Waikato Home Birth Association Inc. Newsmagazine 1998

Expiry 7/99

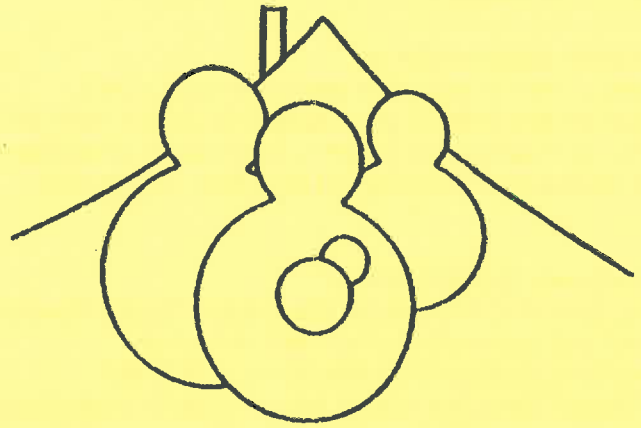
Disclaimer: Opinions expressed in this magazine are not necessarily those of the Waikato Home Birth Association Inc.

WHBA CORE GROUP MEETING
MONDAY 21 SEPTEMBER 7.30 PM
PHONE 855-6997

SENDER:
Waikato Home Birth Association Inc.
P.O. Box 12099
HAMILTON

Waikato Home Birth Association Inc.

Newsmagazine 1998



SEPTEMBER

PHONE NUMBERS:

Karen Benge	855-5003	Chairperson WHBA Inc.
Glennise Head	846-4925	Treasurer
Joanne Ridder	847-4987	Mailing List Coordinator
Karen Walker	825-5025	Newsmagazine Editor

Please post Birth Stories & articles to Karen
Old Mountain Rd, R.D. 1, Waitetuna Valley, Raglan

The **W.H.B.A. Library** is now located at
"Parents Place" 113 Rostrevor St, ph 838-2229 Hamilton.
Phone Joanne Ridder if you have any problems.

COMING EVENTS - September - October.

Note these dates on your calendar

WHBA Core Group Meeting
Monday 21 September, 7.30pm at 28 Claudelands Rd, ph 855-6997.
Contact Gabi Klapka ph 849-7015 for the agenda.
ALL MEMBERS INVITED TO ATTEND.

Home Birthers' Coffee Morning
Friday 25 September, 10am, bring a plate and share morning tea at 40 Vardon Rd. Bring your babies and toddlers. Welcome to all members.
Contact Brigid Devcich ph 849-9478.

Cambridge Home Birth Support Group
Tuesday 13 October, 10am bring a plate and share morning tea.
Contact Tania Bullick ph 827-5165 or Vanessa McColl ph 827-4516 for details of the address. Bring your babies and toddlers. Welcome to all members.
Meeting regularly on the first Tuesday of the month. (Note this exception)

Immunisation Awareness Support Group
Sunday 4 October, 2pm at 10 Thames St. **Discussion Topic: Diptheria,** bring any information you have collected to share with others.
Welcome to all members. Contact Clare Shallcross ph 855-6997.
"For an Informed Choice" tapes -two copies are available to borrow from the WHBA Library.

Preparation for Birth Classes
Series begins **Thursday 15 October 1998,** 7.30 - 9.30pm for 5 weeks at the "Parents Place" 113 Rostrevor St.
Weekend Series: Saturday 21 & 28 November.
Contact Vanessa McColl ph 827-4516.

Raglan Preparation for Birth Classes
Saturday 17 October, 10am - 3pm. Contact Adele Buckton ph 825-8942.

Pregnancy Yoga and Relaxation Classes
Thursday evenings at 5.30pm, at the "Parents Place", 113 Rostrevor St.
Contact Paulette Whitford ph 847-7033.

Te Ahuru Mowai o Waikato - Whakawhanau ki te kainga. The Sheltered Haven Homebirth for Maori Women. Contact Rangimarie Hohaia 07-871-5858
Te Awamutu Home Birth Support Group
Contact Karene Clark ph 07-871-9114 or Helleni Quirke ph 07-870-2622
Morrinsville/Te Aroha Area Home Birth Support Group
Date and time to be confirmed. Welcome to all members.
Contact Heidi Jennings ph 07-889-0581.

Have You Considered A Home Birth?" Booklets.

Free copies of these booklets are available for distribution by Midwives, who are financial members of the WHBA.
Copies are also available free to interested members.
For non financial members of the WHBA there is a 50cent charge per copy.

AHBA: A Guide to Healthy Pregnancy & Childbirth.

These books are also available for purchase at $25 per copy.
Please contact Joanne Ridder, ph 847-4987.

SUBSCRIPTION FORM

If there is a **GREEN** spot on this form then it is time to renew your subscription.

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The **$20 minimum fee** will list me as a member of the Association and entitles me to 11 issues of the Newsmagazine and use of the Library, located at the "Parents Place" 113 Rostrevor St, Hamilton, ph 838-2229.

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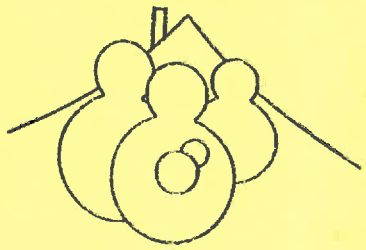

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.....

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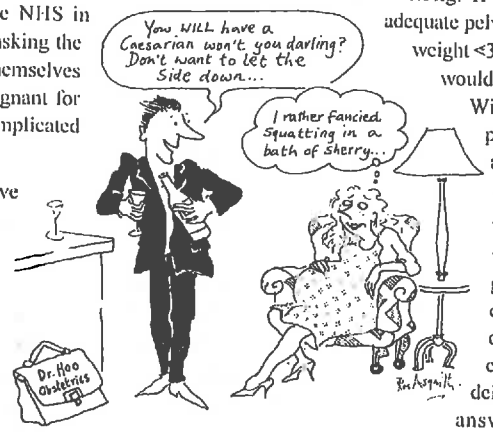
Obstetricians' personal choice and mode of delivery

How would obstetricians choose to give birth? A structured anonymous postal survey of 282 obstetric consultants, senior registrars nd registrars working in the NHS in London was carried out, asking the respondents to imagine themselves or their partners to be pregnant for the first time, with an uncomplicated pregnancy.

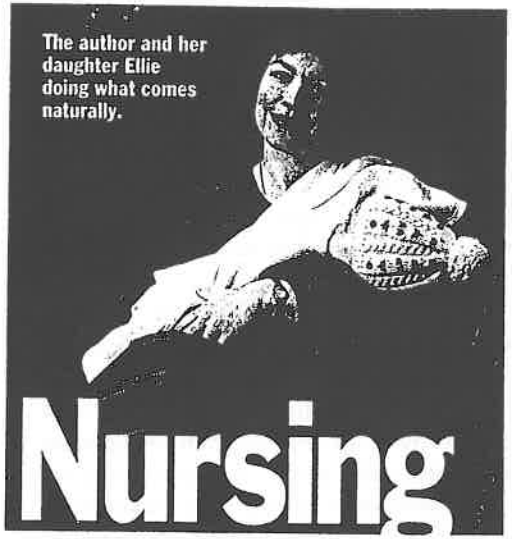


17% would opt for an elective caesarean section for a singleton, term, cephalic presentation — 31% of the female obstetricians, and 8% of the males (p=0.001). Of this group, 80% gave fear of perineal damage as a reason, and all indicated fear of long term sequelae such as incontinence. 58% acknowledged concerns about damage to sexual function; 39% cited fear of damage to the baby and 27% wanted a known time and date of delivery. With an estimated fetal weight between 4–4.5kg, 39% would go for an elective section; this figure rose to 68% if the baby was estimated to wiegh over 4.5kg. If the baby was breech, with adequate pelvimetry and an estimated fetal weight <3.8kg, 57% of those questioned would opt for an elective caesarean. With an uncomplicated twin pregnancy, 40% would choose an elective section rather than any trial of labour.

This personal preference is at variance with current clinical guidelines and raises questions about the way obstetricians counsel their clients about choices for delivery. How would midwives answer the same questions, I wonder?

Al-Mufti R, McCarthy A, Fisk NM. Lancet, vol 347, no 9000, 24 Feb 1996, p 544.

In My Opinion



Nursing a Grudge

Why is it that women who bare all in Wonderbras and bustiers are the height of fashion, while breast-feeding moms are social pariahs?

BY PAULA SPENCER

Understand this about me: I don't wear Birkenstock sandals, eat tofu, meditate or practice yoga. Nor do I abhor mascara or leg shaving. In short, I am not the earth-mama type. Nevertheless, the one "natural" behavior I do indulge in—breast-feeding my baby—manages to cause embarrassment and discomfort to others, all the same.

Luckily, I have yet to be treated as rudely as the mother I read about recently in Princeton, New Jersey, who was asked by a store manager to stop nursing or leave his store. She might offend other customers, he said. What if a young child should see her? Since she was in a toy store, the chances were pretty good that a child *would* see her, though what emotional damage might result was never made clear.

The store manager should be glad he doesn't work in New York, which just became the latest of a handful of states to make it a civil-rights' violation to kick a breast-feeding mother out of a public space. In Albany, some 50 women held a nurse-in to lobby for such a law. It's a sad commentary on our national nervousness about breasts that women should be so harassed over feeding their infants that they need civil-rights protection.

Sad, yes. But surprising, no. Breasts are the object of more double standards, if you will, than any other part of the human anatomy. Americans are breast obsessed—which unfortunately isn't the same as breast mature.

Every day, every few minutes, for that matter, you can tune in the TV or go to the movies and watch breasts jiggling and bouncing across the screen, on everything from sitcoms to serious dramas. But when's the last time you saw a nursing mother depicted on a soap opera or a made-for-TV movie? Surely decency isn't the issue—the average high-school prom dress today exposes more bosom than a nursing infant does. You see breasts at the beach covered by nothing more than a wisp of Lycra and nobody complains, but watch people squirm when they see a baby latched on.

You'll find plenty of breasts in your mailbox too: cleavage in catalogs, bare nipples in fashion magazines and celebrity photos that specialize in navel-grazing décolletages. But don't even waste your time looking for real clothes tailored to the purpose of nursing.

Granted, before my firstborn arrived, the idea of breast-feeding made me a little nervous. Chalk it up to an uptight cultural conditioning that programmed me to consider my breasts some titillating secret not meant for polite society. I knew in my heart, however, that breast milk was better for my child, not to mention convenient and cheap, and so I joined the more than half of all new mothers who nourish their babies this way.

I have opened my shirtfront in stores and restaurants, at my office and at church, and even on airplanes, once in the middle seat between two suited businessmen. Between my nursing bras with their discreet, easy openings, and a receiving blanket or a shawl draped across my shoulder, few around me have been aware of the feeding. But even if onlookers are as distressed as that Princeton toy-store manager, it's just not my problem.

In fact, to mortified onlookers I say, "Grow up!" And wake up to some basic anatomy: Breasts are functional. There is more to having them and exposing them than silicone implants and Wonderbras and Playmates of the Month.

I'd like to think that by the time my daughter is ready to nurse her own babies, she'll find a world more welcoming of breast-feeding than the one she was born into. Maybe by then mothers won't feel as if they have to hide in shame while doing with their breasts what nature intended. It's a nice wish and one that makes a lot of sense. Still, I wouldn't bet the Birkenstocks on it. WD

EDITOR'S NOTE: We open this page to opinions everyone can learn from, even if we don't always agree.

LITTLE VALENTINE

While I was pregnant I loved getting my Home Birth Magazine and reading the birth stories - they all bought loving tears to my eyes as I felt along with the woman and as I anxiously awaited my turn. I never considered how difficult it is to express your true feelings and the birthing experience in words but I have attempted to at least capture part of this amazingly awesome experience....

It all started just after midnight on Thursday the 12th of February - I got up for one of my many nightly visits to the toilet, had a show and realised that the heavy "period like" ache I'd been feeling over the last couple of days was, as I had suspected, the start of our new life - things would never be the same again! I woke Karl up and told him things were happening and like every other couple, we tried to get some sleep. I was too excited though but did manage to doze. I continued to have very comfortable contractions through the night and most of the next day up until about 2.00 pm. We'd made a bed in our lounge and I just lay there relaxing thinking to myself "well if this is what contractions are all about, I can handle this", boy was I wrong!!! We phoned our support people: my Mum and Dad, a good friend Lynda and my sister Rachel and told them things were underway but not to hurry as we had plenty of time and we phoned Paulette, our Midwife and she told us to call her back around 6pm to see how things were going. Karl managed to fill his day looking after me and doing all those necessary preparatory things such as going to the supermarket and mowing the lawns?? My parents arrived around lunch-time stocked to the hilt with food which came as a blessing during the week after the birth - I think the best support a new family can have is plenty of pre-cooked, yummy dinners all ready to go! By 2pm the contractions were getting pretty full-on and we began timing them - 3 minutes apart and lasting about 1 minute (what ever that means!! who cares, they were really starting to hurt!!). Anyway by now I was starting to get a bit scared - thinking that things were about to happen pretty soon so I got Karl to ring Paulette who said she'd be around soon (boy was I wrong again!! And I'm sorry Paulette for calling you in so soon). I spent a very long, tiring 24 more hours moving around the house going from hands and knees, to birth pool, to sitting on the toilet where Paulette and Maggie both decided I was better off since that was where I was having my strongest contractions and we really needed to get things going - they told me I had to go and sit on the toilet and do 20 more contractions - "20 MORE CONTRACTIONS!!! WHAT" - but to everyone's relief, it worked. And when I felt his head crown I was so relieved, I knew we were almost there and I could do anything now! Towards the end I was utterly exhausted, my knees ached and I was shaking uncontrollably - on the surface I was ready to give in but deep down I wanted to birth this baby naturally and the thought of giving up and transferring to hospital was a disappointing one, never mind the thought of a car trip at this stage - that in itself was enough to stay put?! Everyone knew how much I wanted to give birth naturally at home and they fought my "I can't do it anymore and I'm too tired,

rewards; a trip to the playground or something of this nature gives them positive time with you and does not get you trapped into ongoing bribes.
Do not keep insisting that your child uses the potty if you are getting nowhere. The best time is when they are interested, which may not coincide with your wishes. Try not to overdo the number of times you ask them to use the potty as this will often produce refusals. Before bed or a car trip, and after meals is usually enough.
Remember, you are not failing as a parent if your child is not trained when some of his peers are. Sometimes it is just not possible to put in the extra time needed for all those false alarms and clothes removals. Moving house and other family crises don't schedule themselves around toddlers' toilet training and the interest may wane, but it will return (although not always as soon as you would like).
Some children will train for urine, but refuse to open their bowels anywhere but their nappy. The more fuss you make, the longer this goes on; left alone it does come right, although it can take some time and become hard to ignore. Be very matter of fact about cleaning up after a dirty nappy; use cold water to wash his bottom so that it is not pleasant for him, and try not to say too much. Praise him if he uses the toilet or potty for urine and remind him that this shows he is a "big" boy now. Leaving nappies off in an endeavour to force your child to use the potty often makes the child wait until night time when the nappy is put on, with all the unpleasant upset when the child is settling for the evening.
Alternatively, it can lead to the child holding onto their bowel motion for several days causing constipation which makes everything worse. A star chart may help.
Children with a family history of late training are often later than usual to gain bowel and bladder control. The positive side of this is that, because there is not the same expectation, the eventual training is accomplished quickly when the child is interested and aware of his body's messages.
Sometimes a child who has been reliably trained for some time regresses with a change in their life (anything from a new baby in the family to moving house).Try to keep calm, give them some special time with you each day so that they feel secure and loved, and quietly retrace your training steps. It usually passes quite quickly.
Night control comes as the child learns to wake up when his body tells him his bladder is full. Some time after 3 years of age when your child is reliably trained during the day, you can try leaving the nappies off one night, after first telling him that he could try going to the toilet that night. Protect the bed from any accidents and see what happens. If the child wets the bed, just matter of factly put the nappies back on the next night and say "we'll try again when you are a little bigger". This avoids making an issue out of it, and the child is usually quite happy to try again at some other stage.
Remember that more than 10 per cent of children aged 5 years of age still wet the bed at night. Each year after that about 15 per cent of those children become dry at night. Toilet training is a major step in independence for your child. Be as relaxed as you can. There is no "right way" to toilet train a child; everyone does it a little differently. Your Plunket nurse or Plunket Karitane Family Centre may be able to help with specific problems.

Helen Tomson. Little Treasures Oct/Nov1995

TIME FOR THE TOILET: When should I toilet train my child? And how?

Most children gain control of their bowels and bladder between 18 months and 5 years. Usually day control comes several months earlier than night control; and the children who train early (from around 18 to 20 months) are usually girls.

Well-meaning people make comments like:

· Is he still in nappies?

· My children were all trained day and night by one year.

· Don't you think you should have him out of nappies before the new baby comes?

These can make parents feel they have failed in their parenting. A lot of this implied criticism comes from the days of "holding out": a child-rearing practice of over 20 years ago, which involved putting young children on a potty after a meal, the time most likely to produce a result. It was purely a "catching" method and had little to do with the child learning control. You cannot force control of your child's body on them; they have to learn how to gain control themselves.

Children are ready to start training when they become aware of passing urine or having a bowel motion. They may tell you as they are doing this. This occurs more commonly about 2 years of age, however about one third of children are not trained until about 3 years of age (most often boys).

Children learn most quickly by copying so, when the interest is there, go out of your way to show them another child successfully using a potty, or take them with you into the toilet. Leave the potty in the same place - somewhere accessible is best, like the floor in the toilet. Dress your child in easily removed clothes: they get very little warning in these early stages.

Sometimes you need to "prompt" your child, by asking if they need to do wees or poos now, and asking where they go to do this. You won't always get the answer you want, because toilet training coincides with the age of learning how to make choices. Your children will learn what is acceptable behaviour and what is not but, while learning this, can be quite contradictory.

Try to remain relaxed if your child is contrary and, if there is an accident, treat it with the minimum of fuss. You might say "Did you forget to do wees on the potty?" and let them help clean themselves. Mistakes and accidents can, and do, occur - often for some time after training has commenced - and can lead to a battle of wills between child and parents. Try to anticipate these accidents - as with all new skills, there are refinements to be made. When children start to walk, they take numerous tumbles before they get it right, but with toilet training parents are inclined to think that after one perfect day the child is fully trained - and any accidents are naughtiness.

Often, in the early days, the only warning a child gets is as the action starts to take place. If they say something, but their pants are wet, praise them anyway: it will make the outcome seem better. For children who get engrossed in their play and miss the message, a star chart may help. At first, give them a small reward when they have received about two stars for successfully using the potty. If success follows, lengthen the intervals of reward. Try not to use food or toys as

I've had enough" with reassurance and sincerity telling me "I really think you can do this Rebecca" and I thank them all for sticking with me. So around 4.30 pm on Saturday the 14th February little Paddy (Patrick Alexander Little) was born (7lb 9oz). The whole experience was very intense but also the most incredible thing I have ever done and the actual birth I really enjoyed - feeling the head move down and twist, the absolute stinging stretch of my perineum and then his arrival into our world with a big gush and the most beautiful scent which overpowered any pain. It is painful but not pain as we know it and the pain is soon over ridden by a sense of empowerment. My waters broke as he was born and Karl, looking both shocked and ecstatic, caught him. To see the tears and the look on Karl's face (both of happiness and relief I imagine) bought a real warmth to my heart and topped off a perfect day. Karl cut and tied the cord and after birthing the placenta I lay on the bed and cuddled and fed our new little friend; it was bliss to lie there with him and to have my family around - I had a smile a mile long. It was a beautiful experience for us all and I was the proudest Mum on earth that day!

Rebecca Baxter and Karl Little

BIRTH NOTICES

On	these parents:	had a:	named:	where:	Midwife / s
6/8/98	Jody & Marshall Christian	son	Taran	Hamilton	Dawn
11/8/98	Andrea McMurray & Robbie Lewis	son	Levi	Hamilton	Pat
12/8/98	Sarah Carroll & Eddie	son	Jason	Hamilton	Adele
14/8/98	Judith & Peter Challis	son	Finn	Matamata	Maggie/Kerri
17/8/98	Trudy & Darren Cutler	son	Zachari	Hamilton	Christine
20/8/98	Catherine & Graeme Hall	son	Drew	Hamilton	Maureen/Maggie
20/8/98	Antoinette Van de Weerden & Peter Caldwell	son		Hamilton	Maggie/Kerri
20/8/98	Margaret & John Wisst	son	Jordan	Taupiri	Maggie/Kerri
20/8/98	Yvette Harry & Stu	daughter	Reeve	Raglan	Lyn/Adele
20/8/98	Corrie Rangiwaia & Donald Dunsmuir	son	Christian	Hamilton	Paulette/Heather
24/8/98	Rachel Gregory & Kelly Tait	son	Jordan	Hamilton	Lyn/ Liz
29/8/98	Vicki & Ian Pullon	son	Troy	Putaruru	Lyn/Rangimarie
4/9/98	Miriama Kupe & Nathan Kennedy	daughter	Mere	Hamilton	Paulette/Heather

When mother knows best

Science has hijacked childbirth and has done its best to dictate the do's and dont's of infant care. Mary Nolan argues that parental instincts should be encouraged and nurtured, even when they conflict with the 'experts'

IS PARENTING IN CRISIS? Are the natural instincts so deadened that mothers and fathers have to rely on professionals to guide them through every aspect of caring for their new babies? If, for example, a mother feels she and her baby are happier, and have a better night's sleep if they share a bed, should she feel constrained by 'expert' advice that co-sleeping is dangerous?

The Department of Health's recent report, *Improving the health of mothers and children*[1] states: 'Infant health problems include colic, night waking and crying. Such problems can cause great disruption to the family and are a common cause of primary healthcare consultations for children under four years (and out-of-hours consultation) and of accident and emergency admissions. Little is known about what constitutes 'normal' behaviour in infants or the most effective forms of treatment and management of these common complaints.'

Over the past 50 years, the medicalisation of childbirth has effectively convinced women that they do not know how to give birth. Now, it would appear, the ability of parents to recognise normal behaviour in their children is being doubted. However, the debate about parenthood cannot afford to be merely scientific. It must reaffirm the importance of instinct, of women's and men's innate understanding of the business of infant rearing.

Bonding

During the first few hours after birth, the behaviour of the baby is designed to attract and retain the mother's attention and activate the natural protective mechanism that makes women place the well-being of their children before all else. A baby who has received no drugs during labour is alert at birth, and keen to make eye contact with his mother — to fix her gaze on his.

Most undrugged women are elated after labour. Even those who have had long, difficult births often find that they cannot sleep. They want to be with their babies, getting to know them, bonding. These first hours are meant not for sleep, but for closeness.

When a baby is born in hospital, he is placed in a see-through crib at his mother's bedside. The separation is justified on the grounds that the mother needs to rest and that the baby may fall out of the bed if she has him next to her.

Postnatal wards are full of mothers, lying gazing at their babies through the sides of the cots or stretching out to touch them. Women who take their babies into bed with them may be reprimanded.

A baby who is born at home is much more likely to be tucked up in bed with his mother, and perhaps his father, for the first hours of his life. Instinct directs that the baby is going to feel most secure in his strange new world if he can feel his mother's skin, smell her smell and hear her voice close by.

The first days of motherhood are a time when women can learn about their babies and enjoy them if they are well supported and given confidence in their own abilities. Women often complain of conflicting information during this period and are puzzled when the advice they receive is directly opposed to what they instinctively want to do.

These mothers' experiences are perhaps not unrepresentative: 'I was sitting very comfortably in a chair in my hospital room, feeding my baby, when a nurse came in and said: "Feeding again? You're making a rod for your own back with that baby." I didn't stop feeding Sophie, but all my pleasure in holding her had disappeared.'

'I carried Josh with me everywhere. I didn't want to put him down. Then a midwife told me I must wheel him around in his cot and she didn't want to see me walking up the ward carrying him again. I didn't do what she said, but I did go home as soon as possible.'

Child seat link to back problems

The Press, Christchurch, April 1998

Babies left in car seats for long periods are more likely to grow up with back problems, physiotherapists say. The seats, originally designed to be used while driving from one place to another, hold the spine in an unnatural position, New Zealand Society of Physiotherapists President Lee Gardiner said.

Modern car seat "capsules" could be taken from the car and the baby carried around in them, she said. This meant babies spent much longer in the capsules. Manufacturers had also provided buggies to slot the capsules into.

Mrs Gardiner said although there had been no research linking the car seats with back problems, physiotherapists were seeing more and younger children with neck and back problems.

"Capsules were not intended to be used as cots or prams. It is not good for children to be in the curved posture, they should be taken out and laid flat," she said. Poor posture, inadequate school furniture, and hours spent in front of computers and televisions also contributed to back problems.

I Am a Midwife

I visit you at home,
learn your children's names,
drink tea with you,
I talk with you,
hear your hopes and dreams for this child of yours.
And your fears?
I hear these also.
I get to know you and all you care about.
The time has come,
there is power in your body.
It slowly builds up,
then slowly goes.
Like waves breaking on the beach,
the power ebbs and flows.
You welcome each wave but want them to stop.
I am there,
I hold your hand,
smile.
I whisper "you are doing this,
you are strong,
I am with you."
I rub your back,
help you to the shower.
I try hot packs,
I encourage you to change position,
to sweat, to cry, to laugh, to groan.
The waves continue,
getting stronger and stronger,
relentless.
When will this end?
The energy within scares you.
You feel lost,
cast adrift,
isolated somehow from those so close.
Soon this energy will leave your body.
Before then, though, there is more work to do.
Your family encourage you,
tell you they love you,
believe in you.
I am there.
I say to you,
"Don't be afraid,
trust your body,
do what it is telling you to do."
You move around, you try to get comfortable.
It is impossible.
You groan, you scream, you swear.
Your whanau surround you.
I am there.
You have waited expectantly for this moment.
It is here.

Soft,
silky hair slowly emerges.
Breathe, breathe your baby out.
You reach down and touch your baby's soft slippery skin
for the first time.
You hold your baby.
Your baby is wide-eyed,
taking in his new world.
I am there.
But this is just the beginning,
there is so much to learn.
Your baby feeds hungrily at your breast,
he has worked hard also.
Slowly you get to know your baby.
He feeds, he cries,
he sleeps, he cries.
You bathe him, you change him;
he is yours, you are his.
Again I visit you at home.
I listen to your questions. Are those spots normal?
Should he be drinking this often?
Are you sure his pito is supposed to look like that?

You are tired.
How can a baby possibly take up this much time?
I express my admiration,
you are doing so well.
Your baby is well cared for.
You are this baby's mother.
I am with you.
I am a midwife.

Annie Hogan – Midwife

NZ College of Midwives Journal 17 – October 1997

Caroline Flint, President of the Royal College of Midwives, urges midwives to promote women's confidence in their mothering skills. She believes advice is rarely needed and should never be offered unless asked for, but reassurance and encouragement are always welcome. She suggests that women can be encouraged by remarks such as 'You do look after your baby well,' and 'Doesn't he love your milk! You breastfeed him so beautifully.'[2]

The conflicting advice from health professionals is exacerbated by society's attitudes. The principal goal of early parenting seems to be to have an undisturbed night's sleep. Mothers are asked 'Is he a good baby?' which means 'Does he sleep for long periods?'

All sorts of strategies are suggested to encourage the baby, and later on, the toddler, to sleep for longer. Most of these fail to recognise that tiny babies do not have routines and are not designed to sleep for hours on end. A routine is an entirely adult concept and means nothing at all to a newborn infant who is driven by the need to survive — which means filling his walnut-sized tummy at regular intervals.

Rather than advising women how to fight what the baby wants, it may be better to help them respond to their babies' needs in a way that conserves mother's energy and baby's temper.

A breastfed baby is most easily fed in the middle of the night if he is tucked up in bed next to his mother, but many people argue against co-sleeping. The overriding argument is that it is dangerous.

The cot death debate

It is tempting to think that the reduction in cot deaths we have seen in recent years means the problem has been successfully tackled by getting mothers to put their babies to sleep on their backs or sides.

However, a letter to the *British Medical Journal* warns against complacency: 'For the 10 years up to 1991, about 10 cases of sudden unexpected infant death occurred each year in South Glamorgan, an incidence of just under 2/1,000 live births. As in the rest of Britain, the incidence halved in 1992.

'In the first six months of this year, six sudden unexplained deaths in infancy occurred in South Glamorgan — more than we saw throughout the whole of last year. We cannot tell whether the present decline in cot death in Britain and elsewhere is real or just a random variation in incidence. To imply that the nut has been cracked is to invite complacency.'[3]

Researchers are still trying to identify the factors that contribute to sudden infant death syndrome (SIDS). Scragg *et al.* have looked at the exceptionally high rate of cot death in New Zealand's Maori community, where mothers and babies routinely co-sleep and many mothers are smokers.[4] The study concludes that although there is no evidence to support the theory that babies are at risk from overheating or of their mothers rolling over on them, they are at a significantly increased risk of cot death if they share a bed with mothers who are smokers. Scragg *et al.* are unable to decide whether co-sleeping without maternal smoking is a risk factor: 'Our findings for infants of non-smoking mothers are conflicting. Any increase in the risk of sudden death from bed sharing in this group needs to be balanced against the possible benefits from bed sharing.'

Benefits of bed sharing

These possible benefits have been explored by James McKenna and his team of researchers in California, who have monitored the sleep patterns of mothers and infants co-sleeping and in separate rooms.[5]

The team looked at the evidence from medical anthropology and asked why nearly all cultures worldwide practise breastfeeding and co-sleeping in tandem, while western industrialised societies largely frown on mother and baby sharing a bed.

Their studies show that the environment of babies who sleep with their mothers is infinitely richer than that of babies who sleep alone. The team reports: 'Through a combination of nursing, active or passing embracing, enclosing and passive touching, co-sleeping infants and mothers are in physical contact ranging from 28% to 99% of the observed period compared with 2% to 14% on solitary sleep nights.'[5]

Co-sleeping infants in the study spent less time in deep sleep than when sleeping alone. This may be a natural mechanism for preventing cot death while the infant's respiratory centre is immature.

Mothers breastfed their babies more frequently when co-sleeping, but for shorter periods. The researchers conclude that the large number of small interactions between co-sleeping mothers and babies during the night causes an increased physiological variability in the infants' sleep patterns, and suggest that protective arousals are produced in response to infant cardiorespiratory crises.

Face-to-face orientation is usual when infants sleep with their mothers. Perhaps the proportion of carbon dioxide in the air around the baby is increased, thus stimulating respiration.

The Californian findings raise the question of whether infants who enjoy a rich sensory sleeping environment are better protected from cot death than those who sleep alone.

Speaking at a meeting organised by the Foundation for the Study of Infant Deaths in 1994, Davies asked whether it was reasonable to terminate suddenly the close relationship between mother

and baby by putting the infant to sleep separately.[6]

He said: 'The fact that in so many developing countries of the world and amongst certain ethnic groups in developed countries, SIDS is not recognised can only mean that protection is being conferred upon the very vulnerable baby. This is surely the time to change some fundamental attitudes in this country in how we look after young infants.'

Three in a bed

How many times does a midwife hear a new mother say she gets up in the night, not because her baby is crying, but simply to check that he is still breathing. It may be a myth that mothers sleep better if they are separated from their infants. Natural anxiety seems to demand a closeness that allows the mother to check the well-being of her baby at all times.

The findings in California suggest that arousal during the night when mother and baby co-sleep is frequent but brief. The baby often latches on to the breast to feed, and the mother wakes momentarily to adjust the baby's clothing or reposition him.

Deborah Jackson, in her controversial but well-argued book *Three in a Bed* contends that babies who co-sleep cry far less frequently than babies who are separated from their mothers at night.[7] She considers that the disruption to sleep caused by a baby screaming in the next room or in a crib next to the bed is far more profound than the small interactions that occur between a half-sleeping mother and a secure, contented baby.

She argues that separate sleeping does not encourage independence in the baby, but has the opposite effect of promoting clinginess. 'Every child has a capacity for independence. If pushed too hurriedly into leaving his mother's side, he is likely to cling to her skirts for longer. Putting a baby to sleep in another room is the best way to create a rift and ensure that he comes running back for more.

'So when should a baby leave the parental bed? When he and his co-sleepers are ready.'

Developmental benefits

The practice of kangaroo care for premature and weak infants has become increasingly widespread. These babies thrive when carried close to their mothers at all times, and women bond more closely with these babies when they have constant skin-to-skin contact with them. It does not seem unreasonable to presume that healthy, full-term babies will also benefit from being kept close to their mothers.

French obstetrician Michel Odent has observed that Ugandan babies, whose mothers are often the victims of malnutrition and starvation, are developmentally more advanced at six months than their western counterparts. His explanation for this difference is that the Ugandan baby belongs to a culture where his dependence on his mother is acknowledged and facilitated at all times.[8]

It is not possible to verify babies' feelings scientifically. But perhaps we should ask ourselves how we think a baby feels when he wakes up in the middle of the night alone in his cot. He cannot see anything. His highly developed sense of smell is unable to detect the only smell he knows represents security — his mother. He cannot feel his mother's skin. He tastes nothing in his mouth. All is silent.

Sensual deprivation is known to cause serious psychological disturbance in adults. The baby lying alone in his cot responds to his isolation by crying. The consequence could well be a major night-time disturbance, with a screaming, inconsolable baby who takes a long time to feed, and longer still to coax back to sleep.

Combatting guilt

There is no doubt that many parents do sleep with their babies or small children. Few admit to it because they fear censure.

The late Hugh Jolly, an eminent paediatrician, recognised that his earlier views on co-sleeping needed to be reconsidered. 'I always used to advise parents against bringing their children into bed with them, but I have now changed. Many mothers have told me they cannot sleep if their baby is not in the bed. Many others have had their babies in their beds for years but felt guilty.

'Everything is much simpler if the baby is allowed to "sleep-feed", meaning that he sleeps alongside you in bed and feeds when he wants, often without waking you.'[9]

Parents do know how to care for their babies. Science can easily get in the way of successful parenting and we should take care not to rush in where angels fear to tread.

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References

1. Department of Health. *Improving the health of mothers and children: NHS priorities for research and development.* London: HMSO, 1995; 35.
2. Flint C. *Sensitive widwifery.* London: Heinemann Midwifery, 1987.
3. Davies D. Don't be complacent about cot death. *Br Med J* 1993; 307: 447.
4. Scragg R, Mitchell EA, Taylor BJ *et al.* Bed sharing, smoking and alcohol in the sudden infant death syndrome. *Br Med J* 1993; 307: 1312-1318.
5. McKenna J, Mosko S, Richard C *et al.* Experimental studies of infant-parent co-sleeping: mutual physiological and behavioral influences and their relevance to SIDS (sudden infant death syndrome). *Early Human Development* 1994; 38: 187-210.
6. Davies D. Ethnicity and SIDS: what have we learnt? *Early Human Development* 1994; 38: 219.
7. Jackson D. *Three in a bed.* London: Bloomsbury, 1990.
8. Odent M. *Primal health: a blueprint for our survival.* London: Century Hutchinson, 1986.
9. Jolly H. *Book of child care* (Revised Edition). London: Unwin, 1985.

trepidation, because I had experienced those feelings in my visualizations!

I didn't get to the hospital until I was six centimeters dilated. An hour later, I was fully effaced, dilated, and ready to push. Twenty minutes after that, Hannah Michelle was born!

During my labor, I was very excited to see my "ideal" birth unfold. But afterward, I looked at the experience realistically. It had provided me with confidence. It had readied me emotionally. The events themselves were so similar to what I had imagined. The clinical information corresponded exactly. Was it just a coincidence? Or, did it really influence the way my body reacted to the birth? I held on to the idea that somehow it *had* contributed.

When I became pregnant for the second time, I began to visualize again. My circumstances were different. I had chosen to have this baby at home with the help of two excellent midwives from my area. When I spoke to them about my first birth experience, I was encouraged to continue talking to the baby and "seeing" the birth.

My visualization began with time alone with my husband. I imagined a relaxing breakfast together. The afternoon would be spent with our two-year-old Hannah, the three of us at the park playing and laughing. As my labor began, I wanted to be able to walk on the beach. The gentle ebb and flow of the ocean waves often calms me. I could think of no better place to be, the rolling waves rising and falling, emulating my own body rhythms as my uterus tightened and then relaxed. As with the birth of Hannah, I pictured myself being checked for dilation only after I had progressed to six centimeters. Once again, I concentrated on how the birth would feel.

I had my doubts about the feasibility of these events occurring. My thoughts seemed too idealistic. I managed to remind myself that it was my dream, my image. It could be anything I wanted it to be.

Finally, I was very big, and ready to deliver. I had expected the baby a week before, so I felt like I was going to be pregnant forever! It was a Wednesday morning. I felt good, too good. I was sure another day was going to come and go before the baby would be born.

As I stretched out of sleep, my husband surprised me by announcing that he was going to stay home for the day. I tried to explain to him that I felt fine, and that he may get anxious if he stayed around me waiting for some sign of labor. My arguments were not convincing.

We ended up going out to breakfast, taking a walk on the beach, and spending a wonderful day together. It was not the kind of Wednesday to which we were accustomed. At six p.m. that evening I went into labor. Again we went to the beach. I labored there until dark (about eight p.m.). Haley Elizabeth was born at 10:45 p.m. My wonderful midwives did the first cervical exam when I was six centimeters dilated. My labor unfolded before me, familiar and welcomed.

After the birth of Haley, I began to talk with other mothers about my experiences. I was encouraged and strengthened when I became aware of so many birth stories that unfolded much the same way as mine. Like me, they were cautious about the outcomes. Mind power is such an intangible concept, especially when practiced in a society that values "seeing as believing."

I am now convinced that imagery influenced the way my body reacted in both of my labor experiences. The conditions for each birth were so different, and yet visualization unified them. The actual times and places were strikingly similar to my "imagined" births. More profoundly, my body both physically and mentally responded, working with the labor dance that my mind had choreographed months before. Perhaps the act of "seeing" our babies, our births enables us to contact our feelings about ourselves as women. Through visualization we can gain confidence in the idea that we are equipped with all the tools necessary to give birth. This precious gift of insight can empower and strengthen us. We need only believe.

Seeing Our Births

by Terri Bowman

Visualization. I'd heard the word batted about in a variety of situations, from sports training to medical miracles. How could such a thing possibly affect the outcome of my child's birth experience?

When I was three months pregnant with my first child, a very good friend of mine suggested I begin to visualize my birth. A licensed marriage and family counselor, she assured me that visualization (also known as imagery) was second nature to all of us. She maintained that almost everyone visualizes at some point during each day.

My friend went on to explain that in our everyday lives, visualization can best be described as the daydreaming we do while driving, doing household chores, or puttering around the garden. At times like those, our bodies go into "overdrive" to let our minds work out the details in future or past situations.

Ultimately, by giving purpose to our daydreams, we can actually practice for future undertakings. As with any physical or mental event, practice can greatly influence the outcome. World class athletes have known about this important body/mind connection for years. They spend a great deal of time visualizing themselves achieving their goals. As I looked to the upcoming labor and delivery of my own child, I realized that the birthing process itself could be described as a physical event more challenging than that of any sporting event. Visualization was beginning to make sense, so I decided to try it.

I began by relaxing and putting the events of the day out of mind. With a deep breath, I focused on the baby. I saw her face small and delicate; the curve of her spine as she nestled inside me; her legs tucked, cross-legged, next to her chest. Visualizing transformed her from textbook abstraction to reality. Over the months, these "pictures" were invaluable. When my arms ached to hold her, I'd sit down somewhere and just "see" her. I'd talk with her and hold her in my arms. We shared our love. She gave me patience.

I let the visualization progress. I thought about the nature of my labor. Where would I be when it began? How would my husband react? How long would it last? More important than the events themselves, I concentrated on how the process of labor would feel. My excitement, anticipation, joy, and fear all manifested themselves at some point during my relaxation time.

The whole scenario was quite idealistic. After all, I was concentrating on my idea of a wonderful birth. During my meditations, I did not need to be concerned with any limitations. I was free to explore all feelings and situations.

I wanted my labor to begin in the morning after a good night's rest. By midday, my labor would grow more intense. My husband would call the doctor. I didn't want to get to the hospital until I was at least six centimeters dilated—an arbitrary and subjective number, I admit, as each woman's labor progresses differently.

I concentrated on the efficiency of second stage labor. I envisioned myself working with the contractions, letting my uterus nudge the baby out of the womb, its strength massaging the baby from her place within me to the world at large.

I made every effort to interject the feelings of birth into my scenario. Many times, tears would flow when I imagined the happiness and amazement I would feel as I lifted my new baby to breast.

The day came for my child and I to work together toward her birth. I began my labor at seven a.m. What had started out as an intermittent stomach ache progressed to a breath stopping wave, the muscles of my uterus gripping me tightly. With each contraction I pictured my cervix like a fresh new flower opening, each petal simultaneously stretching toward full bloom.

By one p.m., my contractions were coming every five minutes. The events themselves were unfolding in such a way as to give me the impression I had already been through this labor before. I knew the anxiousness, the excitement, the

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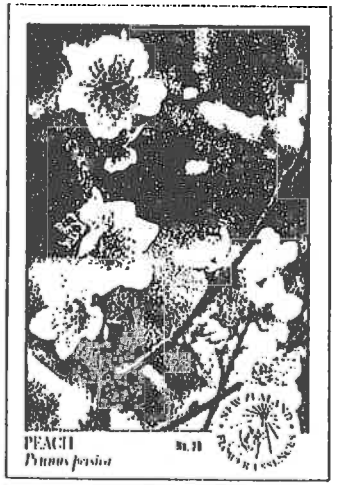
Bach Flower Remedies for Childhood Emotional Conditions

BACH FLOWERS for Children

by Rixt Zenhorst



Taken from the New Zealand Flower Essences Photo Cards Produced by Mary & Dale Garbely, photo by Oliver Piper

Children with their rapidly changing lives can benefit greatly from Bach Flower Essences. Being safe, effective and easy to administer. A few drops (preferably 4) from a medicine (not stock) bottle or added to their drink will have good reactions from children. A child more often than not will ask for their drops if the right remedies are given, they still tend to have their inner voice uncluttered and will 'know' when a remedy is right for them. If the wrong remedy is given no harm is done. Nothing will have changed, the emotional and mental outlook will still be the same. I have listed some remedies to various childhood emotional conditions. Do keep in mind that we all react to situations differently and that the list of remedies are suggestions only. One can also give more than one remedy at a time (up to seven but this again is no hard and fast rule). Thus observe the child closely.

All remedies may be used for babies, children or young adults. When taking the remedies balance and peace will return. The Bach Flower Centre does not add brandy to medicine bottles. The medicine bottle is made by adding 2 drops of each appropriate Bach Flower stock to a dropper bottle with spring or mineral water. From this 4 drops are taken 4 times daily . This may vary due to the needs of each individual. For further reading I suggest "Growing up with Bach Flower Remedies", by Judy Howard. Available through Weleda in Hastings and most bookshops.

Rixt Zenhorst, a registered Bach Flower Therapist (U.K.),Registered Medical Herbalist and Aromatherapist. All Bach Flower items are available by mail order from Rixt Zenhorst, R.D. 3, Tauranganuru Road, Waiuku, Ph/Fax (09) 235 7057.

Rockrose: Nightmares and terrors, teething.

Aspen: Waking from a nightmare but not remembering what it was about.

Walnut: Teething, puberty, going to school or kindy for the first day, moving house, any change whether physical or emotional.

Holly: Jealousy of new baby in household, teenagers suspicious of others, the "I hate you" or "I hate school syndrome", fiery tempers.

Crabapple: Dislike of self; "Look at my pimply face", "I am fat", "My hair looks awfull", also for illness used as physical cleanser, externally with Rescue Cream for mucky sores.

Mimulus: Shy, timid child, stuttering, could be fearful

Chicory: The clingy, needy baby or child, wanting attention, can be manipulative, over care for others.

Gentian: A child who is easily discouraged, just needs something to go wrong at school or in life and will only see the negative side of the event.

Heather: The 'chatterbox' in class or home, continuous talking to draw attention to self due to loneliness.

Honeysuckle: For homesickness, e.g. when going to school camp or sleeping over. (WALNUT may also be appropriate).

Olive: End of term weariness, complete mental and physical exhaustion.

Larch: Lack of confidence. "I wish I could do that", not said with envy but with awe.

Pine: The apologetic child. For guilt, e.g. when knocked over by another they are the ones to say "I'm sorry".

Wild Rose: Complete apathy. The "who cares" syndronie, mentally or physically in an apathetic state, common amongst some teenagers.

Cherry Plum: Despair, feeling of not coping or the mind giving way, fear of doing something terrible to others or self, out of control tantrums, may experience with great workload at school or pre-exams.

Prolonged Labor and Normal Birth

by Marion Toepke McLean, CNM

Prolonged labor has been highly associated with cesarean section in recent years; it has been suggested that close to one-third of the rise in cesarean rates in the United States in the 1970s and 1980s was due to dystocia—prolonged and difficult labor. Nonsurgical approaches to prolonged labor are critical to lowering cesarean rates. We will examine two modes of practice which have produced very low cesarean rates.

Labor is a natural event with natural variations in length; nevertheless, maternal exhaustion is an inevitable consequence at some point and dehydration and fetal distress may follow, especially with prolonged rupture of the fetal membranes. Today's birth attendant has a range of potential interventions when prolonged labor becomes distressing, from the simple to the complex and technological. Knowing when to wait and when and how to intervene is a vital aspect of the art and science of midwifery.

Older texts stress the risks of prolonged labor; thus DeLee and Greenhill in 1947 state that "An important part of the diagnosis is the determination of the instant when the mother and child begin to be endangered." This is not bad advice today. Indeed, modern studies suggest that with careful observation and treatment of complications, prolonged labor does not lead to poor outcomes. Cesareans should never be the primary intervention of choice for prolonged labor. While lifesaving when needed, surgical delivery in the best of circumstances has been shown to carry a two to three-fold increased risk of maternal mortality, as well as increased maternal morbidity.

Divergent approaches to prevent or treat prolonged labor emphasize, on the one hand, medical management, and on the other, respect for maternal autonomy—the preferences of the woman giving birth in choice of birthplace, attendance and the use of activity, positioning, and psychological/spiritual modalities.

Modern studies suggest that with careful observation and treatment of complications, prolonged labor does not lead to poor outcomes.

Medical Management

Kieran O'Driscoll was head obstetrician at the National Maternity Hospital in Dublin, Ireland when he and his associates developed the set of procedures which have become known as "active management of labor." In 1969 he published his developing theory and results in the *British Medical Journal*. In his introduction we find the negative view of prolonged labor which justifies the need for vigorous intervention.

"Prolonged labour presents a picture of mental anguish and physical morbidity which often leads to surgical intervention and may produce a permanent revulsion to childbirth, expressed by the mother as voluntary infertility; it constitutes a danger to the survival and subsequent neurological development of the infant. . . . The harrowing experience is shared by relatives and by doctors and nurses to the extent that few complications so tarnish the image of obstetrics."

In this publication, O'Driscoll and associates report on a prospective study of 1,000 primigravid deliveries in which, after diagnosis of true labor was carefully made, amniotomy and high dose oxytocin were given to every first time mother who did not progress at least a centimeter an hour on her own. All but one of the women delivered within 24 hours, and the cesarean rate was 4 percent. The authors show pride in their achievement. They state that "During recent years an active approach to labour has been adopted progressively at the National Maternity Hospital, and as the definition of prolonged labour was reduced from 48 to 36 and then to 30 hours the incidence (of prolonged labor) continued to fall. The standard was finally reduced to 24 hours." They proceed with the claim that "prolonged labour can be prevented." At the time of that study, the overall cesarean rate in the United States was just slightly higher than that which O'Driscoll et al achieved with their study primips. However, it was to rise precipitously, reaching 9.1 percent in 1974, 14.7 percent in 1978, and 21.2 percent in 1984. Since 1984 it has risen more slowly, leveled off, and begun to drop a bit. In 1984, O'Driscoll focused on cesarean prevention instead of prevention of prolonged labor in "Active Management of Labor as an Alternative to Cesarean Section for Dystocia." His study is "a prospective examination of abnormal labor, mainly as an indication for cesarean section for 1980. The number of mothers delivered was 8,742." The standard for normal labor has been shortened. The authors state that "The longest acceptable time period was twelve hours: ten hours to reach full dilation and two hours to traverse the birth canal. After 12 hours in the labor unit, cesarean section was performed unless safe vaginal delivery could be predicted within the hour." The cesarean rate was 4.8 percent; 5.5 percent for primips and 2.8 percent for multips.

The hard line on surgery after 12 to 13 hours labor in the Dublin National Maternity Hospital did not persist. P.C. Boylan, then chief of staff, writes in *Birth* in 1989 that a cesarean is not automatically done after 12 hours, but that labor is classified as prolonged after that point. Other aspects of active management of labor as practiced in Dublin include midwifery attendance of each woman throughout labor, midwifery management of labor with consultation from senior staff (residents are not decision makers), less than 10 percent rate of induction of labor and discouraging of pain medication. Active management of labor has had a profound effect on mainstream obstetrical practice in recent decades as obstetricians, concerned with the 1979 U.S. Public Health Service report on the increased risks of cesarean over vaginal birth, have sought ways to decrease their cesarean rates.

A Midwifery Approach

Ina May Gaskin, a midwife who began practicing and publishing in the early 1970s, has been an influential person in another direction. She and the women of the community she serves turned away from paternalistic, fear-based medicine. They have their babies, with certain exceptions, at home, and promote an acceptance of birth as natural and holy. In her book *Spiritual Midwifery* under "Slow Progress During the First Stage," she states, "You don't have to have any preconceived notions about what is too long for the first stage. If the mother is replenishing her energy by eating and sleeping, rushes [contractions] are light, the baby's head is not being tightly squeezed and the membranes are still intact, the first stage can stretch over three or four days and still be perfectly normal." She proceeds to discuss "managing the energy." "There should be no inhibitions or unspoken thoughts with strong emotional content. . . . Make sure that you are in good touch with the mother. You should feel friendly and relaxed with each other; it should feel comfortable to look in each other's eyes. Be friendly and intimate in the way that you touch her. . . . Make sure that the husband is really attentive and compassionate with her. You may need to instruct the couple on how to talk to each other. . . . Since body and mind are One, sometimes you can fix the mind by working on the body, and you can fix the body by working on the mind."

The midwives at Ina May Gaskin's farm community practice natural childbirth. "The antidote for fear is courage." Out of 1,917 consecutive births attended over fourteen years, there were 35 cesareans, a rate of 1.8 percent. The rate of prolonged labor is not given. *Spiritual Midwifery*, now in its third edition, has given courage to a lot of women. This book has been the antidote to fear for thousands of mothers and midwives around the world.

Discussion

Trials of active management of labor outside Ireland generally do not include midwifery attendance of labor and birth or the low rate of induction of the National Maternity Hospital. This may be the reason they have not duplicated Dublin's low cesarean rate, which, nevertheless, is higher than their rate before the initiation of active management policies.

Many studies have been conducted on the use of variations of active management of labor, suggesting that giving the women more time to progress at the start of their labors, and using lower doses of Pitocin, offers comparable results and is more acceptable to the mothers.

It is important to note, in comparing midwifery models with active management of labor, that what is meant by "labor" and the duration of labor may differ. For O'Driscoll and associates, painful contractions alone do not define labor. There must also be show, complete effacement or rupture of the fetal membranes. When Ina May says, "if the mother is . . . eating and sleeping the first stage can stretch over three or four days and still be perfectly normal," she is in many cases talking about something that at the Dublin National Maternity Hospital would not be considered labor, though the woman may have been admitted to an antenatal ward for pain relief, rest and hydration. The language used is somewhat different between the two practices.

While active management of labor can be an effective tool, ethical values insist that its procedures should not be forced on women. The majority of labors will progress safely to delivery on their own, although perhaps more slowly. Families should be able to choose midwife attendants, out of hospital birth, and a wide range of methods in dealing with prolonged labor like positioning, ambulation, herbal remedies, and supportive measures, within considerations of safe outcome for mother and baby.

Marion Toepke McLean, CNM received her nursing degree from Pacific Lutheran University in 1966 and her midwifery degree from Frontier Nursing Service in 1974. She is a midwife who has done hospital, clinic and homebirths. Her

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