (VBAC) rate is less than 5%. Epidurals, recommended in labor for relaxation and pain relief, are subject to the availability of competent anesthetists. Epidurals are used with 10-15% of cesarean births. Fathers are allowed to attend cesarean births (75%) only if an epidural is used and subject to approval of the doctor, anesthetist and surgical staff. The most common reason stated for cesarean birth is "failure to progress" (70%) followed by fetal distress. Currently, no cesarean birth classes are being offered except what is covered "adequately" in antenatal classes.

The usual hospital stay for cesareans is five to seven days versus three to five days for vaginal births. Almost 100% of women utilize rooming-in. Sibling attendance at vaginal births is nil, but flexible hours for visitation after all births are allowed to facilitate bonding. New mothers are visited regularly at home during the first two weeks postpartum by Community Health nurses to assess maternal and baby well-being, as well as to provide ongoing support where needed or requested. The hospital nursery provides routine care for births as needed, while the majority of critically ill infants are transported to larger medical centers.

Education of the public has become the priority of all local educators. The Childbirth and Parenting Education Association of Alice Springs, (CPEA) is influential in promoting public awareness of current worldwide practices with well attended antenatal classes, up-to-date lending library, and an annual "Birth Week". Birth Week highlights guest speakers within the medical community and educational films and seminars. An offshoot committee called, "The Childbirth Support Group," is

Taken from the International Journal of Childbirth Education Vol. 1 No. 1, May 1986

ALICE SPRINGS.
the most visible and effective lobby for the birthing women in Alice Springs. They offer 24 hour patient advocacy and birth attendance. They also are solely responsible for the financial and actual implementation of renovating a conventional delivery room into an esthetically pleasing birth suite, set for completion in late 1986.

Prenatal yoga and antenatal exercise classes are available and well attended. The Community Health system is accredited with early pregnancy and antenatal classes as well. The Nursing Mothers Association of Australia is responsible for the high rate of breastfed babies and the continued support pre and postnatally of the Australian family structure.

The Aboriginial Congress health scheme seeks to educate and support aboriginal women both in town and in the bush outback regions. Due to regional and traditional mores of the various tribes, existing obstetrical services are rarely in sympathy to meet the needs of pregnant aboriginal women and their families. For this reason, the aboriginal community is in heated debate with the government to establish an "Alukera," a traditional birthing centre outside the hospital structure, run exclusively by aboriginals. The ultimate decision may be influential in assessing areas of progress in maternity care for all Australian women. Alice Springs has the potential to offer a wide range of birthing alternatives to the pregnant community. The community can also be lauded for its flexibility and growth *only if* parents continue to be assertive of their needs and desires, despite established and firmly rooted "hospital policies." Although apathy is the leading contributor to acceptance of routine procedures, keeping the lines of communication open among all involved in maternity care will bridge the desert oasis of Alice Springs and the rest of the birthing world.

Doreen is a childbirth educator (twelve years) and has taught in several remote countries. She currently serves on the ICEA Committee for International and Remote Educators. Presently teaching antenatal classes and Advocate Training courses as well as being a Multiple Birth Support Counselor for the Alice Springs Childbirth and Parenting Association. Doreen has lived in Alice Springs with her husband and her five children for three years.

. . . . . Information for this article was supplied by an extensive survey conducted by Doreen. Local hospital statistics were also used in compiling figures.

An issue of birth and power

Mrs Wendy Savage has commendable patience, for a doctor who has been accused by her colleagues and her local health authority of professional incompetence, suspended from her work, then conclusively cleared—and who then finds those same colleagues still unready to work with her.

She should have been welcomed back to her hospital work in east London—with the health authority's blessing this time, and well they might after their earlier behaviour—two weeks ago. Yet this week, 18 months and some £250,000 of legal costs after her suspension, Mrs Savage's work was restricted to "administration", while lawyers argued over the terms on which her colleagues would allow her—or the terms on which they could be disciplined if they refused—to resume what doctors are paid for, seeing patients.

Mrs Savage's suspension has earned her more media attention than any British doctor of her gender since Marie Stopes. She remains, as her book* on the affair shows, opinionated and forceful as ever, justifiably content in victory, but plainly not in pursuit of publicity for itself. Yet the Savage affair will not retreat into obscurity even if its victim wished to and could.

The issues it raised are partly those of public administration: not least the astounding time and cost spent trying to get rid of a public servant wrongly alleged to be incompetent and just as likely to be spent another time—in the health service or elsewhere—getting rid of people who actually are so.

But the real issue is the one that separated Mrs Savage from her colleagues. This was not, as some press comment summarised it, one of natural childbirth versus "high-tech". In the context of modern medicine, Caesarians or induced labour are about as high-tech as the horseless carriage. The argument is, as Mrs Savage puts it, one about "birth and power: who controls childbirth?" The answer today is obstetricians. Mrs Savage thinks that mothers should count as much. Many male obstetricians—let alone society at large, still dominated by men—barely realise that such an issue arises at all. Mrs Savage's real battle is barely begun. She is putting profits from her book into a new campaign, "Womanschoice", which will ask women what health care women want.

Still battling

*A Savage Enquiry. Virago. £2.95.

THE ECONOMIST OCTOBER 25 1986

A Savage Enquiry is now available at the Corner Bookshop for $13.95 N.Z. (Auckland): see Review P. 23.

OBSTETRIC CARE IN BRITAIN

25th Birthday Conference of AIMS (Association for Improvements in the Maternity Services), London, November 1985

AT A national conference held at the Friends House, Euston Road, North West London on Friday, November 29, 1985, the Association for Improvements in the Maternity Services celebrated its 25th anniversary by inviting some well-known people in the maternity field to take a long, hard look at obstetric care in Britain today.

"The number of doctors in 1985 who have actually seen a natural labour and birth through its entirety can be counted on the fingers of one hand," said Caroline Flint, a senior midwife at St George's Hospital. "Most doctors have no idea at all of what a normal labour is like".

Wendy Savage, consultant obstetrician and lecturer, spoke on ways in which women can seek to change the attitudes of the medical profession and suggested that the root of the problem lay in the medical schools: "We need more mature students who have done other jobs which bring them into contact with people ... rather than recruiting scientifically based bright young people straight from school".

"Obstetricians could be changed by taking the control ... of pregnant women out of their hands and putting it back into the hands of women—i.e. midwives".

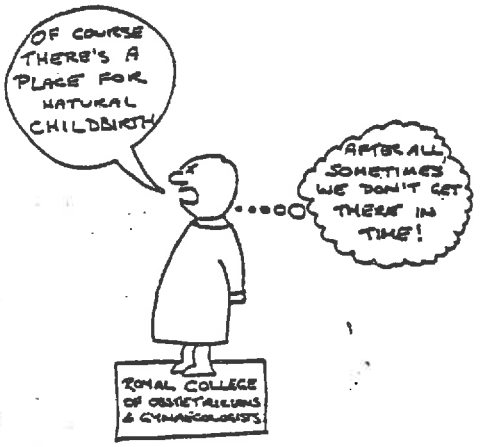
Sociologist Ann Oakley looked back at the history of women's experience of childbirth and noted that maternity care had become an industry. It was, she said, big business in the commercial sense as well, for whatever technologies were introduced they always carried with them specific commercial interests.

French Obstetrician Michel Odent emphasised how birth used to take place in an entirely female environment. He evaluated how the medicalisation of birth had turned obstetrics into a male-dominated specialisation and posed the question, "Is there a role for men in childbirth"?

Sally Willington, Founder and President of AIMS, remembered her letter to *The Guardian* in 1960, which advocated the need for a women's group; "the suggested title for which was The Society for the Protection of Pregnant Women! However, this rapidly became AIMS and a pressure group was born".

Chairwoman of AIMS for the past seven years, Beverley Beech, summed up the Conference by asking whether medical intervention in childbirth had benefited the huge majority of women who could expect healthy, normal pregnancies and normal childbirth.

One of the tragedies of 1985, she told her audience, was that letters received today were all too similar to those received by AIMS in the 1960s. "Women are still abused in childbirth and let down by the system. What is clear is that many women are coming to question whether hospital is the right environment for normal childbirth".



Midwives: still pushing for recognition

From a paper by Auckland midwife Anne McQueen, delivered at the ICM's Western Pacific Regional Conference in Jakarta, Indonesia, late last year. (Some statistics have been updated.)

NEW ZEALAND midwives have survived several attempts to undermine their role and sphere of practice since the establishment of the midwife register in 1904. One such threat came in 1938 from the Government of the day, who considered it uneconomic to provide finance for the specialised midwifery programme. Another threat came in 1945 from within the ranks of the medical profession who considered the training of midwives to be non-essential and who were happy to practise obstetric care with the lesser-trained maternity nurse.

The battle for our existence continues with the present-day threat posed by the implications of the 1983 Amendment to the Nurses Act of 1977. This means that registered nurses with a maximum of 12 weeks' obstetric training can give obstetric care unsupervised by a midwife.

Unlike the majority of our overseas colleagues, who work as practitioners in their own right, the New Zealand midwife works under the supervision of the medical practitioner, who would most commonly be a general practitioner, an obstetrician or a paediatrician.

Midwives in New Zealand still retain their own register, as set up in 1904, of which we are proud and which considerably enhances our status.

We work in all areas of obstetric practice, as well as domiciliary situations, doctors surgeries, Family Planning Clinics and community health.

Lack of autonomy affects midwives in their professional practice as well as affecting their status as a

professional body. Midwives can only voice opinions and concerns through their parent body, the New Zealand Nurses' Association, which liaises with the International Confederation of Midwives.

The following outlines the problems facing New Zealand midwives today.

The lack of professional autonomy

The NZNA set up sections within its Association to bring into accord nurses with similar interests. Midwives constitute one such group.

The lack of a code of practice for midwives

The Midwives Section comprises 10 regional groups of some 600 members. It functions in a similar manner to its parent body, the NZNA, with a national committee and regional representatives. *But*, the ultimate policy – and decision-making – is made by the parent body. All communication with the International Confederation of Midwives indirectly reaches midwives at the discretion of the NZNA. Therefore the midwives of New Zealand have no direct communication with their international body.

To legitimise this claimed autonomy, New Zealand midwives need their own code of practice. The composition of this document currently has top priority.

Midwifery education

The numbers of midwives trained in New Zealand has dropped dramatically since the inception of combined midwifery/Advanced Diploma of Nursing course in 1979. In 1976 there were 157 midwives trained, compared with 185 in 1977, 163 (1978), 120 (1979), 18 (1980), 13 (1981), 24 (1982), 23 (1983), 21 (1984). In short, 99 since 1980!

Reasons

(a) The pressure of studying for an Advanced Diploma and the registration course of midwifery is too great. Nurses are requiring to study midwifery only and will travel abroad rather than submit to this course. Of the 196 midwives who registered with the NZ Nursing Council from March 31 1984, 12% qualified from New Zealand courses and 88% qualified from programmes conducted overseas. Of the latter group 56, or 29% were New Zealand registered nurses who had gained a midwifery qualification overseas.

(b) Once the qualification is obtained, there is no way of returning for advanced midwifery preparation.

(c) There is no reciprocity with other countries.

A remit to have the midwifery component of the course separated was passed at the NZNA Conferences of 1980, 1982 and 1984, in spite of the fact that technical institutes are in favour of retaining the status quo. Midwives strongly resist this and demand a separate course.

The acute shortage of midwives

There is a shortage in New Zealand of 249.5 full-time equivalent midwives! Funded vacancies number 159.6 and midwifery positions filled by other than midwives number 89.9 (These figures come from the Department of Health as of March 31, 1986.)

These are the official figures, but midwives are concerned by the lack of midwives in Community Health Services, ie none in Invercargill, none in Christchurch and a desperate need in Wellington and Auckland due to early hospital discharge caused by complete closure of post-natal beds. Further in-depth investigation will reveal greater deficits.

Hospital boards have suggested that midwifery positions can be filled by midwives from abroad. The UK Central Council for Nurses and Midwives has recently conducted a workforce planning exercise, and numbers of nurses for midwifery training have been reduced by about 30 per cent due to the length of the training.

These are real and grave concerns. Midwives demand the highest possible standards of care for the mothers and babies of our country.

If the three concerns, as outlined, are allowed to remain unchallenged, the need for employing midwives will be removed due to Section 54 of the Nurses' Act, which in turn will obviate the need to train midwives, thus removing the shortage!

The New Zealand Nurses' Act 1977

In 1983 the 1977 Nurses' Act was amended and midwives strongly objected to the proposed changes. Submissions were made through our professional body, and we were informed that our concerns were groundless. As the Act now stands, it is not an offence for an obstetric unit, whatever its size, to be staffed entirely by people untrained in the special skills of midwifery.

This amendment *must* be changed. Midwives throughout the country have lobbied their MPs for this Act to be rectified.

The lack of recognition of midwives

Midwives throughout the country are genuinely concerned about the erosion of their role.

This striving for autonomy has led to a degree of professional isolation from some nursing and medical colleagues, who would appear to be threatened by our aim to become practitioners in our own right.

IN CONCLUSION, New Zealand midwives regard midwifery as an entity in its own right, although in our tradition it is founded on the practice of nursing. The Midwives' Section upholds the International Confederation of Midwives' definition of the role of the midwife, which midwives see as relevant to practise in New Zealand – a country of 3¼ million people, with a live birth rate in 1985 of over 50,000.

Although the problems presented here of the New Zealand midwife, appear daunting, they are not, we hope, insurmountable; and with the same tenacity shown by those who have preceded us, we will achieve the objectives, and the quality of service will not be compromised. ■

taken from :

Bits & Pieces.

Auckland's shortage of midwives is chronic

St Helens Hospital in Mt Albert is chronically short of midwives, despite a recent recruitment of overseas staff.

Principal nurse Anne Nightingale says there is an urgent need for more midwives to be trained in New Zealand.

But Auckland Hospital Board chief nurse Anne Murphy says while there has been a nationwide midwife shortage in the past the situation has improved considerably.

Miss Nightingale says St Helens has not had a full complement of midwives in the past two years.

At best the hospital is short of three or four midwives but there have been 16 or 17 vacancies at times she says.

"If we don't get on and do something about improving the numbers training we'll be in queer street soon."

While midwives are seldom required to work extra shifts Miss Nightingale says most seniors do regular overtime.

The hospital has supplemented staff with bureau nurses but nursing agencies face a similar shortage of midwives.

The arrival of some six overseas midwives in the past few months has eased the shortage, and another three or four are expected before Christmas. But overseas staff provide only a temporary solution, as most do not stay in New Zealand.

"Nurses who tend to want to come here are usually relatively young in their careers, and are often on short term working holidays," Miss Nightingale says.

She claims New Zealand is not training enough midwives to meet the needs of hospitals here.

Shortages are nationwide and most severe among senior staff Miss Nightingale says.

Between 1980 and 1985 only 105 trained midwives graduated from New Zealand programmes.

Numbers are slowly increasing with about 30 qualifying last year.

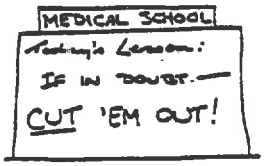
But Miss Nightingale says St Helens alone could "swallow up 10 midwives at any time".

More than 3000 babies are born each year at St Helens alone, and the hospital's birthrate is steadily growing.

Miss Nightingale says Auckland Hospital Board funds allow for only 10 midwives to be trained each year though the board has New Zealand's three largest obstetric hospitals.

Miss Murphy says the board will train another three midwives at the Auckland Technical Institute next year, bringing the total to 13.

The board is working towards improving the situation all the time and will continue recruiting staff in Great Britain.



* * * * * *

New Zealand women are by far the major users and beneficiaries of private health insurance — especially for hospitalisation and surgery — says the Southern Cross Medical Care Society. Although females constitute 50% of the society's membership, they absorb the vast majority of the funds paid out in claims for operations.

Between 16 and 55, women incur at least 75% of all private surgery costs. Two main factors emerge: women prefer to have operations carried out by the specialist they actually consulted (this is not usually possible in public hospitals) and, secondly, gynaecology is one of the major claiming areas of health insurance.

* * * * * *

Male Pregnancies

Many scientists believe that men may be able to give birth within five years. Male pregnancy would mean fertilizing a donated egg with a sperm outside the body and implanting the egg again so that it could attach itself to the bowel. They believe the egg could eventually produce sufficient hormones to continue its own growth.

Dr Trounson, a leader in the I.V.F. program, says he has already refused hundreds of requests from men wishing to have a baby.

Melbourne Age, May 10, 1986

* * * * * *

And it was also reported that women who are exposed to pesticides early in pregnancy have an increased risk of bearing children with Thalidomide-like defects. The study, undertaken at the University of Sydney, was not able to identify specific chemicals, but reported that women who have a personal exposure to an environmental chemical have 3.4 times the risk of having a child with limb defects.

Melbourne Age, April 29 1986.

Doctor-Midwife Teams

In Adelaide, a pilot trial was instituted to assess the practicality of team obstetric care by an obstetrician and a midwife. The midwife joined with the obstetrician in the care of the patient at all antenatal visits and attended the woman on her admission to hospital until one hour after delivery. This provided the woman with continuity of care by someone known to her. The midwife also visited the patient twice postnatally.

All 60 patients in the trial were very enthusiastic about the service. The midwives found the "on call" duties could be tiring and inconvenient but professionally very rewarding and satisfying. The obstetricians noted an increase in communication and felt the system greatly improved obstetric care.

The trial suggests that team care by a private doctor and midwife could be a feasible system.

Australian and New Zealand Journal of Obstetrics and Gynaecology. Vol. 40 1986.

* * * * * *

Alcohol -
Alcohol related birth defects are the third leading disorder associated with mental impairment, ranking below Down's Syndrome, and Spina Bifida in the US. 'National Inst. on Alcohol Abuse and Alcoholosm.'

Birth in Sweden: Many Benefits, Few Choices

Sweden has about eight million inhabitants in an area about the size of California. The vast majority of expectant women are either employed, students or looking for employment. The socialized medical care in Sweden offers unusual maternity benefits, but few alternatives.

All maternity care under the Modravardscentral. Outpatient Maternity and Family Planning Clinic (MVC) is free. Private physician care is available, although most care is still through the MVC. Women do not have a choice in MVC health care providers. If women are dissatisfied with their provider, petitioning for a change is often futile. As clinics and hospitals are "assigned," another MVC may refuse services to those outside of its area.

At the MVC, pregnancy tests are free to encourage first trimester registrations. After an initial examination by a physician, visits are with a midwife. Ultrasound is done early in pregnancy to establish due date.

Since 1979, psychoprophylaxis is a compulsory benefit at MVC for all expectant parents. Both mid-pregnancy and late pregnancy classes are offered. Mid-pregnancy classes consist of four to six couples who meet with a midwife during pregnancy. For a year after birth, couples meet with a nurse. Late pregnancy classes meet for four to six sessions before birth and one after birth with as many as 20 couples.

Childbirth preparation is also taught by FFF, the Association for Preparation for Childbirth and Parenting. FFF has trained about 30 childbirth educators who lead independent, consumer-oriented classes. There are, unfortunately, many misunderstandings between the FFF and the midwives/childbirth instructors of the MVC.

Pregnant women whose employment requires heavy lifting or is considered dangerous during the third trimester, have the right to apply for reassignment to lighter duty. Women also have the option to use sick leave for the last two months of pregnancy.

The vast majority of births take place in hospitals. Extremely few midwives assist at home births and there is no back-up system. Birthing couples (the father is expected to be present) are attended by a midwife. Swedish midwives handle most births, including twin and breech births. A physician is always on call for emergencies. Midwives may administer pudendal blocks and, in some hospitals, paracervical blocks. They also perform episiotomies and repairs, vacuum extractions and forcep-assisted births, though the latter is extremely uncommon.

Procedures are standard among hospitals: enemas are given; shaving is rarely done; women are encouraged to be mobile and are allowed fluid intake. Stockholm hospitals use a fetal monitor "door test" for 15 minutes. Amniotomies, fetal monitoring (except for the door test) and episiotomies usually are only done when medically indicated. Although hospitals and midwives vary, official hospital policies allow the parents' wishes.

The hospital stay varies from a few hours to ten days. The long stay is to allow breastfeeding to get firmly established and to give parents time to learn about infant care under the guidance of the special baby nurses. Visiting hours are flexible for siblings and fathers.

At the time of birth, the father has the right to 10 days off work with sick pay, usually taken when the mother and baby come home from the hospital.

Mother and father may share 180 days with full sick pay before the child is 270 days old and another 180 days with partial sick pay during the first eight years.

Either parent may also stay home for up to 60 days per year with sick pay if the child or his regular care taker is ill.

Although seemingly progressive, the system breeds a complacency that carries over to other areas of life. Many of the parents get very passive. Everything is decided for them before they have even thought about the problem. It is easy to feel that there is little one can do to change the situation. The same passivity can be seen in the whole medical system, the day care for children and in the schools. Swedish people are used to things being decided for them that not many question if there is another way and, perhaps, even a better way.

— Catharina Wijnbladh Byers

Catharina is a registered nurse and midwife who works both as a childbirth educator and head nurse of a postpartum ward. The mother of two children, she is active with FFF.

I.C.E.A. News Feb. '86
Vol. 25 No. 1

HOME BIRTH
IN NORTHLAND

BY

MICKY HARRAWER

Home birth is alive in the far north, not exactly thriving but there ia a core of dedicated women here who have been meeting regularly together for the last five years to support our domiciliary midwife and inform and lobby about home birth.

Unfortunately many women don't regard homebirth as an option and we have had only 3 planned home births here this year. This is probably due to the fact that both doctors who tentatively support home births have made distance restictions from the hospital, approximately 10 km's, and in a rural area this means that a lot of women are just not within these limits. First babies are regarded as too risky to be birthed at home by both doctors so all in all the situation is frustrating.

There are wpmen whose first choice is homebirth but who end up as reluctant hospital clients because of the restrictions on our homebirth service here.

thanks to the Midwives Chronicle January 1984

MIDWIVES' UNITS
– Wishful thinking or reality?

JEAN TOWLER, BA, SRN, SCM, MTD, FETC (Distinction).
Director of Midwifery Services, Trafford Health Authority, Manchester

Nature is often hidden, sometimes overcome, seldom extinguished. **Francis Bacon.**

THE THREATENED extinction of midwives as a species has highlighted the uniqueness of the role of the midwife and stimulated a determination for its revival and perpetuation. The midwife has been maligned and discredited as a professional, and the erosion and contraction of her function and under-utilisation of her skills are well documented facts[1–8].

In an attempt to redress the balance, and to endeavour to explain the midwife's legal position and role, discussions have been held between representatives of the Royal College of Midwives, the Royal College of Obstetricians and the British Paediatric Association. Radical and independent midwives have emerged and some medics and many midwives and mothers have united to form an Active Birth Movement, which sees pregnancy as a physiological, not a pathological, condition and egress as a natural act.

Schemes to develop the profession have been proposed[9]. What is now required is the setting up of a pilot scheme or working model that allows the midwife to use her clinical and social skills to the full, to meet the physical and emotional needs of parents and their babies.

Maternity Medical Services

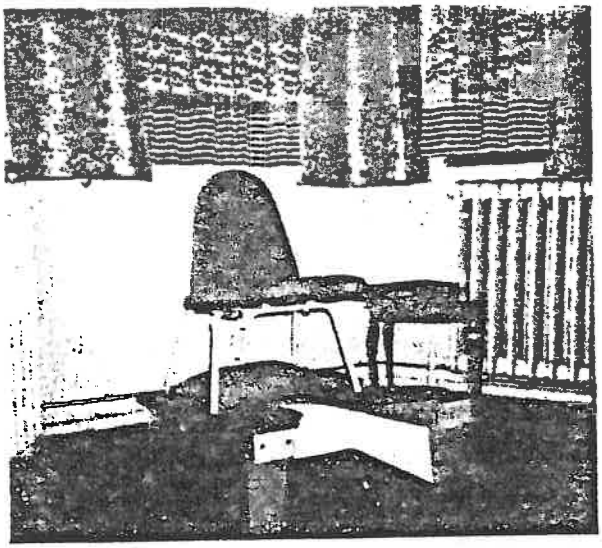
Over the past 30 years there has been pressure to aim for a 100% hospital confinement rate but despite this general practitioners have retained the right to give maternity medical services to "low-risk" mothers. For this service they may use general practitioner units within a maternity hospital, and in such cases the mother is seen by a consultant only *if* she is referred to him by the general practitioner. This system allows the midwife quite a lot of scope, especially if she shares the antenatal care and then delivers and nurses the patient as per the Domino scheme. On the other hand, the family doctor may refer his patients to a GP/midwife unit which, although staffed by unit midwives, has a consultant obstetrician nominally "in charge". In these cases mothers may be booked (or refused a booking) by the obstetrician even though they meet the low-risk criteria. If booked, they are seen again by the obstetrician at 36 weeks (more often if he chooses) but the remainder of the antenatal care is undertaken by the GP. It is only a recommendation, not a regulation, that patients booked for GP unit services are seen by a consultant but failure of the GP to refer his mothers may result in much criticism should the consultant unit facilities be required later in the pregnancy. As in the Domino scheme, it is the *midwives* who assist the mother at the birth and who nurse her and her baby in the postpartum period. Some of the aforementioned units are thriving but many are under-used and economically non-viable so that they have been, or are, threatened with closure. Such systems engender many problems of a financial, political or clinical nature mainly related to the refusal to book mothers or a refusal on the part of the consultant unit staff to see a mother unless the GP visits the unit and makes a personal request. On the other hand, a considerable number of mothers, anxious for a birth experience such as these units offer, are denied this experience and are booked for the consultant unit by the GP because, due to lack of practice, he has lost the art of suturing perineums or of setting up an intravenous infusion. The present situation in respect of GP obstetric services is unsatisfactory and recognised to be so by the respective Royal Colleges[10].

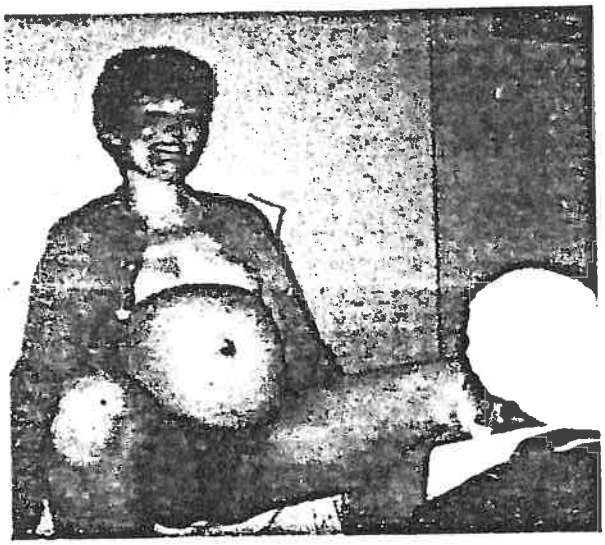
As an alternative, I would like to suggest the setting up of midwives' units within a consultant unit for potentially "low-risk" mothers, where midwives would be responsible for antepartum, intrapartum and postpartum care, with the consultant unit facilities in reserve. The midwives should be able to refer the mothers directly to the consultant team whenever this proves necessary. Their mothers would be "creamed off" from consultant referrals *or* mothers who elect to book directly with the midwives. The midwives would be based on their, say, six-bedded unit, but would service the antenatal clinic and undertake parentcraft sessions for their own parents. This would relieve pressure in the antenatal clinic and eliminate the long waiting period for a short contact time with the doctor, which is at present the experience of many mothers with uncomplicated pregnancies. It would also allow the skills of the consultant team to be "devoted primarily to the care of those women in greatest need of specialist advice"[9]. Midwives would be responsible for all necessary antenatal screening tests and examinations and refer mothers if they detected, or suspected deviation from the normal[9]. Alternatively, the Swedish model could be adopted, where the mother sees the obstetrician twice but the midwife on all other occasions. Sweden has an enviable perinatal mortality rate.

Battery of Tests

Our French counterparts are authorised to request all necessary haematological, bacteriological and biochemical tests in pregnancy, to monitor the fetus in the last trimester and to prescribe radiological examination (in the last eight weeks)[11]. Is there any reason why we should not be permitted to do likewise? The efficacy of current obstetric antenatal care, with its subjection of all women to a great battery of tests, has been questioned. It has been demonstrated that despite such rigorous tests there exists *failure of diagnosis* and conversely much *over-diagnosis* leading to over-investigation and unnecessary interference[12]. This may be obviated by the obstetricians

thanks to Aileen Sprock for this article.





having more time to give to the percentage of mothers who require their expertise. Mothers attending the midwives' clinic would see the same midwives at each visit, who would have time to listen, answer questions, explain and advise. An increasing number of mothers is presenting with high levels of social stress: midwives could well use a modified Life Events Inventory to assess a woman's need and then help to alleviate the stress. It has been shown that many women have had continuous worry during their pregnancy (resulting in premature labour), totally unbeknown to the antenatal clinic team[13]. It is conceivable that some of the antenatal examinations could be undertaken by the community midwife if the mother's social circumstances dictated thus. The "midwifery process" could be used and developed, and parents could be involved in preparing a birth plan that would include options and preferences reflecting their philosophy of, and attitudes to, childbearing. There would be built-in flexibility determined by progress in labour, or lack of it, with explanations of possible complications.

Midwife - Mother Allocation

Mothers admitted in labour would know the unit midwives, having met them in clinic or at parentcraft talks. There would be midwife-mother allocation and empathy with, and respect for, each mother's known wishes.

The birth room, attached to the ward, should simulate a bedroom, with soft lighting, carpet, curtains and bedspread to give a feminine and non-clinical touch[14]. It should house comfortable chairs, table, bed, birth chair, mattress and bean bags. Music, board games or television should be provided for the couple during early labour. Without attachment to a machine or "drip" the mothers could be ambulant — walking about, bending over or kneeling with contractions. They might choose to spend some time relaxing in a bath. They would have freedom to adopt the position of their choice in which to give birth. The fetal heart could be monitored using a Pinard's stethoscope. Sonicaid or an Electronisches stethoskop (Bosch). Obstetricians are themselves now acknowledging that there is no place for the *routine* use of *continuous* fetal heart monitoring, and are, moreover, demonstrating positive benefit to the fetus when the mother is in an upright posture[15]. The non-drugged, alert baby would not be placed on a Resuscitaire but would be handed to the mother and have the comfort of warm flesh and loving hands as it begins its physiological, psychological and socio-spatial adjustments to life outside the womb. Midwives would undertake perineal repairs but these should be minimal if the mothers breathe the head out *between* contractions.

We should take full advantage of the fact that we *are* independent qualified practitioners, and become clinical experts of the normal process. Midwives' units would

---

Top Left: *Birth chair in the birth room of the G/PMidwife Suite at Park Hospital, Manchester.*
Centre: *Here a mother is shown relaxed in the birth chair. The baby's head is visible.*
Left: *Baby suckling immediately after delivery.*

provide student midwives with normal midwifery experience, which is at present somewhat limited in high technology units. One consultant said recently that he saw no reason why midwives should not put up drips[16] and in a recent Chelsea research project 48.9% of midwives and 58% of doctors thought that midwives should set up intravenous infusions[4]. If this were approved, we would then be able to cope initially with a postpartum haemorrhage and could also intubate an asphyxiated baby should this be required.

Should midwives tremble at the thought of taking full clinical responsibility for the "normal" they would do well to remember the Swedish midwives and the Tennessee Farm lay midwives who, in addition to normal births, also undertake breech deliveries and have remarkably good perinatal statistics[17].

Distinct Midwifery Service

A midwives' unit would allow for a distinct midwifery service vis a vis an obstetric service — this would, of course, require the co-operation of the medical staff and would demand very high standards of clinical care and judgement, as well as keen diagnostic skills on the midwives' part to recognise the abnormal and potentially abnormal. The midwives would need to work as a team, with clinical consultation between junior and senior members up to the team leader, who might be one of the new senior clinical nurses to emerge from reorganisation, or the head midwife/director. She is after all, primarily a midwife: she should perhaps be thinking of offloading much of her "office"work to a personal assistant and practising as a clinical supervisor and consultant. Too many experienced midwives have become involved with management matters to the detriment of using and sharing their considerable clinical expertise. This does not happen to doctors, who retain their clinical practice. Such consultation would obviate many of the unnecessary initial calls to junior medical staff and would provide an excellent teaching/learning arena for student midwives attached to the team.

Thanks must go to those midwives on the Maternity Services Advisory Committee for helping to shape the philosophy of the "Maternity Care in Action" Report. Some maternity units have already introduced recommendations contained in the report and innovatory schemes, including the team concept[19], which maximally involve the midwife, have already been suggested. There are obviously many midwife-orientated units already in existence[20].

Is the proposition of a midwives' unit within a consultant unit too revolutionary? Or have we reached a point of no return? Are there midwives now prepared, for the sake of the profession, to put such a concept before their Maternity Services Liaison Committees? After all, we are not asking to extend our role, merely fully to care for and support healthy women in the whole child-bearing process within the parameters afforded to us by statute. Can we overcome the undoubted opposition and counter-arguments from obstetricians and GPs who may feel threatened? For indeed, if we do succeed in fulfilling our role, "it is obvious that the demand for the obstetricians' skills will be reduced"[21].

Midwives' units would provide facilities for research, evaluation of procedures and techniques, and a chance for midwives to abandon prevailing obstetric custom and fashion and to develop their clinical competence. They would also offer to mothers an optimal environment in which to experience one of life's most exciting events.

References

1. WALKER, J. Changing role of the midwife. *Int. J. Nursing Studies* 1972, vol 1.
2. DONNISON, J. The role of the midwife. *Midwife, HV & Comm. Nurse* 1979, July.
3. KITZINGER, S. Midwives have lost status. *Nursing Mirror* 1981, October.
4. ROBINSON, S., GOLDEN, J., BRADLEY, S. Role & responsibilities of the midwife. Chelsea College Project. See *Midwives Chronicle* 1981, Jan, Feb, March.
5. SHORT Report. 1980.
6. MORRIN, H. Are we in danger of extinction? *Midwives Chronicle* 1982, January.
7. TOWLER, J. A dying species? *Midwives Chronicle* 1982, September.
8. O'DRISCOLL & MEAGHAN. *Active management of labour.* W.B. Saunders 1980.
9. Maternity Care in Action. Antenatal care 1982.
10. RCOG & RCGP. Joint Working Party Report on Training for obstetrics & gynaecology for GPs. November 1981.
11. ORDRE DE SAGES-FEMMES. Extension de droits de prescription. July 1980.
12. HALL, H., CHING, P., MACGILLIVRAY, I. Is routine antenatal care worthwhile? *Lancet* 1980, July 12.
13. NEWTON, R.W. et al. Psychosocial stress in pregnancy. *BMJ* 1979, August.
14. ADAM, N. Home sweet hospital. *Nursing Mirror* 1981, March 12
15. IVESON-IVESON, J.N. Focus on the family — summary of symposium (Caldeyro-Barcia). *Nursing Mirror* 1982, August 11.
16. BEARD, R. *Nursing Times* 1981, September 16.
17. HENNESSEY, S.P.N. "The Farm" community in Tennessee. *Midwives Chronicle* 1983, January.
18. THOMSON, A. Planned or unplanned — are midwives ready for the 1980s? *Midwives Chronicle* 1980, March.
19. FLINT, C. Antenatal clinic series. *Nursing Mirror* 1983, January 5.
20. DETTOL Midwifery Care Award.
21. NEWSON, K. The future of midwifery. *Midwife, HV & Comm. Nurse* 1982, December.

thanks to the :

Fetal Stress Response in Labor

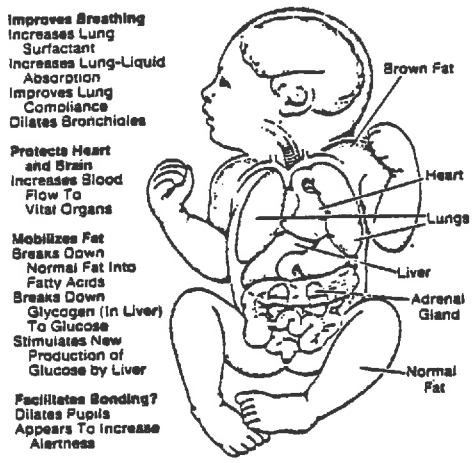
by Cheryl H. Coleman

Catecholamines (adrenalin and noradrenalin), also called *stress hormones*, are found at alarmingly high levels in the infant at birth. Since these hormones are most often seen as a sign that the organism is in danger, one may think that the fetus may be in a life threatening situation with normal vaginal birth. However, Hugo Lagercrantz and Theodore A. Slotkin in their article, "The *Stress* of being Born" in the April 1986 issue of *Scientific American*, are suggesting that catecholamine release by the infant throughout gestation and, in particular during the second stage of labor, are actually survival and adaptation mechanisms.

Catecholamines are the hormones responsible for *fight or flight*, causing an increase in the heart rate, increased cardiac output, constriction of peripheral and non-essential blood flow and increased blood flow to essential organs (heart, brain and skeletal muscles). In addition, they dilate bronchioles, cause fat and glycogen to be broken down into useable fuel, dilate pupils and cause hair to stand up on end. The hormone most available to the fetus is noradrenalin, which though very similar to adrenalin, does not increase blood flow to skeletal muscles and does not cause a slowing of the heart rate, thus decreasing the work and oxygen requirements of the fetal heart (Phillippe 1983). There is also an increase in blood flow to the adrenals and placenta in the fetal response. The result of all this is the fetus and infant's amazing ability to withstand asphyxia.

The sympathetic nervous system, source of catecholamine release after birth, is not functioning early in gestation and appears to be very immature until possibly several weeks after birth. Therefore, the catecholamine release in the fetus is the result of a direct response to stress by the adrenal glands, which are much larger during gestation. The infant also secretes catecholamines from paraganglia (extra tissues that secrete noradrenalin) which are located near the adrenals and the aorta.

During gestation, catecholamine surges have been seen during hypoxia, hypoglycemia and any other challenge to the fetus. They have also been suggested as a factor in facilitating parturition (Irestedt et. al. 1984). During second stage of labor, the role of a catecholamine surge is to protect the fetus during the stress of birth and to enhance fetal function after separation from its mother. Part of this surge is due to normal hypoxia occurring in nearly all newborns. Fetal head compression as well accounts for an increase in sympathoadrenal activity leading to catecholamine release. The actions of catecholamines during this stage are shown in the accompanying illustration that details their activity in improving breathing, protection of the heart and brain, mobilization of the infant and also in facilitating in bonding.



ADAPTATIONAL EFFECTS of a catecholamine surge during delivery include promotion of normal breathing, alteration of blood flow to protect the heart and brain against potential asphyxia, immediate mobilization of fuel for energy and, possibly, enhancement of maternal-infant attachment. In general the effects prepare the body to sustain homeostasis (stable functioning) at birth even if the neonate is exposed to such adversity as oxygen deprivation. After delivery catecholamines can also activate, in response to a cold, a specialized heat-producing tissue called brown fat that is unique to the infant and young child.

Since the catecholamine response was almost always less in infants born by cesarean, Lagercrantz and Slotkin mentioned that many obstetricians are allowing women to labor as long as possible before surgical intervention to allow the infant the benefit of higher plasma catecholamine levels. The researchers also found, in looking at unnecessary cesareans, that this catecholamine surge within the normal birth process can cause changes in the fetal heart rate that may be interpreted as distress. Therefore, they recommend the use of fetal scalp sampling to determine true fetal distress and asphyxia (Bisstoletti et. al. 1983).

Medications that have been shown to have a negative impact on catecholamine surge are those that block the response, beta-2 receptor blocker, as found in some antihypertensives. Beta adrenergic drugs, such as those used to prevent preterm labor, are of benefit to the fetus in terms of catecholamine response.

The effects and benefits of catecholamines are not only seen at birth, but may also be apparent several hours later. In one case the researchers found little difference at birth in lung compliance between infants born by cesarean and vaginally. There was, however, a significant difference at birth in lung compliance in favor of the vaginally born infants two hours after birth. When Apgar scores and catecholamine levels were correlated in moderately asphyxiated infants, those infants with normal Apgar scores had higher plasma catecholamine levels and those with low Apgar scores (less than seven) had low catecholamine levels (Jones et. al. 1985).

Though initial appearances may lead to the thought that high levels may be detrimental, as in adults, the benefits of a catecholamine surge cannot be ignored and may actually lead to not only a better baby physiologically, but better bonding as well.

continued on page 21

NEW ZEALAND
OBSTETRICAL and GYNAECOLOGICAL
SOCIETY Inc.

National Summer

UPDATE CONFERENCE

for general medical practitioners,
general practitioner obstetricians,
family planning officers,
obstetricians,
midwives,
and others with an
interest in these fields.

THURSDAY 26th FEBRUARY, 1987
FRIDAY 27TH FEBRUARY, 1987
SATURDAY 28TH FEBRUARY, 1987

HYATT KINGSGATE
Waterloo Quadrant
AUCKLAND

VISITING SPEAKERS

Dr. JOHN STUDD (London) - Consultant Obstetrician and Gynaecologist, Kings College Hospital, London
The visit of Dr Studd has been generously funded by PHARMACO

Prof DEREK LLEWELLYN-JONES (Sydney) - Professor of Obstetrics & Gynaecology, University of Sydney
The visit of Prof. Llewellyn-Jones generously funded by CIBA - Geigy (NZ) Ltd.

PROGRAMME

WEDNESDAY, FEBRUARY 25TH, 1987

Introduction

1930 Wine and Cheese / registration Evening for Delegates and Associates - Abel Tasman Room
(Courtesy of Douglas Pharmaceuticals)

THURSDAY, FEBRUARY 26TH, 1987

"Gynaecological Problems"
Chair: Dr Michael Hoogerburg

0830 Late Registration
0900 Welcome - Dr Sun Chau, President NZ O&G Society
0915 Investigation of the Infertile Patient - Dr Peter Benny
0945 Management of the Menopause - Dr John Studd
1030 Morning Tea

Chair: Dr Ron Jones

1100 Persistent Vaginal Discharge - Dr Richard Meech
1130 Smear Tactics - Dr Graeme Duncan
1200 Panel Discussion
1230 Lunch

Chair: Dr Paul Hutchison

1330 Premenstrual Syndrome 87 - Dr John Studd & Prof Llewellyn-Jones
1415 - 1515 Workshops (Topics to be arranged)
1515 Remainder of Afternoon Free
1930 Pre-Dinner Drinks and Conference Dinner - Main Ballroom, Hyatt-Kingsgate Hotel - (Event subsidised by Schering AG (NZ) Ltd)

FRIDAY, FEBRUARY 27TH, 1987

"Obstetric Problems"
Chair: Prof Denis Bonham

0900 Managing Recurrent Abortion - Dr Neil Pattison
0945 Antenatal Monitoring - What's Left? - Prof John Hutton
1015 Obstetric Analgesia Dr Mohan Lala
1045 Morning Tea

Chair: Dr Cathy Miller

1115 Modern Management of Labour - Dr John Studd
1215 The Home Birth Option - Dr Diana Nash
1245 Panel Discussion
1315 Lunch
1415 - 1800 Waitemata Harbour Cruise - see Enrolment (Cruise subsidised by Allen & Hanbury's)
1930 Cocktail Hour - Regatta Room Hyatt Kingsgate Hotel - Please make own Dinner arrangements.

SATURDAY, FEBRUARY 28TH, 1987

"Politics and Survival"
Chair: Dr Phillip Rushmer

0900 The Client as Consumer - Prof Derek Llewellyn-Jones
0930 Litigation in Obstetrics & Gynaecology - Ms. Jane Lovell-Smith
1000 Is There A Future in GP Obstetrics? - Prof Campbell Murdoch
1020 Open Forum
1040 Morning Tea
1110 Negotiating With Government - Mr Paul Temm QC
1140 Closing Comments - Dr Sun Chau, NZ O&G Society
1145 Final Workshop Session
1300 Lunch
1400 Afternoon Free (Afternoon and/or evening social options may be available)

NEW ZEALAND SPEAKERS AND PANELISTS

DR PETER BENNY -	Obstetrician, Christchurch Womens Hospital
PROF DENIS BONHAM -	Head, Postgrad School of Obstetrics & Gynaecology, Auckland
DR GRAEME DUNCAN -	President Royal NZ College of Obstetricians and Gynaecologists
DR HELEN FRITH -	Anaesthetic Registrar, Auckland
PROF JOHN HUTTON -	Professor of O&G, University of Otago, Wellington Clinical School
DR MOHAN LALA -	Anaesthetist, Waikato Women's Hospital
MS JANE LOVELL-SMITH -	Barrister and Solicitor, Auckland
DR RICHARD MEECH -	Physician in Infectious Diseases, Napier Hospital
PROF CAMPBELL MURDOCH -	Professor of General Practice University of Otago, Dunedin
DR DIANA NASH -	General Practitioner, Auckland
DR NEIL PATTISON -	Obstetrician National Womens Hospital
MR PAUL TEMM QC -	Queens Counsel, Auckland

ENROLMENT DETAILS

Delegate Full Name:
Badge Name Requested:
Address:
Practitioner Type (GP etc):
Associate's Name:
I/We wish to enrol for:

		Delegate	Associate	Itemised Fee
1. Full Course Registration				
- Delegate (1)	$175/hd	☐		$
- Associate (2)	$100/hd		☐	$
2. Partial Course Registration				
Single Day Registration (3)	$75/hd	☐	☐	$
Conference Dinner (Thurs)(4)	$60/hd	☐	☐	$
3. Special Activities (NOT included in Registration)				
Harbour Cruise (only 80 places available)(5)				
a. 50' Keeler Race (2x20 places)	$30/hd	☐	☐	$
b. 60' Catamaran Cruise (40 places)	$30/hd	☐	☐	$

Associate's Activities Programme: Please indicate if interested: ☐

Please send cheque with Enrolment Form to:

Dr. J.B. Wilcox
4 Channel View Road
Campbells Bay, Auckland 10

Total $

Air New Zealand discount voucher required? ☐

LATE REGISTRATION

Late Enrolments may be accepted subject to availability after 12th January, 1987. Please add a LATE FEE of $30.00

(ALL PRICES QUOTED ARE IN NZ DOLLARS AND GST INCLUSIVE)

NOTES

1. Full registration cost all-inclusive, excepting for Harbour Cruise because of limited places. Seats allocated in order of receipt.
2. Associate's full registration cost all-inclusive except for Harbour Cruise as above. Associates will be welcome to attend academic sessions if interested.
3. Single Day registration Fee includes lectures, morning/afternoon tea and buffet lunch on that day.
4. Conference Dinner is included in Full Registration Fee unless only attending on Single Day basis.
5. Harbour Cruise options of Keelers or Catamaran will be allocated in order of receipt. Refund available if oversubscribed.

↑ CONFERENCE ON OBSTETRICS ↑
IN NEW ZEALAND

FETAL STRESS RESPONSE IN LABOR *from page 20*

Cheryl Coleman, BSN, is an ICEA member from Tulsa, Oklahoma. She is a childbirth educator and president of CEA of Tulsa. Cheryl and her husband, Bob have two children, Kevin, 4 and Kari, 2.

References

Bisstoletti, P., Nylund, L., Lagercrantz, H., Hjendhal, P. and Strom, H. 1983. Fetal scalp catecholamines during labor. *American Journal of Obstetrics and Gynecology*, 147, 785-788.

Irestedt, L., Lagercrantz, H., Belfrage, P. 1984. Causes and consequences of maternal and fetal sumpathoadrenal activation during parturition. *Acta Obstetricia et Synecologica Scandinavica Suppl.*, 118, 111-115.

Jones, C.R., McCullouch, J., Butters, L., Hamilton, C.A., Rubin, P.C. and Reid, J.L. 1985. Plasma catecholamines and modes of delivery: the relation between catecholamine levels and in-vitro platelet aggregation and adrenoreceptor radioligand binding characteristics. *British Journal of Obstetrics and Gynaecology*, 92, 593-599.

Lagercrantz, H and Slotkin, T.A. 1986. The *stress* of being born. *Scientific American*. April, 100-107.

Phillippe, M. 1983. Fetal catecholamines. *American Journal of Obstetrics and Gynecology*. 146, 840-852.

thanks to the International Journal of Childbirth Education Vol 1 No 2 August 1986 for this article

letters

Dear Editor,

RE: DOMICILIARY MIDWIVES PAY

The recent increase that took midwives fees to $270 per case is not a reason to be jubilant!

Before this 50% increase I calculated their net pay after expenses to be $2.22 per hour. A 50% increase on this gives $3.33 per hour, before tax.

This is an insult.

If, in the meantime, it helps to take some pressure off our hard-working midwives this is good but the Negotiating Committee (of which I am part) is looking for a completely new deal.

If you are going to tell Dr Bassett or Dr Salmond anything, tell them that it is TOO little, and that the pressure is still on for a professional fee to be paid comensurate with their skill and level of training.

A. Livingstone, B Com., ACA.
17 Matapana Rd
Palm Beach
Waiheke Island
Auckland

RECENT DEVELOPMENTS

HAVE YOUR SAY...

At the recently held National Midwives Conference in Christchurch - New Zealand's first - there was much discussion re separation of the Midwives Interest Section of the N.Z. Nurses Association from the Association. Midwives seem divided on this issue.

Many feel midwives should be a seperate professional body with their own professional status, and not merely a branch of nursing. They could then negotiate training, working conditions, and salaries for ALL midwives.

Equally as many feel that midwives on their own are not a big enough group to have effective political clout.

What do you think? Tell us your opinions on the particular mood of your area of the country. Tell us what you think.
All letters will be published in the next issue of Save The Midwives.

BOOK REVIEWS

" THE MOTHER MANUAL " - Jenny Phillips, Reed Methuen 1986, about $20.

"You have a manual for the car, a manual for the garden - here's one for you." - this is how Jenny Phillip's third book is advertised. Acknowledged by the auther to be pakeha and middle-class in orientation, this manual is designed to assist such women to find ways to lighten their load. Jenny Phillips is a feminist, and adresses the social and economic factors that contribute to a mothers "place", as well as offerring practical suggestions to ease the pressure, such as a re-assessment of one's priorities, self-evaluation, even more effective organisation of household chores.

Other chapters cover Occupational Hazards, Oppression, the Mother Person, Mothers Rights vs Childrens Rights, What People Can Do To Improve the Situation of Mothers, Resources. Topics are covered in short and easily-read sections, with consequently little depth. A good 'primer' for mothers, but not a book to dip into time and time again. After 7 years mothering, and two childen, I found most of what Jenny Phillips said already known to me, but I think this book could be a good present for a first-time mother. Have a look and see what you think.

Judy Larkin.

" A SAVAGE ENQUIRY " - Wendy Savage, Virago Press 1986,$13.95(NZ).

Wendy Savage is the British 'natural childbirth' obstetrician who was recently suspended from her hospital post for 15 months pending an inquiry into her alleged incompetence.

She was cleared of all charges, with the 'verdict' being no charge to answer. Her supposed incompetence was in relation to 5 births that she had supervised, and she was charged by her Professor of Obstetrics and another 3 of her obstetrician colleagues.

The major issue in this case was power - what do women want in birth, and what are doctors willing to 'let' them have? Wendy Savages colleagues thought she was too 'pro-women', too ready to give natural birth a try, too ready to co-operate with GP's and midwives. She even encouraged home births!

"She should have been a good and agreeable girl and made sure she got on with her colleagues. If she had played her cards right she would have found being a woman was to her advantage and her male colleagues might have been prepared to do her more favours." - A senior obstetrician quoted in the Sunday Times, 9 March 1986.

Wendy Savage has written a fascinating account of her suspension and subsequebt inquiry. Lies, fabrications, falsehoods - its all there, and all dirtily done by doctors. For an insight into the way the medical profession enforces its unspoken rules this book is hard to beat.

Judy Larkin.

CONGRATULATIONS

to Ruth Nicholson, our editor, on the birth of her first baby. Her son, Redmond, was born at Middlemore Hospital, a 'surprise' breech! Ruth had worked at Middlemore herself, as a midwife, and recieved superb care from her midwife and obstetrician.

Ruth's workload has increased since Red was born, quite a bit, so if anyone can spare a few hours now and again to help out with the newsletter, please contact her or me - phone numbers on inside front cover.

J.L.

SAVE THE MIDWIVES

24 ASHTON RD, MT EDEN, AUCKLAND
NEW ZEALAND

NEWS FROM OUR ORGANISATION

MERRY CHRISTMAS AND A HAPPY NEW YEAR!

REPORT FROM SPECIALIST MIDWIFERY TASK FORCE

After a somewhat gloomy, muddy and wet winter deep in the rural North, Judi Strid and I have put pen to paper and written many letters as our first task in researching overseas 'direct-entry' midwifery programmesWe have written to many in the U.S.A. including "The Farm", the underground midwifery school in Canada, the direct-entry task force in Australia, and to various other organisations such as NapSac and W.H.O. and others in the U.K. If anyone has any information that would be of use to us please send it to either Micky Harrower, Fern Flat Rd., R D 3, Kaitaia, or Judi Strid, P O Box 183, Ruakaka, Northland.
We would also like to hear from anyone who might be interested in learning midwifery through a direct-entry course.

REPORT FROM MATERNITY ACTION

Maternity Action, a coalition of Auckland's 16 major parents' and women's groups, of which Save The Midwives is a founding member, has achieved a major success for home birth parents in the city. For many years, mothers who needed to be transferred to hospital became the patient of the hospital staff on admission. This made the experience of transfer an uneasy one for many women, who could no longer choose their doctor but just had to accept whoever was on duty. Challenged on legal grounds, i.e. that every woman is entitled to choose her own doctor to attend her in a New Zealand public hospital, the Auckland Hospital Board has changed its ruling and has informed its hospitals that home birth mothers on transfer are to continue in the care of their G.P. unless the G.P. decides otherwise.

SAVE THE MIDWIVES ASSOCIATION

EDITOR: Ruth Nicholson, 11 Morrin St, Ellerslie, AK 5.
SECRETARY: Judy Larkin, 24 Ashton Rd., Mt Eden, AK3.
SUBS SECRETARY: Lynda Schroeder, 56 TioTio Rd, Strathmore, Wntn.
SPECIALIST MIDWIFE TASK FORCE: Micy Harrower, (see above).

SAVE THE MIDWIVES ASSOCIATION SUBSCRIPTION FORM
please post to Lynda Schroeder, 27 TANERA CRES, BROOKLYN, 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_____

Medical Students Learn From Consumers

In early 1981 I learned of a program at the University of Tennessee in Memphis, in which well-informed women taught medical students the procedural and interpersonal aspects of the pelvic exam. This idea was extremely intriguing to me since recently I had experienced having the exam room door left open twice during the course of an exam.

Traditionally there are three ways that medical students learn to perform pelvic exams: performing exams on indigent women in clinic or emergency room settings, examining anesthetized women prior to surgery, or utilizing plastic models for exams. Each of these methods has its own advantages and disadvantages. Examining anesthetized women or learning on plastic models eliminates embarassment in both the learner and the woman, but does not allow any opportunity to practice communication skills. Women in clinic or emergency rooms may be in pain or terrified of the exam itself. In the past few years, several universities have developed alternative programs to teach students to perform pelvic exams.

The Patient Instructor (PI) program at the University has been in existence since 1978. Currently about 10 women participate in the instruction of second year medical students in their Introduction to Clinical Skills Course, and work with third year medical students at the beginning of their two-month clerkship in obstetrics and gynecology. Working in pairs, with approximately six students, one woman first performs a demonstration exam on the other PI. The students observe; then each has the opportunity to perform an exam. For almost all second year students it is their first experience performing a pelvic exam. Most of the third year students have not had an opportunity to do a pelvic exam since the teaching session with the PIs during their second year. It is usually mentioned that the feelings of apprehension, nervousness and embarassment that the students experience are very similar to those experienced by many women during a pelvic exam.

The students' response to the program has been uniformly enthusiastic. Students often comment that the pelvic exam is the only part of the physical exam with which they felt confident when they completed their Introductory Clinical Skills course. Another common remark is that this type of learning experience has made the situation for the students much less stressful.

One of the most interesting aspects of being in the program is the chance to present information about various aspects of childbirth that the students might not be exposed to otherwise. It is extremely interesting to observe reactions to an explanation of an episiotomy. It is not unusual to notice one or more male students unconsciously crossing his legs when an incision into the perineum is mentioned! We are able to discuss such topics as Kegel exercises, vaginal-birth-after-cesarean and episiotomy. Hopefully we help shape attitudes of future physicians.

One important aspect of the pelvic exam that is continually stressed is the importance of communication between the woman and the examiner. The use of the exam as an educational opportunity is emphasized, with instruction given on how to perform pelvic examinations using a mirror. It is hoped that this type of training will have positive effects in the practices of future physicians. Such things as handwashing before the exam, knocking (and waiting for an answer) before entering the examining room and introductions are emphasized.

Since most medical students will not become gynecologists, we particularly stress the fact that many of the techniques taught by the PIs can be utilized in almost any area of practice, not just obstetrics and gynecology. Using the exam as a time for patient education is a technique that can prove beneficial to both physicians and patients in any medical specialty. The common courtesies that are taught by the Patient Instructors would be appreciated by anyone who is visiting a doctor.

— Ann S. Lemar

Ann is currently ICEA Tennessee Coordinator and a candidate in the ICEA Teacher Certification Program.

COMMENTS on this topic are welcome and will be printed in the next newsletter

Cesarean Deliveries and Transmission of Herpes

A new study by the Centers for Disease Control (CDC) in Atlanta has reported that cesarean delivery is not a fail-safe preventative against transmission of herpes from mothers with active genital herpes to their infants. Of 190 cases of neonatal herpes reported to the CDC from October 1983 to March 1985, 10 of the infants had been delivered by cesarean section. While the researchers note that cesarean delivery can and does prevent most cases of neonatal herpes, other modes of transmission (such as the possibility of the virus crossing the placenta, or a person with a cold sore kissing the infant) also appear to pose a risk. Neonatal herpes is an extremely serious disease with a two year survival rate of approximately 60 percent.

Reported in: Science News 128: 232. 1985.

ICEA NEWS 25:1:86

Thanks to ICEA News 25=1=86