SAVE THE MIDWIVES

21 SUMMER 89/90

CONTENTS

PAVING THE WAY FOR CHANGE:

Following the 91 submissions sent in on revision to the Nurses Act, the Minister of Health Helen Clark presented an amendment on Nov. 10th 1989 proposing to amend Section 54 (1) (2) so that registered midwives can assume responsibility along with medical practitioners. This when passed will apply to all midwives irrespective of where they practice, and means that each midwife will once again be able to take responsibility for her own practice. The rest of the Act will come up for review later in 1990.

It is now time to send in further submissions, as the Select Committee do not automatically receive the ones sent in before. It is therefore necessary to either send another copy of your submission to the Select Committee, or do another, covering the particular points pertaining to this amendment. It is very important to respond to this so it is seen that there is a strong demand for this legislative change from both midwives and the women of NZ. (Due date for submissions Feb 9th 1990)

Midwives Day was very successful, raising the profile of midwifery right around the country. The visits of Shelia Kitzinger and Ann Oakley offered both inspiration, and affirmation that we are making exciting progress. Many areas are now offering or planning a greater variety of childbirth options involving midwifery care in particular, with an emphasis on continuity of care and more choice for women.

This has been further endorsed by the Department of Health's Policy Recommendations for Care for Pregnancy & Childbirth on Safe Options for Low Risk Pregnancy which actually acknowledges that " pregnancy is a natural physiological function which, in the majority of cases will have a normal outcome ". (Copies from Health Dept.)

Henny Ligtermoet from the Midwifery Contact Centre in Western Australia has written to highlight the centenary of the natural childbirth pioneer Dr Grantley Dick-Read on January 26 1990. She has taught his program for 30 years and is convinced it is a superior method with better results than any other method. She feels strongly that his work must not be lost, and is attempting to have his well known film CHILDBIRTH WITHOUT FEAR put on to video.

Congratulations to midwives Michele Fill and Karen Guilliland on being successfully elected to the Waikato and Canterbury Area Health Boards respectively. Great news!

Congratulations also to Joan Donley for being awarded the OBE in the New Years Honours. Very appropriate and fitting to see both Joan and midwifery being given such recognition.

Judi Strid

New Zealand College of Midwives

National Conference — Women in Partnership
August 17 to 20, 1990, Knox College, Dunedin

Keynote Speakers (to be confirmed)

Dr. Marsden Wagner
Regional Officer for Maternal and Child Health, WHO

Chloe Fisher
British Midwife and Breast Feeding Specialist

Programme

Friday 17		Annual General Meeting (evening)
Saturday 18	***Consumerism***	Opening Ceremony, Cocktail Party (evening)
Sunday 19	***Midwifery***	Conference Dinner (evening)
Monday 20	***Feminism***	Closing Ceremony

Conference proceedings will be published after the Conference and be available for purchase from the College in November 1990.

Otago Region
P.O. Box 6243
Dunedin North

New Zealand College of Midwives *Journal*

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NURSES AMENDMENT BILL

Presently, an amendment to the Nurses Act 1977 is before the Select Committee. If this amendment is approved, registered midwives will be able to take responsibility for their own practice when attending pregnant & birthing women, instead of having to be supervised by a medical practitioner.

Submissions regarding this aspect must be sent to:
The Secretary
Social Services Select Committee
Parliament Buildings
Wellington

The following are those MPs making up the Social Services Select Committee.

Judy Keall	Chairperson
Don McKinnon	
Jenny Kirk	
Dave Robinson	
Jim Gerrard	
Kathy O'Regan	
Ven Young	
Donna Churnicliffe	Secretary Ph (04) 719-534

Assistance with submissions can be obtained from STM or the NZ College of Midwives. They must be sent in by 9 Feb. 1990. Speaking with the MP in your area is another way to gain support for midwives & to highlight issues of concern. Other aspects of the Nurses Act will be reviewed later in the year.

Hon. Helen Clark

This Bill will enable a midwife to take responsibility for the care of a woman throughout her pregnancy, childbirth, and post natal period. At present Section 54 of the Nurses Act 1977 makes it an offence for a midwife to provide a service unless a medical practitioner has undertaken responsibility for the care of the client.

The effect of the clause is to allow a registered midwife to undertake sole responsibility for the care of the patient in such cases. This places a registered midwife in the same position as a medical practitioner for the purposes of section 54.

In recent years there has been a consistent message from various groups and organisations that childbirth is a natural process, and that a woman should be able to choose to have a

midwife deliver her baby without the need for a woman to also be under the care of a medical practitioner.

Mr Speaker, in removing the restrictions on the practice of midwifery, it is essential that the safety of the woman and baby remain paramount. I am confident that such safety will be maintained because registered midwives are competent to undertake the more independent role proposed.

Having a baby is not an illness. It is a normal physiological process that for generations was viewed as such. With the advent of medical technology, there has been a trend towards treating pregnancy and labour as an illness. This has resulted in an increasing amount of medical intervention in the management of normal pregnancy which has led to the erosion of the midwives' role. This has proved to be both costly and in many cases inappropriate.

The care that a midwife is qualified to give includes detection of abnormal conditions in mother and child. A midwife is ultimately concerned with the healthy, well woman, and is skilled in assessment and referral of women with complications to medical practitioners.

The midwife has an important role in the prevention of complications, and achieves this through education of the woman, and her family within the wider community. She is qualified to work in any setting, be that home, hospital, or community.

In conclusion, Mr Speaker, this Bill will allow qualified midwives to take responsibility for the care of their clients. It will encourage better utilisation of skilled health professionals. It acknowledges women's childbirth choices, makes the service more accessible, and maintains safety standards for mother and child.

DIRECT ENTRY MIDWIFERY UPDATE

Final results of 1988 DE questionnaire (includes late replies)

The Save The Midwives Organisation with the assistance of a financial grant from the McKenzie Foundation distributed a questionnaire in 1988 as part of a study to assess the feasibility of establishing Direct Entry Specialist Midwifery Training Programmes in New Zealand.

691 replies were received, including replies from individuals, midwives, nurses and organisations. The replies indicated a strong support for Direct Entry, both from women wishing to participate in this form of training, and from those who support its availability as a training option. We would like to take this opportunity to thank all those who participated.

Total Responses - 691

85% (585) were unhappy about midwifery training

80% (551) believe that midwifery is separate from nursing

95% (654) would like to see midwives recruited to meet special cultural needs

88% (607) agree that an autonomous midwifery profession is essential for a high standard of midwifery care

96% (661) agree that midwives are essential in the preparation of positive parenting

80% (554) strongly urge the establishment of a 3yr Direct Entry midwifery course, to be available in accessible areas

61% (107/175) would apply for a DE course, if available

57% (99/172) would have done a DE course had it been available (331 answered both sections of Q7)

HAVE YOUR SAY ABOUT DIRECT ENTRY TO MIDWIFERY

The Save The Midwives Direct Entry Midwifery Task Force, in conjunction with the Carrington Polytechnic School of Health Studies & with the endorsement of the NZ College of Midwives invite you to comment on a **Discussion Paper and Draft Proposal** for a Direct Entry Midwifery Course.

If you would like to receive a copy of this 32 page document, please send a self addressed & stamped envelope (long 40c size) to:

Judi Strid
Save The Midwives
Direct Entry Midwifery Discussion Paper
RD 3
Wellsford

(All STM members will receive a copy automatically)

DATES TO REMEMBER

* **FERTILITY ACTION COURSES ON WOMEN'S HEALTH ISSUES** - Auckland
  Course 1 commences 15 Feb (6 Thursday evenings)
  Course 2 commences 29 March (6 Thursday evenings)
  $100 for 1 course or $180 for both - Educ.College,Epsom Ave.
  Contact: Fertility Action,PO Box 46148,Herne Bay (09)780 357

* **DRAGON BOAT FESTIVAL** - Auckland - March 4th
  St. Helens Hospital Auckland have a team entered in this.

* **INTERNATIONAL WOMEN'S DAY** - March 8th

* **BREASTFEEDING AWARENESS WEEK** to show Breast Is Best March 29
  Contact: Jackie Gunn - ATI or Betty Jenkins - National Womens

* **COMPLEMENTARY MEDICINE & HEALTH LIFESTYLE FAIR** - 31 March
  Students Union Building Cafe, Auckland University

* **THE HEALTH PROMOTION FORUM OF NZ ANNUAL CONFERENCE** April'90
  Theme: Working Together - Health as a Social Movement
  Contact: Kim Conway,c/-Community Health Dept.Auckland Univer.

* **1990 NZ NATIONAL HOMEBIRTH CONFERENCE** - Whangarei
  Calling for ideas and input, suggestions, fundraising etc.
  Contact: Agnes Hermans - 24 Pah Rd, Onerahi, Whangarei

* **1990 NATIONAL NURSES FORUM** - Victoria University, Wellington
  May 18-20 Theme: Partnership in Health - The Future Is Now
  Contact: Nursing Educ.& Research Foundation,PO Box 2128,Wgtn.

* **AUSTRALIAN 11th NATIONAL HOMEBIRTH CONFERENCE** - May 19-21
  Adelaide. Theme: "Unity In Birth"
  Contact: GPO Box 703, Unley,South Australia 5016 (08)3394195

* **INTERNATIONAL WOMEN'S DAY FOR PEACE & DISARMAMENT** - May 24th

* **NZ COLLEGE OF MIDWIVES BIENNIAL CONFERENCE** - Aug 17-20 1990
  Knox College - Dunedin (AGM on the Friday night)
  Enquiries: Conference Cmttee. NZ College of Mws, Otago Region
  PO Box 6243, Dunedin North. (Calling for abstracts/ideas)

* **INTERNATIONAL CONFEDERATION OF MIDWIVES 22ND INTERNATIONAL CONGRESS:** October 8-12 1990 Kobe, Japan
  Theme: " A Midwife's Gift - Love, Knowledge and Skill "
  Enquiries: ICM International Congress, Nursing Association International Relations, 8-2, 5-Chrome Jingumae,Shibuya,Tokyo
  (or to NZCOM Board of Management, PO Box 21106, Christchurch)
  Deadline on abstracts - Jan 31st 1990

* **EARTH FIRST EXPO** - Avondale Racecourse and Showgrounds
  Oct 18-22 1990. Contact: PO Box 8371, Symonds St. Auckland
  To celebrate the spirit of co-operation between the different cultures which now make up the NZ community in the search for better ways of co-existing with each other & the natural environment on which we ultimately depend.

* **FOURTH INTERNATIONAL CONGRESS ON WOMEN'S HEALTH ISSUES:**
  14-17 November 1990 - Massey University, Palmerston North
  Theme: Women as Health Providers Within a Context of Culture, Society & Health Policy.
  Enquiries: Dept. of Nursing Studies, Massey University, PN.

* **AUSTRALIAN COLLEGE OF MIDWIVES 7th BIENNIAL CONFERENCE**- Perth
  16-18 September 1991 Theme: " Birthdays, Birthways "

* **2ND INTERNATIONAL HOMEBIRTH CONFERENCE** - 1992 Sydney
  Enquiries & Input: Jane Thompson,12 Thornton St.Fairlight,NSW

MIDWIVES

–are the women who help see our babies into the world on their way out?

Little Treasures Aug/Sept '89

by Maureen Thompson

Most mothers remember with warmth and appreciation the women who supported and attended them through the labour and birth of their babies. But how many know much about the profession and art of midwifery? How many realise midwifery is fighting for its survival in this country?

Maureen Thompson presents an impassioned plea for the cause of midwives as a profession in their own right. Such is Maureen's respect for midwives that she says that if she had her time again she'd "probably be a midwife". This time round though she spends her weekdays teaching and her weekends watching her three sons play sport. Prior to her return to the classroom she had eleven years intensive involvement in Parents Centre and other community work.

Marg was the first midwife I ever met. She was on duty when we arrived at Howick Hospital with me in the early stages of labour.

Her welcome was warm and calming to our first-time nerves.

Over the next seven days Marg became my guide, my teacher, my friend and my "mother." She coaxed and comforted me through labour, and rejoiced with us in our successful birth. She bolstered my sagging confidence in my mothering with infinite patience, and I give her entire credit for getting me going with breastfeeding. Never once did she make me feel stupid, a nuisance or inadequate. When we left to go home she pressed a piece of paper into my hand — "phone me anytime, if you're worried" — she said, and I did.

Since then, in the course of my involvement with and interest in birthing issues I have met many more midwives and come to share their concern at the decline and devaluation of midwifery in New Zealand. We are not training enough midwives, we're not keeping the ones we've got, and our training programmes are under criticism from midwives themselves.

Struggle for Survival

Right now, midwifery in New Zealand is struggling to survive. How has this situation arisen? What will be the consequences for New Zealand families if midwives disappear from the childbirth scene?

For as long as there has been any kind of society there have been midwives. Even mentioned in the Old Testament, midwifery could legitimately claim to be the second oldest profession.

Women have always attended women in childbirth. In cultures largely unaffected by Western medicalisation this is still so.

But as science and medicine have grown in knowledge and expertise, and obstetrics became a speciality, so has the exclusive women-for-women relationship declined in birthing.

It was more than just science that brought about the change. Fashion and status were party to the swing to male-managed birth in the days when doctors were almost exclusively male and if you could afford a doctor to attend your wife's birth your social status was enhanced.

The village midwife who attended layings-in (and layings-out) was losing ground in the face of "progress." In colonial countries such as New Zealand her decline was hastened by the radical change in social structure. Whole generations of young women lost, by migration, the traditional support of the older women in the community for their childbearing time. Maori women too, were losing their traditional whanau support as they moved into towns and sought or were encouraged to adopt pakeha ways. As nursing gained status after the Crimean War and the lead of Florence Nightingale, training became established. Hospitals, too, were viewed in more favour with the development of antiseptics and better management of infection.

Birth was moving into hospital and midwives with it.

In 1904 New Zealand set up a Midwives Register. The following year the St Helens Hospitals were established for the training of midwives and to provide low cost maternity care for the wives of working class men. Soldiers' wives were cared for free of charge.

However status played its part again. New advances after the War meant women could be offered sedation — the twilight sleep — with a specialist in attendance, then everyone wanted it too. Midwives were taking on more the role of helper rather than the primary birth professional. The doctor was in charge.

Loss of Status

Midwives have steadily lost status in New Zealand. A major factor has been the change in training. The St Helens hospitals were the backbone of the on-the-job training system, where student midwives worked alongside experienced midwives, as well as spent time in the classroom. But in 1979 this all changed. Midwifery training was moved to technical institutes. It lost its separate status and became combined with the Advanced Diploma of Nursing. Basic midwifery has been combined with post graduate study. Women wishing to do midwifery must leave their jobs to do the Diploma and finance themselves through that year.

Not surprisingly the average number of trainee midwives per year has dropped to one sixth of the number prior to the change to technical institute training. Add to this the normal reduction in number due to retirement, travel overseas, maternity leave and so on, and we face an alarmingly bleak future for the profession, and for New Zealand mothers.

New Zealand requires its midwives to be registered nurses first, doing midwifery as post-graduate study. Overseas, in Britain and Holland for example, women wishing to be midwives can train specifically and solely for this under a direct entry programme. These overseas courses range from three to five years in length. The New Zealand technical institute training in midwifery is measured in weeks, being only part of a 40-week diploma course.

Ironically, direct entry (overseas trained) midwives are refused work here on the grounds of insufficient qualifications, and New Zealand institute-trained midwives are similarly refused employment overseas for the same reason.

It's becoming harder to become a midwife at a time when we need them more than ever.

The World Health Organisation's definition of a midwife is ... "a person who is qualified to practise midwifery. She is trained to give the necessary care, supervision and advice to women during pregnancy, labour and the postnatal period, to conduct deliveries on her own responsibility and to care for the newly born infant. This care includes prevention measures and the detection of abnormal conditions in mother and child, the procurement of medical assistance, and the execution of emergency measures in the absence of medical help.

"The midwife has an important task in health counselling and education, not only for parents, but also within the family and communities. The work should include antenatal education and preparation for parenthood and extend to certain areas of gynaecology, family planning and child care."

We need Midwives

Given this role description we can see how far reaching the influence of midwives can be in the community.

They are ideally trained to tutor expectant parents in childbirth preparation classes and run antenatal clinics in hospitals and in the community. Midwives are valuable for visiting mothers and new babies at home, following up both normal and difficult births. Midwifery experience is valuable for Plunket and district nurses. They are needed in gynaecological wards, in delivery suites, in postnatal wards, and caring for premature and sick infants.

"Flying Squad" emergency teams, rural communities, and large urban obstetrics units are enriched with the midwives' special skills.

Women couldn't give birth at home without a domiciliary midwife.

Midwives can train new midwives, and new doctors, about normal birth.

The face of obstetrics as we know it would change dramatically if it weren't for these dedicated women.

Midwives see their role as one of support, to advise and coach a woman through her pregnancy and labour in such a way that the woman spontaneously delivers her healthy baby herself. They do not view the pregnant, labouring or newly delivered woman as a patient in the throes of an illness. Birth, while being hard work, is none the less what women are designed for. Our bodies are not placed under abnormal stress by birth — reproduction is our biological destiny. The countless millions of the world testify to nature's efficiency in this matter!

For women unfortunate enough to be in the

minority whose births need medical intervention (and they are a minority), midwives are needed even more to preserve as much as possible of the normal birth, for the sakes of both mother and child. Difficult births with high levels of medical intervention can be a predisposing factor for postnatal depression and difficulties in mother/child bonding.

Only domiciliary midwives in New Zealand are able to maintain their total role in birth, although a doctor must attend the birth itself. The domiciliary midwife establishes her relationship with the mother early in the pregnancy and continues her contact well into the postnatal time.

Job Satisfaction

Midwives in the smaller obstetric units, which are attended by G.P.s, have a reduced role from the homebirth midwives but still maintain close mother/baby contact, following through from admission in labour to discharge of mother and child. In the large base hospitals midwives may stay in the one section all the time, not following through with the women. So although midwives may attend a woman at all stages, they will be different on each floor with no continuity of care.

With numbers declining, both in training and with natural attrition, it is clear positive steps must be taken to ensure the continuance of the profession.

Firstly it is important for us as consumers to recognise and appreciate what midwives mean to childbirth. Midwives should be valued for their unique and special skills, by us, by the medical profession and by themselves. The status of midwifery as a profession needs raising. Training new midwives is particularly crucial.

A new option for training has been implemented this year whereby a registered nurse may take a separate midwifery course. Because these courses are not involved in the Advanced Diploma of Nursing the courses needn't be tied to centres where technical institutes are situated. This will mean greater accessibility for those wishing to undertake training. The Diploma course will still be available for post graduate study for practising midwives.

While this move, will be of some benefit we will still be lagging behind European countries and their standards of training. Perhaps we should also be looking at a form of direct entry training—entrants could share a first basic nursing training year with other general nurse trainees, then branch off to specialise in midwifery for another two years.

'With Women'

Midwives have a special affinity with women. The very word, Anglo-Saxon in origin, means "with woman". They are an indispensible and essential part of obstetrical organisation.

I've finished my childbearing but I would want other women to have the opportunity to share their birth experiences with women like Marg. Her calm manner, gentle hands and quiet confidence epitomised a midwife. Let's hope we continue to see many more like her beside New Zealand birthing beds.

Midwife lobbies MP over changes to law

with Rosemary Roberts

Advocate 15.11.89

Midwives produce better birthing experiences for healthy women than doctors because they approach birth as a natural and normal "health" experience rather than a medical crisis.

This was the message given Whangarei MP John Banks by domiciliary midwife Lynley McFarland when she spoke to him about legislation now before Parliament which proposes to allow midwives to operate independently without the supervision of a doctor.

The legislation, in the form of two amendments to the Nurses Act, went to the House last week.

Under the present Nurses Act it is illegal for anyone to carry out obstetric nursing unless responsibility has been taken by a medical practitioner. Offenders can be fined up to $1000.

Asked by Mrs McFarland if he had an opinion on the issue, Mr Banks said health was not his field and he would vote with the National party.

However, he did not know what its stance was and advised her to contact National's spokesman on health, deputy leader Don McKinnon. It was reported last week in an Auckland newspaper that the party supports the amendment.

Mr. Banks said two Whangarei doctors had told him they were against the legislation, since they said midwives did not have the necessary qualifications and experience to take full responsibility for birthing.

Mrs McFarland pointed out that midwives were already taking birthing responsibility as some 50% of all babies born in hospital, excluding Caesarian births, were delivered by midwives.

A doctor's training was not what was needed for effective midwifery — "We don't want that," she said.

Practising midwives in New Zealand had had at least five year's nursing training — 3½ years general or comprehensive training, which included obstetric nursing, a year's practical work and a year's specialist midwifery training, she said.

Trainee doctors did a six-month obstetric diploma after leaving medical school.

Both general practitioners and midwives immediately called for specialist care where there was any abnormality or the pregnancy appeared to be high-risk. Midwives were at present doing exactly this sort of assessing in hospital situations, and taking a good deal of responsibility for birthing, she said.

Mrs McFarland told Mr Banks she did not think many midwives would wish to operate independently outside the hospital system, nor would there be a huge demand for their services, and GP's should not fear that their livelihoods would be threatened by the proposed legislation.

"Doctors are eminently more suitable for doing 'the fancy things' in an emergency and that is really what their role is," she said.

"We support birthing as a normal healthy process for most women, and statistics here and overseas show that midwives produce better birthing experiences for healthy women."

Mrs McFarland works for the Northland Area Health Board on its "domino" birth service, under which the midwife gives pre-birth care, visits the mother-to-be at home, attends at the birth in hospital, and at home afterwards for post-natal checks. Mother and baby stay in hospital only a few hours. Mrs McFarland also does some home birth work.

● Introducing the legislation, Health Minister Helen Clark said 85% of births in New Zealand did not need medical intervention, but with the advent of medical technology there had been a trend toward treating pregnancy and labour as an illness.

"This has resulted in an increasing amount of medical intervention in the management of normal pregnancy which has led to an erosion of the midwives role.

"This had proved to be both costly and in many cases inappropriate," she said.

□ Lynley McFarland, domiciliary midwife.

The telephone rings at 3 am.

It is cold and raining, but Sian Burgess gets out of bed and into the car.

The Welsh-born midwife sometimes wonders why she does it, but once at the house where the birth is to take place, "the light switches on, so to speak."

"It has never failed to be exciting."

After working in Europe, Thailand and East Africa, the 36-year-old has been delivering babies in New Zealand homes for nine years.

An increasing number of women are opting to give birth at home.

"Birth is a lot less complicated than it is made out to be," she says.

"If things ever go wrong, the signs are obvious very early.

"As a hospital charge nurse I might be looking after 10 to 12 women at one time, and wouldn't notice as early."

Of 88 babies delivered in 1988, only four involved a transfer to hospital.

Sian Burgess continues to visit the mother for two weeks after the birth, and often develops lasting relationships with families.

Living in Mt Albert, she travels throughout greater Auckland at all hours of the day and night, even to the Waitakeres, where tiny Sian Cottrell-Davies was born two weeks ago.

"It totally disrupts my private life, but that is what you take on. It is just great."

News

Boys and their toys

Sir,—Rather than bemoaning the closure of St Helens, energy should be directed towards demanding more community-based midwifery services. Many women are discharged from hospital within a few days of delivery and the follow-up midwifery service they get (unless visited by a home-birth midwife) is seriously inadequate, with hospital-based midwives attempting to visit as many as 18 women in one day.

At the same time there should be provision of a home-help service for women who do not have enough support at home in those first few exhausting weeks, either after a home birth or an early discharge.

Your correspondent Ann Clark states that women at 18 weeks of pregnancy have a scan and talks of queues for scans or paying $75 for a private scan.

The World Health Organisation is against routine scans, recommending that they be done only when really necessary. Women with sure dates which match clinical findings do not need scans, especially as there is no conclusive evidence that scans are totally harmless.

So the imminent closure of St Helens is not to blame for bigger scan queues. Blame the boys and their dependence on their technological toys for wasting time and money doing countless, unnecessary routine scans.

Mary Hammonds.
St Johns. HERALD 12-10-89

Clark wants women to have say

HERALD 29-8-87

The Minister of Health, Helen Clark, wants women from all professions to have a say on health services.

At a meeting of the New Zealand Medical Women's Association at the weekend, Helen Clark said more women needed to get behind health matters.

Women used a large percentage of health services in New Zealand and they should have a say in how the services are administered, she said.

"The emphasis should expand from reproductive and family-oriented matters," she said. "We need to develop a consensus to make sure women have their say."

Helen Clark hopes that through the new area health boards women will be heard and the boards will respond to their needs.

"The area health boards are there to promote public health. And the main way they can do that is to look to the community and respond to their health needs."

Through the new Ministry of Health and the area health boards, women would get services they were comfortable with.

"And that can only be achieved through consumer and community involvement."

Midwives' role

Sir, — Three cheers for a return to normality. How refreshing to see that midwives are once again being recognised for their true worth in terms of work and skills, and that human birth is actually possible without the omnipresent male doctor hovering by ready to interfere at any moment that he chooses to. I would like to register a particular vote of confidence in domiciliary midwives. Both our sons were born at home because of the courage of my wife and the skills and confidence of the midwife concerned. As pay equity is now an issue that the Minister of Health wishes to push, maybe she would like to address (or redress) the pittance that these midwives earn and, let us face it, they are saving the public health system considerable sums of money. Birth is an issue that men should play very little part in, in terms of control and decision-making. Doctors will, no doubt, greatly resent the loss of power and control they still desperately wield in the birth process, but let us see this control return to the hands of women, where it more properly belongs. — Yours, etc.,

B. KENNEDY.
November 12, 1989.

Midwife bill 'still-born monster'

Star-Phoenix 22-6-89

QUEBEC (CP) — A provincial bill aimed at allowing midwives to help deliver newborns in selected hospitals over the next five years was blasted Wednesday as a "still-born monster" by the president of the Quebec Corporation of Physicians.

"It's a premature bill which doesn't stand a chance of surviving," Augustin Roy said.

"It smacks of sheer political opportunism," said Roy, who accused Health Minister Therese Lavoie-Roux of running roughshod over Quebec hospitals.

"There's only one hospital which accepted the pilot-project proposal and that only if it's legal and doctors also agree to it," an angry Roy told reporters.

The bill, tabled by Lavoie-Roux on Wednesday, provides for the creation of up to eight midwifery pilot projects, which must be located in a hospital or premises adjoining a hospital.

Hospitals which are involved will have to set up a separate maternity-care unit and form a council of midwives which will be responsible for supervising the work of the midwives.

Roy said he believes midwives are not necessary because Quebec obstetricians already are doing a fine job.

Henri Favre, president of the association representing Quebec hospitals, said the bill is "unacceptable" and would provoke "real destabilization of perinatal services."

Favre said he is not categorically opposed to the idea of allowing midwives in hospitals but stressed that the bill could lead to "confrontation and a struggle for power."

Lavoie-Roux said Quebec is the first province to table such a bill.

She said she did not know which hospitals will get the pilot projects but mentioned she would like them spread throughout the province.

Although the bill will die on the government's order paper when the legislature session ends this week, Lavoie-Roux said she expects it to be automatically retabled in the fall.

Midwives win right to deliver babies alone

By Simon Collins CDT 10-11-89

Midwives have won the right to deliver babies without the attendance of doctors for the first time since 1971.

A simple two-clause amendment to the Nurses Act, introduced in Parliament yesterday, will give mothers an alternative to what Government backbenchers described as the present "medical model of birth".

The bill, introduced by the Minister of Health, Miss Clark, was warmly welcomed by the Opposition spokeswoman on women's affairs, Mrs Katherine O'Regan.

"Many of our mothers would have been delivered at home in this country by midwives who were well respected in the community and knew their skill very well," she said.

"As we see a closure of maternity hospitals under this Government, choices are narrowed for many women, and they may turn in due course to home delivery."

Mrs O'Regan said she trusted midwives to know when a doctor should be called in.

Under the present Nurses Act, it is illegal for anyone to carry out obstetric nursing unless responsibility has been taken by a medical practitioner. Offenders can be fined up to $1000.

But Miss Clark said 85% of births in New Zealand did not actually need medical intervention.

"Having a baby is not an illness," she said.

Mrs Judy Keall (Govt, Glenfield), said the women of New Zealand wanted to claim back childbirth as a natural process.

The Opposition health spokesman, Mr Don McKinnon, said his party supported the bill, but asked whether midwives should be allowed to take swabs and prescribe drugs.

Miss Clark said the bill would not change the normal work of midwives, which included taking swabs but not prescribing drugs. This would remain the work of a doctor.

The bill was referred to Parliament's social services committee for public hearing of submissions.

New Zealand Herald Service

Homebirth champion now OBE

Herald 26-12-87

Until last night Mrs Joan Donley had not told any of her family and friends she was on the New Year Honours list.

"I feel very honoured," she said, "but I also feel a bit shy."

Mrs Donley, of Mt Albert, Auckland, has been appointed an OBE for her services to midwifery.

Regarded as something of a homebirth champion, she has delivered 679 babies in homes around Auckland since she became a domiciliary midwife in 1974.

She has written a book on attitudes to birth in New Zealand as well as numerous educational articles and papers for journals.

Mrs Donley founded the New Zealand Home Birth Association, the Domiciliary Midwives' Society and the New Zealand College of Midwives.

Her appointment as an OBE, she said last night, was "recognition for midwifery and for the role of midwives."

For many years "midwives nearly went into a state of extinction," but she said that was no longer the case.

Mrs Donley, aged 73, said she was not as busy as she used to be, because more domiciliary midwives were practising in Auckland now.

The new year promises to be busy for her, however, with many midwives on leave and a number of due babies on her books. The first is expected on January 8.

Mrs Donley with her 679th home delivery, one-month-old Jerome Webby. PICTURE: GLENN JEFFREY

Home births: a woman's right to choose

SIR, Kapiti Coast women at least have a local doctor prepared to attend home births. Other local doctors will not take on home births on advice from Wellington Women's Hospital professor, John Hutton. (Post, April 5).

The reason: Professor Hutton believes "the more requests for home births, the bigger the threat to Paraparaumu Maternity."

Surely health services are supposed to reflect the needs of the community? Women have the right to choose where and how their babies are born. Deciding to have your baby at home does not necessarily mean you are anti-hospital. I see it as an affirmation of a women's ability to cope with one of the most important events in her life.

It is hard to describe what this means in reality. I had a home birth four months ago and am still "on a high". My self-esteem has been raised and this has had a positive effect on my relationship with my partner and family. Everyone comments on how alert and content our baby is.

Opting for a homebirth meant I had a midwife who provided continuity of care. The same person looked after me during pregnancy, supported me in labour and provided care for me, the baby and the rest of the family for two weeks after the birth.

Professor Hutton's advice to Kapiti doctors not to take on homebirths makes me think he has not really learned from the recent National Women's Hospital inquiry — that is, the issue of whether the women concerned or her doctor is in control.

While I understand that not all women can or want to have a homebirth, I believe that women have the right to choose.

THEA ROORDA
Petone

Home birthers get GP

By PHILIPPA LAGAN
Kapiti Coast reporter

Paraparaumu home birthers have achieved "a major breakthrough" this week, Kapiti Coast midwife Mary Garner said.

She was contacted at the weekend by a local doctor who offered to attend home births in the area on a year's trial basis.

Ms Garner said this was a "first" in the three years she had worked on the Coast.

Until now it had been a "no-go situation" for Kapiti women wanting to have their babies born at home, but the arrangement was still unsatisfactory.

"What happens when the doctor goes on holiday or the year is up?"

Also, the doctor stated certain conditons — complicated pregnancies and first pregnancies would not qualify.

Nevertheless, demand for home births was on the increase. Ms Garner said she covered the area from Porirua to Levin and already had 30 bookings for this year. Some women even swapped homes with Wellington friends for a while so they would not have to give birth in a hospital setting.

But she was disappointed about the number of women who missed out on home births because they were not vocal enough or up to fighting the system.

"I get very angry at the extra stress this situation puts on pregnant women."

Mrs Michelle Orchard, of Waikanae, was determined to have her third child at home, after an unpleasant hospital experience.

She said she had a "really bad time" and was annoyed about how she was treated in hospital.

When she told her doctors she wanted to have a home birth their negative attitudes made her depressed and "worn out."

"Eventually you start to believe that maybe you are irresponsible and stupid wanting to have your baby at home."

She got so frustrated that she actually "went it alone" and had her son last July at home, without a doctor or a midwife.

However, her husband rang Ms Garner after the baby was born and she arrived immediately.

Although she had an uncomplicated birth, Mrs Orchard felt she should not have had to give birth without any medical support.

Mrs Orchard said she was forced to "pretend" through her pregnancy that she intended to give birth at hospital, in order to get medical ante-natal care.

Although Ms Garner was permitted to deliver a baby in an emergency, if she planned to carry out deliveries she would have to deregister which would remove her medical status.

Consequently, she could not take haemoglobin or blood tests — critical at the time of a delivery.

She said the Home Birth Association knew of about 15 reasons why local doctors refused to deliver babies at home, and none concerned the women. They were about ethics, overstepping boundaries or professionalism, she said.

Waikanae doctor Clive Cameron said he was happy to assist at home births as long as there were no medical complications and the family support was good.

But he was not keen to get involved in Paraparaumu and Raumati as he imagined he would be swamped with requests.

Paraparaumu doctor Fiona Millard said she sympathised with the women but local doctors acted on advice from Wellington Women's Hospital Professor John Hutton.

Professor Hutton said doctors were free to do as they liked but the issue was a "numbers" one.

The more requests for home births, the bigger the threat to Paraparaumu Maternity, which he wanted to keep open.

About 110 babies were delivered each year at Paraparaumu but if the number fell below 100, he would have serious reservations about supporting the hospital.

"Also, the board [Wellington Hospital Board], in light of its financial circumstances, would be likely to turn around and say, "What the hell are we doing trying to keep this unit open?"

But Ms Garner disagreed, saying the number of women wanting home births was too small to pose a threat to the hospital's future.

She said the association supported the hospital and wanted it to stay open.

"Kapiti women are just unlucky because they believe there should be a choice about how their babies are born but the doctors do not believe in a choice." Professor Hutton said Kapiti was too small an area to support both home births and a maternity unit.

"One will have to go."

He said he discouraged fellow obstetricians from planning deliveries on the Coast because of the impracticality.

Time was a crucial factor in births, so doctors had to live near where they worked.

Midwives and mothers celebrate

() The two midwives who will be offering the domino option, Lynley McFarland, left, and Feliz Barnett, far right. With them are Jane Scripps of Whau Valley with daughter Anna, and Julie Aperahama of Ruakaka with daughter Jardena beside Ms Barnett.

At the launching party of the new service, Mrs McFarland said: "We know from our experience how much good birthing influences our ability to cope as mothers.

"We have seen how well women in New Zealand can give birth at home, partly through having the support of midwives they know.

"This new service will give women who would still like a hospital birth some of the same benefits, through the continuity of care."

Party launches domino option

Northern Advocate 16.9.89

It was a good party. Some of the guests slept, some ran squealing round the car-yard chased by a boy with a toy gun and some lay under the tables eating muffins and sandwiches.

All around the grown-ups, mostly women, were in a quietly jubilant mood celebrating the official start of a new service with a name like the title of a Robert Ludlum novel — "The Domino Option".

A New Zealand first, domino is a contract arrangement between the Northland Area Health Board and independent midwives to provide a short-stay hospital birth with continuity of care before, during and after the birth.

Domino is an acronym of the words "domiciliary (home) in-and-out".

The arrangement caters for women who do not want a home birth but who wish to spend as short a time as possible in hospital, and be attended throughout by someone they know rather than a variety of personnel on shift work.

As in home births, midwife and mother get to know each other at pre-birth domiciliary checks. The same midwife stays with the mother during labour and birthing in hospital and later makes post-natal home visits following the early discharge.

The first practitioners are Lynley McFarland, formerly afternoon supervisor on the base hospital's obstetric ward, and Whangarei's domiciliary (home birth) midwife, Feliz Barnett.

Both have signed "a domino contract", under which they may use the hospital's delivery suites.

It is similar to a general practitioner's contract, except that the Department of Health pays doctors for delivering babies, and the board pays the independent domino midwives.

But just to complicate things, the department pays for the midwives' domiciliary care — not the board.

It adds up to the same free service that all women having babies in New Zealand are legally entitled to.

Mrs McFarland currently has about six clients and hopes eventually for a case-load of about 10 a month.

Ms Barnett will continue to deliver babies at home, topping up her case-load with "dominos", and the two women will provide back-up support for each other.

Formalities were minimal at the very informal lunch party, held at the Hearing Association rooms in Whangarei.

Mrs McFarland read a telegram from the New Zealand College of Midwives sending "warmest wishes and congratulations to consumers and all concerned on the success of their lobbying which has resulted in achieving New Zealand's first official domino scheme".

Women were working all around the world for better birthing facilities, she said, and many were concerned at the increasing drive toward intervention in birth.

In England Caesarians had increased from four to 11% of births, and in New Zealand from the same level to about nine per cent.

She thanked the area health board for making the contract possible, and its women's service development group, the Home Birth Association, the Parents' Centre and others who lobbied for the service.

The board's medical officer of health (head of community health services) Dr David Sloan, welcomed the contract which he called "an important and sensible arrangement".

A few women had already taken advantage of the service, and two of them at the party both said the domino option had suited them very well.

Leanne Rouse, mother of a toddler and a new baby, was in hospital for six hours before the birth, and went home three hours afterward.

Eileen Reynolds, mother of five, said it was a joy having a midwife she had got to know previously, with her throughout labour and birth. While she might have wanted to stay longer in hospital if she had been a first-time mother, she was delighted to return quickly to her own family with her new baby.

—— Rosemary Roberts

Midwives sign contract

ODT 2.11.89

By Joelle Thomson

A new contract between the Otago Area Health Board and the Dunedin Domiciliary Midwives Collective has given the midwives rights to use hospital facilities and equipment previously unavailable to them.

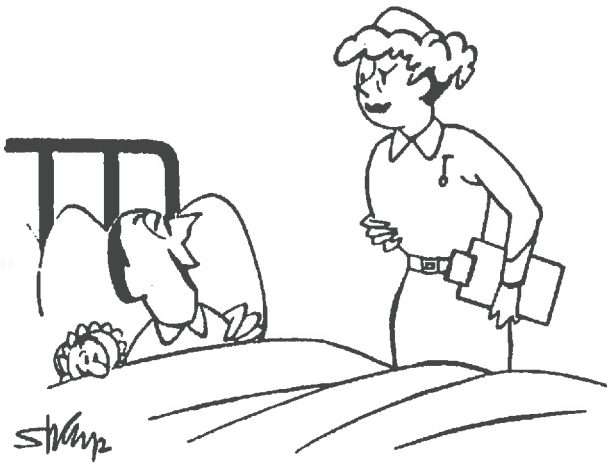
The contract was approved at the beginning of September, midwives collective member Sally Pairman said yesterday.

Intravenous equipment, monitors and the availability of an anaesthetist were among the facilities the midwives were now able to use.

Some doctors might not have realised the new contract existed, but the midwives and good relationships with the doctors they did work with, she said.

The move had "really opened the door for midwives to have their own clients", and was probably the beginning of increased independence for midwives to practise without the supervision of doctors, Ms Pairman said.

Under present legislation doctors must be present at deliveries, but they are giving increased responsibility to midwives.

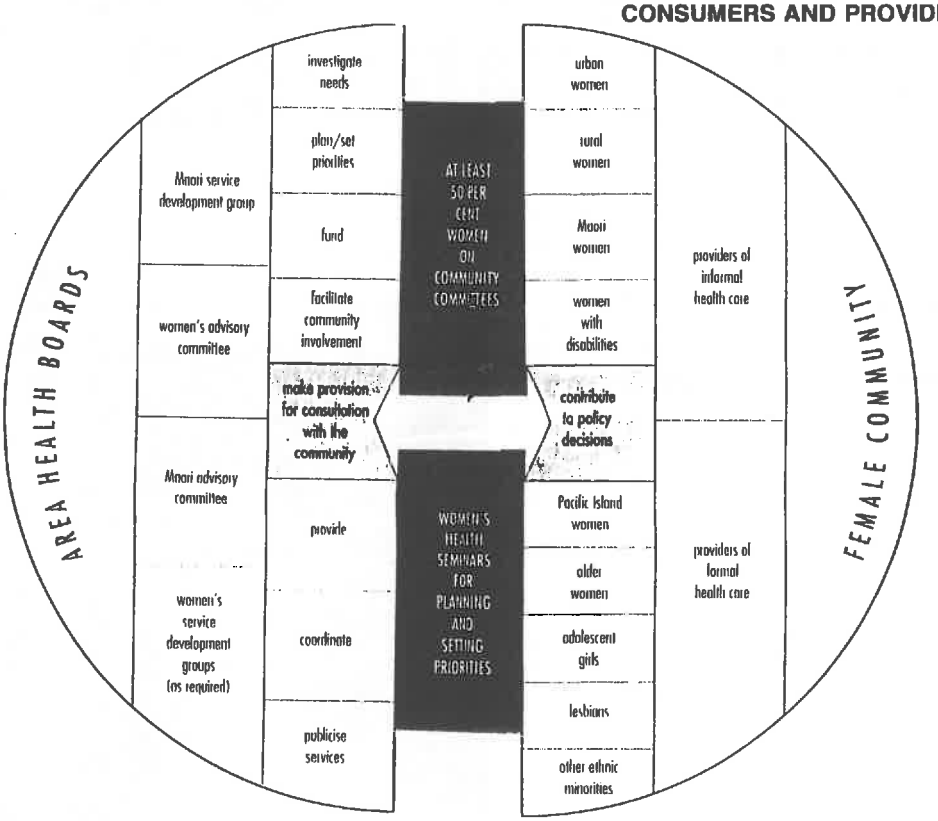


"My wife had to go back to work today!"

Think Women's Health

The Ministry of Women's Affairs

PARTNERSHIP BETWEEN AREA HEALTH BOARDS AND WOMEN HEALTH-CARE CONSUMERS AND PROVIDERS



FIVE BASIC QUESTIONS

When presented with a policy proposal, there are five basic questions which Boards should ask to find out whether the policy is going to affect women positively:

- What direct involvement have different groups of women (providers and consumers) had in the development of this proposal?
- What impact will the policy have on the well-being of women in the area?
- What impact will the policy have on Maori women?
- What implications does this policy have for equal employment opportunities as required under the Area Health Board Amendment Act 1988?
  Under the Area Health Board Amendment Act 1988, the board is required to be a 'good employer'. The general manager must establish an equal employment opportunity programme. It is the board's responsibility to monitor this programme. With an EEO programme operating efficiently, there will be women with a woman's perspective on health in key policy-development jobs.
- What involvement will there be by different groups of women in the further development of this policy proposal?
  Input may be provided by women in the community (Pakeha, Maori/iwi authorities, Pacific Island, representatives from other ethnic groups) or by women employed by the Area Health Board, for example, nurses. The key requirement is that they have an understanding of how the health system can be made more effective for women, and that their own practical experience is recognised and taken into account in the planning and implementation of any significant policy proposal.

LYNDA WILLIAMS... DOING WHAT COMES NATURALLY

Lynda Williams' new job, as patient advocate at National Women's Hospital, has a familiar feel. After all, she's been doing something similar — unpaid — for several years. Leigh Parker reports.

N.Z.W.W. DECEMBER 11, 1989

LYNDA Williams believes in destiny. She says her appointment as patient advocate at Auckland's National Women's Hospital was meant to be.

In August last year a friend phoned Lynda telling her to read page 173 of the cervical cancer inquiry report. That page outlines the role of the patient advocate Judge Silvia Cartwright recommended for National Women's.

"My friend said to me: 'Read it — it's you'," recalls Lynda. "So I did and I realised she was right — this was something I'd been working towards for the past 10 or 12 years without realising it. I felt very strongly that it was my job."

Lynda immediately posted her job application to the director general of health George Salmond — eight months before the job was advertised. When it was advertised, she revised her original application and resubmitted it.

"Even though I heard there were 47 other applicants, I still felt very clear that this was my job and all my previous experiences and everything I'd been doing in women's health had led me to this point."

A mother of four, Lynda has worked as a childbirth educator teaching private antenatal classes since 1980. She has been actively involved in women's health issues, working for Fertility Action part-time and as a member of the Auckland Women's Health Council since its formation.

"At times I felt concerned that so much of my work and energy was on a largely unpaid basis," she says. "But at other times I felt very clear there was something up ahead that all this work was for."

And she was right. On September 13 she became the first patient advocate at National Women's and only the third in the country. (Two patient advocates have been working at Auckland's Kingseat Hospital since the beginning of the year.)

She is independent of the Auckland Area Health Board and is responsible to Dr Salmond until a health commissioner is appointed later this year.

Lynda isn't new to advocacy. She has been doing the same thing unpaid for several years. She explains: "I used to get calls from women outside my antenatal classes asking me for help and information. I had also become increasingly involved in birth support for women where I'd go in and ensure the couple were able to give birth to their baby without unnecessary intervention or influence from hospital staff.

"Those are the sorts of things I've been doing for the past three or four years anyway but now I'm doing it full-time and getting paid for it."

She also feels she's now doing it from a position of more status and power. "When I was a childbirth educator I didn't have much clout. Now I do."

Although it's early days yet, after only a short time in the job Lynda has become aware of issues she intends to tackle.

One is the right of women to have their babies with them in the recovery room after having a caesarian section. Lynda is concerned that women are being separated from their babies in some cases without good medical reason.

She is finding that issues, which at first appeared quite simple, are in fact complex. "I can see how, in an institution like this, the rights of the patients it's meant to be here for get lost in other kinds of issues, such as staffing, which start to assume more importance than the needs of individual women."

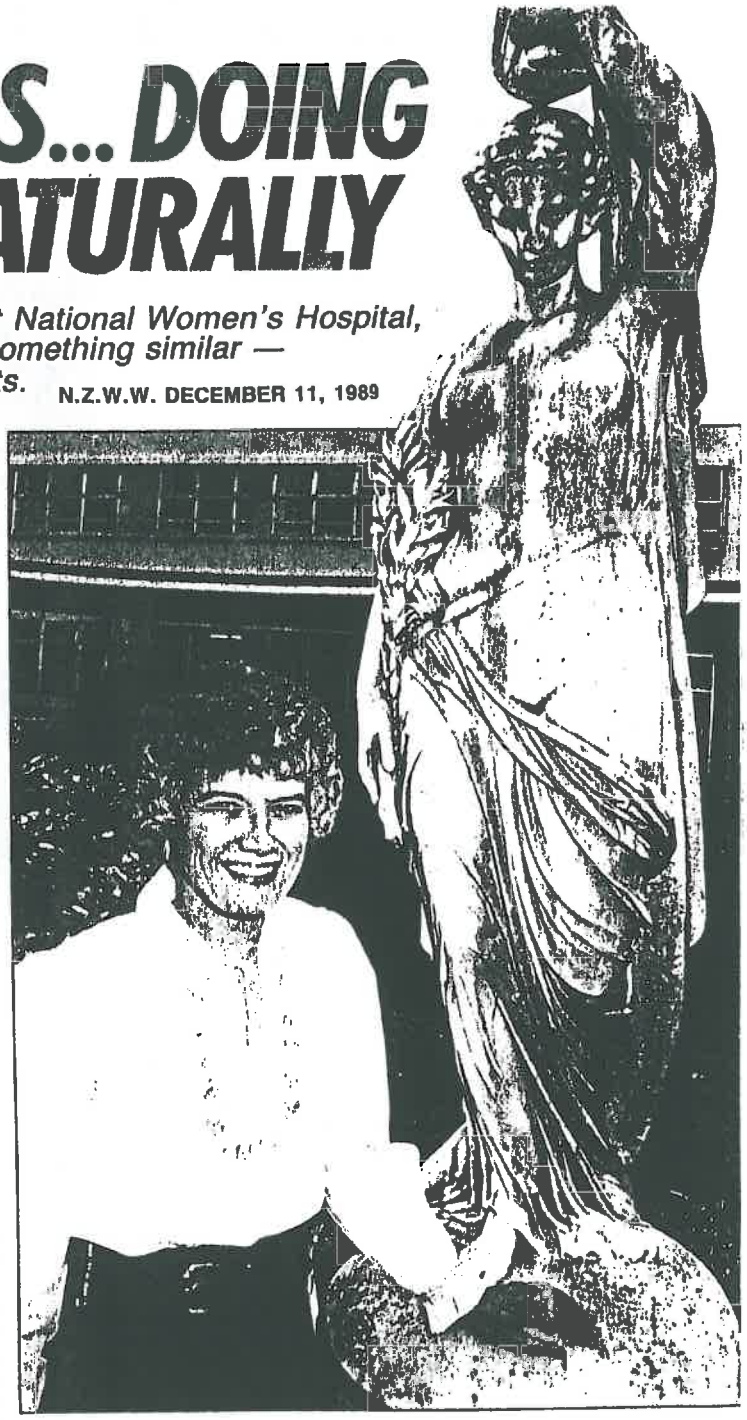
Lynda says there's a big need for interpreters in the hospital and for more written information to be printed in languages other than English.

She'd like women to know it's their right to have copies of their medical notes. She'd also like all women to be offered a copy of their delivery notes when they leave hospital; they can then read them to understand what happened during labour.

Lynda has also been dealing with patients from other Auckland hospitals. She receives many calls from people outside National Women's asking for help on accessing their medical records and asking about the procedures for making a complaint.

She believes there's a real need for a maternity hotline, similar to the hotline run during the cervical cancer inquiry, so women can ask questions about their pregnancy and birth experiences.

Lynda attended a recent public lecture by British pregnancy guru Sheila Kitzinger at which question time was dominated by



ABOVE: New patient advocate Lynda Williams outside National Women's Hospital in Auckland ... "I can see how, in an institution like this, the rights of patients ... get lost in other kinds of issues such as staffing."

ABOVE RIGHT: Lynda believes there's a need for a maternity hotline and counselling for women who have had bad birth experiences.

RIGHT: Pregnancy guru Sheila Kitzinger ... Says Lynda Williams: "I find it appalling that we have to have someone come from overseas so women can ask questions about the things that happened to them during birth."

Photographs: Michael Gillies.

personal questions. "I found it appalling that we have to have someone come from overseas so women can ask questions about the things that happened to them during birth."

Another need is counselling for women who've had bad birth experiences. Lynda has been trying to meet this need but doesn't really have time.

"I see my role as working on issues like access to information and protecting the rights of women in hospital. If I get completely tied up dealing with individuals all the time, we're going to need a dozen patient advocates here."

She has had a positive response from most staff and patients. Most of the feedback comes from staff members and Lynda feels it will take time before all patients are aware of her role. But she is confident word will spread.

She feels a little daunted at the tasks which lie ahead. "It's early days yet but already I've had glimpses of what seems to me to be a tidal wave of pressure and I feel like turning and running.

"But at other times I feel really confident that I can handle it and I look forward to being joined by other patient advocates and forming a network."

Patient advocates are needed in all major hospitals because of the way the public health system works, she says.

Lynda has a support group of five people that meets fortnightly to discuss issues. She sees the support she gains from the group as vital.

She says National Women's is probably more aware of patient rights and information issues than other health services because of the cervical cancer inquiry.

Changes are being made which will ensure nothing like the "unfortunate experiment" that led to the inquiry will happen again and women are also more aware of the kind of care they have a right to.

Lynda is conscious of some residual bad feeling in the hospital from the inquiry and some hesitation and anxiety among staff about her role. Because of her involvement in women's health issues, Lynda thinks many people only know her by reputation. She believes that when they meet her they will realise she — like them — wants what's best for women.

Lynda says attitude changes are still needed at National Women's.

Women are vulnerable when in hospital so health care providers have to ensure they don't abuse the power they have. A good example, she says, is with obstetricians, some of whom wrongly believe they are the baby's advocate.

"If you disempower women like that by separating their needs from their baby's needs you have a recipe for disaster. Women must leave this hospital empowered by the experience of having given birth."

Lynda will continue to teach childbirth classes and offer support to women during birth. She will also continue her work with the Auckland Women's Health Council.

In fact, she says, nothing has really changed except she's now doing the job full-time and getting paid for it. "I really see this job as just an extension of everything I was already doing."

Midwifery and Nursing: Apples and Oranges

By Frances Cowper-Smith

The international definition of midwifery was jointly formulated and endorsed by the International Confederation of Midwives, the International Federation of Gynecologists and Obstetricians, and the World Health Organization fifteen years ago. It is quite unequivocal the midwifery is unique and distinct from other professions.

By contrast, no international definition of a nurse has ever been agreed upon. This is because the role of nursing is a constantly shifting one, expanding and contracting, moving into new areas and away from others. However, nurses are very much aware that the profession still needs to be understood and agreed upon. This is why the International Council of Nurses has adopted a definition of "the unique function" of the nurse, described by eminent American nurse academic Virginia Henderson(1):

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.

This makes explicitly clear that nurses help people who, for lack of strength, will or knowledge, cannot function independently. The prime responsibility of the nurse is to help the sick, or potentially sick, patient with his daily living activities and/or with those aspects of care he would normally perform without assistance: breathing, eating, elimination, rest, sleep, exercise, hygiene and keeping the body warm and properly clothed.

Henderson also describes the nurse as being "part of the medical team." Today, as ever, the medical team is directed and supervised by a physician, whose own function is defined as "diagnosis, prognosis and treatment (of illness)." In addition to assisting the patient, the nurse, as a major part of her work, carries out the instructions and directions of the physician.

The female mammal has evolved to reproduce the species by pregnancy and childbirth. All mammals, including humans, perform these functions best with minimum interference. This unassailable fact is borne out time and again by evidence that, left alone, at least 80 per cent of pregnancies proceed normally to a satisfactory outcome: a healthy baby and mother. There is also more somber evidence which which shows that babies who are at some risk in utero are also the least able to withstand the onslaught of obstetric interventions (Tew2). By examining birth outcomes, using figures previously unavailable to the public, Tew was able to show that babies at high risk had a far better chance of a healthy outcome to the pregnancy if attended by a midwife or general practitioner outside of hospital than do those babies at low risk where the pregnancy was in the care of obstetricians in hospitals.

Nature is not perfect: not every pregnancy will proceed to a normal outcome. This is true regardless of the place of birth and the choice of birth attendant. In British Columbia in 1986 there were 465 perinatal deaths (perinatal mortality rate (PMR) 11.11/1000 live births occuring between the 28th week of pregnancy and the seventh day following birth). Internationally agreed criteria in perinatal audit indicate that approximately one-third of all perinatal deaths are preventable. In B.C. this would mean 155 preventable perinatal deaths occurred in 1986, almost all of which took place in hospital under the direct supervision of physicians.

We also know that obstetric intervention rates in B.C. are among the highest in the industrialized world. In 1986, the cesarean section (CS) rate in B.C. was a staggering 21 per cent (excluding other instrumental deliveries, such as forceps and vacuum, which are likely to be in the same range). The World Health Organization has repeatedly stated that no country or state anywhere in the world should have a CS rate over fifteen per cent. Some European countries now have rates of around seven percent, with lower perinatal mortality rates. It has been estimated that the dollar saving alone from reducing the CS rate in this province to seven percent would be $17.5 million a year (Wagner3). The World Health Organization states that the best perinatal services and outcomes are those where there exists a strong, independent counterbalance between midwives and obstetricians, and has observed that those countries where the PMR and intervention rates are lowest are also countries which have a strong, self-regulating midwifery profession.

The time surrounding childbirth is a time of intense vulnerability for the woman and her baby. This is why, down through the ages, pregnant women have sought the services of a skilled, sympathetic atten-

dant who is in tune with both the physiological and psychological processes; who is proficient in the art and science of being with a woman in childbirth; who is able to provide knowledgeable advice, loving support, and skilled supervision of both mother and baby; who is competent to recognize risk factors and deviations from normal; and who has the means to consult with medical colleagues, procure medical assistance when necessary, and institute emergency procedures.

It is not surprising that pregnant women still seek a midwife in places where they are not provided by the official health services. Consumer demand has kept the midwifery profession alive. However, consumers choosing a midwife in B.C. do so at some risk. They know that their midwife is practicing outside the present law, and this puts stress on both midwife and family. Although the Midwives Association of British Columbia consists of qualified midwives who practice within guidelines for safety and quality of care, clients have no way of being assured in any official way of the competency of their midwife. This is not the midwife's fault, but that of the system. Clients are at further risk if choosing a midwife as their birth attendant (especially if they choose home birth) precludes, or reduces the chances of fast referral to an obstetrician if risk factors or emergencies occur. Some women are deliberately put at increased risk by those physicians and hospitals who deny support services to the midwife and her clients.

Those of who are committed to the legalization of safe, autonomous, self-regulating midwifery services in British Columbia are convinced that what the government needs now, to push them into taking the plunge for recognition and legislation, is a massive "Yes" to midwifery from consumers. Physicians are intelligent people, and will be able to understand that their role has to change. They can no longer monopolize and control childbirth, but they could share with midwives the joys and challenges of safe midwifery, and appropriate obstetrics. British Columbia still has the opportunity to create the strongest, safest, most valuable midwives on earth. We could be the envy of the world.

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Reprinted from ***The Midwifery Task Force Journal***, Volume II, Number 1, January 15, 1989.

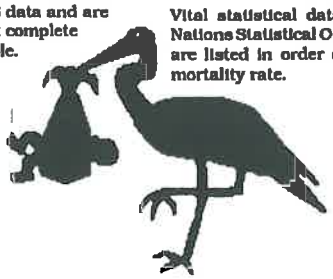
Infant Mortality & Ratio of Health to Military Spending

(Infant mortality = Deaths in First Year Following a Live Birth)

World Rankings by Infant Mortality		Military	Health	Ratio Health to Military
1. Japan	5.2	103	474	4.6
2. Finland	5.8	174	598	3.4
3. Sweden	5.9	386	1,114	2.9
4. Switzerland	6.8	362	902	2.5
5. Hong Kong	7.7			
5. Netherlands	7.7	304	631	2.1
7. Norway	7.8	420	914	2.2
8. Canada	7.9	309	855	2.8
9. Denmark	8.2	275	665	2.4
10. France	8.3	421	676	1.6
11. West Germany	8.6	359	891	2.5
12. Iceland	8.7	92	384	4.2
13. East Germany	9.2	392	235	0.6
14. Singapore	9.4	420	121	0.3
15. United Kingdom	9.5	470	470	1.0
16. Belgium	9.7	274	514	1.9
17. Italy	9.8	187	406	2.2
17. Australia	9.8	369	606	1.6
19. Austria	10.3	112	430	3.8
20. United States	10.4	1,002	674	0.7
21. Spain	10.9	117	224	1.9
22. New Zealand	11.2	155	396	2.6
23. Israel	11.4	1,604	208	0.1
24. Greece	12.3	308	156	0.5
25. Cuba	13.6	136	66	0.5
26. Czechoslovakia	13.9	252	329	1.3
27. Bulgaria	14.5	199	198	1.0

* These are 1986 data and are the most current complete statistics available. They were published in the December 1988 issue of Pediatrics.

Vital statistical data from United Nations Statistical Office. Countries are listed in order of 1986 infant mortality rate.



Childbearing in hospital

SIR, As a midwife I am conscious that any "maternity care message pushed" (The Post, Nov 1) must be accurate.

I can understand the concern of Hutt Valley doctors as they see a known and valued community service replaced by something foreign to their experience.

I surmise their concern relates to the welfare of the women who will use the maternity services of the Hutt Health District.

Whatever the reason, getting it wrong is inexcusable, particularly when one consequence must be an increased anxiety among the childbearing women of the area as they are used as pawns in a political game.

No one in New Zealand is entitled to a hospital stay of a legally specified length. Contrary to popular opinion, previous custom is not enshrined in statute. In the section of the Social Security Act relating to the payment of maternity benefits one reads that "all necessary medical and nursing attendance, maintenance and care" will be eligible for the benefit "for a period of 14 days succeeding the date of birth of [the] child."

This allows for professional judgments relative to a woman's need.

If no such medical or nursing need is identified it is questionable whether the health service can or should provide "hotel" services.

As many women can attest, even in today's straitened climate it is possible to stay in hospital well beyond 14 days if the legitimate need for care exists.

The process of childbearing is normal — for the greater number of women.

For this group the principal requirements following birth are the opportunities to rest, recover, initiate successful infant feeding and establish a healthy relationship with their baby.

Hospitals may never provide the ideal setting in which to achieve these goals but it certainly does not require skilled medical decision making to help the woman decide when she is ready to go home.

Care providers and consumers of the maternity services must take a broad view of what is needed and what is achievable in the context of the realities of the 1990s.

Only then can the services be reshaped to the best advantage of all who use them.

MAUREEN LAWS
Houghton Bay

CATHERINE WILLIS

"DIRECT ENTRY MIDWIFERY"

Catherine has been active in the area of Maternal and Perinatal Health for a number of years.

As a prospective student of a direct entry midwifery course, Catherine has been active in promoting this type of education model.

She is coordinator of the Direct Entry Midwifery Establishment Committee, and has contributed several submissions to inquiries related to the provision of maternity care, eg Review of Obstetric Services in NSW, NH&MRC enquiry into Homebirth, Women's Health Policy Review.

This paper supports the introduction of a direct entry model of education for midwives whereby students would not be required to complete training in nursing before entry into the program. It argues that the present situation of restricting entry into the education programs for midwifery to those who hold a nursing qualification is inhibiting the process of professionalization and is preventing midwifery from realizing its full potential as an independent profession. It argues that maintaining this system of education amounts to condoning the nursing profession's monopoly over midwifery. Further it suggests that allowing such a monopoly to continue threatens professional autonomy, encourages the practice of lay midwifery and compromizes the focus of delivery of care from mother centred care to institutional centred care.

The consequences for midwifery of limiting selection and restricting experience in training are far reaching for the profession.

Fundamental to a consideration of the nature of the midwifery profession in Australia is the issue of qualification for practice. Qualifications reflect how a profession sees itself, its degree of independence from other professional groups and its intrinsic feeling of autonomy (Ontario Report 1988). Prerequisites for eligibility into a course, the content of theoretical and practical material and the mode of presentation of this material all reflect the standard a profession has set for future graduates. Further, by establishing a model of practice through training, it reflects the direction in which the profession is to progress. Through this control over the type of graduate produced the process of education will influence the rate at which change will occur within the profession.

This paper critically evaluates midwifery education as it exists today in Australia. It suggests that the profession must reconsider its educational strategy for the future and immediately consider the introduction of direct entry training as an important step in the professionalization of midwifery.

EDUCATION OF MIDWIVES TODAY

There are two models of midwifery education. One model requires every person who wishes to study midwifery to obtain an education in nursing first and is referred to as nurse midwifery. The other model permits a person to study midwifery without prior education in nursing. This model is often referred to as direct entry midwifery (DEM). Although up till 1965 in NSW and earlier in other states both models operated, the model universally adopted in Australia today is nurse midwifery.

Contemporary concern about the future of midwifery training follows upon the high rate of attrition of newly qualified midwives (Grant, 1988). It has been demonstrated that there are large numbers of graduates from nurse midwifery programs who never practice in the profession (Barclay, 1985). Studies of the career intentions of recent nurse midwifery graduates demonstrate that many midwifery students never intended to practice midwifery (Golden, 1980; Robinson, 1986). In Australia the tradition seems to have developed that nurses complete the midwifery course in order to gain further qualification or to maximize opportunities for promotion into another career structure e.g. administration of teaching (Barclay, 1985). This alarming rate of wastage in training brings the adequacy of nursing as the primary selection criteria into serious doubt.

Without exception in Australia midwifery schools train midwives to be hospital midwives. Because experience beyond the hospital is at the discretion of the course organizers, this means that midwifery students might complete a training program with no experience of midwifery practice in the domicillary situation, in community health clinics or in private practice. The realities of the profession are however, that there are increasing requirements that the midwife be a reflective, independent and critical learner/practitioner (Grant, 1988) and that care be given according to a woman/family centred model of care and not from institutional centred care model. Midwifery programs as they exist today are not preparing the graduate for the realities of all areas of midwifery practice [as outlined by the International Confederation of Midwives (ICM) and the World Health Organization (WHO)] and therefore cannot be regarded as comprehensive. This was recognized in the recent review of maternity services in NSW which calls for a comprehensive review of the theoretical content and practical training of 'midwifery/nursing' educational programs (NSW Department of Health, 1989).

With the inevitable move of midwifery training towards Colleges of Advanced Education or amalgamated universities, midwives have an opportunity to reassess the direction and rate of change of education strategies and through this influence the future direction of the profession. It is necessary therefore to examine more closely the relationship between education, the profession and professionalization.

Education, professions and professionalization

The process involved in changing from an occupation to a profession is known as professionalization (Carr-Saunders, 1966). There are certain characteristics that are seen by most writers to be common to all professions. These are a systematic body of theoretical knowledge; a professional authority over the field of competence; community approval or sanction for the specialist domain; and a code of ethics focusing on service to a particular clientel. We can therefore use the concept of the degree of professionalization of an occupation according to the presence and strength of these characteristics (Boreham et al, 1976). Each profession will vary in its degree of professionalization.

Clearly, midwifery has many of these characteristics already. There are professional associations at both a state and national level; there is a long history of the practice of 'being with woman' and of women healers (Ehrenreich and English, 1973); there is recognition of the role of the midwife by official organizations such as the World Health Organization and the community alike; there has been a long established code of ethical practice and now a developing accreditation system for independently practising midwives. However it is on the issue of the systematic theory that the situation is not so clear.

Professionalization involves the establishment of the appropriate body of systematic theory or knowledge and the formal training of students in this knowledge (Carr-Saunders, 1966; Jackson,1970). The control over this dissemination process is implicit in the proces of professionalization (Boreham et al, 1976). The control over the education of midwives is firmly in the hands of the profession of nursing. Clearly the exclusive preselection of midwifery students from nurses, development of the midwifery syllabus by the nurses registration board, the development of graduate programs in the "nursing specialty of midwifery" strongly supports this claim. However the necessity, appropriateness and desirability of this relationship must be questioned in view of the goal of developing professional autonomy.

Nursing and Midwifery

Two recent developments on the international midwifery scene serve as examples of current moves within the midwifery profession and cast light on the complex relationship between nursing and midwifery.

In England since 1985 there has been a number of documents produced that discuss the education of nurses (Royal College of Nursing, 1985), the education of health professionals (English National Board,1985) and the improvement in the education of midwives, health visitors and nurses (United Kingdom Central Council, 1986). These documents made the education of midwives a live issue. They produced an overwhelming response from the midwifery profession in favour of separate and distinct competencies for midwives, maintenance of the present 18 month post registration education and support for development of direct entry training. As one commentator put it, midwifery sees itself as a "separate tree" rather than a "branch" (Scruggs, 1987). The direct result of the support for direct entry midwifery was a project commissioned to investigate and promote three year (direct entry) midwifery training (Radford and Thomas, 1989).

The report is an excellent resource which presents a discussion on the broad range of issues including the ideal and actual role of the midwife; the variety of options within the profession; on the sort of midwife who should be produced and the implications of this decision; appropriate prerequisites to gain highly motivated raw material for midwifery; the cost of developing and implementing direct entry training and curriculum areas necessary to support the projected aims of the profession.

The second major development internationally occurred in Canada in 1986 when the Ontario Minister for Health created a task force to investigate the establishment of midwifery in Canada. This was an historic step as midwifery was not a legally recognized profession in any of the Canadian provinces. The report is a comprehensive and well reasoned examination of midwifery and its possible contribution to maternity care in Ontario. One of the recommendations of the report is that midwifery practice be recognized as separate from nursing and that the scope of the autonomous practice be based on that outlined in the ICM/WHO international definition of a Midwife. Another recommendation supports "multiple routes of entry" to midwifery education meaning the provision of four year university based direct entry degree and a shortened (12 - 18 months) diploma course for nurses. They go on to suggest that these two courses would be intregrated, and that there would be one provincial examination set for both streams (Ontario Ministry for Health, 1987). Both these examples are a strong statement that parts at least of the international midwifery community support autonomy for midwives and direct entry training.

In Australia as has already been pointed out, restriction in the preselection of students and in the content of the midwifery syllabus are universally practised. These and other restrictions have occurred gradually but have contributed to a nursing monopoly over midwifery. Other changes include the elimination of direct entry midwifery programs, and the elimination of the midwifery registration board and separate midwifery registers.

Despite the fact that directives of the European Community indicate a consensus among its member nations that both those who are nurses and those who are not can become equally well qualified midwives (Ontario Report 1987), Australia will not recognize any midwife who does not have nursing qualifications. Obviously there are many who see this nursing monopoly as appropriate and oppose independent education for midwives. For example, as a Head of a School of Nursing was once heard to say, "Direct entry midwifery will come into this college over my dead body".

The inevitable move of midwifery education into Colleges of Advanced Education or the amalgamated university system has precipitated interest in midwifery programs. So far however, initiatives have come from the schools of nursing and are generally suggestions for post graduate courses following a basic nursing degree. Such proposals do not risk confronting the issue of the relationship between nursing and midwifery and in fact would tie midwifery to nursing even more than it is already by preventing midwifery from becoming a separate identifiable profession educationally.

The Consequences

Despite strong evidence of both need and demand for direct entry midwifery in Australia (Willis, 1989), it is worthwhile speculating about the consequences of not strongly moving towards educational independence and professional autonomy as this may well be the course that the profession may drift towards.

Firstly, it can be expected that the erosion of the role of the midwife as the primary carer of the woman with a normal pregnancy will continue as it has over the last forty years (Robinson, Golden and Bradley, 1982). The organizaiton of care, in which services are primarily hospital based and midwives are assigned to work in a specific area, and not to care for women through pregnancy, delivery and the post partum period is responsible to a significant degree for the narrowing of the midwife's role, the dimunition of her responsibility, leading to job dissatisfaction and high rate of attrition (Ontario Report, 1987).

Secondly the present trend in the use of alternative perinatal care including lay midwives and homes births will increase. Many women who practise as lay midwives feel drawn to the profession but cannot or will not undertake nursing training first. These midwives are serving a community demand for the provision of care based on a holistic approach, continuous care throughout all stages of pregnancy and a flexible and attentive attitude to the needs of the birthing woman.

Thirdly, the system of delivery of care will not be challenged from within so inspite of some cosmetic changes such as curtains in the labour wards and birth centres things will remain undisturbed. Midwives will continue to be educated to work in a medical system characterized by the domination by male obstetricians, where most babies are born in hospitals and where the extensive use is made of technology in antenatal care and a higher and higher percentage of pregnancies are classified high risk (Houd and Oakley, 1986).

It is fatuous to believe that a change in training and education alone will bring about the desired changes within the profession of midwifery (Newson, 1986). However it must be accepted that direct entry training is potentially a powerful instrument in shaping the future of midwifery as distinct from nursing (Grant, 1988) and in the development of the profession as a whole.

Support for direct entry in Australia is broad: the Australian College of Midwives Inc. has a policy that supports in principle direct entry training; there are members of the midwifery profession who do not consider nursing to be a necessary prerequisite for midwifery and a number of women who have expressed interest in undertaking direct entry training (Willis, 1989). There is a national organization known as the Direct Entry Midwifery Establishment Committee which prepares submissions presenting the case for direct entry and are pressing for the introduction of this type of training at educational institutions.

However the reality of the situation is that if the midwifery profession as a whole does not take positive steps, direct entry midwifery will not develop in Australia. The wheel does not have to be reinvented. There is now a considerable body of literature and a substantial ground swell of support.

It really comes down to whether midwifery in Australia is prepared to face the challenge and the responsibilities of full professional autonomy. The decision is yours.

Thanks to Karen Guilliland for supplying this paper which was delivered to the Australian College of Midwives Conf. in Darwin in June'89.
References available from STM upon request.

EVALUATING ULTRASOUND IN OBSTETRICS

This quote is extracted from an article which was originally adapted from the International Childbirth Education Association's (ICEA) position paper on Diagnostic Ultrasound in Obstetrics, March 1983.

ICEA makes the following recommendations with respect to the use of diagnostic ultrasound in obstetrics:

* Pregnant women should avoid ultrasound exposure unless there is a documented medical reaon for its use and/or disease is suspected. Pregnancy, as a normal physiological process, should not, by itself, constitute a medical reason of ultrasound exposure.
* Participation in an ultrasound examination must be vouluntary. Pregnant women should be specifically informed that the Doptone and electronic fetal monitor are both ultrasound devices. Written informed consent should accompany the use of electronic fetal monitoring.
* Ultrasound examination should not be withheld when there are valid indications af potential psychological and physical benefit. The desire of a healthy pregnant woman to know the baby's sex or "see the baby move" should not, by itself, be considered a valid reason for exposure to ultrasound.
* Before an ultrasound examination, expectant parents should be given information about the procedure; its benefits and known risks; gaps in knowledge about biological effects; alternative tests which might be done and their benefits and risks; how the test results will determine the course of care, and how the course of care will be affected if the test is not done.

The pregnant woman's partner (ie support person of her choice) should be offered the opportunity to accompany her during the scanning procedure to allay anxiety and promote family involvement. Pregnant women should be given the opportunity to view the untrasound screen during the procedure.

*Pregnant women should not undergo an ultrasound examination for commercial demonstration of equipment.
*Ultrasound examinations should be conducted and interpreted only by skilled personnel trained in ultrasound use and interpretation. The pregnant woman has the right to inquire about the training in ultrasonography of her physician and operators of the equipment. Physicians should be able to verify qualifications on request.
* Public health agencies and medical and scientific organisations have an obligation to publicise information on the biological effects of ultrasound, known risks, areas of uncertainty, and availability of guidelines for ultrasound use.

More women turn to home births

ODT 1-11-89

By Joelee Thomson

Home births are on the increase in Dunedin, according to a member of the Dunedin Domiciliary Midwives Collective, Ms Sally Pairman.

"A year ago we were averaging one home birth a month and we now average five," she said.

Out of 1184 babies born in Dunedin, 5% would have been home births, she said.

This figure did not include births in the province.

The Dunedin collective, which started a year ago, receives bookings and inquiries every week.

They were already booked into the New Year, Ms Pairman said.

She said home births seemed to be on the increase nationwide.

"I think women are beginning to see home birth as a safe choice for them."

ANN OAKLEY

WHO CARES FOR WOMEN?

Science versus Love in Midwifery Today

TO USE a fashionable phrase, midwifery today is "in crisis"[1]. In part, this is because the maternity services are themselves suffering from the cumulative effects of economic starvation, political neglect and enduring social inequalities, which serve to increase the burden of stress and ill-health carried by the health services and, of course, by society generally. The recent rise in the UK infant mortality rate may be a statistical freak, or it may signal a real effect of worsening social conditions[2]; at any rate, we cannot say that this is an era in which life for women and babies is getting demonstrably better. Recent changes in maternity leave provision, for example, mean that pregnant women in Britain have no universal, legally enforceable right to maternity leave; many of the hard-won benefits of the 1976 Employment Protection Act have been lost, and the qualifying conditions and level of payment imposed on British women are now more stringent than in any other European country[3]. Furthermore, while mothers' rights are being eroded and undermined in this and other ways, midwives themselves are having a difficult time. There are not enough of them, and the importance of their work in both hospital and community does not seem likely to be recognised by the new clinical grading structure. The dissatisfaction many midwives feel with this situation matches the lack of continuity of care about which many mothers complain; but the policy-makers appear to be incapable of adding two and two together and remedying this situation by increasing the opportunities midwives and mothers have to get to know one another.

Perhaps most sinister of all these developments, a series of legal challenges to the autonomy of particular midwives in the UK and elsewhere is effectively questioning the extent to which midwives can, in the 1980s, protect the interests of mothers and babies without being seen as meddlesome witches intent on emasculating the medical profession and damaging the moral fabric of society. Since some of the same issues are arising in these cases as were aired in the inquiry into obstetrician Wendy Savage's suspension[4], it is clear that the confrontation between the different groups of care-providers is also across gender lines (much as it was historically with the persecution of witches).

The Art of Obstetrics: gender (and other) divisions

In 1902 a doctor called Henry Garrigues published a book entitled *A Textbook of the Science and Art of Obstetrics*. Chapter 9 of Dr Garrigues' book is called "Midwives" and it begins:

In the city of New York more than one-half of the parturient women are attended by this class of helpers [i.e. midwives]. Most of them are Germans, Scandinavians or Italians by birth, and are employed chiefly by their own countrywomen, the American and the Irish women being too intelligent and well informed to avail themselves of these ignorant and uncleanly beings. . .

Even in European countries, where the pupil midwives are instructed in universities by the same professors who teach the students of medicine, where they have a course extending through years and where they, after having entered on practice, are under strict government control, even there constant complaints are being uttered in the medical press in regard to the inefficiency and shortcomings of midwives.

Midwives do harm not only through their lack of obstetric knowledge, their neglect of antiseptic precautions, and their tendency to conceal undesirable features, but most of them are the most inveterate quacks. First of all they treat disturbances occurring during the puerpery, late gynaecological diseases, then diseases of children, and finally they are consulted in regard to almost everything. They never acknowledge their ignorance, and are always ready to give advice. They administer potent drugs, such as ergot and opium. Their thinly veiled advertisements in the newspapers show them to be willing abortionists; and since they have the right to give certificates of stillbirth, who knows whether or not an infant's death is due to natural causes or to criminal manipulations?

Although an evil, midwives are, however, in most countries a necessity, in view of the fact that physicians would not find time to do the work needed; this does not apply to America, where there is a superabundance of medical practitioners. . .

The institution of midwives is a remnant of barbaric times, a blot on our civilization which ought to be wiped out as soon as possible.'[5]

The year Dr Garrigues' book was published was the year of the Midwives' Act in Britain, which obtained for midwives here a role and position which has for long been the envy of their transatlantic colleagues. There are certain critical assumptions in this quotation.

1. Midwives are ignorant and dirty, therefore their practice is dangerous.
2. Even trained midwives are incompetent.
3. Midwives are especially unscientific because they care for women and children's health generally.
4. Men know more about obstetrics than women.
5. Doctors know more about obstetrics than anyone else.
6. Obstetrics is a science.

Actually, Garrigues wasn't quite sure whether obstetrics is a science — he referred to it as "the science *and* art of obstetrics," but there was no doubt in his mind that it was superior to what midwives do, and that this superiority had something to do with medical expertise. He was not alone in this, for many medical men on both sides of the Atlantic had written, and were writing, similar kinds of anti-midwifery tracts.

We have here, in these assumptions of Dr Garrigues and others, a certain polarisation of concepts — words and their opposites which sum up the terms of a continuing debate about the occupational identity and unique contribution of midwives to the care of childbearing women. Figure I lists these concepts: on the one hand we have midwives, women, health, normality and so forth, and on the other we have obstetricians, men, disease, abnormality, science. These oppositions represent something that goes far beyond the domains of obstetrics and midwifery: we are talking about a very deep-seated cultural divide. However my argument is that the dilemma of all the various parties involved in the maternity services today — including the midwife, the obstetrician, the paediatrician, the mother, the baby, the father and not forgetting the policy-makers — their dilemma, our dilemma, is that we are trapped within this language of opposition, which is an intensely misleading language. As a consequence we are unable to

make any real progress in our understanding either of the processes involved in reproduction or of how best to help the key actors in the drama of childbirth — the mother and the baby.

FIGURE 1: Midwifery and Obstetrics: conceptual domains.

Midwives	Obstetricians	Emotion	Reason
Women	Men	Intuition	Intellect
Health	Disease	Nature	Culture
Normality	Abnormality	Feminine	Masculine
Art	Science	Community	Institution
Social	Medical	Family	Work
Subjective	Objective	Private	Public
Experience	Knowledge	Care	Control
Observation	Intervention	"Soft"	"Hard"
Practice	Theory		

The best way to explain this is to refer you to studies which in some way bridge this divide. One such is the work done by Richard Newton on life events — stressful occurrences — in the lives of pregnant women, and the relation between these and the risk of preterm delivery and/or low birth weight[6]. These studies found a clear association between pregnancy stress and the risk of these adverse outcomes. The point they are making is one about the *social* causes of an obstetric problem. Conversely, Klaus and colleagues' study[7] of the effectiveness of social support in labour makes a different, but related, point about the *prevention* by *social* means of obstetric problems. Their study demonstrates that providing social support during labour can have a powerful effect on the occurrence of problems and the need for medical intervention.

The message of studies such as Newton's and that of Klaus and colleagues is that the mind-body divide does not work as a model for explaining childbearing. The theory dominant in Western medicine that the body is an organism and that the functioning of particular bits of it can be explained by looking at functioning elsewhere in the body, simply does not fit the facts so far as childbearing is concerned. However the "body as a machine" model produces certain well-known analogies, for example the garage analogy according to which the doctor is a mechanic and the pregnant woman is a broken down Ford (or Mercedes, depending on her social class). The garage is the hospital, providing the tools necessary to fix the malfunctioning parts. An American magazine in 1926 contained the following obstetrical dialogue:

"But is the hospital necessary at all?" demanded a young woman of her obstetrician friend. "Why not bring [have] the baby at home?"

"What would you do if your automobile broke down on a country road?" the doctor countered with another question.

"Try and fix it" said the modern chauffeuse.

"And if you couldn't?"

"Have it hauled to the nearest garage."

"Exactly. Where the trained mechanics and their necessary tools are," agreed the doctor. "It's the same with the hospital. I can do my best work — and the best we must have in medicine all the time — not in some cramped little apartment or private home, but where I have the proper facilities and trained helpers. If anything goes wrong, I have all known aids to meet your emergency"[8].

Proponents of "natural" childbirth have also appealed to the idea of the garage. Here is Grantly Dick-Read in 1942, talking about women's increased efficiency at motherhood:

Since when have repair shops been more important than the production plant? he asks. *In the early days of motoring, garages were full of broken-down machines, but production has been improved; the weaknesses that predisposed to unreliability were discovered and in due course rectified. Today it is only the inferior makes that require the attention of mechanics. Such models have been evolved that we almost forget the relative reliability of the modern machine if it is properly cared for . . .*

The mother is the factory, and by education and care she can be made more efficient in the art of motherhood. Her mind is of even greater importance than her physical state, for motherhood is of the mind. . .[9]

Dick-Read has his metaphors mixed here: if motherhood is in the mind what is the mother doing in the garage? It is well-known that language embodies the interests of the user: in another medical field, Susan Sontag[10] has written about the military metaphors used by oncologists; and male fertility specialists apparently refer to the genetic material in human sperm as "nuclear war-heads"[11].

While the mechanical model of childbearing may appeal to the mechanics amongst us, it is not a good description of how it is in reality. In reality pregnant women are not ambulant pelvises, but individuals with minds, emotions and complex personal and social lives. So where did the model come from? And why is it still around today?

Science as Opposed to Love

The outline of the story is familiar[12]. First of all, Dr Garrigues was right in associating the role of midwives with the more general role of women as carers of the community's health. Throughout history and in all human cultures it has been predominantly women who have cared for dependent and vulnerable individuals, including children, the old, the sick and the disabled. Female midwifery fitted easily and logically within this overall caring function. Onto this traditional fabric was then grafted the new imprint of the emergent medical profession, which laid its claim to fame not on caring — with or without continuity — but on technical expertise: science as opposed to love. Or forceps and the lying-in hospital as opposed to the purely domestic art of "catching" babies at home. Dr Garrigues and others like him needed to argue that the practice of female midwives was dangerous and unscientific and that the status of midwives in society was low. They had to do this in order to get people to accept obstetricians, and they also needed to claim that obstetricians could work the wonders that midwives were not able to do. However, these claims were unsupported by scientific evidence. In the early 1900s, for example, obstetricians said they could prevent miscarriage, preterm delivery and toxaemia. These goals have yet to be achieved today[13].

Closer examination of the evidence, therefore, reveals a profound need for obstetrical self-defence. For example in 1913, in New York City, midwives attended 40% of all births but had only 22% of maternal deaths from sepsis. Physicians, with 60% of births, had 69% of the deaths. Although midwives may have attended some less complicated cases, they were also the only attendants for poorer women who are likely to have been in the worst general health[14]. In Europe as well as North America, introduction of the forceps — the major technical advance claimed by obstetricians — is likely to have increased rather than decreased mortality[15]. Some of the reasons for this are clear from the arguments of the early obstetricians. For example, Joseph DeLee, the American doctor who recommended the routine prophylactic use of forceps, described obstetrics in 1915 as "a major science of the same rank as surgery" and went on to assert that "even natural deliveries damage both mothers and babies, often and

much. If childbearing is destructive, it is pathogenic, and if it is pathogenic it is pathologic". In short, DeLee concluded that childbearing could no longer be considered a normal function; thus, in relation to it, "the midwife would be impossible even of mention"[16].

Between 1918 and 1925 in the States, when midwifery declined nationwide, infant deaths from birth injuries rose by 44%[17]. Perhaps fortunately, and certainly not coincidentally, when the first male midwives established instruction courses in England in the 18th century, the art or science of instrumental delivery was not taught to women (who paid lower fees for the course), only to men[18].

A common medical therapy in pregnancy and childbirth, for many centuries, was bloodletting. Iatrogenic haemorrhage was the treatment of choice for many complaints. Some doctors even bled women into unconsciousness as a remedy for delivery pain. Bloodletting, emetics and mustard plasters (for the feet) were recommended for toxaemia of pregnancy. Routine maternity care as practised by William Goodell, Professor of the Diseases of Women at the University of Pennsylvania in 1874, is described by historians Richard and Dorothy Wertz in the following terms:

When the patient came to the hospital, some days or weeks before delivery, she was put on a regular dosage of quinine, then a kind of all-purpose preventative. Each woman received drugs for constipation, headaches, and sleeplessness. When labor began, each received a cathartic and a bath. The staff then ruptured the amniotic sac, used forceps to expedite delivery, gave ergot when the head appeared, and hurried the expulsion of the placenta by pressing on the stomach. After cutting the cord and bathing the woman again, they gave her morphine each hour until she felt no more afterpains, and gave her quinine "until the ears rang"[19].

At the height of the anti-midwife phase, there *were* some medics who acknowledged the lack of scientific evidence against the midwife; some were prepared to say that women were safer in the hands of ignorant midwives than in those of "poorly educated medical men". However, according to one prominent and outspoken obstetrician in the early part of the century, "such a conclusion is . . . contrary to reason" and what reason dictated was that "the obstetrician should not be merely a male midwife but a scientifically trained man"[20]. In the early 20th century, obstetricians' desire to expand the influence and increase the status of their profession seems to have been the basis of their opposition to midwives. As a group, 19th century doctors were not particularly affluent. Though midwifery itself was not a particularly lucrative speciality, it was guaranteed income and, more important, it opened the door on family practice[21].

Midwifery and Witchcraft

The history of midwifery also tells us that there is a well-established historical connection between midwifery and witchcraft. It is worth noting a few points about this link. First of all, midwives were associated with witchcraft because not all witchcraft was bad — it was recognised that there were good witches and bad witches in medieval Europe. Another name for the good witch was wisewoman[22]. It is for this reason that the modern name for midwives in French is *sage-femme*. Secondly, the claim that midwives were bad witches was an important part of the Church and the State's attempt from the 15th century on to control both the role and the power of women, and to restrict the practice of medicine to the new university trained male medical practitioners. This is evident in one of the earliest preserved oaths made by an English midwife applying for a Church licence in 1567. After being questioned by the Archbishop of Canterbury — no less — and eight women (presumably experienced midwives themselves), the midwife had to swear that she would "not use any kind of sorcery or incantation in the time of travail of any woman" and would baptise every infant with pure, clean water, notifying the parish curate of each baptising. It is of interest that that same oath obliges the midwife to promise "to help and aid as well, poor and rich women" and not "permit or suffer that women . . . shall name any other to be the father of her child"[23]. Witnessing the biological connections of kinship systems was an important social function of the midwife.

In political terms witchcraft was, of course, also the very opposite of science. In line with this argument, efficient midwives were apparently particularly likely to be branded as witches. The tale of the midwife who in the eastern counties of England reached a confinement in an impossibly short time produced the answer that a broomstick was responsible[24] (is this the origin of the modern term "flying squad"?).

Science and the "Mastery" of Childbirth

The rise of obstetrics and its eventual dominance over midwifery was thus achieved in part by the argument that those who care for childbearing women can only do so properly by viewing the female body as a machine to be supervised, controlled and interfered with by technical means. Science, or reason, were given (are given) in support of this approach. Although the scientific basis of obstetrics was poor, doctors were committed to the "mastery of birth". In the absence of understanding, control and management were important — childbirth and women had to be "mastered". The masculine gender of this word is, for once, highly significant. The male role in obstetrics paralleled the male cultural role; socialised to be masters of their own fates, families and environments, it appears that the same kind of impulse possessed the men who first took over childbirth from those who traditionally cared for women — midwives.

Today the technological imperative in obstetrics remains dominant and continues to be problematic. Over the past 20 years the use of such technologies as induction of labour, electronic fetal heart rate monitoring, ultrasound, episiotomy and Caesarean section has risen; the accumulated evidence of randomised controlled trials has suggested that frequent and/or routine use of these technologies cannot be justified: nonetheless they continue to be used[25].

In part this is a problem that extends to the whole of medicine. According to a World Health Organisation report, the three most common criticisms of health care expressed today are: 1. that its benefits are distributed in a socially unequal way; 2. that it has harmful effects; and 3. that it is characterised by excessive technological intervention[26]. But the place of technology in maternity care is also a unique one, in that control and intervention versus a different attitude of watching and waiting — the prescription of normality as against the belief that childbearing is an inherently pathological process — is a division that has a unique professional representation in the form of two distinct groups of care-providers: the obstetricians and the midwives.

If technology is the obstetrician's weapon, what is the midwife's? What is a midwife anyway? According to the *Oxford English Dictionary*, the word midwife comes from middle English, "mid" and "wife" meaning "a woman who is *with* the mother at birth". More technical definitions also exist, stressing the importance of formal training and registration procedures:

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant[27].

This second definition, though it stresses the need for professional qualifications, also highlights the continuity of care provided by the midwife and her proper independence in delivering the baby — that all-important phrase — "on her own responsibility".

So midwives care for women and obstetricians control and master childbirth. If obstetric technology has been shown often to rest on weak scientific foundations, its *routine* use being neither effective *nor* safe, then what evidence is there for the effectiveness and safety of caring? What is the scientific value of love, if you like?

The Value of Caring

One way this question can be addressed is by reviewing studies of midwifery care, social interventions or "social care" during pregnancy. The best of these studies (scientifically speaking) are those that have been carried out as randomised controlled trials, because only studies with this design enable one to be confident that the groups of women on whom different "treatments" are tried are otherwise as similar as possible. To criticise obstetricians (past and present) for being unscientific places a particular responsibility on the critic to establish as soundly as possible the basis of any counter argument. There have been few properly controlled trials of midwife care — which is, on its own, an important observation. One of the few studies that have been done was published some time ago by Lilian Runnerstrom in the States. This compared nurse-midwifery care with care provided by obstetric residents for 4,500 women with uncomplicated pregnancies[28]. Runnerstrom found that nurse-midwives, compared with doctors, more often used no, or only inhalational, analgesia, their care was associated with shorter labours, a much lower operative delivery rate, a somewhat lower LBW rate and fewer complications in the puerperium. A second study, also American[29], was carried out in the mid 1970s in North Carolina: this found that nurse-midwives achieved a higher spontaneous delivery rate and less use of low forceps, or rather, that *mothers* cared for by nurse-midwives achieved more normal labours, with the midwives' help.

The third study is French and is interesting because its findings are somewhat more complex than the others[30]. Spira and colleagues, in evaluating a programme of domiciliary midwifery care, appeared to find that it added to the risks of childbirth. However, on closer inspection the data yielded the finding that socially disadvantaged women did benefit from home care; but those with medical risks did not. Furthermore, as Judith Lumley[31] has pointed out, the high rate of obstetric complications and cervical cerclage among the "home" group in this study, raises the possibility that the randomisation did not work as intended, so that these women were, in fact, a higher risk group anyway.

Although not about midwifery as such, the study by Olds and colleagues[32] looked at the effect on pregnancy outcome of home visiting nurses. During their visits, the nurses provided parent education and set out to enhance "the woman's informal support systems" (something which midwives often do). A central aspect of their approach was "to emphasise the strengths of the women and their families". Significant differences in favour of the home visited group were found for a mixed bag of outcomes including "awareness of community services" (a direct effect of the parent education, presumably), attendance at childbirth classes, discussions with family and friends of stress-related issues, paternal interaction with babies, smoking in pregnancy and the incidence of LBW — though this applied to the younger (adolescent) mothers only. Similar findings obtained in a smaller more recent study by Judy Dance in Birmingham, where a social support intervention was provided by linkworkers to pregnant Pakistani women[33]. The linkworker group experienced fewer medical problems in pregnancy, more happiness (and less unhappiness), shorter labours, less use of analgesia in labour, higher mean birth weight and fewer feeding problems.

The effectiveness of childbirth preparation in improving pregnancy outcome has never been scientifically proved, though it may of course have increased women's satisfaction, which is important. The very expectation of a pleasant delivery can affect the length of labour, as Nelson and colleagues[34] found in their Canadian study of "Leboyer" deliveries. Another study compared the effects on labour outcomes of prenatal education versus knitting classes versus nothing at all[35]. The prenatal classes contained fairly standard information about the anatomy and physiology of labour, pain medication, relaxation techniques, hospital organisation, etc. The knitting class included instruction in basic knitting techniques and "guidance in knitting a shirt for the expected infant". Results of the study showed that birth weight in the prenatal class group was lower than in the no class group which in turn was lower than among the knitters. Use of medication was, however, lowest among the prenatal class attenders and highest among the knitters. Such results are very likely, of course, to be mediated by women's attitudes to knitting. There is a study of the effect of music on fetal activity which demonstrates precisely this: that it is not music *per se* that affects the infant's prenatal activity, but whether or not the mother likes the music being played[36]. The use of Barry Manilow as a childbirth analgesic is only effective if the mother likes Barry Manilow in the first place!

Social Interventions

Some social interventions consist of reorganising the pattern or the location of care so that it becomes more satisfying to the mother. A Scottish study[37] involved a comparison of care provided in a peripheral community, as opposed to a centralised hospital, clinic. The authors of this study found that community based care is of material and practical benefit to the mother: it costs less, and half the mothers - as opposed to none in the hospital group — are able to walk there. It is also of interest that (as all good midwives know) a community clinic facilitates conversation between midwives and mothers. A somewhat different study was carried out by Klein and colleagues comparing pregnancy outcomes in women cared for in birth rooms as against more conventional hospital settings[38]. Use of oxytocin, forceps and episiotomy was significantly lower, though the two groups of women receiving the different patterns of care had a similar level of risk.

One of the interesting messages that comes out of reviewing these social intervention studies is the relatively powerful effect even an apparently insignificant intervention can have. Carpenter's study[39] looked at the effect of one pregnancy interview with a medical student (no less), and found significant effects on pregnancy anxiety and use of pre-delivery medication. If one interview with a medical student can work such wonders, what miracles attend many prenatal conversations between mothers and midwives? The answer to this question is of course provided by the world famous study carried out by Caroline Flint[40] who was anxious to prove to the scientific world the value

to women and their babies of continuous personal relationships between mothers and midwives in pregnancy. Those in the "Know Your Midwife Scheme", as opposed to those receiving standard antenatal care, felt encouraged to be more questioning antenatally, more often experienced spontaneous onset of labour, felt in control during labour, had no analgesia or Entonox only, had few episiotomies, produced slightly bigger babies that needed less resuscitation, were breast feeding at six weeks and found it easier to be a mother.

In other words, communication increases women's "mastery" of their childbirth experiences (and all these studies show that mastery is as important for women as it is for obstetricians). "Mastery" is facilitated by access to information: two randomised controlled trials of mothers holding their own case-notes as opposed to the somewhat less informative so-called "co-operation" cards[41] demonstrated increased feelings of control among women holding their own notes. Similar beneficial effects of information, though with more directly measurable health effects, were found in a trial of different ways of carrying out ultrasound examinations of pregnancy[42].

Finally, counselling and/or nonspecific social support also have the potential to influence a range of pregnancy outcomes. For example, discussing with pregnant women the likely realities of motherhood in advance will significantly reduce problems after delivery, as the Gordons showed in a now classic 1960 study of postpartum emotional problems[43]. The results of the study, by Margaret Gutelius and colleagues[44], of child health supervision, which included pregnancy counselling, were quite dramatic, not only in making children whose mothers were receiving counselling sleep through the night and give up nappies earlier, but in effecting the likelihood with which husbands kept their jobs in the first three years of a child's life. A number of these studies demonstrate a serendipitous effect of social care during pregnancy on men who were not even the recipients of it, including the study I have been responsible for at the Thomas Coram Research Unit in London[45]. This study was a randomised controlled trial of social support provided by research midwives to women at risk of delivering low birth weight infants (see *Midwives Chronicle,* March 1989). We found that men living with women who received social support in pregnancy were significantly more likely than those whose partners were not supported, to help with the shopping and other children, both in pregnancy and after delivery. Equally (but not more) seriously, our study found differences between women who had social support in pregnancy and those who did not with respect to a wide range of health indices, including use of analgesia in labour, onset of labour (spontaneous or otherwise), type of delivery, infants' postnatal health care use, and mothers' health and health-care use in pregnancy and after the birth. The greatest differences were observed for antenatal hospital admissions, babies' use of neonatal care, health problems in babies after discharge from hospital, and mothers' confidence and emotional wellbeing in the early postnatal weeks.

It is important to emphasise that our "social support" midwives gave no clinical care. When asked what they had appreciated most about this type of help, the mothers put the fact that "she listened" first; 80% of them said this was important.

Who Cares for Women? The Logic of Intraprofessional Disputes

In other words, love is a scientific concept and its effects on perinatal health can be quantified. Conversely, there is much in obstetrics that claims to be science but does not have this status. Behind these differences, the motives of midwives and obstetricians are also different. The whole ideology and professional training of midwives qualifies them to care for normal women, while that of obstetricians orientates them to controlling the abnormal. Though these different qualifications would seem at first sight to constitute an excellent "package" when taken together, one problem is the psychology of what has been called the "as if" rule. By treating all pregnant women as if they are about to become abnormal, obstetricians are inclined to make them so. On the other hand, the disposition to regard pregnant women as a normal class of beings will help to facilitate this. This would seem to be one of the key processes lying behind the findings of the studies I have referred to: midwifery care encourages the normal, both directly and by enabling women, through information and greater self confidence, to take control of their own reproductive fates.

None of this is really surprising when you consider that obstetricians are doctors and thus trained in the diagnosis and management of disease. A review by Carol Sakala[46] in the United States, of midwives' and obstetricians' attitudes to pain in childbirth, highlights this particularly clearly. Looking at published information on approaches to pain as well as empirical practice, Sakala found that, in the medical domain, pharmacological approaches to pain relief were discussed almost exclusively, while midwifery practice emphasised other ways of dealing with pain, including relaxation, massage and social support. In medical practice, relief of pain was almost obligatory, while midwives recommended relying on the mothers' individual preferences. In line with this, it is significant that in Jean Walker's[47] study of how midwives and obstetricians perceive the role of the midwife, most midwives thought midwifery different from obstetrics while most doctors thought they were the same. In the Chelsea College study, four times as many doctors as midwives claimed that doctors manage normal labour[48]. But when it comes to the question of who *ought* to do what, the Chelsea College study found the obstetrical claim to exclusive expertise rearing its head again: doctors do not mind midwives sewing and fixing clips on, but they do not much like the idea of midwives carrying out breech or forceps deliveries or intubating infants. Partly for this reason, the number of midwives actually performing these tasks is much lower than many midwives would like.

We hear quite a lot these days about the desire of women to receive satisfying care — but one problem is that the professionals providing the care also want to be satisfied, and the job satisfaction of obstetricians relies on a desire to control and intervene in the birth process. This is clear in studies such as Ann Cartwright's survey[49] of induction of labour, in which a majority of obstetricians said that induction rates of over 40% increase their job satisfaction. Midwives also said that increased rates of induction made obstetricians happier, but had *decreased* their own satisfaction. This was in contrast to the view expressed by obstetricians who claimed that increased induction had made life better for midwives as well. Doctors know best; but they know best about themselves, and not about other people.

To summarise then: first, love — caring — is as important as science — technical knowledge, monitoring and intervention — in the maternity services today. Rather than being a soft option, it is a fundamental necessity. Secondly, this can be proved (for those who wish to concern themselves with scientific proof) from published studies examining the effects of *social* support as distinct from *clinical* care. Thirdly, and consequently, the goals of satisfying mothers and producing healthy babies, which are so often deemed by obstetricians to be at odds with one another, are in reality the same goal. Fourthly, the definitions of caring given by midwives on the one hand, and obstetricians on the other, have been different and opposite from the very beginnings of their uneasy collaboration in this complex, but wonderful, business of helping babies into the world. Fifthly, midwives must do everything to reclaim this concept of care (and the rest of

us must do everything we can to help them), both for the sake of women and babies and for the sake of themselves.

To end, it is appropriate to quote one definition of the kind of person a midwife is, and one mother's view of the contribution good midwives are able to make to the care of women in childbirth. The definition of a midwife is offered by Soranus, who wrote the first textbook for midwives in Rome some 18 centuries ago. Soranus identified the special qualities a midwife must possess:

She must have a good memory, he wrote, *be industrious and patient, moral so as to inspire confidence; be endowed with a healthy mind and have a strong constitution; and finally she must have long delicate fingers with nails cut short*[50],

The mother, delivered in Cambridge in 1987, said "I think that in a perfect world every mother should have what I had — a midwife's face that said "look, we have performed a miracle together". (And there was nothing to it!)[51].

Sweeping saga of satire

HERALD 26.9.89

By Camille Guy

● Ann Oakley . . . at first she settled for the academic life.

DR Ann Oakley, in Auckland as the ASB Bank visiting professor in women's health, has been immortalised in a limerick.

The winning entry in a *New Statesman* contest ran:

A jaded young housewife from Wapping
Said her life was all cleaning and shopping
Her husband said jokily
Try reading Ann Oakley
So she did and left home without stopping.

Best known as a feminist sociologist — and for books such as *Housewife*, *From Here to Maternity*, *Miscarriage* and *The Captive Womb* — Oakley has more recently branched out into autobiography and fiction.

Actually, writing fiction was Oakley's original aspiration. When her first two novels were rejected she settled for sociology and an academic life. But she never gave up her fiction ambitions, and about 1984, when Oakley was 39, she suggested the idea to Virago, a women's publishing house.

"I had got into the habit of writing to a contract and deadline. I needed that to make me take it seriously. I said to Virago, if you give me a contract without seeing a word, I will write a novel. They sent me one the next day."

That summer Oakley went away to a house, with no telephone, in a forest in France with a woman friend, also a writer. *The Men's Room* (Collins $15.95) was the result.

It is a satirical novel covering a 20-year sweep in the life of a woman sociologist and mother of four who has a long-standing affair with her head of department. The book explores feminism in quite a deliberate way; but Oakley still had difficulties with her original Virago publishers over whether the novel was "feminist enough," and over a scene that could be construed as rape.

PERHAPS as a precursor to the novel, Oakley had written and published an autobiography, *Taking it Like a Woman*. She has received more letters in response to that book than to anything she has ever written.

It is a remarkably honest, vivid and intimate account of a life which has so far entailed: having a famous father (socialist academic and writer Richard Titmuss); emotional breakdown as a young woman; and depression as a full-time mother; marriage, three children and a contemporary kind of separation (they divided their north London house in two, so both parents can remain close to daughter Laura who is 12); a brush with death — Oakley suffered cancer of the tongue when Laura was only a few weeks old; and a long love affair about which Oakley somehow manages to be both discreet and frank.

Most readers must have wondered about Oakley's family's response to such unshrinking public exposure of Oakley's intimate feelings.

They might wonder even more after meeting her, for Oakley herself is acutely shy, nervous of public appearances and says she hates publicity. She says she and her husband Robin separated three or four years ago, but "he is a good friend and my best advocate."

Oakley invited her mother to read the manuscript before publication and make changes. They turned out to be only minor factual alterations.

"It would have been easier to do it in novel form. Writing autobiography is not an easy thing in terms of the people around you."

OAKLEY says that having cancer prompted her to write her autobiography. "It was a major shock in that it made me realise life did not go on forever. It makes you go back over your life and think about it. Autobiography is an odd process of putting a retrospective meaning on your life, in the light of the present."

She says that, like fiction and sociology, autobiography is about contradictions and ambiguities and conflicts, and about being open and articulate about those.

But fiction is what she most enjoys writing and she is working on another novel.

"You have more control over what you write. You invent characters who take off and lead this amazing life of their own.

"If you don't like what they say you can scrap it and change the dialogue," which is rather a different experience for someone used to scrupulously careful recording of interviews for sociological research. She still works in sociology — now as a researcher in medical matters, and is deputy director of the Thomas Coram Research Institute in London.

Although she would give it up to write full-time if she could earn a living that way, she wonders if she really means that. "I particularly enjoy research, and there are similarities to fiction writing. Both require getting inside other people's lives. I think you can say some of the same things in both ways."

NZ midwifery 'excellent'

Sun Star 15.10.89

By JULIE MIDDLETON

"Things are moving fast in New Zealand," says Sheila Kitzinger, wife, mum of five girls, world-renowned authority on women's experience and author of new book *Breastfeeding Your Baby*.

"Your midwifery is excellent, GPs are willing to be involved with home births and there's a patient advocate at National Women's Hospital," says the largely-built and brightly dressed Kitzinger.

"Women in this country are getting a voice," says the writer of highly-acclaimed *The Experience of Childbirth*, *The Experience of Breastfeeding* and *Woman's Experience of Sex*. "They're very concerned to discover everything they can before they have their babies."

During her trip to New Zealand Kitzinger has lectured, assisted at births and been impressed by what she's seen. Breastfeeding is often frowned upon in public, and Kitzinger says women worry about whether they will be able to breastfeed.

"I think many woman expect it to come naturally," she says. "But you've got to teach the baby to do it. Many women don't have confidence they can do it."

Human milk is best for babies — "it adapts in 24 hours to suit the baby's needs" — as it is safer and more convenient than a bottle, and provides a special sort of emotional commitment.

Some mums worry about physical changes; but Kitzinger says advantages of breastfeeding outweigh the negatives.

Lavishly illustrated, the clearly laid-out book explores the psychosexual process of breastfeeding and offers suggestions to cope with anything from handicapped babies to soreness and sucking rhythms.

The illustrations were taken at a "breastfeeding party" at Kitzinger's Oxford, England, home.

Twenty-five babies and their mothers — including Kitzinger's daughter and her 17-month-old first baby, Sam — spent a long day at the house sharing information and having pictures taken. "They felt part of a sisterhood," says Kitzinger.

A disciplined worker, Kitzinger starts writing at 5.30 every morning. She dictates into a tape recorder and her secretary returns the transcript for more work. Kitzinger says this is what gives her writing its chatty, human edge.

● **BREASTFEEDING YOUR BABY, Sheila Kitzinger, Doubleday, $34.95.**

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