SAVE THE MIDWIVES

CONTENTS

NO. 13
AUTUMN 1987

REMEMBER
INTERNATIONAL MIDWIVES DAY : JULY 10
1987

HOME BIRTH - NOW A REALITY IN WHANGAREI:

After a year of constant lobbying and increasing political awareness on the behalf of those of us determined to see the choice for home birth become available to women in the Whangarei area, it has finally happened.
The first planned HB with a supportive GP in attendance went very successfully, and has encouraged other GP's to also make the same committment to attend HB until a domiciliary midwife is practising in this area.

12 months ago, the MOH attached to the Northland Area Health Board expressed his surprise at the suggestion of a dmw service in the Whangarei area, and stated that there were no supportive GP's, and no apparant interest from the community either.
However, a brief questionaire to Drs in the Whangarei District , showed that of the 16 Drs attending births, 12 were supportive of the home birth option; although the level of support varies between them and most require approval from their "peers" to be involved.
The majority also required the presence of a dmw service, plus the availability of backup facilities - in particular oxygen/rescus. equipment.
Support from the community - particularly from women has been continuing to increase, and we have established a strong network of people determined to see that the HB option in Whg. is readily available to all women.

Following submissions from all 3 Northland HB groups to the NAHB requesting (in brief) an expanded dmw service with access to equipment/facilities, support for midwives, GP's and parents involved in HB, appropriate professional recognition and renumeration for dmw, plus the establishment of a home help service for mothers with new babies - supportive recommendations were passed by the Board.
The submissions were received with a generally favourable response from the Health Services Committee, despite opposition from the senior obstetricians employed by the Board. The committee acknowledged the reality of the existance of HB; and that HB are happening anyway, whether midwifery attendants are available or not.
There have been 44 HB in Northland from Jan'83-Aug'86. Of these, 16 were planned and supervised; and it was suspected by the Bd. that a large percentage of the others were also planned but unsupervised due to the lack of a dmw service.
Therefore, in acknowledgement of public pressure and the increased demand, they have recommended a more supportive policy on HB. They feel this will lead to a better supervised and safer situation.

Unfortunately, the cost effectiveness issue which should logically be attractive to the Health Service - particularly the NAHB which has a cost effective community orientated concept - was overlooked in favour of moral judgements like.....

> "The Board would be unwise to develop a HB service at the expense of its present hosp. services."
> "The obstetricians believe that HB involves a potential extra risk for mother and child which would be better avoided."

These statements had no accompanying data to support them, and in fact, well respected statistics and references presented to the Bd. with the submissions indicate quite the opposite, so these issues needed addressing.
The good news on a practical level was the recommendation that HB services be assisted through the provision of equipment/facilities, access to inservice education for dmw, plus home help for all new mothers.
The report also recommended that its in-hospital and follow-up services s hould be developed in such a way as to encourage their acceptability to expectant women. They are feeling the heat in this area also.

We felt the Bd's moves to be positive ones we welcomed; but considered a general statement of support was not enough, and that most of the recommendations required clarification.
Indeed, following these recommendations, the situation for women in Whg. remained unchanged.
At this stage the options available to women wanting a HB were as follows -

1. To experience a pregnancy full of uncertainty and stress, worrying about how to have the HB they choose when the proper service isn't operational.
2. To "go it alone" if they are determined to have a HB.
3. To find a sympathetic support person to assist them at home.
   (? increase in lay midwifery)
4. To travel long distances in labour to have a HB in Auckland or Kaitaia in someone elses home (sometimes a strangers).
5. To have the birth in hosp. with early discharge; unknown midwives, uncertain control over the birth, disruption to their family and no post natal followup.

It also became critical to clarify the provision of equipment/facilities so women wanting HB understood the procedure necessary for home confinements to take place under the care of a GP only - now that equipment was to be made available to them.

Consequently, further discussion was arranged with the Chief Nurse to clarify these issues. A representation of 3 HB members attended this session, taking notes to report back to other members.
We felt we had a good hearing with a positive exchange on both sides, although it was made clear to us that the NAHB will not take active steps to endorse its statement of support.
The NAHB has a critical shortage of midwives for its hosp. services, and we were informed that it is up to the HB Assoc. to find a dmw, and that the Bd. will not provide advertising facilities for this purpose.
It is also up to the HB Assoc. to make these new recommendations known to the community, although the NAHB state they have notified their staff who have been requested to pass this information on to hosp. patients where appropriate.
The NAHB is agreeable for a dmw on contract to also be employed within the hosp. services on a part time basis.

Following this discussion, a brief summary was made in the local HB newsletter to clarify for members the procedure necessary for equipment to become available to GP's so they will attend HB until a dmw service becomes operational.

Much to our surprise (or perhaps political naivity?) this summary caused an explosion of some magnitude.
Apparantly, the information was not to be made public. Although pregnant women and GP's found it a helpful and successful guide to obtaining equipment, the Bd. considered our public statement to be "unwise and unacceptable" and our group has been told "not to instruct GP's".
A correction was requested by the Bd. to state -

> "...that any arrangement regarding the use of equipment/facilities for home births be between the licensed practitioner and the NAHB, and the HB Assoc. is not to be involved."

We have agreed to print this as we feel it says alot in itself, and indeed clarifies the political implications involved in the HB issue.
It has also been cause for some reflection on our strategies, as we are obviously making an impact on the Health Services and are observing some resistance to this.

Politically it is quite a revelation to see the NAHB resisting their own policy of involving the consumer in the health care services. In our case, they have actually instructed us to not be involved, although a clearly stated AHB objective is -

> "The community has a duty and right to participate individually and collectively in the planning and implementation of the health care services."

We wonder why they are so reluctant to involve the consumer.
Further political manoeuvring has been apparent in the appointment of a Community Liason Midwife which is a positive step (probably from pressure) but also a restrictive compromise in that the position operates only on a Mon-Fri basis, with postnatal follow up until Day 6 only, and provides a service only for mothers and babies who live within the Whangarei City limits and preferably on the phone.
We are hopeful that the demands on this position will result in an expanded and more flexible service in the near future.

In the meantime, women in Whangarei are feeling encouraged by the results of their determination and pressure on the Health Services; and wait hopefully for a dmw prepared to practise in Whg. so the full service can be operational and easily available to all women in the area.

Judi Shid and
Micky Hanover

Making birth more comfortable

By Ruth Kerr

Trying to bring a 1950s built hospital into the 1980s is an unenviable task.

But it is one that Gabrielle Collison, National Women's medical superintendent, relishes.

She admits, however, that it is hard juggling financial needs and availability — witnessed by gross overcrowding in the neo-natal unit.

"That's our most urgent job," says Dr Collison. "Plans are being drawn up at present to extend the unit but we have no money as yet."

Other changes are evident though — like carpets in post-natal wards, murals in delivery theatres and the Rose Room option, a comfortable, self-contained unit with mauve-coloured wallpaper and pictures on the walls.

"We really are trying to move with the times and adjust to the needs of women today," says Dr Collison.

This adjustment has seen the abolition of routine enemas and shaving of pubic hair along with leggings, only generally being used in a forceps delivery.

On the positive side, husbands can stay overnight in reclining chairs and other children are welcome to attend their brother's or sister's birth if they are supervised.

Charge midwife, Colleen Green, confirms the changes saying the aim is to create a tolerant atmosphere.

"It's harder when we are busy but we try to cater for individual situations," she says.

Although each woman is assigned a doctor, midwife Green explains their involvement may vary with midwives playing a predominant role.

"It's a team approach now," she says. "Some of the younger doctors are prepared to stand back more and let midwives take responsibility for delivery."

Of the 100 births per week at National Women's, Dr Collison says 70% are normal, healthy ones requiring no medical intervention.

This means 50% of births now occur in First Stage rooms with women only being transferred to theatre if necessary — and many women choose "Active Birth" where they can do what feels right for them.

"So the biggest change is in our approach to birth," she says. "Now it's health oriented instead of illness oriented."

Good ante-natal care is helping to foster the health orientation says Dr Collison.

Those familiar ante-natal classes are now called Education for Parenthood and are much more comprehensive.

"After all it's a life-long thing isn't it?"

Principal nurse, Edna Davis, decries the public view of National Women's as a baby factory.

"We do a lot more than deliver babies," she says. "We want to be known as a health unit for women."

Dr Collison agrees.

"I'm proud of what we do here," she says.

"We are not in the business of setting up in opposition to the Regent Hotel."

"But I think we do a good job at being as efficient as possible with the resources we've got."

Left: Murals in the delivery suite ... National Women's medical superintendent Gabrielle Collison and charge midwife Colleen Green explain some of the changes in birth, 1980s style.

Central Leader - Auckland
28/1-86

Letters

Dear Editor,

I would like to see separate self-determination for midwives which I feel cannot be achieved while they are merely a branch of the NZNA which has conflicting interests to midwives.

It seems more logical to have a separate professional body that can unite with a common interest to restore autonomy to the NZ midwife, and make policy decisions that are appropriate to the profession.

Midwives have been undermined and virtually eliminated as physicians in their own right, and being a branch of a Nures's Assoc. endorses this. Community and political awareness will not be achieved by hiding within the ranks of a nursing body with peripheral interests only in the profession of midwifery - irrespective of the numbers involved in the NZNA.

Don't underestimate the power of a smaller well-motivated body with positive direction and a vision for the future.

Judi Strid
Ruakaka

Maureen Thompson's article "Midwives in Crisis": A Profession at Risk" made a timely appearance in an '86 Parents Centre bulletin.* It drew a nationwide supportive response. It was the response which prompted me to write this, because with such consumer support midwives can take the initiative, make a stand and get results. We could -

*break away from the NZNA if we choose to
*domicilary midwives could receive a salary equivalent to that of their hospital based colleagues
*midwifery clinics could be set up where continuity and quality of care are available to women as a matter of course
*schemes where women are cared for by the same midwives antenatally, during labour and postnatally could become available
*midwifery training could be removed from the Advanced Diploma of Nursing course
*and a direct-entry programme could be initiated

If midwives and women want these options then enthusiasm, hard work, a combining of strenghts and outside support is necessary.
The outside support is already there.
What are we waiting for?

Maureen concludes her article thus-

"The dying out of midwifery in New Zealand would change the face of obstetrics irrevocably. The rate of intervention in birth would soar. We too could have a 20% caesarean section rate (as in some parts of the U.S. where midwives are scarce). We too could have routine scans, episiotomies, inductions, and fetal monitoring. Overseas studies on groups of low risk mothers have shown that midwife care as opposed to specialist and G.P. care achieves the best results. It makes sense that a midwife whose sole job is to attend during labour and delivery can offer a higher standard of care than the doctor who is fitting you in between morning surgery and lunch.
We need midwives, our babies need midwives, the doctors need midwives
The whole health system needs midwives.
For heavems sake, lets do something about this - Parent Power needed here!"

.....Ruth Nicholson

Electronic Fetal Monitoring and Cesarean Births: New Studies, New Implications

by Diony Young

The escalating debate on the issue of appropriate use versus overuse of electronic fetal monitoring and cesarean sections has received new impetus with the recent release of two major studies in *The New England Journal of Medicine* (Levano, et al. 1986; Haynes de Regt, et al. 1986). The significance of their findings is underlined in an accompanying editorial by Emanuel A. Friedman (1986).

A large-scale, three-year study conducted in Dallas, Texas, examined the effects of using electronic fetal monitoring on all woman in labor (universal monitoring) compared with using it only in cases when the fetus was considered to be at high risk (selective monitoring) (Levano, et al. 1986). A total of 34,995 deliveries were studied. Results showed that the neonatal and perinatal mortalities were not significantly different between the two study groups. Universal monitoring was associated with twice as many cesarean sections performed because of fetal distress, but there was no significant difference between the universal and selective monitoring groups in the number of intrapartum stillbirths, newborn seizures, need for newborn assisted ventilation or admission to the intensive care nursery. The authors "conclude that not all pregnancies, particularly not those at low risk of complications, need continuous electronic fetal monitoring during labor" (Levano et al. 1986).

The second study of 65,647 deliveries at four hospitals in Brooklyn, New York, examined the relationship between private or clinic care and the cesarean birth rate (Haynes de Regt et al. 1986). Despite the fact that the clinic patients had significantly more medical problems, included significantly more adolescents, and delivered significantly more low birthweight babies, it was found that (after adjusting for birthweight) private patients had significantly more primary and repeat cesarean sections with no demonstrable benefit in perinatal outcome. There were fewer perinatal deaths among private patients, but their babies had a significantly higher rate of low Apgar scores and birth injuries than the babies of clinic patients.

The authors attribute the higher surgery rate among private physicians to a variety of factors, including concern about potential liability if the outcome is poor, time constraints that preclude waiting out a long labor and medical training. The authors point out the need "to focus on ways to reduce the discrepancy in cesarean birth rates related to whether the patient receives private or clinic care" (Haynes de Regt, et al. 1986).

Friedman, in commenting on the fetal monitoring study, notes that despite their technological promise and value in detecting fetal hypoxia, electronic fetal monitoring and fetal-scalp sampling "have proved to be of only limited use" and have "serious shortcomings." He states, in agreement with the authors, that there is no proof of the overall value of electronic fetal monitoring for low risk women. The cesarean section investigation, Friedman observes, contains the "unstated, but nevertheless clearly implied . . . idea that cesarean sections are being performed unnecessarily."

These two studies are of major importance in adding to the weight of evidence which demonstrates that expanding the use of electronic fetal monitoring to all women and increasing the use of cesarean sections do not improve the outcome of pregnancy. In addition, the findings hold significant implications concerning the defensive use of these procedures as protection against a possible malpractice suit for a less-than-perfect birth outcome.

Diony is ICEA Public Policy Liaison and a resident of Geneseo, New York.

References

Friedman, E. A. 1986. The obstetrician's dilemma: How much fetal monitoring and cesarean section is enough? *New Engl. J. of Med.* 315(10): 641-643.

Haynes de Regt, R., Minkoff, H. L., Feldman, J., and Schwarz, R. H. 1986. Relation of private or clinic care to the cesarean birth rate. *New Engl. J. Med.* 315(10): 619-623.

Levano, K. J., Cunningham, F. G., Nelson, S., et al. 1986. A prospective comparison of selective and universal electronic fetal monitoring in 34,995 pregnancies. *New Engl. J. Med.* 315(10):615-619.

Continued best wishes for the very important work you are doing in New Zealand for midwives + for all childbearing women.

Love,
Diony

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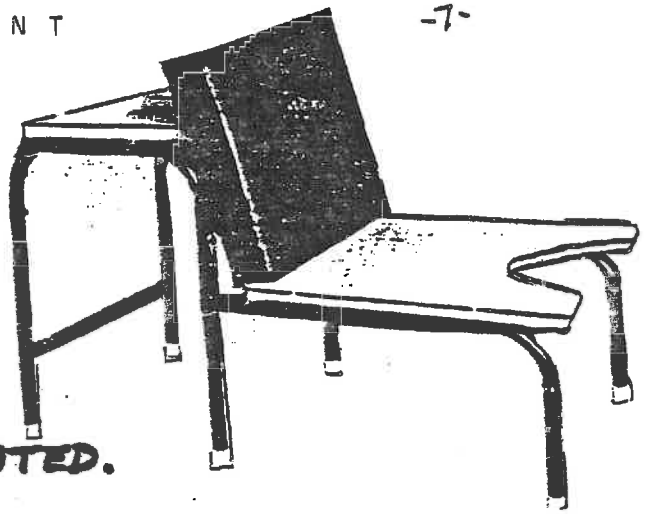

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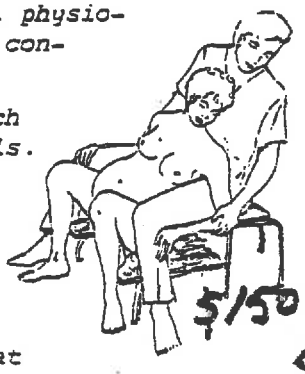

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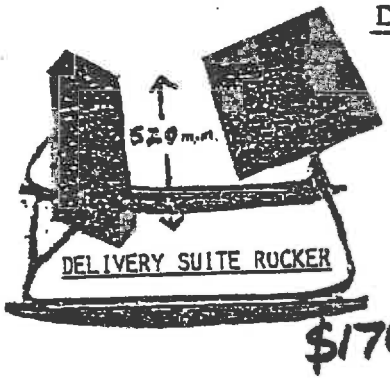

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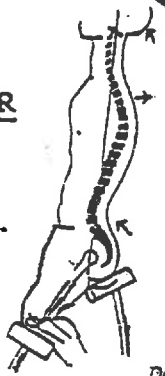

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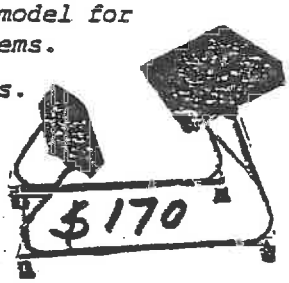

ACE ENTERPRISES 50A Beerescourt Rd, Hamilton, Ph. 496-240

Dear Ruth,

.....I should like to comgratulate you on the newsletter which I found extremely interesting, and extend my good wishes to you for its success which I hope will bring benefit to supporters. I am a "one-man band" and do all my own work except welding. It is fully guaranteed and having won numerous awards for my products, I am well established.
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Yours sincerely,
Iain Henderson

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BOOK REVIEW

REMINDERS FOR CHILDBIRTH by Adele Birkbeck

Longtime Dunedin domiciliary midwife Adele Birkbeck has produced an excellent, concise, easy-to-follow booklet on birth. There are plenty of photos showing positions for first and second stages of labour- promoting free movement both in hospital and at home, also lots of questions and answers about labour and birth including 'how it feels', 'what is happening', 'what you do' sections. The support person is included in the 'Reminders for the partner &/or companion' chapter. Cost is $5 per copy, obtainable from

Professional Publishers Ltd
P O Box 37 - 116
Parnell
Auckland

A REPORT ON CHARLES MAHANS ADDRESS TO THE SYDNEY ICEA CONFERENCE – by anna hedley....

In recent years it has become apparent that there is more consumer interests in education and information about caesarian sections.

We have seen the initiation of the Caesarian Birth Network throughout New Zealand, to provide contact, information and support.

Overseas childbirth education journals have been reporting on the caesarian issues for years. It seems that New Zealand women and their partners, childbirth educators and health professionals are increasingly becoming aware that we are seeing the same trends towards higher rates of caesarian sections in our local hospitals.

At a conference held in 1985 to discuss appropriate technology for birth, the World Health Organisation (WHO) made a statement that there is no need for the caesarian section rate in any region of the world, to be higher than 10-15%.

It is difficult to acquire statistics from New Zealand hospitals on operative birth procedures as Diony Young (expatriate New Zealander, author and consumer advocate) reported at the 1984 New Zealand Parents Centre Conference. She conducted a survey of hospitals throughout New Zealand, and discovered C/S rates ranging anywhere from 15-22%.

At the Sydney ICEA conference in September guest speaker Charles Mahan, Professor of Obstetrics and Gynaecology at the University of Florida College of Medicine, and director of Maternal and Child Health in Florida conducted several lectures on caesarian section issues. He dispelled many of the myths surrounding the reasons for the overuse of this birth procedure.

In conjunction with Diony Young, Mahan has written a book called Unnecessary Caesarians: Ways To Avoid Them.

Mahan was main speaker at the opening session of the Sydney ICEA conference, entitled Reducing The Caesarian Section Rate.

Mahan started by saying that in the US the C/S rates have spiralled over the last 20 years from an average of five percent in the 1960s to 28 percent in the 1980's. He considered that there existed an "insanity" in the US concerning C/S rates and warned: "You can get to where we are very quickly if you're not careful." He suggested the extreme situation being that we will reach a point where all babies will be born by caesarian.

In the US there are wide variations of C/S rates depending on certain hospitals and regions. Some areas are lower than five percent, others higher than 60 percent. He included mention of one notorious Miami hospital (in an upperclass area) where 65% of low risk women has caesarian births. He said that often women in the very upper income bracket choose a C/S for convenience. His example was Brazil, where very few native women have caesarians, but over 90 percent of the upperclass do because that is what they want!

Generally it seemed that the older the woman (eg. over 35) the more likely she is to have a C/S. Mahan drew comparison with teenage pregnancies, where women under 20 have the lowest C/S rate. His comment: "Perhaps we don't want to put a scar of the belly of the 14-year-old, but the same concern for a 35-year-old doesn't exist." (A discontenting idea indeed.)

Using a graph. Mahan showed the relation between the "type of doctor" and the C/S rate. There were lower rates for those who practised both obstetrics and gynaecology. They tended to react with a C/S:

Mixed ob/gyn — 19% C/S rate
Primarily gyn — 54% C/S rate

Another indictment on the medical professionals connected the "perils of the private patient" with the caesarian rate. At present this is not quite the same issue in New Zealand with out primarily "free" care. Mahan gave evidence to show that when a fee was paid the C/S rate doubled.

Many studies were cited to show the connection between high C/S rates and routine electronic fetal monitoring routine monitoring poses several problems, including the confinement of the woman to bed (difficult to be active), and also fetal monitors are often inexact. Because monitoring often shows inaccurate details, Mahan believes other methods, such as scalp sampling, should be used to determine whether the baby is in trouble or not.

Scalp sampling is about 70 percent accurate, whereas monitoring is usually 30 percent accurate (ie. even when the monitor shows acute fetal distress only about 25% of these babies require special care.) It is interesting to note that the WHO 1985 report recommends simple auscultation (listening with an ear trumpet) should be used for all routine cases, and electronic monitoring should only be used in carefully selected cases.

Mahan pointed out, again with references and resources, that higher C/S rates make no change to the perinatal mortality rate, (death from 20 weeks of pregnancy to 28 days after full term). Unfortunately morbidity (problems resulting from birth like cerebal palsy etc.) statistics are not usually kept in many countries. So it is difficult to assess birth outcome using morbidity information.

Mahan explained that for low birth weight babies, whether head first or breech, there was no difference in outcome between vaginal birth and caesarian. Also babies' outcomes were the same in studies comparing mid-forceps births to caesarians.

When induction rates are high there is often a high failure rate leading to C/S. The FDA (Food and Drug Administration) in the US has made a statement that oxytocin should not be used unless in absolutely bonafide cases. Consequently there has been a dramatic fall in induction rates, for fear of malpractise situations.

Discussing the much higher incidence of breathing difficulties of the newborn (TTNB — Transient Tachypnea of Newborn) associated with caesarians (eg. vaginal 18 percent compared with 54 percent C/S) Mahan explained the importance of

the stress hormones involved with the labour process. These hormones are good for the baby involving important steps in toning and development, including the experience of being squeezed through the vagina and against the perineum. (See the latest Caesarian Birth Network newsletter Sept/Oct '86 for an article called Stress Of Being Born.)

Mahan emphasised the fact that caesarians are such a "common" occurence that we forget that it is a major abdominal operation. The incidence of infection picked up by being in hospital after a C/S was high, but higher again after a repeat caesarian — more evidence that this is not a benign procedure.

Drawing this session on Reducing The Caesarian Section Rate to a close, Dr Mahan received spontaneous applause from the audience when he suggested that medical students should attend births with midwives, and that midwives should be on the faculty to teach students. He believes physicians can and should practise midwifery and not always obstetrics!

The final statement from Mahan about caesarians:

"Generally, the attitude is 'hands off' unless there is a very good reason to intervene."

Thanks to Parents Centre Bulletin No. 108 '86

Childcare for public servants

An annual sum of $1 million has been allocated by the State Services Commission towards the costs of establishing childcare facilities for public servants.

The scheme involves a joint approach, with the employer contributing to the cost of land and buildings, while the employees (the users) form an incorporated society to manage the running of the centres.

Applications were received from public service groups around the country, and were assessed in August and October this year by a joint State Services Commission/Public Service Association committee. Approval has been given for 8 centres, to be located in Henderson, Otahuhu, Ruakura, Lower Hutt, Dunedin, Manukau, Wanganui and Wellington.

M.W.A's Newsletter 12/86

Midwives in England plan to use **equal pay laws** to claim pay parity with hospital doctors. If they succeed they will double their pay. Three or four test cases, backed by the Royal College of Midwives, are expected to come before industrial tribunals. The aim is to counter the shortage of midwives by attracting them back with higher pay. To succeed, they will have to show that the value of the work a midwife does is similar to that of a doctor when caring for a mother whose pregnancy is progressing normally. The RCM is also debating a motion that midwives rather than GPs and obstetricians should be responsible for caring for women during normal pregnancies.

(MIDIRS Pack No 2, July 1986 UK)

Caffeine -

Caffeine studies on rats, mice and chickens indicate such genetic problems as cleft palate, missing fingers and toes, stillbirth, spontaneous abortion, prematurity, and low birthweight with caffeine consumption in pregnancy.
'The Compleat Mother,' Spring, 1986.

Minimal Breastfeeding

Current advice to breastfeeding mothers is that breasts must be emptied regularly and frequently to help maintain lactation. An alternative method of maintaining lactation, minimal breastfeeding, in which mothers nurse once or twice a day without expressing the breasts between breastfeeding has been investigated. A sample of 30 mothers using minimal breastfeeding was interviewed monthly until the babies were weaned.

In all cases weaning occurred because the mother or infant chose to wean, not because the mother produced insufficient milk. The researchers concluded that for working mothers who cannot express between feeds, breastfeeding can still be maintained, and that minimal breastfeeding is an important alternative to early weaning.

Journal of Obstetric Gynaecologic and Neonatal Nursing, Vol 15(4), July/August 1986.

Postnatal and Postpartum Care

APPROPRIATE TECHNOLOGY FOLLOWING BIRTH

A symposium assembled by the regional office for Europe nd the regional office for the Americas of the World Health)rganisation met in Trieste on Oct 7–11 to debate this ubject and to construct recommendations. Earlier omplementary meetings (in Washington, DC, in 1984 and Fortaleza, Brazil, in 1985[1]) had discussed how best to rovide care during pregnancy and during birth. The rieste symposium was composed of about 40 participants rom some 20 countries in Europe and the Americas. Those resent drew their experience and views from careers in: idwifery, obstetrics, paediatrics, community medicine, sychology, sociology, epidemiology, economics, health rvice administration, international health care, medical urnalism, women's groups, and parenthood.

The following were among the symposium's ecommendations, which will be published in full by WHO.

PUBLIC POLICY

Poverty is the greatest threat to the health of the woman and the fant. In the absence of concerted measures to promote social uity, little improvement can be expected in maternal and infant ortality and morbidity. Mortality and morbidity rates are higher socially disadvantaged communities, which may also receive uch less in the way of formal health care. Thus (a) in the allocation resources, nationally and locally, direct spending on health rvices may not be given sufficient priority; and (b) services for althy women and babies should be organised so that those most in ed have access to adequate care.

The structure of health care systems and the way they operate are fluenced by commercial interests and by the needs and rspectives of professionals and others who work in them. When ch influences are strong, they must be publicly recognised and, if cessary, controlled.

The improvement of postnatal and postpartum care must be a llaboration between: parents; health professionals; health anners; health-care administrators; other related sectors; mmunity groups; policy makers and politicians. Policies and echanisms should be developed which will guide decisions about e care of women and babies—for example, multidisciplinary mmittees on ethics and review boards for the assessment of care. ommunities must examine how far their attitudes and practices pport or obstruct the opportunity for women and babies to ceive the best available care.

The allocation of health care resources to intensive life support stems for the newborn should be determined nationally. That cision must be informed by research findings, socioeconomic ctors, and moral and ethical considerations. It should be based on nsultation among care providers and representatives of parents d of the community as a whole. It should include the tablishment of minimum standards and requirements for staffing, uipment, and siting of units for the newborn.

Every woman in employment should have an adequate period of id maternity leave before and after childbirth. Social security stems should not penalise women for motherhood. Women ould also be relieved of unpaid work after childbirth, and home lp services should be available. After birth paid leave should be ovided for the father so that he can foster a relationship with the by and support the mother.

Self-help groups should be promoted and funded in local mmunities to enable parents to meet the responsibilities of infant re. Professionals have a duty to be knowledgeable about self-help oups in the community and they should inform parents about these groups. As one example, breast-feeding support groups in the community provide a valuable form of information exchange and support among women.

In any country or region existing cultural practices in the period following birth should be respected and maintained—unless they have been proved to be harmful. Better communication between women and health workers would improve opportunities to recognise strengths of local traditions, which could then be disseminated to other women.

HEALTH AND MEDICAL SERVICES

For healthy women and babies, support equivalent to that provided in hospital should be made available to all mothers and babies at home.

If the mother desires breast-feeding, it should be initiated within the first hour after birth. Practices concerning breast-feeding should follow the resolutions adopted at the 34th World Health Assembly in 1981.

All parents and infants have the right to be in close contact from the time of birth. Closeness between mother and infant should be promoted in all circumstances, including the period after caesarean birth or other medical interventions affecting the woman or infant. Women and babies should not be separated and should be together as much as the mother wishes. Rooming-in should be promoted; and thought should be given to abandoning central nurseries for normal babies. Furthermore involvement of parents in the care of the unhealthy newborn should be promoted, including the actual care of the unhealthy infant and participation in decisions about treatment.

Mothers and babies should not be kept in hospital beyond the time when they can benefit from further hospital diagnostic or therapeutic measures. If rest or social or educational support are needed, they should be provided in the home.

Every baby should have its own record from the moment of birth, which may include data about pregnancy and birth. This record, or at least a copy of it, should be kept at home by the woman. It would include data about growth, development, nutrition, immunisation, and medical history. It can form a basis for communication among givers of health care and with the woman. The woman should also have her own health record in her home. Confidentiality of these records must be protected.

PREVENTION AND SCREENING

All women and newborn infants should receive immunisation and screening tests in accordance with the recommendations of their own countries, whether at home, in a clinic, or in a hospital. Before screening of women or babies is contemplated, it must be evaluated by random controlled trials, examining not only efficacy and safety but also psychosocial costs and benefits. Each country should evaluate the relevance of particular screening procedures to its own particular needs or resources. The means of administration of vitamin K and the type of eye prophylaxis in the newborn need further evaluation. When indicated, immunisation with Anti-D is recommended for the woman.

The period following birth may be an important time for making family planning advice and services available to both parents. The person giving such information to women should be someone in whom they have confidence. In many contexts, the best person would be a nurse or midwife. Information should be given on a variety of contraceptive techniques, so that women can make informed choices.

Eradication of neonatal tetanus is a high priority.

Low birthweight, which correlates strongly with both perinatal mortality and morbidity, should receive high priority for research into causes and prevention. Meanwhile, however, some actions seem to reduce the incidence of low birthweight and other causes of perinatal mortality and morbidity. Services should be developed with such actions in mind and the public should be fully informed of the reasons for and importance of these actions, which include: family planning (to avoid a large number of children and too short intervals between children); prenatal care to identify possible risks to the fetus and woman and to treat any diseases or conditions

developing during pregnancy; nutritional and social support during pregnancy; avoidance of cigarettes, alcohol, and drugs during pregnancy; appropriate care during labour and delivery.

ROUTINE POSTNATAL AND POSTPARTUM CARE

Every woman and infant should have access to a basic level of carer regardless of whether the birth takes place at home or in a primary or secondary health care setting. At every birth, wherever it takes place, one attendant should take overall responsibility for the woman and infant.

Government agencies should support the provision of health care by alternative providers, such as empirical midwives. The role and efficacy of these alternative providers should be systematically evaluated.

A first priority is that every baby, whether born at home or in hospital, should be assessed for breathing difficulties and be given the necessary support to initiate and sustain respiration. Every birth attendant should be trained and equipped to deal with immediate care and resuscitation of the newborn, including identification of the need for consultation or referral to more specialised care.

Every newborn should be evaluated initially for vital signs and gross congenital abnormalities. Evaluations should take place next to the mother if possible, in a room at the right temperature and without hazard to baby or woman.

Discharge from hospital should depend on the wellbeing of the mother and infant, the wishes of the parents, and the availability of home support. In particular, discharge policies should not be based on the single criterion of weight and should concentrate on earliest possible discharge.

UNHEALTHY INFANTS

Parents have the right to active early involvement in the care of their unhealthy infant: early and free visits to the special care infant unit; encouragement of feeding and skin-to-skin contact, whether or not the infant is connected to monitoring systems; facilities where parents can live while the infant is in special care; participation in decisions regarding diagnosis and treatment.

All countries should develop criteria by which to determine whether or not certain treatments for the newborn should be regarded as experimental. Examples of "experimental" treatment, in present circumstances, include the management of extremely premature infants and serious congenital defects. Guidelines should be formulated for the selection of infants for whom maximum intensive care and surgery are justified. The possibility of short- and long-term negative consequences of such treatment should be fully communicated to the parents.

Ideally, unhealthy infants requiring intensive care should receive it in special units within maternity hospitals. In these units, paediatric and specialised nursing staff should be on duty for 24 hours a day. The minimum acceptable facilities for life support, including biochemical tests and radiology, should be available. No institution providing tertiary care should be permitted to refuse to accept a case presenting at their facility, at least for assessment, stabilisation, and referral.

RESEARCH

Any technology used in postnatal or postpartum care should undergo evaluation before its introduction for general use. Such evaluation should include efficacy and safety, economic implications, and cultural acceptability. The results of technology assessment should be widely disseminated to professionals and the general public. WHO should continue to promote and expand a network of technology assessment centres to assist countries in selecting new technologies and assessing them. This network will constitute a focal point for the dissemination of information.

Two areas of research needing high priority are: fetal growth and its retardation and the prevention of low-birthweight infants; health problems in the woman following birth, including postpartum depression.

All governments should appoint a broad-based representative committee, including health-care providers and the users of health care to establish guidelines and recommendations for the care of mothers and infants. These guidelines should be based on a continuing evaluation system and should be widely distributed and frequently revised. Such guidelines should include minimum standards for equipment and care practices following birth.

All countries should make an effort to improve perinatal records. Birth and death certificates should include birthweight and they should be linked whenever possible. A good statistical system is essential, beginning with registration of all births and deaths. Permanent perinatal surveillance systems are needed at the national level.

PUBLIC INFORMATION AND MEDIA

Information about the period following birth which is accurate, clear, attractively presented, of high quality, and consistent should be disseminated widely to parents, schoolchildren, teachers, health professionals, and politicians.

WHO and its regional offices should institute a regular programme of meetings with journalists, media and public-relations leaders, and editors of professional journals in order to familiarise them with the recommendations of WHO meetings and other issues affecting maternal and child health. WHO should promote the implementation of the recommendations of the Trieste meeting and the two earlier meetings.

Lancet 13/12-86
Sent in by Medical Superindent in chief A.H.B.

See "Appropriate Technology for Birth" S.T.M's No 10
or Lancet 1985 p 436-37

Reproductive health/damage

The Working Women's Resource Centre, a Federation of Labour research officer and the Trade Union Health and Safety Centre have recently begun work on the issue of reproductive health. They want to hear from women and men who have had reproductive damage occur because of their work.

You can write to them at: Reproductive Health Committee, Working Women's Resource Centre, Private Bag 5, Newton, Auckland 1.

The YWCA in Auckland has begun a support group for women who have suffered as the result of wearing an IUD. Damage from the Dalkon Shield and other IUDs includes infertility, pelvic inflammatory disease, ectopic pregnancies, perforation of the uterus, septic miscarriages and painful intercourse.

MWA's newsletter 12/86

DIRECT ENTRY MIDWIFERY TRAINING INITIATIVE

A presentation held in London on September 3 by the English National Board for Nursing, Midwifery & Health Visiting

DIRECT ENTRY training should be the predominant feature in the midwifery profession of the future if the mood of those participating in a recent presentation on direct entry training has been gauged correctly.

Organised by the English National Board for Nursing, Midwifery and Health Visiting, the afternoon meeting, held in London on Wednesday, September 3, was attended by nearly 200 teachers, managers and clinical midwives from midwifery training institutions from all over England.

Chairman Mrs Kate Newson opened the proceedings by explaining the background to the decision to hold the meeting. After publication of the English National Board's strategy on education the Midwifery Committee (of which she is chairman) had presented a paper to the Board indicating that there was uncertainty as to where the Board stood on direct entry training for midwives.

This meeting, she said, had been held to hear what the midwifery profession itself felt about direct entry and, also, about the recently published Project 2000.

The first speaker was Miss Sue Downe, now a Staff Midwife at Derby City Hospital. Miss Downe described her own experiences and what she and others had felt "On being a direct entry student midwife".

After graduating from university Miss Downe had gone to Botswana, where she first became involved in midwifery. Her work there had convinced her that her career was to be in midwifery—*not*, she said firmly, nursing, but in midwifery.

On returning to this country she had applied for direct entry training to the Edgware Road and Derby hospitals, both of which had long waiting lists. She eventually got in through a cancellation.

She spoke of the antagonism existing between the direct entry students and the 18-month State Registered Nurses. At Derby they had all sat down one evening and "talked it through", after which things had been for the better. She advised anyone starting mixed training to be "scrupulously fair" and to bear in mind the need for counselling; it was a good idea to get both groups together. Talk to the staff as well, she suggested, to see how they felt about direct entry training.

Prejudice against direct entry midwives was now not as strong as it used to be, said Miss Downe, but she warned that it should be borne in mind that direct entry midwives would only be "as good as their course".

She ended by listing some of the strengths and weaknesses of direct entry training. These included: *Strengths:* no sickness module—and direct entrants stay on: training includes relevant data, which makes it cost effective to the NHS (but not, she added, to midwifery); direct entry midwives can practise in the EEC as soon as they qualify; increased time to attain skills; ideal for someone who has no wish to be a nurse. *Weaknesses:* still experimental courses; reduced career prospects (Miss Downe was not convinced that this argument was true); difficult to cope with being a student after coming from life in a university or with experience of working; takes longer to be accepted as a competent practitioner; lack of medical knowledge (this also was refuted by Miss Downe); expensive for midwifery budget.

She summed up her lists by reminding her audience that the majority of direct entry midwives would all want to stay on in midwifery—their chosen career—and, as they were committed, were likely to involve themselves in research and in discussion on issues such as Project 2000.

Although the next speaker was listed as Miss Young, it was in fact Mrs D. McDonald, Senior Midwife Teacher, Wolverhampton School of Midwifery, who took the floor. She began her talk on "Preparing the ground" by asking a question: "Why prepare for a three-year course?". And then proceeded to answer it, for the benefit of those present. At Wolverhampton, she said, where they had been preparing for some years to introduce direct entry training, they believed in what they were doing—they felt that the time was right and that there was a need for such a course. There was no shortage of applicants and, said Mrs McDonald, it was good for the profession.

She acknowledged that they were treading virgin ground. From the start they had proceeded cautiously, using guidelines from the (then) CMB and the ENB. She described how they had formed a committee and had gone on a fact-finding mission to the then two schools running three-year courses. Lines of communication had been set up with other midwifery schools and feasibility studies carried out. The next step had been to develop a curriculum, deciding on its philosophy and the clinical content of the course.

It had taken six full months to plan the courses but there was reward in the enthusiasm shown in the ward chosen to take direct entrant students. Now, she said, the curriculum plan was nearly finished, having been approved in principle by the English National Board. The target date for the start of the course was late 1987 or 1988. There would be a yearly intake of eight students.

Mrs McDonald was immediately followed by Miss M. Young, Senior Midwifery Tutor at Derby City Hospital. Also speaking to the theme of "Preparing the ground", Miss Young emphasised that Derby was a very different proposition to Wolverhampton. In Derby they had been training direct entrants for 50 years—although she admitted that she did not know such a scheme existed when she applied for her post!

She explained that Enrolled Nurses had been dropped from the hospital and that there were only SRNs and direct entrant midwives (a decision in which she had not been involved).

In providing direct entry training, Miss Young said that backup from existing staff was very necessary. She conceded that preparation of staff was perhaps not always as good as it should be, for it had to be recognised that direct entry training was very heavy on tutors' time. She found direct entry students enthusiastic and questioning; many, she thought, knew more about the profession than the trained staff.

Long Waiting Lists

She emphasised the necessity for "other people to take up the need for direct entry training". There were long waiting lists of—mostly—young women eager to take up midwifery as a career. Often she found that by the time she got round to writing to applicants when there were vacancies they would have moved on or got other work. She had gone through as many as 100 names to get eight—this was a terrible loss of potential midwives.

Miss Young did not believe that teachers should be pressed to take direct entry students. It was better to get over any problems by discussion, confrontation and talking them through. "I firmly believe", Miss Young concluded, "that direct entry is the way we should be going".

This first part of the programme ended with questions and answers, in which concern about the shortage of tutors was very evident.

The latter half of the afternoon was entitled "The way forward" and the two speakers were Miss Ruth Wilday, Director of Nursing Services (Midwifery), Birmingham Maternity Hospital, and Dr E. R. D. Bendall, Chief Executive Officer, English National Board.

As RCM members know, Miss Wilday is a witty and innovative speaker and she took the theme of "The way

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MIDWIFERY SEMINAR

JUNE 15, 16, 17, 18

FICKLING CENTRE, MT ROSKILL, AK 4.

guest speaker: Prof. Peggy Ann Field (Canada)

Contact Aileen Coppock, Auckland Midwives Section, NZNA, for details.

forward" to imply a journey through direct entry training with its purpose being meditation on the next move: the training needs of a student with no previous experience, developing programmes to meet the needs of that student and of the manpower needs of the service in the most efficient and cost effective way.

Using pictures of road signs to illustrate her talk Miss Wilday guided her audience through a maze of traffic warnings and other hazards to journey's end and its four-way signpost to: Research; Teaching; Clinical practice; and Management.

It is not possible, in a brief report, to take readers through the whole "journey". Among the points made by Miss Wilday were that she believed direct entry for midwives to be a matter of urgency—she pointed out that its preparation took a minimum of two years. Forward planning would include discussion with all those involved—your immediate boss, the education officer at the ENB, the CNO, general manager, health authority and, most certainly, your clinical colleagues.

There was not just one way to achieve direct entry, said Miss Wilday. One had to accept that resources were not the same in different health authorities and there was the time factor to be considered. She listed some of the "needs" for this journey. Residential accommodation alone was a major undertaking. Then there were "communications"—the most important part of the journey—keeping people up to date, participating in curriculum development. She suggested the use of tapes, a bulletin or newsletter. What about "finance"? What was needed for direct entry? Some resources were "shareable" but there would always be an initial outlay. Direct entry was cheaper in the long run but initially it was expensive. She set out the financial resources to be considered: pay for tutors, student midwives' salaries/grants for three years. Other, less obvious, considerations were interview expenses; audio equipment, books and magazines; lecture/index/examination fees; travel costs; telephone; uniforms; education budget for tutors.

After all this, Miss Wilday said, the question to be asked was: "Do you believe this journey is really necessary today?"

Project 2000

Dr Bendall, the final speaker of the afternoon, said that there was a feeling that the majority of midwives were in favour of direct entry and she disclosed that funding for its extension was "in the pipeline". Referring to Project 2000 she acknowledged that midwives thought that a major problem lay in the Common Foundation Programme. She asked them to remember that "There is good in common establishment", citing shared libraries, audio-visual equipment and buildings. There was, she admitted, trouble when you started applying commonality in all specialties—e.g. nutrition. However, midwifery was not the only specialty with a problem.

Dealing with some of the criticisms that had been voiced following publication of Project 2000, Dr Bendall pointed out that it was envisaged that the Common Foundation Programme would take *up to* two years rather than the full two years so often quoted. She begged midwives not to be "overly defensive". There were admirable strengths in midwifery but some schools were too small.

Referring to the suggestion that students should be supernumerary Dr Bendall said that this was the "biggest single change" that the professions could need. Speaking of the possibilities for the professions in the future she warned that "the only thing that would stop us is if we shoot ourselves in the foot by not considering each other".

After this contribution it was perhaps inevitable that during the question-and-answer session that followed there was much discussion about the purpose of Project 2000.

The afternoon's proceedings were summarised by Chairman Kate Newson, who asked: "Why haven't we prepared for direct entry?" Was there, she wondered, a commitment to the system? A decision, too, had to be made on Project 2000. Should midwives decide to take on their own profession and go their own way it was an "incredible responsibility". If, in a few years' time, it became clear that they had chosen wrong it would, she warned, be the fault of the midwives, not the nurses or the health visitors or anyone else.

Listening to the afternoon's speakers and the debate, she had heard issues raised which she had not previously thought of. She urged those present to go back to their places of work, to talk over the afternoon's discussions with their colleagues. And then, having talked and made their own decisions, to let the ENB know what those decisions were. The outcome would depend on the response from the midwifery profession.

Midwives Chronicle & Nursing Notes Nov'86.

"Project 2000 : A new preparation for practice" is the United Kingdom Central Councils Consultation document on Nurse Education & Training. See M.C.&N.N July for further information.

Wendy Savage : on birth

"On the other hand there is the pessimistic view (of labor), which says that no labour is normal except in retrospect. But at the other end are people who say that everything is normal, unless something goes wrong.

"Pregnancy is not an illness: it is a very important part of a couple's life together. It is very important to allow a woman to feel in control, rather than taken over by the doctor, by the hospital, by the system.

"If you're not careful, you could label almost the whole population of women having babies as of high risk.

"Men are onlookers, bystanders, who have a feeling that they have got to do something about the pain and the birth which is progressing.

"Women, on the other hand, understand that it is a very important function and that there are worse things in life than pain."

Birth Gazette Vol 3 No2

HALF Considering Suit Against Hospital

Court-Ordered Cesarean Delivery

HALF's legal advisory committee is in the process of reviewing the case of a 19-year old college student who was forced to undergo cesarean delivery of her first child after a hospital physician persuaded a judge to issue a court order in the middle of the night. Mother and child are doing fine, but the troubling legal precedent set by this case concerns many who are opposed to such state intervention into private health care decisions.

The patient was admitted to a major city hospital in July, 1986 experiencing normal labor pains. An electronic fetal monitoring device was attached to her and she was forced to lie in bed on her left side for extended periods of time. When she asked to be allowed to get out of bed and walk around to help with her natural delivery, she was advised that hospital regulations and city statutes required her to remain in bed on the monitoring device.

Several hours passed, yet the frightened mother was unable to deliver her child. The chief of obstetrics examined the patient at noon on Friday and advised that the baby was in a vertex position face up, that both baby's and mother's temperatures were normal, and there was no evidence of infection or other abnormality. Later that evening, the resident physician in charge advised the patient that he would like to administer a drug (Pitocin) to help speed up the delivery process, but he would not administer it without her consent to do a cesarean delivery should he deem it advisable. She refused to consent to the surgery under the circumstances and requested that she be allowed to continue her course of natural childbirth, in accordance with her Muslim religious principles.

Shortly thereafter, the physician telephoned a local judge, who convened a hearing at the hospital for the purpose of determining whether to order the woman to undergo the requested surgery. The judge appointed attorneys for the parents and the fetus; the hospital's attorney was also present at the midnight hearing. The parents were not given an opportunity to confer with their appointed attorney before the hearing began, nor were they able to secure the services of a medical expert to counter the testimony of the hospital's physician.

The resident testified that he thought the fetus was in danger of infection due to the length of time since the patient's membrane had ruptured (60 hours earlier). On cross examination he admitted there was no objective evidence of any fetal disease. Nevertheless, at 1:05 A.M. the judge ordered the hospital to deliver the patient's baby by surgical intervention. The parents attempted to appeal his ruling, but at 2:08 A.M. two appellate justices affirmed the judge's order. The cesarean delivery was immediately performed and no infection or injury to the fetus was discovered.

The patient's husband complained about the forced delivery procedure to the National Organization of Women and was referred to the National Women's Health Network. HALF was then contacted and the resulting case review was begun.

This cesarean case is deemed important because it represents what some believe is unwarranted state intrusion into the privacy rights of individuals making health care decisions. No woman should be forced to submit to continuous electronic fetal monitoring against her will, and certainly no one should be ordered to undergo surgery in the middle of the night after a one-sided judicial hearing such as the one held in the present case. Such blatant misuse of the judicial process by allopathic physicians and hospitals to enforce their medical views to the detriment of the fundamental rights of mothers to protect their offspring erodes the rights of all Americans and should be vigorously resisted.

HALF is contacting numerous women's groups across the country to enlist their support for this case and urges readers of Alternatives and The Birth Gazette to do the same.

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Dothan, Alabama 36303

Taken from The Birth Gazette Vol 3 No 2.

Medicine men and menopause

I have sometimes wondered what attracts so many male doctors to that most intensely female area of medicine — gynecology and obstetrics. There are 150 obstetricians and gynecologists in New Zealand and all but 12 of them are men. At a conference I attended recently, I had a fascinating peek into the psychology of the "women" doctors.

Sandra Coney

The occasion was the first National Summer Update Conference of the New Zealand Obstetrical and Gynecological Society. More than 300 specialists and general practitioners, a smattering of midwifes and four "consumers" gathered in the peach marbellised ballroom of the Hyatt Kingsgate to hear a succession of male doctors, two imported from overseas, discuss women's "problems".

It was during the presentation on the second day by Dr Mahan Lala of Waikato Women's Hospital — on the subject of obstetric analgesia — that a rather unnerving event occurred. He showed a slide of a woman in all the cliched accessories of porn mags — stilettos, stockings and suspenders — pointing her bum at us, while her frock was lifted over her head. This, I guessed, was supposed to demonstrate that women anesthetised during labour are alive below the waist, but dead above it, or soemthing like that. I do not presume to know how the mind that devised this "joke" works.

This was not the first time during the conference we had been treated to "jokes" about women. It seems that surprising slides are as much the stock-in-trade of the gynecologists as their speculums. On the first day, the guest speaker, Dr John Studd (the name was real, but no one joked about that) of Kings College Hospital, London, showed a slide of the Victoria Falls during his presentation on Management of Menopause.

"You may think that's a picture of the Victoria Falls," he said with a twist at his bowtie and a flick of his boyish Eton crop. "It's not. It's the biggest hot flush in the world!"

'Self-indulgent'

Well, what a jolly little giggle we all had with Dr Studd about that.

Dr Studd has a low opinion of menopausal women. "These wretched women," he called them, suffering from "a multi-system deficiency disorder". When women used to tell him about thinning skin and hair, he thought it was "the self-indulgent manifestation of their own misery".

Now science has validated their imagingings and Dr Studd knows better. All they need is estrogen! Estrogen to swallow, estrogen creams for the vagina and best of all, estrogen implants.

(You put your estrogen in, You take your estrogen out, You put your estrogen in and you shake it all about . . .)

"Estrogen," says Dr Studd, "does no end of good." What about the known risk of uterine cancer from estrogen therapy? That's why estrogen's best for women who've had their uterus out, announces Dr Studd triumphantly. You just sew it in the wound!

Failing that, you just add another hormone to cancel it out.

It just happens that Dr Studd's visit was funded by a New Zealand company which markets estrogen implants, a connection none of the media which gave much space to Dr Studd's views thought to ask about. A 6.30 television news item not only showed Studd promoting his wonder hormone but also showed packets of estrogen products. The morning paper obliged by starting its news report: "A British specialist says that most middle-aged New Zealand women should be asking their doctors for estrogen treatment . . ."

The same company which funded Dr Studd, Pharmaco, arranged a visit last year by a doctor who told us copper IUDs were really safe. It just happened that it marketed the biggest-selling copper IUD in New Zealand. Once again the media fell for it and never thought to ask, if the doctor was truly independent, why a public relations firm was handling publicity for his visit.

I learned lots of things at the conference about what's going on in some doctors' heads when they see women. I heard about the "lunacy" and "colossal self-indulgence" of home birth, and that women who come into hospital after "failed" home births are "the maddest of women". I was told that if women had been sheep, most would be culled for not getting pregnant fast enough.

I also had explained for me why so many of the women I've met with IUD injuries have been given tranquillisers for the pain. "We all know," you see, "that women focus problems into the pelvis." I haven't yet been to a men's disorders conference, but do they have speakers on "psychosomatic disorders in prostate" and get told the importance of recognising that "men focus problems on their testicles"?

Doctors at the conference were anxious that their patients no longer have blind faith in them. Why, they asked plaintively, won't women come to us for their cervical cancer smears? The answer to this, they decided, is teaching "communication skills" in medical schools, listening to patients and taking time to talk to them.

All very well, but the doctors showed no signs at the conference of practising their own "cure". Two of the three consumer representatives who spoke were booed. I was one of them. When I asked Dr Lala to apologise for insulting the women present by showing a pornographic slide, I was booed. What am I to make of that?

Probably that I'm mad and menopausal and didn't have my frock over my head.

Nothing that a little estrogen wouldn't fix.

Reprinted from New Zealand Times 14-3-87

MIDWIFERY CENTRES

Many pregnant women would like to recieve complete care from a midwife. I would like to put forward, for comment, a proposal that makes this possible.

Here is an outline of the proposal; a task-group of Save The Midwives is currently working on it and we would very much like your comments on other possibilities or pitfalls before we go any further.

WHY?

This is a health-care option for women who wish to obtain prenatal, intrapartum and postnatal care from a midwife.They want a midwife because they want a health professional who is highly trained to care for normal births and who works from a holistic base;that is, a professional who recognises, respects and values the emotional, social and spiritual aspects of birth in addition to the physical and physiological aspects.

HOW?

Midwifery Centres would be located within existing maternity hospitals and obstetric units, providing care for women assessed, by midwives, as low risk.
Midwives would be salaried on a full-time or part-time basis, and would provide:

- hospital birth and hospitalised after care
- hospital birth and early discharge
- home birth

Midwives would work in teams of three to five people, so pregnant women could see all members of the team antenatally.The mother would have the midwife of her choice for her birth if possible, with midwives making informal arrangements between themselves to facilitate this.
Women would refer themselves to the Midwifery Centre, or perhaps be referred by G.P.'s who choose not to practice obstetrics.

WHATS IN IT FOR WOMEN? AND MIDWIVES?

1. Choice of caregiver for the mother.
2. Continuity of care for mother and babe.
3. The social, emotional and spiritual dimensions of birth will be recognised; for most women, who are healthy and have normal births, this is the most important aspect of childbirth. It is largely unrecognised by medicalised obstetric care.
4. Greater opportunities for education for parenthood than is presently the case.
5. Maori and Polynesian midwifery teams could cater specifically for women of their own culture.

.....continued

6. Much higher job satisfaction for the midwife.
7. Better training opportunities in normal birth for student midwives.
8. Less expensive hospital care ; midwives could replace house-surgeons and registrars to some extent, with a consequent advantage to Hospital Board resources.
9. Fewer opportunities for abnormal births to be created by medical students/house surgeons/registrars as fewer of these health professionals would be needed.

HOW IS IT GOING TO HAPPEN?

An informal working party has been considering this for about six months now. In Auckland we are considering two pilot projects, initially functioning with five to ten midwives each specifically employed to work in the Midwifery Centre.
Overall staff employed by the hospital would not increase as these midwives would be catering for the same number of births as before, but within a Midwifery Centre rather than the general hospital.
A lot of work needs to be done to iron out the details, make it logistically possible, and persuade the hospital boards to try it.

We see this as an excellent way to provide women with greater choice and control in childbirth ; and midwives with considerably greater job satisfaction. What do you think? Write and tell us.

...Judy Larkin.

BOOK REVIEW

UNNECESSARY CAESAREANS AND WAYS TO AVOID THEM by Diony Young and Charles Mahan

This booklet is written with the basic premise that optimal birth outcome is directly related to an individualised approach to each pregnancy, labour and birth. The authors intention is to educate expectant parents about caesarean birth and to explore alternatives that may enable them to safely avoid an unnecessary caesarean. The booklet willa also help parents to plan ahead to make decisions about the birth that meet their particular needs without compromising safety should a caesarean be necessary. Sections include; 'Factors influencing the course and outcome of labour and birth', 'Indications for caesarean section', ' Breech presentation', 'Vaginal birth after caesarean', 'Emergency caesarean', 'Elective Repeat Caesarean', 'birth and postpatum'. A glossary of medical terms used is at the back of the book. This is an excellent reference book for responsible prospective parents, childbirth educators, midwives, G.P.'s, obstetricians and other obstetric 'co-workers'. Published by the

International Childbirth Education Association
p o Box 20048
Minneapolis MN 55420
U.S.A.

Ruth Nicholson

The First International Conference
on

Home Birth

Wembley Conference Centre London
October 24th & 25th 1987

PRESS RELEASE

The Home Birth Conference will be an historic event. It will unite people from many different countries who are concerned about childbirth today.

Throughout the developed world, nearly all babies are born in hospital. More and more, this results in a cascade of intervention. Rarely does hospital provide the right conditions for normal physiological birth.

The view that hospital is the best place for birth has gone largely unchallenged. The time has now come to challenge it.

Home Birth has many advantages. If more women gave birth at home, it could improve the maternity services as a whole. For those women who do not give birth at home, it is vital to bring more of the qualities of home into hospitals.

The Home Birth Conference is for all who wish to reconsider the modern way of birth and explore alternatives for the future.

Speakers will include:

Suzanne Arms	(USA)	Sheila Kitzinger	(UK)
Janet Balaskas	(UK)	Gerrit-Jan Kloosterman	(Holland)
Rahima Baldwin	(USA)	Michel Odent	(France)
Beverley Beech	(UK)	Wendy Savage	(UK)
Carole Eliott	(Australia)	Beatrice Smulders	(Holland)
Caroline Flint	(UK)	Lee Stewart	(USA)
Ina May Gaskin	(USA)	Marsden Wagner	(W.H.O.)
Yehudi Gordon	(UK)	Melody Weig	(UK)
Suzanne Houd	(Denmark)	Luke Zander	(UK)

Together with speakers from other European countries and the Third World.

An audience of 3,000 is expected. Following the conference, there will be a week of workshops.

Full details of the Conference programme, including papers by the leading speakers, will be made available nearer the time.

Conference Fee (meals excluded):
General public £25; Professionals £45; Unwaged £15.

Booking information and tickets are available from the Conference mailing address below. Please include a S.A.E.

For more information, contact: Janet Balaskas 01-267-3006
or Beverley Beech 0753-652781
or Melody Weig 01-677-9746
or Judy Graham 01-485-0095/267-512

iling Address:
e Birth Conference.
Mount Nod Road.
ndon SW16 2LP

Conference Organisers:
(U.K.)
Janet Balaskas (Active Birth Movement)
Beverley Beech (Health Rights. A.I.M.S.)
Melody Weig (Independent Midwives' Association)

(U.S.A.)
Rahima Baldwin (Informed Homebirth)

Special Advisers:
(U.K.)
Sheila Kitzinger
(U.S.A.)
Suzanne Arms

about 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

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P O Box 183, Ruakaka, Northland.

SAVE THE MIDWIVES ASSOCIATION SUBSCRIPTION FORM
PLEASE POST TO THE SUBS SECRETARY, Lynda Schroeder, 27 Tanera Cres, Brooklyn, Wellington

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_____ PHONE_____

Midwife?_____ Mother?_____ Other?_____ NEW?_____ RENEW?_____

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BIRTHS

SAVE THE MIDWIVES ASSOCIATION

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THIS IS A NATIONAL ORGANISATION FORMED TO SUPPORT AND PROMOTE THE PROFESSION OF MIDWIFERY

ERRATUM

The article appearing in the last newsletter "Midwives Still Pushing For Recognition" reprinted from the November '86 Nursing Journal, was wrongly attributed to Anne McQueen. The paper was actually prepared and delivered by Carol Hosken at the ICM's Western Regional Conference in Jakarta, Indonesia. Apologies to Carol for our error.