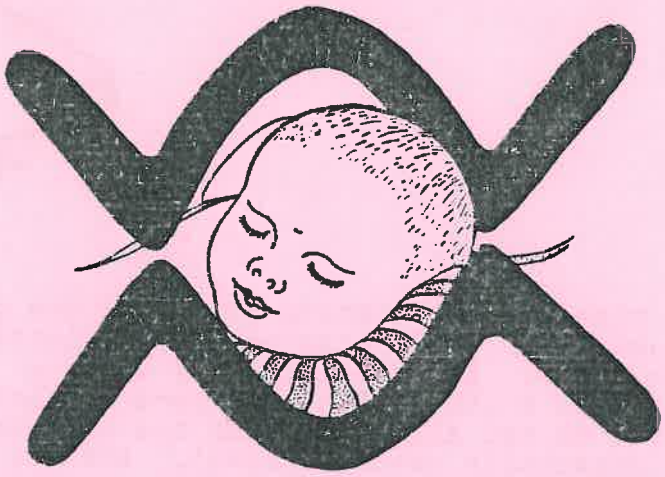
SAVE THE MIDWIVES

winter
1985



number 7

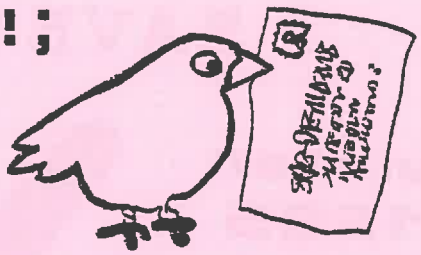
INSIDE:

MATERNITY ACTION

EPISIOTOMY

SMALL UNITS REPRIEVED

LETTERS?!;



Dear Editor,

At the risk of establishing myself as the gadfly of your correspondance columns, I must respond to the letter from Nigel Costley (Newsletter No 6). I suggest that he takes a more rational approach and investigates a little first. Anyone who actually knows me will recognise that I do not always support the orthodox views of the medical profession (especially obstetricians), and for the very same reason that I do not support his views: I ask for objective evidence of efficacy of a medication (herbal or otherwise) when therapeutic claims are made for it. The same applies to other medical practices. I would agree that many obstetrical "routines" are based on little more than that somebody once thought it would be a good idea.

Mr Costley is a lukewarm advocate for herbal remedies: the best he can say is that they will do little harm! This suggests that they will do little good either. Modern drugs have indeed been misused, but your correspondant should not have failed to note that they have saved lives too. Indeed not all herbals are so weak: digitalis is very powerful [and is easily more lethal than diuretics], and has been used for centuries. [Incidentally it also acts by interfering with potassium metabolism]. I wonder how many simple folk were poisoned by early herbalists getting the dose wrong? The vinca [periwinkle] alkaloids are extremely powerful anticancer agents. Mr Costley seems eager to leap upon evidence of misuse of pharmaceuticals but neglects to mention their successes, or the dangers of not using them and relying on worthless nostrums instead. It would be far better if we all concentrated on ensuring the proper use, <u>when necessary</u>, of ANY remedy, reasonably PROVEN to be beneficial, rather than on selective criticism.

In any event my message was quite different: if an organisation is seeking to promote change in "the establishment", as I well know a difficult task, it is more likely to be heeded if it shows itself to be responsible and objective, than if it is seen to be allied with those manifestly not objective.

Perhaps I can close by quoting Macchiavelli [in fact my own motto]: "There is no undertaking more difficult to accomplish, nor more uncertain in its outcome, than to take the lead in a new order of things."

Yours sincerely,

John Birkbeck, Director, Nutrition Foundation of NZ.

Department of Human Nutrition
University of Otago
Box 56
DUNEDIN

****

Letters can be addressed to:- SAVE THE MIDWIVES
c/- 24 Ashton Road,
Mt Eden
Auckland
NEW ZEALAND

News And Events

1. WOMEN'S STUDIES ASSOCIATION 8th ANNUAL CONFERENCE

   'Feminism, Racism and Heterosexism in Aotearoa'
   Hamilton Girl's High - August 23-25
   Contact: Women's Studies Association Conference
   P.O.Box 13-027, Hamilton

2. 'Women's Health In A Changing Society' - sponsored by the Federal Government to mark the end of the U.N Decade for Women. September 4-7
   Contact: Joanne Wood, Taylor Conventions
   1st Floor, 45 Grenfell Street,
   Adelaide SA 5000 AUSTRALIA

3. CEA ANTENATAL TEACHER'S COURSE
   September 13th 7.30-10pm and 14th 9.30-4pm
   A course to assist antenatal educators with their teaching skills, arranged by Tony Morrison of Auckland University's Continuing Education Department.
   Contact: Lynda Williams - CEA Secretary
   16 McEntee Road, Waitakere.

4. MIDWIVES ALLIANCE OF NORTH AMERICA 3rd ANNUAL CONVENTION

   'The Midwifery Tradition: Roots and Renewal'
   October 18-21
   Lone Mountain College, San Francisco, California.
   Contact: MANA Conference
   3722 Randolph Avenue
   Oakland, Ca. 94602

5. ICEA INTERNATIONAL MEMBERS COMMUNIQUE June 3/85 - noted two firsts for New Zealand (from Jackie Cooper)
   (i) The opening of the first hospital-based Alternative Birth Centre at the Queen Mary Hospital in Dunedin. (Parents Centre Bulletin - Autumn 1985 states "Dunedin's birthing centre has been in constant use since its opening in early November.")
   (ii) La Leche League leaders have been invited to visit mothers before discharge from hospital.

6. NEW BIRTH TECHNOLOGIES (Auckland University Student Newspaper - excerpt)
   On Saturday, June 15, a seminar was held on artificial insemination, in-vitro - fertilization and surrogate motherhood. It was organised by the Auckland Women Lawyer's Association and based on an Issue Paper titled 'New Birth Technologies' recently released by the Dept. of Justice. The paper explores the medical, ethical and legal issues involved and was prepared by Margaret Nixon, a lawyer with the Dept. of Justice. The issues raised need general public input and submissions. The Paper is available from the Government Bookshop at $9.95.

7. Auckland Domiciliary Midwives are now able to provide postnatal care (daily visits for ten days postnatally) for women wanting an immediate or early discharge from hospital following giving birth.
Contact: Auckland Home Birth Assoc.
P.O.Box 7093
Wellesley Street
AUCKLAND

8. Excerpts from ICEA book review -

Birth Reborn - by Michel Odent

'Birth is a special event in the life of every woman, and in his new book, Birth Reborn, French physician Michel Odent reawakens the world to the meaning and magic of birth as it should be. Childbirth has been taken away from women in Western society, but Odent, with his team of midwives, has found the way to give it back to them. In this book are the beginnings of a childbirth revolution.'

'Ultimately, the key element became, in Odent's words, to let women give birth to their children, to leave women free to labor as they wished.

This attitude and practice of nonintervention and individualized care prevail throughout labor and birth. Many photographs show the variety of laboring positions women discover for themselves. Odent sums up the essential features this way: privacy, intimacy, calm, freedom to labor in any position, and the helpful presence of midwives are crucial to a spontaneous first-stage labor. In sharp contrast, he observes that the trappings and restrictions of modern labor management all inhibit labor.'

'This is a physiological model of birth management, with minimal use of drugs, forceps, and episiotomy, and a cesarean rate of 6% to 7%, in striking contrast to rates elsewhere in the Western world. Delivery is almost always in the supported squatting postion, since Odent has found it to be by far the most efficient and safest way.

As word spreads - and it is beginning to - about the revolution at Pithiviers, a new but old childbirth will emerge. Odent, the catalyst, stands back and tells us rightly that the most powerful movers of this revolution will be the women themselves.'

- Diony Young, Geneseo, New York, USA

MIDWIFE WANTED

A Domiciliary Midwife wanted in New Plymouth. To work with and be supported by a newly formed New Plymouth Home Birth Association. The Association is in the process of looking into setting up equipment for a midwife. For more information ring 36070 New Plymouth or write to New Plymouth Home Birth Association 14 Julian Place New Plymouth.

The New Zealand Herald
Published since 1863
AUCKLAND, WEDNESDAY, MAY 1, 1985

Maternity Units Reprieved

An Auckland Hospital Board decision to reprieve four small maternity hospitals should receive applause from the wider public as much as from the communities which fought for their retention.

While the board's task of fulfilling a litre of health-care expectations from a half-litre of funds and resources is manifestly difficult, the proposal to close the units and use the funds to upgrade maternity services at central hospitals was ill-conceived. In many areas, centralisation may well be the most cost-effective approach and best solution to staffing problems; in health care other factors must also be heeded.

The board's care of mothers at high-technology base hospitals is probably second to none but pregnant women, per se, are not sick. Birth is normally a joyous event that ideally occurs as close to home as possible so that all the family can be involved. The base hospitals now recognise this with less clinical and more family-like conditions in their maternity quarters.

However, growing medical as well as social opinion favours ancillary low-technology units, staffed by general practitioners and midwives. The provisos are that there should be satisfactory screening for potential complications and that there are enough births to justify such local facilities.

3RD LEADER

MEDIA WATCH

A 4 Auckland Star, Tuesday, April 30, 1985

Reprieve for maternity hospitals

By RACHEL VEALE

Auckland's four outlying maternity hospitals are no longer under threat of closure, provided they serve more than 50 patients a year.

This follows a revision of the Auckland Hospital Board's 10-year strategic plan based on submissions received for the maternity and neonatal services.

A board committee yesterday recommended for board approval that all reference to the closure of smaller obstetric hospital units be removed from the plan.

Board chairman Dr Frank Rutter said in earlier years he had considered the high cost but small delivery numbers of the small rural hospitals which included Helensville, Warkworth, Howick and Papakura.

"More recently I have been aware of the social and community costs of closing them."

He said while the small hospitals were comparatively expensive to operate they provided a good service in association with specialist units.

About 20 members and sympathisers of the Maternity Action Group attended the meeting. Afterwards spokesperson Ms Judy Larkin said they were pleased with the change in policy.

☆ ☆ ☆

Small Units Escape Axe

Four small maternity hospitals near Auckland have been reprieved from threatened closure.

The Auckland Hospital Board planning, services and works committee yesterday voted to keep the maternity units at Warkworth, Helensville, Howick and Papakura open unless the number of deliveries falls below Health Department guidelines. All the hospitals are well above the guideline figure.

A proposal to close the units to provide funds for expansion of North Shore and Middlemore Hospitals was made last year in a draft of board strategy.

Guarantee

But it brought an outcry from hospital staff and community groups who drew up petitions and presented submissions opposing the closure.

A revision of the strategy tabled at yesterday's committee meeting softened the blow. It said units would remain in operation but maternity would be monitored.

Costly

The board chairman, Dr Frank Rutter, succeeded in amending this wording to guarantee the continued existence of the units as long as their birth numbers stayed high enough.

He said deliveries were more costly at the small units than at base hospitals but the board was aware that this was outweighed by the social and community costs of closing small units.

AUCKLAND, TUESDAY, APRIL 30, 1985
STAR

REPRIEVE FOR SMALL MATERNITY UNITS

BROADSHEET

When *Broadsheet* published in its October issue the contents of a "leaked" report showing small maternity units are safe, groups fighting to save the units from extinction were given important ammunition. JUDY LARKIN outlines a success story.

Auckland's small maternity hospitals are staying open. How did it happen? The Auckland Hospital Board's chairperson, Dr Frank Rutter, has said that he has "recently become aware of the social and community costs of closing them". The Save The Midwives Association has worked in close co-operation with other groups in Auckland over the last six months to inform both the board and the public of the strength of support for the city's small hospitals.

When the Auckland Hospital Board released its Strategic Plan in mid '84, Save The Midwives prepared a submission that criticised the plan point-by-point and outlined safe, realistic and less costly alternatives. Over 90 substantial submissions were received by the board, many of them prepared by parenting and women's organisations. These same groups held public meetings in their areas: at Papakura and Helensville there were hundreds of supporters.

In July the Rosenblatt report was leaked to *Broadsheet*. This piece of research showed that birth was as safe, if not safer, in cottage hospitals than in the large high-tech units that the board proposed should be used by ALL women in Auckland. Here at last we had well-researched evidence that New Zealand's small maternity hospitals were doing an excellent job. Moreover the "safety" argument against small hospitals used by the Strategic Plan had been scotched.

Interest in Rosenblatt's research, plus opposition to the Strategic Plan, led the major women's and parenting groups in the city to form a coalition. We called it MA — Maternity Action. In early March our coalition was formalised; organisations had joined, the common thread being the wish to retain the small maternity hospitals. We began to approach, both in person and by letter, the elected members of the Auckland Hospital Board, some of whom themselves disagreed with the maternity provisions of the Strategic Plan. It was up to the elected members of the Board to accept or reject the plan, and because we had been attending Board meetings since September '84, we had a fairly clear idea of when their decision would be made.

Back in '84, a copy of Save The Midwives submission had been sent to Margaret Wilson. She made the suggestion that we approach the Labour women's caucus for assistance. Part of the government's women's affairs policy is to "ensure that the provision of maternity care is in the best interests of the woman and her baby". The Labour women's caucus was extremely supportive, and put our point of view to the Minister of Health, who makes the *final* decision on whether or not a hospital is closed. Judy Keall, MP for Glenfield, agreed to act as our liaison person with the Labour women's caucus. We will in future be keeping each other informed on maternity care issues.

While the Strategic Plan catered largely for the needs of specialists — four maternity hospitals instead of nine means obstetric specialists can consolidate their power base and slowly squeeze out the remaining 36% of births done by general practitioners — Maternity Action represents the needs of women and babies. To this end we worked with the media, and we were pleased to receive the support of midwives and GPs who themselves practise family centred care, and were prepared to say why.

Twenty-five representatives of the coalition attended the board's meeting on April 29 when the decision was made to keep five small maternity hospitals open. The Auckland Hospital Board made a decision that is supported by thousands of families in Auckland: it is to be hoped that other hospital boards will follow suit.

Maternity Action will remain active, continuing to function as a network of women whose major concern is to promote the right of women to make decisions on how, where, and with whom they will give birth.□

STOP PRESS STOP PRESS STOP PRESS STOP PRESS

Professor Rosenblatt's research has been published by the Department of Health with a complete disclaimer. Any enquiries are to be directed to Prof Rosenblatt himself in the United States! The reason for this extraordinary action is not given in the newly published version, but one can assume that the Department will now not feel obliged to incorporate Rosenblatt's findings in its future planning. The N.Z. public should not accept this - Rosenblatt was partly funded by a grant from the Medical Research Council, (public funds), and his co-researcher, Judith Reinken, was employed by the Health Dept. - public money again. This is an unprecedented move by the Department and strong letters of protest should be sent to the Director-General, Dept of Health, Box 5013, Wntn, and to the Minister of Health at Parliament Buildings, Wellington.

STOP PRESS STOP PRESS STOP PRESS STOP PRESS

Battle of the birth rights

Sheila Kitzinger reports on the doctor caught between high and low tech labour

"If I could get on top of Nelson's column with a megaphone and shout Dr Savage's praises I gladly would." Rita Hotson, a new mother, says. "I was panicky. I'd been told by two obstetricians that I could never give birth naturally – I would have to have a Caesarean. Wendy Savage's attitude was: 'Let's see how it goes'. Everything was done to ensure the safety of me and my baby. She saw me every time through both my pregnancies and instilled such confidence in me. I had two vaginal deliveries. They were the experience of a lifetime."

Wendy Savage is the consultant obstetrician at the London Hospital, Mile End, who has been suspended by the District Health Authority pending an inquiry into five births, in which she is accused by some of her male colleagues of gross malpractice, an accusation which she strongly denies.

The disciplinary procedure adopted against Dr Savage is one put into motion only once or twice a year in Britain and has never before been used in Tower Hamlets. It is usually employed when there is grave danger; when a doctor is an alcoholic or drug addict, for example, or an anaesthetist is under the influence of his own anaesthetics. The inquiry takes at least a year, often two.

Mothers for whom Dr Savage has cared have rallied to her support. Within a few days 67 of the 83 GPs in Tower Hamlets wrote to the District Health Authority paying tribute to her work and saying that they were eagerly awaiting her reinstatement. This is significant, because GPs are in the key position of making choices concerning consultants to whom to refer their patients.

Much more is at issue than whether, in retrospect, everything was done in the best possible way in those five births. One of Wendy Savage's basic principles is that in coming to any decision about care, a major factor is what the mother thinks.

She is in the forefront of those pioneer doctors who are determined to improve the quality of maternity services. It is well known that the present form of hospital antenatal care has major deficiencies, with women herded into cattle-market clinics, little continuity of care, conflicting advice being given, and intervention resulting from mistaken diagnoses of problems – such as foetal growth retardation – where none in fact exist.

In tackling such challenges, doctors taking part in the Sighthill experiment in Edinburgh and in the St Thomas's community care scheme, for example, go out to the women whose needs they serve. There are especially impressive results at Sighthill, with fewer baby deaths and far more satisfied consumers.

Wendy Savage, too, goes to GPs' surgeries so that women do not have the long traipse to hospital, something that no other obstetrician in Tower Hamlets does. She gives strong support to the Domino Scheme ("domiciliary-in-and-out") in which a woman comes into hospital with her midwife, who delivers her there and goes home with her afterwards.

She also helps women who want home births. Sarah Guile, herself a midwife, told me: "I was very impressed by the care she gave. She was totally supportive of home birth and I was confident that if there were complications she would provide the back-up. I have great respect for her". She is the only woman consultant in the area where there are many Asian mothers, for whom it is important to be cared for by a woman doctor, as it is – increasingly – for many other women, too.

Wendy Savage does not induce labour just because a woman is one, or even two, weeks overdue. Instead she monitors the foetal heart, watches carefully and, if all is well, waits patiently for labour to begin naturally. Mile End has an induction rate of only 10%. The forceps delivery rate is never higher than 5%. In many hospitals catering for so-called "high risk" women, such as those who live in Tower Hamlets, induction rates are around 20% or higher, and forceps delivery rates 25% or more.

Lesley Nightingale had a breech birth with her fourth baby, alternately adopting a knee-chest position to slow the delivery down and standing up to let the head slide out smoothly and quickly. She says: "Every other hospital I tried insisted on doing a Caesar, except one that told me I could have an epidural and forceps. My other births had all been natural. Wendy said: 'I don't see why you should have a Caesarean. Let's try!'" The baby slid out easily, pink and perfect. "It was fantastic." The next day, "a paediatrician came and we had a row. He said it was risking the baby's life. 'I wouldn't allow my wife to deliver a breech baby in that manner', he said."

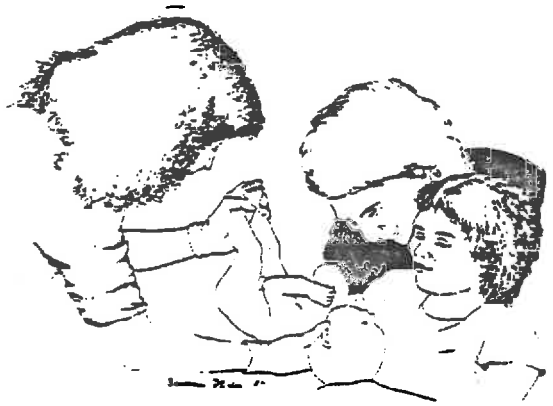
Some doctors treat each pregnant woman as if she were merely an ambulant pelvis, and every woman in labour as yet another contracting uterus. There are many who assume that they know what is best for a woman better than she can know herself but more and more women are unwilling to hand over responsibility to an obstetrician whose kindly professional manner masks determination to keep rigid authoritarian control over his patients.

This is one reason why it is time that the practices of her accusers are given the same careful scrutiny as those of Dr Savage herself. How much time do they spend on National Health Service work? (She has no private practice.) How often are they in the ante-natal clinics? How long do women have to wait to see them? How available are they when needed? Is all this leading to a closing-down of Mile End hospital altogether? There are a host of questions like these which urgently need to be answered at any inquiry.

In 1982 the Professor of Obstetrics at the Royal Free Hospital announced that in future all women in his unit must deliver lying down. There was a spontaneous uprising among women and 5,000 people gathered on Parliament Hill Fields in protest. Shortly after, the professor resigned and went into in vitro fertilisation. His leaving, he said, was nothing to do with the protests. Now women at the Royal Free can move around right through labour and give birth in any position they like.

Changes in care which run counter to those of the obstetric establishment come about only when women say what they want, and say it loud and clear. The issue now concerning the working methods of Wendy Savage is important.

On Thursday, June 13, at 2.30pm, there will be a protest march, from the London Hospital, Mile End, to Whitechapel, supported by the Community Health Council, local GPs, the National Childbirth Trust and other birth and women's organisations to demand the reinstatement of Dr Savage.



(Source not available)

There's A Person There

In 1950 Margaret Mead wrote the following words, "It cannot be argued that child-birth is both an unbearable pain and a bearable pain, both a situation from which all women naturally move readily and happily, both a danger to be avoided and a consumation devoutly to be desired. At least one aspect must be regarded as learned, and it seems simpler in the light of present knowledge to assume that women's attitudes towards child-bearing and men's attitudes towards child-bearing have complex and contradictory elements in them, and that a society may pick up and elaborate any one, or sometimes even a contradictory, set of such attitudes. And as with all learned, culturally elaborated behaviour, the farther away from the biological base, the freer the imagination is. There seems some reason to believe that the male imagination, undisciplined and uninformed by immediate bodily clues or immediate bodily experiences, may have contributed disproportionately to the cultural superstructure of belief and practice regarding child-bearing."

Introduction

All through history it seems, men have not surprisingly been able to remain impartial towards child-birth. In many instances, avoidance ploys such as developing couvade symptoms, or an urgent need to go hunting, or heading off to the boozer, have been acceptable practices. However, the group of men committed to the Hippocratic Oath have seen it as their duty to try and alleviate the pain and apparent suffering that giving birth brings.

When a medical man was able to persuade the Queen of the British Empire to sniff Simpson's chloroform, repercussions reverberated around the Western world. What's more, the lady liked it and she got to do it quite often. (Praise be that it wasn't widely broadcast that Princess Di had an epidural for her first.) At this same time, carbolic acid was making lying-in hospitals a little less life threatening for mothers. Within these institutions, doctors were able to congregate not only themselves, but the paraphernalia of their practice. They exerted unquestioned power and authority. In Britain, it became not only acceptable but fashionable to give birth in a hospital, the home setting being for those 'poor dears' who could not leave their homes, either through impoverishment or through indispensability. Before the Second World War, Western women must have been vacuous and easily vacillated. I ask you, how else could the practice of twilight sleep have become so widespread?

There for us anyway, is probably where it all started. Nothing much has changed. Yes, science and skills have, but male attitudes haven't. I may detect from some of the midwives here who know me, a squirm of anticipation - "She's going to sock it to them". Sorry dears, even if I did have the courage of David, I see nothing to be gained. But I'll make no apology in barking a shin or two.

So, what's the problem? Do too many diverse groups of people now work in hospitals? Is it lack of role definition? Would it help to define everybody's place in the team of care providers? Definitely not - this exercise would simply promulgate and proliferate the already existing territorial rights and alienate us even more from each other. Just look at the range of attendants there are: the obstetrician, the

midwife, the physician, the radiologist, the anaesthetist, the paediatrician and the medical social worker, the latter group now expecting to be the primary grief counsellors. Each member believes they have a vital, valid reason for being there, and each has aspects of education and preparation which entitles him/her to have an opinion on obstetric care management.

Opinions vs Needs

What are opinions? The Oxford says, "they are judgements or beliefs basedon grounds short of proof". When we say, "in my opinion", we are saying, "it seems to me", and by saying that, we are expressing our perceptions and probably our needs and where in this triage belongs our patient who also has opinions and needs? For starters, I am firmly convinced if we could stop calling the parturient woman, 'patient', we might better listen to her opinions and be more mindful of her expressed or non-expressed needs. No, I don't want to call her 'client', that just accentuates the "providing a service for" image. But what's wrong with 'mother'? Most mothers are normal. The second step for the normal pregnant mother may then not include having to traverse landmined ante-natal care of too much or not enough. Too much weight gain or not enough, too much oedema or not enough, too much eating or not enough, too many red blood cells or not enough, too many fetal movements or not enough, too big a baby or too small. I tremble at the thought of my being an ante-natal patient today. I would have had a G.T.T. for sure, for having big babies, all of them overdue. My solution to enforced hospital deliveries was to arrive there fully dilated, but to reinforce my compromise I had to put aside niggly thoughts that maybe, just maybe, by doing this I was putting my health and my baby's health at risk. I never got it all my way anyway. Have you ever tried to climb a flight of stairs with your legs crossed? And I always got a shave after I had delivered. This personal portrayal is meant to convey that in the less enlightened days of 20 years ago, there were patients even then whose needs were not met and probably because there are others like me, the Home Birth movement appeared in our country. Five years ago an obstetrician assured me "it was just a passing fad". Well, I don't see any sign of it passing. Last September, I attended an International Congress of Midwives and was assured by listening to speakers then that selected Home Birthing and Alternative Birthing Centres are here to stay. I have my eye on the house doctors' residence at St.Helens - it would easily convert into an admirable birthing centre and all for the cost of one cardiotocograph. We will never get it, but I guarantee we will get the cardiotocograph. I browse in libraries and bookshops and see a burgeoning array of consumer guide obstetric books. I read some and realise that they are as biased as any other source of highly selected information, but the very fact that they exist points to the need to treat expectant mothers as individual persons with wide-ranging needs.

Surveys

Another example of highly selected information is a research article that I read in the British Journal of Obstetrics and Gynaecology, July, 1984, (Morgan et al 1983). The authors surveyed 1,000 mothers one year after they had delivered at Queen Charlotte's Maternity Hospital. They received 632 replies to some very loaded questions. Example: "an epidural block is the best sort of pain relief in labour". To which 50% agreed.

So would I, but it would not mean that I would want one. In the discussion section the authors frequently referred to the average mother. Who is the average mother? They then topped off the discussion with "the survey gives the attitudes of a large and representative group of mothers and should carry more weight than the opinions of the vocal minority who are frequently quoted in the media". Oh, I forgot to mention that the respondents were 90% white and 28% were from the highest social classes I and II.

Another survey, closer to home and thus possibly more relevant (Skuja et al 1982) 150 expectant mothers of which 39% were lower class, 41% middle and 20% upper class representing a cross-section of the childbearing population of Sydney. Granted the questions were differently structured and the two papers differed in their titles. The first was headed "The Consumers' Attitude to Obstetric Care" and the second " ... on Consumer Demand for Obstetric Services". Nevertheless, the readers would be expecting to read about what mothers want. In the Sydney survey, mothers wanted knowledge and "quality interaction between mother, father and child" rather than "medical technology" and"humanistic alternatives". To my mind, the most fundamental difference between these two surveys is, that the first was conducted by three doctors of medicine and the second emanated from the School of Behavioural Sciences, which demonstrates that you can demonstrate what you set out to demonstrate or you can believe what you want to believe.

Pain Relief Assays

Just one more survey before I abandon my attempt at seeing whether one can empirically portray patients as persons.

We, at St.Helens, recently surveyed 100 sequential non-selected newly delivered women. We wanted to find out their perception of midwifery care and whether they had any suggestions as to how we might improve it. Because of this, we felt that the questionaire should be anonymous and no help was given with filling it out. It served also a good opportunity to include queries on other things such as method of ante-natal preparation, degree of apprehension and with what and by how much pain was relieved. We had 76 returns, 73 of which were suitable for pain relief assays. Fifteen multigravidae and two primigravidae had no pain relief at all. We asked the mothers what form of pain relief they had and whether they would have it again. Interestingly, nobody said that there was not going to be any 'again'. It is admitted that relevant variables are not included, such as type of delivery, abnormal labour and such-like. Therefore the results are presented as non-inferential data, but they do demonstrate wide variations in women's needs. (APPENDIX) Interesting observations are: all four of the multigravidae who received only slight relief from using nitrous oxide were quite happy to have it again. Half of the primigravidae who found epidurals either effective or pain free replied that they would wait and see for next time. There was no significant difference between methods of pain relief between 'Specialists' patients and 'Clinic' patients. 32% of Specialists' patients had epidurals and 36% Pethidine, 35% Clinic patients had epidurals and 43% Pethidine. It could be hypothesised that Clinic patients comprise a higher abnormal component as they include emergency transfers from two Level I hospitals, but this remains a conjecture.

Perceptions

Now all this preamble is meant to be conveying not only different perceptions of childbirth but to illustrate the different need hierarchy of our paturient women. These days, most couples plan two and a half children and usually slot them in somewhere between paying off the second mortgage and buying the home computer. The women in these circumstances are educated, have been in the work-force, are articulate and may have a body image influenced by trendy women's magazines. She does not care to suffer pain and never indulges in primal responses to emotion. Quite likely her self-concept can only be preserved by the prospect of having an epidural for her labour and she will be no less a mother for it. But what of the woman who does not shave her armpits, who plans her baby after the organic grown garlic is harvested. She would probably accuse us of extra-sensory deception if we dared to mention the word epidural. Women enter childbirth under all sorts of circumstances somewhere between these two illustrations. We should be able to identify them all and with our combined knowledge not have to consider the average mother concept but be able to identify the components of care that each mother needs to complete her picture of birthing.

Anaesthetics

I will, without any arm-twisting, say I admire and respect your skills. Unequivocably your presence in the obstetric arena has saved many mothers' lives. But do you really believe that no woman should have pain in labour? The convenor and participants of the first British Symposium on Epidural Analgesia in Labour in 1971 believed this was your goal. If this is your gift of myrrh to the woman in childbirth, you must be prepared for some rejection. Some women would parallel the suggestion of an epidural to offering Graeme Dingle a helicopter to reach his mountain peak. Or as Sheila Kitzinger would put it, "like having sex without emotion". In my opinion, deftness at epidurals and anaesthesia does require a modicum of impartiality towards acknowledging the patient being a person. If this be true, then paradoxically, the anaesthetist may forfeit any contribution towards adjudicating on the needs of women in labour.

Conclusion

The issue is, are we creating a need to meet a service or a service to meet a need? Childbirth can be either an activity or creativity that women engage in, or a service that medicine supplies. Many women's life styles do not prepare them for the dependant state, albeit short and temporary, that the partnership of pregnant state/patient state brings. In the recent T.V. series 'Health of the Nation', the pre-Raphaelite, moony, maiden doctor Jessie made at least one brilliant observation which ejected me from my couch of inertia. She said "... patients are natural victims; they are afraid of being punished if they ask questions". Think of that. Think of clogged clinics, ward rounds, teaching sessions with patients. Think of patients who request 'out of routine' procedures. Think of what mothers had to put up with until the medical profession discovered rooming-in and bonding.

Some believe in an androgynous society, but unless we relinquish childbearing and rearing to a Director of Hatcheries and Conditioning (Huxley 1960), it does not seem imminent. In the here and now, despite all sorts of factions, we seem stuck with the different biological activity of males and females and the different roles they engender. The commitment of the childbirth attendant is to understandthat roles do not or should not ever subjugate the person.

I close with another quote, this time taking some of the lyrics from a Pink Floyd album. It seems appropriate to choose music as its enjoyment in one form or another is something we have in common.

"Breathe, breathe in the air
Don't be afraid to care
Leave but don't leave me
Look around and choose your own ground.
For long you live and high you fly
And smiles you'll give and tears you'll cry
And all you touch and all you see
Is all your life will ever be."

- Beverly Crombie

BIBLIOGRAPHY

Brockington, I. and Kumar R. (Ed.) : Motherhood and Mental Illness
Academic Press 1982 N.Y

Doughty A. (Ed.) : Symposium on Epidural Analgesia in Obstetrics
B.D.H. Pharmaceuticals Ltd. 1972 U.K.

Fagerhaugh S. and Strauss A. : Politics of Pain Management - Staff-Patient Interaction.
Addison-Westry 1977 California

Kitzinger S. : Giving Birth
Schoken Brooks 1978 U.S.A.

Mead M. : Male and Female
Penguin 1962 U.K.

Morgan B. et al. : The Consumer's Attitude to Obstetric Care - British Journal of Obstetrics and Gynaecology
July 1984 Vol.91 pp 624-628

Muff J. : Altruism, Socialism and Nightingalism
Socialization, Sexism and Stereotyping
C.V.Mosby 1982 St.Louis

Older J. : Touching is Healing
Stein and Day N.Y. 1982

Rothman B. : In-Labour Women and Power in the Birthplace
W.W.Norton & Co.N.Y. 1982

Skuja E. et al. : What do Expectant Mothers Want? A Preliminary Report on Consumer Demand for Obstetric Services
Australia/New Zealand Journal of Obstetrics and Gynaecology

Wolkind S. and Zajiceck E. (Ed.) : Pregnancy: A Psychological and Social Study
Academic Press 1981 N.Y.

Young D. : Birth. the Way We Want It
Parents Centre Bulletin No. 99 1984

Proceedings 20th Congress International Confederation of Midwives
Sydney Australia 1984

Epidural

		Number	Again	Wait	Don't Know	No	
MULTI	No pain	●●●	●●			●	MULTI
	Effective	●●●		●	●●		
	Slightly	●	●				
	Not effective					No. = 7	
PRIMI	No pain	●●●●●●	●●●	●●●			PRIMI
	Effective	●●●●	●●	●●			
	Slightly	●	●				
	Not effective					No. = 11	

● = Pts. who received Pethidine & Epidural

Pethidine

MULTI	No pain	●		●			MULTI
	Effective	●●●	●●	●			
	Slightly	●●	●	●			
	Not effective (given too late)	●	●			No. = 7	
PRIMI	No pain	●●●	●●		●		PRIMI
	Effective	●●●●●●	●●●	●●●●			
	Slightly	●●●●	●	●●		●	
	Not effective	●			No. = 16	●	

Nitrous Oxide

MULTI	No pain			●			MULTI
	Effective	●●	●				
	Slightly	●●●●	●●●●				
	Not effective	●●		●	No. = 9*	●	
PRIMI	No pain						PRIMI
	Effective	●	No response				
	Slightly	●●		●	No response		
	Not effective					No. = 4*	

Multi = Multigravidae / Primi = Primigravidae * = I did not respond.

THE USE OF EPISIOTOMY IN NORMAL DELIVERY

A retrospective study by VALERIE A. WILKERSON, BA, SRN, SCM, ADM,
Midwifery Sister, Birmingham Maternity Hospital

THE intact perineum has long been regarded as one of the hallmarks of a midwife's skill in delivery. In recent years, however, a somewhat curious situation has developed. A perineal laceration, however slight, may be regarded as evidence of mismanagement, whereas performance of an episiotomy which, at best, causes trauma equal to a second degree laceration, is entirely acceptable.

The first episiotomy is thought to have been performed by a Dublin surgeon in the mid-18th century, but it was not until the early part of this century that it came to be recommended as beneficial for both mother and baby, and advised as an elective procedure for all primigravidae. It is doubtful whether midwives, as a general rule, shared this enthusiasm when most deliveries took place in the home. The episiotomy rate began to increase noticeably, however, from the early 1960s, when hospital confinement rates began to rise. It is difficult to escape the conclusion that episiotomy, which was a surgeon's invention, rapidly became absorbed into normal midwifery when the management of childbirth came increasingly under the control of obstetricians in hospital.

In 1967 the Central Midwives Board approved the performance of episiotomy by midwives in an emergency where medical aid was not immediately available. Since then the principles and practice of episiotomy have been an integral part of the training of student midwives. Unfortunately, it seems also to have become an integral part of many midwives' normal practice — the emergency element long having been forgotten.

No responsible midwife would dispute the fact that there are occasions when episiotomy is indicated. It should never be forgotten, however, that it is a deliberate operative procedure which, like any other form of surgery, should only be performed when there are definite indications for doing so. There is a great danger that any procedure that has been allowed to become "routine" will be performed without any thought of indications.

Episiotomy has been so completely incorporated into modern obstetrics that it has become a "normal" part of childbirth for most women. It has been suggested that episiotomy rates as high as 90% occur in some British maternity hospitals[1,2].

Indications for Episiotomy

The indications for episiotomy have for so long been handed down with the certainty of Holy Writ to medical students and student midwives alike that until recently few, if any, have stopped to question their validity in normal midwifery.

All midwives are taught that episiotomy prevents lacerations. However, there is actually little evidence for this. In an article on episiotomy published in the *Midwives Chronicle* in 1979, Mr J.S. Fox points out, with apparent satisfaction, that in his hospital (West Middlesex) the episiotomy rate for Domino patients increased from 4% in 1971 to 38% in 1977. Equally interesting (but not commented upon) is the fact that during the same period the laceration rate also rose (from 15% to 23%)[3]. This suggests the possibility that where a liberal use of episiotomy is considered normal, expertise in preserving the intact perineum declines, or is even considered unimportant.

Even with the best of intentions lacerations cannot always be avoided; when they do occur there is no reason to suppose that they constitute anything like the disaster we have been led to believe, or that they produce more problems than episiotomy. There is no evidence that they cause more pain, heal less well or cause more long-term problems. In fact, such evidence as has been accumulated tends to point in the opposite direction[4]. My own impression is that mothers find lacerations less troublesome and also that perineal breakdown is exceptionally rare, whereas it is not uncommon after episiotomy.

Another popular hypothesis (normally stated as incontrovertible fact) is that, without episiotomy, pelvic supports are irreparably damaged and future prolapse is almost inevitable. However, there is no experimental evidence for this claim. A very old study[5] compared the effect on the perineum of forceps delivery with and without episiotomy, but no such investigation has ever been made for normal delivery. Moreover, for such an hypothesis to be tenable it is necessary to accept that the female anatomy incorporates a basic design fault! In which other normal physiological process would routine prophylactic surgical intervention be proposed, or accepted?

In some cases of fetal distress episiotomy may properly assist in hastening delivery. However, fetal distress *in itself* is not an indication for episiotomy. Unless the fetal head is already on the perineum, episiotomy will not facilitate delivery and will achieve nothing but excessive trauma to thick perineal tissues and heavy bleeding (which is frequently underestimated)[6]. In cases where there is no fetal distress there is no evidence to suggest that the use of episiotomy, simply to shorten the second stage of labour, confers any benefit. One suspects that a common reason for the performance of episiotomy by midwives is the fear of complaint from medical staff if the second stage of labour is not completed within a set time limit. It seems very probable, however, that the length of the second stage does not harm the healthy fetus, but that strenuous pushing "against the clock" (as opposed to pushing as and when desired by the mother) can itself be a cause of fetal distress[7,8].

In most cases of pre-term delivery episiotomy is

What Is a Midwife?

"Throughout the world there exists a group of women who feel mightily drawn to giving care to women in childbirth. At the same time maternal and independent, responsive to a mother's needs, yet accepting full responsibility as her attendant, such women are natural midwives. Without the presence and acceptance of the midwife, obstetrics becomes aggressive, technological and inhuman."

Professor G. J. Kloosterman
Chief of Obstetrics and Gynecology
University of Amsterdam Hospital

probably beneficial to the fetus, but even here each case should be judged on its merits. In the case of a multiparous mother a gentler and more controlled delivery may, in some circumstances, be obtained without episiotomy.

In other situations in which abnormal stress may be placed on the fetus or on maternal tissues (such as breech or instrumental delivery, persistent occipito-posterior position of the fetus, or previous major surgical repair — for example, third degree laceration, fistula or bladder repair) episiotomy is probably indicated.

It is surprising to discover that, while hundreds of articles have been written comparing one type of episiotomy with another, one type of suture material with another, or one type of post-episiotomy analgesia with another, no studies have been carried out to compare the effects on mother and baby of episiotomy against non-episiotomy in normal delivery. The alleged benefits of the procedure, stated as fact in most obstetric textbooks, have never been scientifically substantiated.

Hypothetical benefits must, therefore, be set against the known disadvantages. Any midwife knows that episiotomy leads to considerable pain for most women during the early postnatal period, often distracting them from enjoyment of their babies, and is often remembered as the worst feature of the confinement. For an unfortunate few (probably more than we generally realise) the pain or discomfort will continue for weeks or even months, leading sometimes to serious sexual difficulties[1,2]. Some will suffer the misery of perineal breakdown and possible resuturing.

At last, many mothers, midwives and even a few obstetricians[3] are beginning to question the alleged benefits of episiotomy and the need for its widespread use in normal delivery. It is sad that most of the pressure for this re-appraisal has had to come from the "consumers" rather than from among the ranks of the professionals.

Midwives often complain about allegedly high episiotomy rates, yet rarely, one suspects, audit their own performance. Most of the blame is directed at obstetricians, since most of them appear to accept, without question, that episiotomy is a good thing *per se*. It must be said, however, that even in hospital, the majority of normal deliveries are conducted by midwives and that, in the final analysis, it is they themselves who decide whether or not to perform episiotomy.

A Retrospective Study of Episiotomy Rates

Many obstetric units seem unaware of their own episiotomy rates, and I would suspect that very few midwives have any idea of the type and extent of perineal trauma suffered by the women in their care. My own unit is no exception. The unit publishes annually a most impressive and comprehensive report, containing statistics and comment on almost every aspect of obstetric and neonatal care. Nowhere, however, will one find information about episiotomy rates or other perineal trauma. Such a "minor" procedure as episiotomy is, apparently, not considered worthy of comment — the implication being that it is not even seen as an intervention in normal delivery.

For this reason I decided to undertake my own retrospective study, based on information available in the delivery registers.

Background

The study was undertaken in a large, provincial obstetric unit dealing with approximately 5,000 deliveries per annum; 80-85% of women are delivered under consultant care, the remainder under the care of their general practitioners. Since the spring of 1981, when three separate delivery suites were amalgamated, consultant and general practitioner deliveries have all taken place in the same delivery suite, staffed by hospital midwives. Community midwives are seconded to the unit for short periods but there is no specific arrangement whereby general practitioner patients are delivered by community midwives.

Recently qualified staff midwives rotate through the delivery suite as part of their general experience. Midwifery sisters are allocated permanently to the department, as are some more experienced staff midwives who are employed on a part-time basis.

The unit is a training school for both student midwives and medical students.

Method and Aims

My basic aim in undertaking the study was to discover how often and under what circumstances, in my own unit, midwives performed episiotomy. There is no official unit policy on the matter so each midwife ultimately is responsible for her own practice. I planned to obtain an overall picture and also to examine in more detail the practice of individual midwives to see whether or not there were significant differences. I was aware that a few midwives in the unit, like myself, rarely found it necessary to perform episiotomy. My general impression, however, was that the majority of midwives performed episiotomy relatively frequently.

A unit's overall episiotomy rate is not very informative since its significance will depend on the relative proportions of normal and abnormal deliveries. In my own unit approximately 22% of all deliveries are forceps or Ventouse deliveries, 5% are breech deliveries and 14% are by caesarean section. Since it can be assumed that most, if not all, forceps and breech deliveries include an episiotomy, any quoted episiotomy rate for the unit as a whole would give a misleading impression of the practice relating to normal delivery. I intended, therefore, to exclude all abnormal deliveries from my statistics.

I decided to study a one-year period and eventually, fairly arbitrarily, chose the period July 1, 1981, to June 30, 1982.

In the time available it was unrealistic to expect to be able to examine individual case notes. I was, therefore, limited to the information available in the delivery registers. As indicated earlier, this was to entail the examination of more than 5,000 entries. From these I planned to extract the following details for each normal delivery: parity of mother; by whom delivered; whether episiotomy, laceration or intact perineum; any unusual features which might be relevant to perineal outcome (e.g. malposition or malpresentation of the fetus, pre-term delivery, reported signs of fetal distress). One possible factor which I would have liked to have considered, namely the length of the second stage of labour, is not recorded in the register. In retrospect, I think it might also have been interesting to note the type of analgesia, if any, used in labour, especially the use of epidural analgesia.

I decided to "credit" each delivery to the midwife who supervised it, whether or not she actually performed the delivery herself. I believe that, even when a delivery is performed by a student midwife or medical student, the ultimate decision as to whether or not episiotomy should be performed is chiefly determined by the attitude of the supervising midwife.

Results

During the chosen one-year period 5,199 women were delivered. Of these, 2,933 (56.4%) were delivered by midwives (or under midwife supervision). That the number of midwives' deliveries should be so low is, perhaps, in itself, cause for comment, but outside my scope here. Of the remainder a very small number were normal deliveries conducted by medical staff. A few of these were private or "courtesy" patients delivered by consultant obstetricians; others were delivered by less senior medical staff, usually in circumstances where a forceps delivery had been anticipated, but the doctor found himself unexpectedly coping with a sudden spontaneous delivery! I did not compile details of these deliveries, nor of the remaining abnormal deliveries conducted by medical staff.

Of the 2,933 women delivered by midwives, 867 (29.6%) were delivering their first child and 2,066 (70.4%) a second or subsequent child. (*Note:* solely for the sake of clarity I shall, henceforth, refer to the former as "primigravidae" and the latter as "multigravidae". At delivery parity is of greater relevance than the actual number of pregnancies, but, since parity changes during the course of a delivery, there is less confusion if the above terminology is used.)

Of the 2,933 women 141 (4.8%) were delivered by medical students and 1,831 (62.4%) by student midwives, under midwives' supervision; 961 (32.8%) were actually delivered by midwives.

The overall episiotomy rate for the year was 42.9%, but this disguises a considerable difference between the rates for primigravidae (67.6%) and multigravidae (32.5%). I found it remarkable that of the multigravidae who received episiotomy, 33 were being delivered of their fourth child and one her fifth.

14.9% of primigravidae and 32.8% of multigravidae suffered perineal lacerations (overall rate 27.5%); 17.5% of primigravidae and 34.7% of multigravidae had intact perineums (overall rate 29.6%).

One feature worthy of comment is that, in general, as the episiotomy rate fell, the intact perineum rate rose. This does not support the popular thesis that the alternative to episiotomy is perineal laceration.

It is also important to note that of the total lacerations sustained, at least 29.9% were only first degree. The percentage may have been even higher but, since not all midwives specified in the register entries the exact nature of any laceration, I had to assume all lacerations to be second degree unless otherwise stated.

Four women suffered third degree lacerations (all delivered by students under the supervision of relatively inexperienced midwives).

Of the women who received episiotomy, at least 13 also suffered a perineal laceration (one third degree). There may have been more but, again, not all register entries are as informative as others.

A disturbing feature of the register entries was that in only 58 cases out of the total 1,257 episiotomies was an indication for the procedure stated or implied. The 58 cases comprised the following: pre-term delivery 26; persistent occipito-posterior position 17; fetal distress 13; face presentation 1; rigid perineum 1.

During the year in question more than one hundred midwives were employed on the delivery suite at some time or another. From these I undertook a more detailed analysis of the deliveries of 21 midwifery sisters, all of whom were employed in the delivery suite throughout the relevant period, and all of whom conducted or supervised at least 50 deliveries in that time (a total of 1,456 deliveries). All of these midwives were, by definition, relatively well-experienced and, presumably, well able to make their own clinical decisions. They were also less likely than their junior colleagues to be intimidated by real or imagined pressures from medical staff.

The sisters' average episiotomy rate (41.0%) was fairly close to the rate for all midwives in the unit (42.9%). However, the average conceals amazing variations in practice (Figure 3). At the extremes a woman under the care of Midwife "A" was 10 times more likely to receive an episiotomy than was a woman under the care of Midwife "U". On the whole it appeared that the midwives who undertook episiotomy most frequently did so for both primigravidae and multigravidae, but there were notable exceptions. Midwives "O", "Q" and "S", for example, showed a high rate for primigravidae, but a low rate for multigravidae.

FIGURE 3
Comparison of Rates for Episiotomy, Laceration and Intact Perineum of 21 Midwives (1456 Normal Deliveries) Expressed as Percentages of Each Midwife's Deliveries

	All Deliveries			*Primigravidae*			*Multigravidae*		
Midwife	*Epis.* %	*Lac.* %	*Int.* %	*Epis.* %	*Lac.* %	*Int.* %	*Epis.* %	*Lac.* %	*Int.* %
A	67.3	22.5	10.2	92.8	7.2	0	57.1	28.6	14.3
B	61.3	20.0	18.7	79.2	8.3	12.5	52.9	25.5	21.6
C	52.9	24.5	22.6	62.5	25.0	12.5	48.7	24.3	27.0
D	50.6	23.6	25.8	79.4	10.3	10.3	37.5	29.7	32.8
E	50.0	19.2	30.8	53.3	6.7	40.0	48.7	24.3	27.0
F	46.0	28.6	25.4	75.0	15.0	10.0	32.5	34.9	32.6
G	45.7	28.6	25.7	82.3	5.9	11.8	34.0	35.8	30.2
H	43.1	33.4	23.5	71.5	21.4	7.1	32.5	37.8	29.7
I	42.5	27.5	30.0	76.5	17.6	5.9	33.3	30.2	36.5
J	41.6	35.8	22.6	70.0	10.0	20.0	34.9	41.9	23.2
K	41.2	24.4	34.4	68.4	10.5	21.1	33.8	28.2	38.0
L	40.0	32.7	27.3	70.0	30.0	0	34.0	33.0	33.0
M	39.5	27.9	32.6	64.3	14.3	21.4	27.6	34.5	37.9
N	39.5	31.6	28.9	51.9	29.6	18.5	32.7	32.6	34.7
O	39.2	27.0	33.8	81.9	4.5	13.6	21.2	36.5	42.3
P	37.7	34.4	27.9	62.5	18.7	18.7	28.9	40.0	31.1
Q	37.0	36.0	27.0	80.8	7.7	11.5	19.0	47.6	33.4
R	32.0	40.0	28.0	62.5	12.5	25.0	26.2	45.2	28.6
S	26.6	28.6	44.8	65.0	25.0	10.0	17.6	29.4	53.0
T	23.2	37.8	39.0	35.5	19.3	45.2	15.7	49.0	35.3
U	6.1	34.7	59.2	12.5	25.0	62.5	3.0	39.4	57.6

There seems to be a tendency to assume that while a majority of multigravidae can be allowed to deliver without an episiotomy, there is very little likelihood of a primigravida doing so. More than half of the 21 midwives in the sample had an episiotomy rate in excess of 70.0% for their primigravidae. However, if even a tiny minority of midwives are able to deliver the majority of their primigravidae without the "aid" of an episiotomy (and also to have a high intact perineum rate) there must surely be scope for others to consider the possibility. It is worthy of note that just two of the 21 midwives were, between them, responsible for more than 32.0% of the total number of intact perineums in primigravidae.

The results of my study were, in one sense, encouraging in that the overall episiotomy rate was rather lower than I had anticipated, and certainly lower than the alleged typical rates for British maternity hospitals. I suggest, however, that it is still far too high, especially for primigravidae. The lay midwives of the Farm Community in Tennessee quote an overall episiotomy rate of 20.0%, with an intact perineum rate of 54.0%[10]. Should we not, as professionals, be able to do at least as well?

There must be a suspicion that many episiotomies, perhaps the majority, are performed "just in case" without any real indication. There is no doubt that it is "easier" to deliver a mother with an episiotomy. It requires less skill, less patience, less rapport with the mother and probably less time for the delivery. However, we, as midwives, should never forget the aftermath for the mother. There can be no cause for congratulation in managing a delivery in a way that makes it easier for the attendants, but offers no benefit to mother or baby.

In a small number of cases episiotomy may be beneficial, even life-saving. In these circumstances any good midwife will perform one. However, she will not enjoy doing so and will be conscious that exceptional circumstances justify exceptional measures. It is encouraging to learn that in at least one obstetric unit the midwifery policy includes a recommendation that the midwife should always aim for an intact perineum unless there are definite contra-indications. Where an episiotomy is performed the indication must be recorded in the notes[11].

One would not presume to say, without personal knowledge of a case, whether any particular episiotomy was, or was not, justified. All that one would ask is that midwives should carefully consider each case on its merits and that, before picking up the scissors, a midwife should be satisfied that there is no reasonable alternative. It is not a very satisfactory state of affairs to find, as my study revealed, that the likelihood of episiotomy is apparently determined, not by the condition of mother or baby, but by which midwife is allocated to the case.

As I suggested earlier, the onus is not on the midwife to prove that routine episiotomy is unnecessary. The onus lies with the advocates of episiotomy to justify the claims made for it and accepted without question for so long. So far no evidence has been offered. Until, and unless, it is, the midwife should again seek to establish the intact perineum as one of the hallmarks of her skill.

Postscript

This paper was originally written in January 1983 as an assignment for the Advanced Diploma in Midwifery. Since its existence became known within my own unit I have been amazed and gratified by the degree of interest shown by both midwives and obstetricians.

I have been invited to present the paper to midwives' study days, to an obstetricians' clinical meeting and to a meeting of general practitioner obstetricians. Considerable discussion has resulted from these meetings and there is now a clear intention to seek to reduce the use of episiotomy to a minimum. It has also been agreed that, in future, whenever episiotomy is performed, the indication must be recorded in the case notes and in the delivery register.

I hope, after a suitable interval, to carry out a further retrospective study to assess the effect of the recent discussions.

References

1. READING, A.E. *et al.* How women view post-episiotomy pain. *Br. Med. Journ.*, 1982, 284, 243.
2. BUCHAN, P.C. & NICHOLLS, J.A.J. Pain after episiotomy—a comparison of two methods of repair. *Journ. Roy. Coll. Gen. Pract.* 1980, 30, 297.
3. FOX, J.S. Episiotomy. *Mid Chron.* 1979, Oct, 337
4. KITZINGER, S. & WALTERS, R. *Some women's experience of episiotomy.* Nat. Childbirth Trust, 1981.
5. NUGENT, F.B. The primiparous perineum after forceps delivery. A follow-up comparison of results with and without episiotomy. *Am. J. Obstet. Gynaecol.*, 1935, 30, 249.
6. NEWTON, M. *et al.* Blood loss during and immediately after delivery. *Obstet. Gynaecol.*, 1961, 17, 9.
7. CALDEYRO-BARCIA, R. The influence of maternal bearing-down efforts during the second stage on fetal well-being. *Birth and the Family Journ.*, 1979, 6, 17
8. BOWE, N.L. Intact perineum: a slow delivery of the head does not adversely affect the outcome of the newborn. *J. Nurse Mid.*, 1981, Mar/Apr., 5.
9. HOUSE, M.J. Episiotomy — indications, technique and results. *Mid. Hlth. Vis. Comm. Nurse*, 1981, Jan, 6.
10. GASKIN, I.M. *Spiritual Midwifery.* The Farm Book Publishing Co. Tennessee, USA.
11. KESBY, O.M.E. Care in labour — the need for a midwifery policy. *Mid. Chron.*, 1983, Jan 9.

22 Chaseview Road
Alrewas
Burton-on-Trent
STAFFS. DE137EL

8th June 1985

Dear Ms Larkin,

I understand from the Editor of the "Midwives Chronicle" that you would like to reprint my article on 'Episiotomy'. I am happy for you to do so.

You may be interested to know that since September 1983 when my work was first discussed within the hospital there has been a steady decline in our episiotomy rate (at Birmingham Maternity Hospital). The overall rate for 1984 was only 20.3% - less than half the rate I found in my study. Very encouraging!

I wish your organisation well. Midwives and mothers working together to improve conditions can, I am sure, exert a powerful influence.

Yours sincerely,

Valerie A. Wilkerson

****

Another recent study entitled 'Episiotomy in Normal Delivery' by Jennifer Sleep SRN, a midwifery tutor at the Royal Berkshire Hospital - Nursing Times November 21, 1984, provides further information on the controversy surrounding episiotomy.

Thankyou to Lynda Williams

SAVE THE MIDWIVES POLICY QUESTIONNAIRE : MIDWIFERY

Please use extra paper if necessary.

1) Why did you join the Save The Midwives Association?

2) If you are a midwife, are you satisfied with the representation you receive through the New Zealand Nurses' Association?
Comment?

3) Would you support the formation of an association for midwives along the lines of the British Royal College of Midwives?

4) Should such a College of Midwifery undertake full responsibility for midwifery training?

5) What is your attitude to direct-entry midwifery training in the light of the three-year U.K. course?

6)Do you think that current midwifery training in NZ is the best that it could be?

7) Are you a)personally and b)generally satisfied with the current role of the midwife in N.Z?

8) The W.H.O.'s Definition of a Midwife is "a midwife is a person who is qualified to practise midwifery. She is trained to give the necessary care, supervision and dvice to women during pregnancy, labour and the post-natal period, to conduct deliveries on her own responsibility and to care for the newly born infant. This care includes preventive measures and the detection of abnormal conditions in mother and child, the procurement of medical assistance, and the execution of emergency measures in the abscence of medical help. She has an important task in health counselling and education, not only for the parents but also within the family and the community. The work should include antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care".

Does you work experience place you within that definition?

SAVE THE MIDWIVES was formed in response to a crisis in midwifery. The crisis looks as if it may be permanent. We would like your suggestions on the role and future of Save The Midwives.

PLEASE RETURN TO : Barbara McFarlane, 11 Manapau St., Meadowbank, Auckland.
NAME_____ _____Are you a midwife_____parent_____

If a midwife, are you employed in a base bospital_____small hospital_____

domiciliary_____retired(temporarily or otherwise) _____

SAVE THE MIDWIVES

NEWS ABOUT OUR ORGANISATION

NEWSLETTER

Midwife Lil Dunn is now putting the newsletter together.Lil did her nursing in Canada and her midwifery in Scotland, and is presently working in antenatal care at Middlemore Hospital, Auckland,including a couple of mornings a week in the two antenatal clinics that Middlemore runs in the community.Lil lives in Papakura, and could do with some assistance with collating the newsletter - any midwife or mother out that way who would like to help can contact Lil on 298 4610.

SUBS/TREASURY

We still need some help with this small but very necessary task - about 2 hours aweek is all it would take, at the very most.Please contact Judy Larkin, 602 301, if you are able to assist.

ACTION

We have been heavily involved, through the Maternity Action coalition, in keeping Auckland's small maternity hospitals open.We were suœssful! See MEDIAWATCH for more information,and subscribe to MA's newsletter if you want more detail - see below.

SAVE THE MIDWIVES POLICY STATEMENT

Save The Midwives supports and promotes midwifery as an independent profession;supports direct-entry midwifery, domiciliary midwifery, and the right of parents to information and choice in all aspects pertaining to childbirth .
At present we have 300 members, approximately half of whom are midwives.

ma
MATERNITY ACTION

NEWS FROM MATERNITY ACTION

Auckland's small maternity hospitals are staying open!Maternity Action was successful in co-ordinating support for this option in childbirth, and has become a strong, closely knit network of people working towards the same end - freedom of choice in childbirth. MA's first newsletter has just been sent out, and anyone who would like a copy can send $2 to Sue Smurthwaite, MA's secretary, at Mullins Rd, R.D.2, Papakura, to cover photocopying and postage costs.

The Auckland Hospital Board has set up a Maternal and Neonatal Services Committee, to advise it on all aspects pertaining to these services. Fourteen professional members, including 8 doctors(sigh! not again!) were originally appointed but after strong protest from academic obstetricians and consumers, the committee has been disbanded, to be reconstituted in 3 - 6 months.The Board wants a "cooling-off" period before it reconsiders the membership.Hopefully a parents representative from Maternity Action will be on the new committee in 3 months time.More information can be obtained from MA's newsletter (see above).

OUR NEXT MEETING

will be held at the CIVIC TRUST BUILDING, 29 PRINCES ST, AUCKLAND (opposite the University Old Arts Building)
at 8 pm on Monday, August 5
and thereafter at the same time and same place on September 2, October 7, November 4, December 2.
Rental for the Civic Trust is $10 per evening, and if we could recoup this by donation each evening we would be financially healthier. Our present bank balance will just pay for this year's newsletters.
Do come along and meet midwives and mothers of like mind - IT'S JUST WHAT YOU NEED!!!

SAVE THE MIDWIVES supports and promotes midwifery as an independent profession; supports direct-entry midwifery, domiciliary midwifery, and the right of parents to information and choice in all aspects pertaining to childbirth.

SAVE THE MIDWIVES

c/o 24 ASHTON RD. MT EDEN. AUCKLAND
NEW ZEALAND

NAME _____ _____

ADDRESS _____

_____

mother____midwife____other_____

SUB p.a. $4____ $6_____ $10_____ (your choice)

new_____renew_____

Australia $NZ10 International $NZ15

I can help with Typing____

subscription processing_____

posting out____ artwork_____

SAVE THE MIDWIVES ASSOCIATION CHANGE OF ADDRESS FORM

24 Ashton Rd, Mt Eden, Auckland, New Zealand.

NAME _____ NEW PHONE No. ↓

NEW ADDRESS _____ _____

_____

Effect change from_____ OLD ADDRESS_____

This is a quarterly publication. Please allow up to 3 months to receive your first copy.