NEW ZEALAND COLLEGE OF MIDWIVES
P O BOX 21-108
CHRISTCHURCH

Sarah Burgess
17 Malvern Rd
Mt Albert
AUCKLAND 3
Subscription has expired.

PRINTED MATTER
POSTAGE PAID
CHRISTCHURCH NZ
Permit No. 2943

New Zealand
College of Midwives [Inc]

NEWSLETTER

Volume 2, Number 7 : June 1990

Pamela Stirling's Articles : The Response

Subscriptions

MIDWIFERY AND WOMEN'S POWER

BOARD OF MANAGEMENT

Karen Guilliland	President
Kathy Anderson	Finance Co-Ordinator
Jacqui Anderson	
Del Lewis	Correspondence Address:
Julie Hasson	P O Box 21-106
Lynda Bailey	Christchurch

NATIONAL COMMITTEE

LYNLEY MCFARLAND 16 Russel Road Whangarei	NORTHLAND
GLENDA STIMPSON P O Box 24-403 Royal Oak, Auckland	AUCKLAND
KITTY FLANNERY 12 East Street Hamilton	WAIKATO/BAY OF PLENTY
JULIE KINLOCH 76 Charles Street Westmore, Napier	EASTERN/CENTRAL DISTRICTS
KATHY GLASS P O Box 5074 West Town, New Plymouth	WANGANUI/TARANAKI
CAREY VIRTUE P O Box 9600 Wellington	WELLINGTON
ANGELA KENNEDY 32 Tamaki Street Nelson	NELSON
NORMA CAMPBELL/ANNE O'CONNOR P O Box 21-106 Christchurch	CANTERBURY/WEST COAST
SUZANNE JOHNSON P O Box 6243 Dunedin North	OTAGO
MARGARET MCDONALD 8 Home Street Winton	SOUTHLAND
SHARRON COLE 22 Bernard Road Rotorua	PARENTS CENTRE
MARCIA ANNANDALE 16 Shannon Place Christchurch 5	LA LECHE LEAGUE
CELIA GRIGG SOWMAN 102 Sommerfield Street Christchurch 2	MATERNITY ACTION ALLIANCE

New Zealand College of Midwives
Membership Form

Regional Information

Name _____

Address _____

Telephone _____ Home _____ Work

Place of Work _____

Type of Membership

Full Member (Registered Midwife Full or Part Time)	$52.00
Full Member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged)	$26.00
Associate Member (Other interested Individual)	$52.00
Associate Member (Unwaged interested individual)	$26.00
Affiliated Member (Other Groups e.g. Parent Centre, La Leche League, etc)	$26.00

Method of Payment

Please tick your choice of payment method.

☐ Subscription payable to College Treasurer (Please enclose cheque or money order)

☐ Deduction from Salary (Please arrange with your pay office)

National Information

Name _____

Address _____

Telephone _____ Home _____ Work

Date of Birth _____ NZNA Member YES/NO

Type of Membership

Full ☐ Waged ☐ Unwaged ☐

Associate ☐ Waged ☐ Unwaged ☐

Affiliate ☐

Place of Work _____

Please return completed form (together with money if applicable) to
Local Regional Treasurer
New Zealand College of Midwives
Address:

Notes

FROM THE BOARD OF MANAGEMENT

Dear Members,

Thanks for the many contributions we received for this issue of the newsletter and particularly the feedback regarding the previous issues. A number of people have commented that they have difficulty reading the newspaper articles once they have been reduced. We apologise for this and will ensure these articles are not reduced to the same extent in future. The sad thing is that it will cut down the amount of information we can put in the newsletter.

Regions are now formulating remits to be voted on at the AGM in August. If you are aware of any changes you feel should be made to the Constitution or to the College in general, contact your chairperson so as they can be discussed at your next regional meeting. Remits can only be proposed by regions, not individuals.

Please stop sending in requests for NZCOM Founder Member Badges as there are none left. We requested more than were individually ordered to cover those members that may have forgotten to send their order in time, but this supply has also run out. The badges without the Founder Member Bar are now available through your Regional Committee rather than the Board of Management. Cost : a mere $5.00.

Last, but not least,

SUBSCRIPTIONS ARE NOW DUE

which can be paid to your local Treasurer.

The next newsletter will be the last for the Christchurch Board of Management, so we'll make it a good one.

So until August .....

Board of Management

" No, I'm not a nurse. I'm a general manager. Are you a nurse? "

NEWS AND VIEWS

[1] NEW ZEALAND COLLEGE OF MIDWIVES JOURNAL

The second issue of our great Journal is now available from your Regional Committee. It has very good home grown articles in it and should definitely be purchased and read.

A number of unsold copies of the first issue have been discovered. Anyone wishing to purchase this inaugural issue, please write to:

Board of Management
New Zealand College of Midwives [Inc]
P O Box 21-106
Christchurch

Cost of first and second Issue : $4.00 each.

[2] ARTICLES FOR NZCOM CONFERENCE 1990

The Conference Committee in Dunedin are requesting articles that you consider both interesting and relevant to be duplicated and distributed to people attending the National Conference in August.

Everyone will no doubt have at least one informative article that has been of immense value to them.

The articles will be gratefully received and should be sent to the following address as soon as possible. And don't forget to send in your registration forms for the Conference (request form in newsletter). The programme looks superb. Congratulations to the Conference Committee - you're doing a great job!

Contact : 1990 Conference Committee
NZ College of Midwives - Otago
P O Box 6243
Dunedin

[3] EXCELLENT OUTCOME IS LIKELY FOR "ELDERLY" PRIMIGRAVIDAS
- NZ Doctor May 7 1990

The elderly primigravida describes a woman whose first pregnancy occurs after the age of 35 years. Dr Robert Resnik from the University of California suggests this group of women can expect an excellent outcome, given that the pregnancy-related problems that occur more commonly in these women are readily manageable.

For a variety of reasons there has been a trend for women to delay childbearing into their 30s. A study undertaken by New York clinicians involving almost 4000 primigravid women, 1500 between 30 and 34 years of age and 800 over 35, indicated there was no increase in risk of delivering an infant who was small for gestational age, had a low Apgar score or died in the perinatal period although there was an increased chance of having a low birth weight infant.

Kick charts can find at risk foetuses

NZ Doctor 7 May 1990

BY LYN BARNES

In New Zealand, probably the two most commonly used methods of assessing antenatal foetal development are monitoring the movement of a developing baby and using non- stress tests to record the foetal heart rate.

Dr David James, a senior lecturer in obstetrics and gynaecology at Bristol University was invited to appraise these methods of assessment at the Perinatal Medicine Meeting held in Taupo in March.

Dr James has a long term interest in this area.

Kick charts

Integrate the parameters of foetal assessment rather than rely on any one method and above all, do not forget the mother and baby, advises Dr James.

He described the 1970s as the decade of the biochemical tests, and now believes that "we have thrown out the baby with the bath water" by discarding them entirely in many cases.

"The flavour of the 80s was ultrasound, which is more direct and avoids the need to collect urine samples," he said.

However, Dr James added that every test has its limitations and it is not possible to identify every foetus at risk.

Kick charts are commonly used by pregnant women to monitor a baby's movements. Women are asked to start recording movements on a chart from 9am until they have felt 10 movements. If there are less than 10 movements between 9am and 9pm for two days in a row, or if there are no movements during 12 hours, the women are advised to phone their doctor or delivery suite.

"But kick charts have limitations, methodological, biological and maternal," he said.

Over a quarter of the women who keep their own kick charts become anxious that there have not been enough movements within the specified time.

"Mothers are often scared stiff," he added.

Dr James also estimated that 10-19 per cent were unreliable or unusable and added that there was always a minority of women who cannot use kick charts.

Even with the numerous limitations, Dr James believes that kick charts do identify babies at risk.

"There is no doubt about that. However, their value in a high risk population has not been adequately addressed," he said.

But the evidence is confusing as to whether they prevent stillbirths or perinatal deaths, he said.

Another limitation he has found is that there is increased intervention on mothers who keep kick charts, both with follow-up investigation and at the time of delivery.

He sees no advantage in kick charts over "informal enquiry" about movements in low risk women.

WOMEN NEED MIDWVIES NEED WOMEN

$2.00 per Sheet of Uncut Stickers in various sizes

ORDER FORM

To: NZCOM NELSON REGION
c/- Treasurer
13 Brook Street
Nelson

NAME: _____ Please include 80c for postage

ADDRESS: _____

_____

Please make cheques payable to : NZCOM Nelson Region

Midwife

"It's time" one of us breathes into the phone
— but she knows, she's already here putting down
her bag of mysteries (oxygen mask? forceps?)

and the chief performer, first violin, the star,
takes her position; as for the rest of us,
well, we know a maestro when we see one —

she's the one with the supple wrist; easy,
precise, she coaxes us into our parts,
we'd follow her anywhere — when she's ready

for us to move forward, aside, we know by
a particular intentness of fingers and face
that draws us in to the whole resonant magic:

and then we're there — all, even the extras,
have come to a brilliant finale. She steps down,
congratulating the lead (there are two of them now),

us too — and yes thankyou she will have a glass
of champagne — as though she's done nothing
special. Now that's skill. That's style.

Lauris Edmond

...PRIMIGRAVIDAS cont'd

Antepartum complications were more likely. These included gestational carbohydrate intolerance, hypertension, bleeding in the third trimester and a greatly increased likelihood of delivery by caesarean section.

Previous studies have been less favorable but most were poorly controlled and had too few participants. Several more recent studies corroborate the findings of the New York study; in one, high quality antepartum care for elderly primigravid women resulted in a good neonatal outcome and in another favorable results were achieved in a group of nulliparous and multiparous women over 40 years of age.

One of the main considerations in deferring pregnancy until mid or late thirties is the increasing frequency of chromosomal abnormalities in offspring, particularly Down's Syndrome, affecting 1 in 365 infants born to mothers aged 35 and 1 in 32 infants of mothers aged 45 years.

Amniocentesis and chorionic villus sampling enable an early diagnosis to be made so termination can be considered.

The main problem with the New York study was that participants were mainly college educated, white and non-smokers. Whether results are so favorable for a more heterogeneous population is unclear. Nevertheless, with good prenatal and intrapartum care elderly primigravidas "can look forward to excellent outcomes".

Resnik R. NEJM 322:693-694, 8 Mar 1990

[4] KANGAROO MOTHERS

Since 1980, doctors at the Instituto Materno-Infantil at San Juan de Dios Hospital in Bogota, Colombia have been developing a way of caring for premature babies based on observations of kangaroos. All kangaroo babies born prematurely, and the baby, just an inch long, grasps the mother's hair and climbs until it reaches the mother's Marsupium or "pouch". The standard practice in hospitals, following World Health Organisation (WHO) guidelines, is to incubate premature babies if they weigh under 1.500g (3.31b). But to Dr Edgar Sanabria Rey, co-ordinator and founding "father" of the kangaroo mother's project, separating the babies from their mothers in this way seemed a drastic step. He reasoned that if a kangaroo's baby benefited from closeness to its mother, so would a human baby. With this in mind, he developed a special pouch that allowed the mothers to keep their babies, upright so they wouldn't choke, and in skin to skin contact next to their mother's breast 24 hours a day. In this way, the mother becomes a natural incubator that maintains the baby's normal body temperature 37 to 38 degrees C (96F) and the baby can feed on demand. The mother keeps the baby close until it is able to maintain its own body temperature.

Before the kangaroo mothering project began, many premature babies arriving at the hospital each month were abandoned by their low-income mothers. But now abandonment has almost stopped because of the close bonding that carrying a baby in a pouch creates. And care costs are reduced from an average of US$79 a day in an incubator, to US$2 a day with a kangaroo mother.

However, Dr Rey is quick to deny that the program eliminates the need for incubators. All of the premature babies are placed in incubators and closely observed for the first 48 hours after birth. They are screened for any complications that may need treatment. During this period, the mother is encouraged to visit her baby and learn how to be a kangaroo mother. If the baby is underweight, but otherwise in good health, it goes home with its kangaroo mother who is free to return to the hospital whenever she needs to. Close supervision of the baby's development and frequent checkups are part of the program.

Ninety-four out of every 100 babies selected for the program (about one third of all premature births) survive. Before the program started, six out of ten premature babies born in Bogota died.

The United Nations Children's Fund (UNICEF) has followed the project closely and four years ago, they began to publicize it and recommend that specialists from other countries make study visits. The Bolivian Ministry of Health has already adopted "kangaroo mother" as one of its official programs and several other countries, Britain, Ecuador, El Salvador, Haiti, Italy, Norway and Peru are also considering adopting the project.

-Reprinted from Latin America Women's Health 1989. Originally reported in PANASCOPE, USA

[5] HEALING THE PERINEUM
- from Aromatherapy for Women, Maggie Tisserand, 1985

If you were unlucky enough to have had an episiotomy, or have torn, then the perinuem will require gentle care to help it heal speedily and without too much discomfort.

After giving birth to my children, getting to know them and putting them to the breast, the first thing I did for myself was have a sitz bath with cypress and lavender. Cypress is astringent and causes raw blood vessels to close over, and lavender oil is very healing, and gently encourages the growth of new skin at the same time protecting the raw areas.

ARTICLES:

"Hard labour" enabled me to identify with probably many other women who have suffered high-tech birthing procedures.

Several months ago, I was induced with syntocinon and yes, it was extremely painful, meant that I had to have an epidural, and resulted in a Kellands Rotation/forceps delivery. Not only was I physically damaged, but psychologically as well. The birth experience was degrading, frustrating and probably unnecessary. Once I had been internally examined, induction became necessary because of the risk of infection.

I was admitted to Middlemore Hospital, saw three changes in staffing, and found what should have been a joyous occasion (for which my husband and I had prepared for two-and-a-half years) a very frightening nightmare:

- I had a young male doctor attempt to examine me internally (my own female doctor had already done this prior to my admission to Middlemore).
- The nursing staff marched in and out of the delivery suite with total disregard for any degree of privacy.
- The midwife I ended up with was in her 50s, did her training in England, and believed that delivering a baby was done with the mother "flat on her back, legs in stirrups". She was rude, and would not co-operate in any way. She refused to deliver the baby as naturally as possible and intimidated me by saying such things as that if I was not fully dilated by 12 o'clock, it was upstairs for a caesarian.
- What really annoyed me, however, was that I was treated as an ignorant woman who had no idea of what was happening to me and therefore could not possibly make informed decisions for myself or my baby. But having my baby was no accident; I had done a lot of research on it, attended ante-natal classes, etc.

Seven months down the road, I am still very angry at what happened. I wish the so-called "professionals" would bow out and let midwives like Bronwen Pelvin do what they are committed to doing: delivering babies as naturally and comfortably as possible for both mother and child.

I noted that, in your article, those who vetoed midwives delivering were male doctors. Doctors such as Nick Terpstra and Christopher Harison are definitely talking from a textbook, "back-pocket" position. When the male doctor at Middlemore tried to examine me, I said definitely not and insisted on a female-only staff. My belief is that with men not having babies themselves, they have no idea at all what a mother feels. Their conceptions of birth are what they read in books.

Coupled with this is the idea that women don't know what is best for themselves and should leave such important decisions to doctors. I am not simply a baby vessel, and I resent anyone who tries to suggest that I am. I can think and make decisions for myself.

Why then in Middlemore was I ignored? It will be a few years before I attempt to have another child. The saying goes that you soon forget the pain. My birthing experience is still very fresh in my mind, and still makes me very angry. What gives doctors the right to decide how we should have our children? Who made them God?

Patricia Johnston-Epiha
(Papakura)

BIRTH: WHO DELIVERS BEST?

Your third birth article "An unexpected life" (March 26) exposes some troubling problems about obstetric ultrasound in New Zealand. As a practising sonographer, I extend my sympathy to the Gallaghers who nearly lost their baby, partially due to errors involving ultrasound.

The problem is not with the technology but with the people who use the machines. If the skill and knowledge are missing, the results can be wrong, sometimes dangerously.

Two groups of people are involved in ultrasound scanning — sonographers and doctors. The sonographers are drawn almost exclusively from the ranks of radiographers, while the doctors include a variety of specialists and some GPs.

The sonographers and all non-doctors are required by law to be registered by the Medical Radiation Technologists' Board (MRTB) in order to use ultrasound equipment on humans. To achieve registration they must have the Diploma of Medical Ultrasonography (DMU), which is awarded after the sonographer has passed a two-part examination including 12 hours of written examinations and separate practical and oral examinations, as well as two fulltime years of approved practical work.

Doctors are exempt from the requirement to be registered. They are free to use ultrasound equipment whether or not they have training or qualification. There exist two sources of qualification in ultrasound for doctors. The first is the inclusion of ultrasound in the training of radiologists in the years since ultrasound came into existence. Some radiologists build on this training and become ultrasound experts. The other qualification is the Diploma of Diagnostic Ultrasound (DDU) offered by the same body that examines for the DMU. This is the true specialist ultrasound qualification for doctors. A few radiologists hold this qualification in New Zealand.

Most, but not all, sonographers comply with the law, the majority being qualified and registered. The ones who are not have little to fear, however, since the MRTB has never brought action against anyone. Nevertheless, the regulations, peer pressure and the public hospital system have encouraged the formation of a substantial group of well-trained professionals.

Unfortunately, the trend among doctors has been in the opposite direction, much to the consternation of responsible doctors. It is possible for any doctor to buy a cheap machine of limited performance, or a used, obsolete machine, and begin charging fees from both patients and the Government, as Dr Dermot Mora points out in the article. There is an incentive for profiteering. It is in the private sector that this happens, beyond the reach of peer pressure or public scrutiny.

What can be done about the "cowboy element" in ultrasound?

First, the public can ask questions of both the referring doctor and the person doing the scan:

- What qualifications and experience does the operator have?
- How modern and sophisticated is the equipment? (Most machines more than five years old are obsolete.)
- May I see the ultrasound image and will it be explained to me?

Second, the Health Department can take steps against bad ultrasound practice in several ways:

- By not paying unqualified doctors.
- By assisting the MRTB to enforce existing regulations regarding sonographers.
- By bringing in mandatory licensing of all doctors using ultrasound.
- By funding training programmes in ultrasound.

Ultrasound has transformed modern obstetrics. It is an essential tool that is safe and reliable in competent hands. Unfortunately, a profiteering element is betraying the patient's trust and bringing ultrasound into disrepute.

Martin Rothman
(Wanganui)

The stories of the Tisdalls and the Gallaghers (March 19 and 26), though tragic and deserving of public concern, are nonetheless exceptional. They should not have been allowed to dominate two-thirds of what purported to be a general report on childbirth.

Where are all the positive stories? This "major report" would have women look forward with trepidation to the prospect of a hospital birth and this is a great pity. In my experience, having a baby in hospital can be joyful and fulfilling.

The articles led one to believe that the choice is clear-cut: women must decide between an active birth at home in a warm and loving atmosphere; and a high-tech, staff-oriented birth in an unfriendly hospital. This may have been a true picture of the situation 20 or more years ago, but times have changed. I have had three babies at Wellington Women's Hospital in the past nine years, and each time have felt that all the choices were my own.

Though I was happy to be guided through the birth of our first child, I chose to stay upright for most of my second labour and to deliver squatting on the floor. I was totally supported in these decisions by the doctor and midwife. Our third baby had a very rare chromosomal disorder, and though hospital staff did absolutely everything they could, she did not survive. I will never forget the unwavering support I received from all concerned — indeed I continue to enjoy a comforting relationship with two staff members over a year after her birth.

Our fourth baby is due in August. I look forward to being once again in the caring and competent environment of Wellington Women's Hospital where, in all but very rare cases (and contrary to the implications of Pamela Stirling's report), the mother's needs and wishes do come first.

Rosalind Norrish
(Brooklyn)

My hackles alternately rose and fell as I read the fascinating article on midwifery and the birthing scene in New Zealand (March 12). They sat straight up and stayed there when I got to Mr Christopher Harison's comments about active birth positions.

Has Mr Harison been so blinkered throughout his professional life that he has not read even a little of the mass of evidence against a woman labouring on her back? What a terrible tragedy that professionals such as these who are in the best position to encourage women to do what feels right in labour (that "gimmicky stuff" like squatting or standing), have to be so damning and plain wrong.

My sympathies lie with the women of Thames who are dictated to in this manner. They should simply not tolerate it.

Jackie Hoffman
(Riccarton)

BIRTH: WHO DELIVERS BEST?

I would like to say with regard to home birth (March 12) that I am more than grateful to Bronwyn Pelvin for what she has done in our situation.

I would have been a classic example of induced labour had I surrendered to hospital care. My waters broke six days before I gave birth to our son, and what with serious contractions on three of those nights Bronwyn's constant confidence in us that all would go as Nature had planned as long as my temperature was normal and the baby's heartbeat regular, allowed us to have Nicholas in the environment we had chosen.

Bronwyn stressed that an internal assessment was not necessary as this is more likely to lead to internal infection. If *any* problems had arisen we would have gone straight to hospital. In our opinion the purpose of hospitals is for medical complications, not natural functions.

I was in fact one of the illegal births at the time when doctors were all adamantly refusing to back home births. The traumatic effects that I experienced from this, and the doctor's lack of confidence in my ability to give birth naturally, undermined my confidence during pregnancy and caused unnecessary distress. I am thankful that Nicholas arrived safe and well, without any difficulties.

We both believe that midwives are the people for this task — not doctors.

Inez Kolff
(RD1 Motueka)

The article about Cameron Gallagher (March 26) asked, "What went wrong?" The simple answer is that both humans and technology are fallible. There is no question that any of the medical practitioners should be charged with malpractice.

Decisions about whether ultrasound should be used to diagnose foetal death should be made on the study of large numbers of cases and comparing with other options, not on one case that went wrong. Part of the development of any technology is continued questioning of its place in practice. This happens all the time and of course this will be reviewed as a result of this dreadful disaster.

More important, though, are some of the implied messages that came through in the article. There is an implication that doctors insist on using technology for some reason other than the best interests of mother and baby. Do you really think that doctors in good faith would continue using it if they knew it to be harmful?

It is easy to say with hindsight that a mistake was made, but your article did not look at what happened when there was no ultrasound.

The obvious other point is that this is a technological baby. He would not be here if not for in vitro fertilisation or high-tech neonatal care. The fact that one part or the technology was not perfect is actually the norm, not the exception. By implying that such technology can be perfect I believe you mislead the public.

The final issue is the position of the doctors. The essence of the case is that they were all acknowledged as competent, but despite their best efforts the disaster happened. Have you stopped to think what it feels like to be a doctor involved in such a case?

The whole case is a distressing disaster. The family had put trust in their doctors and inevitably lay some blame on those doctors. This eases their grief and the burden of responsibility they feel in such circumstances. But the doctors were responsible, there is no one they can shift responsibility to. This is a part of medical practice (albeit a poorly recognised part, and a part that did not feature in my training) and it could be argued that if you can't stand the heat you should not be in the kitchen. However, sensitivity is an attribute that many would like to see in their doctor. Any sensitive person would feel dreadful about the circumstances of Cameron's birth. Maybe so dreadful that they could not cope with facing the parents. Plastering the story over the pages of the *Listener* does not help.

Shortly after starting in general practice I made an error of judgment and postponed a house call so that I could have my tea. The patient died when I might have been able to save him if I had gone earlier. I seriously considered leaving medicine for some time after that. I did not see the family again to apologise because I knew that all I would end up doing would be to lay my problems of coming to terms with his death on to an already grieving family. If some well-meaning journalist had done an article about that I am sure I would have crumbled.

I hope that in future you will consider more deeply the public benefit of exposing individual cases of medical misadventure where there is no question of malpractice. We do not want to emulate the US, where doctors have difficulty caring for fear of malpractice suits that are the end result of the premise that doctors are able to be infallible.

(Dr) Ben Gray
(Waitara)

BIRTH: WHO DELIVERS BEST?

After reading "Hard labour" by Pamela Stirling (March 12) I felt ambivalent about some of the issues raised. I understand midwives working toward more autonomy in the birth process, but in my recent experience of giving birth, both midwives and obstetricians allowed me to deliver a healthy, unstressed baby.

On February 17-18 I was in Wellington Women's Hospital under the care of a very professional and caring team of midwives and doctors, the latter led by Professor John Hutton, whom the article quotes on several matters.

Although my baby and I went through a long, induced labour augmented by syntocinon, followed by a difficult forceps delivery, I cannot fault the care given me at every step by all professional staff. Professor Hutton is quoted in the article as saying there is mounting mistrust and conflict between midwives and medical staff. I would like to say that if there was such tension it certainly was not relayed to me. For most of the time, care came from the midwives, whom I highly respect, and I felt the doctors obviously trusted them to get on with their job. Both doctors and midwives gave me confidence, despite the high level of technology present, and I trusted their decisions on behalf of myself and my baby. All the professional staff took time to explain procedures clearly as labour progressed. Interestingly, I was periodically reminded by the team of the high possibility of a caesarian delivery, but at the same time told they would avoid this at all costs, which they did. Obviously the doctors were not thinking of monetary gain, as the article suggests, otherwise I could have been operated on.

Heather Sangster Smith
(Raumati South)

PAMELA STIRLING'S

THE RESPONSE

The following letters were written to the Editor of the Listener in response to the articles on birth featured in the Listener between March 12-26, 1990.

I enjoyed your series on aspects of childbirth. However it left me with a major concern — that is, when a patient complication occurs in a private hospital it often becomes the public sector's problem and expense.

Miriam Gallagher was given a scan in the private sector. When the scan was interpreted as showing the baby was dead, her GP referred her to the public hospital for an induction.

When Cameron was induced, 14 weeks premature and alive, it became the public system's fault — and expense. If your costing of $1000-$1200 a day is correct, then the public health system had to pay in excess of $106,000 to rectify the private health "service" error.

I am delighted that the excellence of medicine saved this little boy's life. They were making up for their colleagues' errors. I do wonder if the time has come for the public system to charge the doctors at fault for this sort of referral.

Garry A Moore
(St Albans)

Any honest professional person in the childbirth field has to live with the knowledge that they have made errors of judgment and remember situations that with the wisdom of hindsight they would have handled differently. The two cases chosen by the *Listener* are sad examples of "high technology" going wrong. It is easy to see that in retrospect. A "low-tech" approach sometimes also leads to an equally tragic outcome.

All midwives and doctors approach childbirth with their own biases based on their experience, education and research. I believe that 85 percent of women in this country are "low risk" and could be well served by midwives only, with consultation access to obstetricians as required. But I work daily and happily with many GPs and obstetricians who enjoy attending women having babies. I also know a couple of doctors I would not let loose near a fertilised budgie egg, much less my multiparous cat.

It is the women of New Zealand whose choices I want to see extended. These three articles are part of the information women have access to as they deliberate on the choice of who will look after them during pregnancy, labour, delivery and afterwards. I am not at all sure that the articles have made their choice any easier and am wondering who is to blame.

Jennifer Sage
Charge Midwife
Hutt Hospital

HEALING THE PERINEUM cont'd

A new plastic bowl is ideal for a sitz bath. If you are small like me, then a washing up bowl is adequate. For larger ladies a baby bath would be necessary. I would keep the bowl and essence in the bathroom, and have a sitz bath after every visit to the toilet. As the perineal skin heals up quickly, the stitches (if any have been needed) can be removed by the midwife a few days earlier, and this makes sitting a more pleasant experience.

[6] VBAC GUIDELINES
- from ICEA New Zealand Newsletter, April 1990

The American College of Obstetricians and Gynecologists (ACOG) has published revised guidelines for Vaginal Birth After Caesareans (VBAC). For the first time, ACOG states that VBACs are safer for most mothers than repeat caesareans. They state that repeat caesareans should no longer be performed unless medically necessary.

A prior caesarean is not considered a reason for repeat caesareans and a trial of labour should be encouraged even for women who have had multiple caesareans. This is a major change of attitude by ACOG and should have tremendous impact both in the States and throughout the world.

Hospital names nurse-manager

WAIRARAPA TIMES-AGE MARCH 8 1990

By TINA-MARIE MORRISON

MRS PARRY ... has mixed feelings.

GREYTOWN Hospital's new nurse-manager has been appointed.

Maureen Parry, a midwife at Masterton Hospital, will take up her position on Monday.

Mrs Parry's position is a combination of the principal nurse and hospital administrator jobs.

Principal nurse Bill Graham has been made redundant and finishes this Friday, as does day supervisor Maureen Algie, whose position has been scrapped.

Former hospital administrator Henry Jansen retired last December.

The focus of Greytown Hospital is expected to be more community-based rather than a hospital-based service.

Mrs Parry has background experience in occupational health, community health, rehabilitation, care of the elderly, obstetrics, and emergency nursing.

She also has a diploma in nursing for maternal and infant care. She has also completed a degree in social sciences majoring in nursing.

For the past 2½ years, she has been working as a midwife at Masterton Hospital.

Wairarapa health services district manager, Dr Chris Davis, said Mrs Parry was excellent for the job.

He said the hospital would continue its community-based philosophy under her direction.

Mrs Parry said she was looking forward to taking up the new position.

She said she had mixed feelings about the position.

"I think the job is going to produce a lot of challenges."

About five years ago she was the district nurse for South Wairarapa and lived there about a year ago.

She said the South Wairarapa community were "very enthusiastic".

FUTURE EVENTS

[1] PELVIC EXAMINATION COURSE FOR NURSES 1990

30-31 May
18-19 July
19-20 September
21-22 November

Nursing Administration, NZ Family Planning Association
214 Karangahape Road
Auckland Telephone : (09) 775-049

Cost - $150.00

A skills based course involving a one and a half day theoretical component followed by clinical experience in the taking of cervical smears and bi-manual examinations.

[2] ULTRASOUND SEMINAR

05 June 1990
Stringleman Room, Christchurch Public Library
7.30pm

Cost - Entry by donation

A public meeting organised by Maternity Action Alliance to discuss the performing of ultrasound scans on pregnant women. Questions to be addressed:-

- will they harm my baby?
- are they necessary?
- who benefits from them?

Plus Video. "The Foetal Effects of Ultrasound"

[3] ULTRASOUND IN WEST AUCKLAND PUBLIC MEETING

07 June 1990
Waitakere Hospital Library
Auckland
7.30pm

Discussion and debate on the use of Ultrasound in West Auckland. A panel will offer their views and perspectives.

NEW ZEALAND COLLEGE OF MIDWIVES CONFERENCE

New Zealand College of Midwives

Consumerism Feminism Midwifery

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

Keynote Speaker

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

Programme

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

Those wishing to present papers or workshops should inform the Conference Committee before February 28, 1990.

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

New Zealand College of Midwives — National Conference
August 17 to 20, 1990, Knox College, Dunedin

☐ I will be attending the Conference, please send me a registration form.
☐ I would like information on accommodation / creche facilities.
☐ I would like to present a paper / workshop (please see reverse).

Name _____
Address _____
_____
_____

woman as having a form of diabetes. Her pregnancy is likely to be considered as 'high-risk', invoking an extensive and expensive programme of tests and interventions of unproven benefit. A negative glucose tolerance test, on the other hand, also has a potential for harm by falsely reassuring the physician and the woman that the risk, engendered by the indication for the test, has been removed.

4 Conclusions

Except for research purposes, all forms of glucose tolerance testing should be stopped. Women in whom overt diabetes is suspected should be followed with repeated fasting or blood glucose estimations two hours after meals throughout pregnancy, or simply with repeated urinalyses.

There is a need for population-based research to establish the true risk, if any, associated with sub-diabetic degrees of hyperglycaemia during pregnancy. Once the degree of risk is appropriately identified, therapies designed to reduce that risk must be investigated by randomized trials before being introduced into clinical practice.

"A Guide To Effective Care In Pregnancy + Childbirth" by Enkin M., Keirse M., Chalmers I.

VACANCY

MANAWATU HOME BIRTH ASSOC. INC.
P.O. Box 733
Palmerston North

HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP

ADDITIONAL HOME BIRTH MIDWIFE REQUIRED

we are looking for one more domiciliary midwife to join our enthusiastic team to help cope with the demand.

From September onwards we are left with one midwife working.

The Manawatu Home Birth Association is active and well established and is willing to assist the new midwife in any way possible.

For further information write to the above address or phone Carol (063) 85226

HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP HELP

[4] INTRODUCTION TO FAMILY PLANNING

12-15 June
31 July-03 August
16-19 October

Cost - $220.00

Auckland Education Unit, NZ Family Planning Association
214 Karangahape Road
Auckland Telephone : (09) 796-182

A four day programme introductory course covering all contraceptive methods and aspects of fertility and sexuality.

[5] INTERNATIONAL BOARD OF LACTATION CONSULTANT EXAMINERS CERTIFICATION PROGRAMME

Exam Date : 11 July 1990
Christchurch

For Health Care Providers who are:-
- Involved in Infant Feeding
- Encouraging and Promoting Breast Feeding
- Seeking a challenge

Contact: Rachel Walker
41 Halton Street
Christchurch 5

Closing date for Fees - 15 June 1990

[6] NEONATAL NUSRING WORKSHOP

28 July 1990 8.00am - 5.00pm
Christchurch Womens Hospital

Cost : $35.00 Full Day
$15.00 Half Day

Covering basic neonatal nursing care including:-

- initial resuscitation and assessment
- temperature control
- feeding
- jaundice

For programme and application form, apply to :-
Angela Poat
Neonatal Unit
Christchurch Womens Hospital
Colombo Street
Christchurch

[7] ICEA INTERNATIONAL CONVENTION 1990

03-05 August 1990
Hyatt Regency O'Hare
Chicago
Illinois

Contact: ICEA International Convention
P O Box 20048
Minneapolis
Minnesota 55420
USA

[8] NZ COLLEGE OF MIDWIVES BIENNIAL CONFERENCE

17-20 August 1990
Knox College
Dunedin

Theme : Women in Partnership

Speaker : Marsden Wagner
Director, Maternal and Child Health, WHO

Contact : Conference Committee
Otago Region of NZCOM
P O Box 6243
Dunedin North

[9] LA LECHE LEAGUE NEW ZEALAND SOUTH ISLAND CONFERENCE

22-24 August 1990
University of Canterbury
Christchurch

Theme : Breast Feeding - Passport to Life

Information and support for all those interested in Breast Feeding and Parenting.

Contact : Isobel Fanshawe
243 Port Hills Road
Christchurch

Phone (03) 842-583

[10] A BREAST FEEDING SEMINAR FOR HEALTH PROFESSIONALS

23 August 1990 8.30am-12.30pm
Study Centre 3rd Floor
Rochester & Rutherford Halls
Canterbury University
Christchurch

Cost - $20.00

Contact : Marcia Annandale
16 Shannon Place
Christchurch Phone (03) 23-7124

tal mortality. The effects of treatment with insulin on perinatal mortality have been examined in only one randomized controlled trial. Thirteen of 307 women (4.2 per cent) with a positive glucose tolerance test treated with insulin experienced a perinatal loss, compared to 15 of 308 such women (4.9 per cent) who were treated with diet alone. This small difference is neither statistically nor clinically significant.

The 'adverse outcome' most frequently associated with gestational diabetes is 'fetal macrosomia' (a larger than average baby). Up to 30 per cent of infants of mothers with an abnormal glucose tolerance test have a birthweight of more than 4000 g. A heavy mother and post-term pregnancy, however, are much more strongly associated with fetal macrosomia than is gestational diabetes. Clinical judgement based on assessment of prepregnant weight, weight gain, and a pregnancy past 42 weeks without any reference to glucose tolerance is more predictive of fetal macrosomia than is the glucose tolerance test. Wide application of glucose tolerance testing to pregnant women would thus be of limited value in identifying women at increased risk of fetal macrosomia.

Treating women who have gestational diabetes with insulin can reduce the incidence of macrosomia. A number of studies have confirmed this effect. Despite the observed reductions in birthweight that can be achieved by insulin therapy, there is no convincing evidence of a decrease in the incidence of either operative delivery or birth trauma. There is also no evidence that such treatment reduces the incidence of neonatal jaundice or hypoglycaemia.

3 Effects of glucose tolerance testing

The diagnosis of gestational diabetes, as currently defined, is based on an abnormal glucose tolerance test. This test is not reproducible at least 50 to 70 per cent of the time, and the increased risk of perinatal mortality and morbidity said to be associated with this 'condition' has been considerably overemphasized. No clear improvement in perinatal mortality has been demonstrated with insulin treatment for gestational diabetes, and screening of the pregnant population with glucose tolerance testing is unlikely to make a significant impact on perinatal mortality.

An abnormal glucose tolerance test is associated with a two- or threefold increase in the incidence of macrosomia, but the majority of macrosomic infants will be born to mothers with a normal glucose tolerance test. Thus far, no improvement in neonatal outcome has been demonstrated from insulin treatment for gestational diabetes, nor has there been any demonstrated benefit to the mother or infant from reducing the incidence of macrosomia by insulin therapy.

There is, in addition, a great potential for doing more harm than good by performing a glucose tolerance test. A positive test labels the

Gestational diabetes

This chapter is derived from the chapter by David J. S. Hunter and Marc J. N. C. Keirse (25) in EFFECTIVE CARE IN PREGNANCY AND CHILDBIRTH.

1 Introduction

Gestational diabetes is defined as glucose intolerance appearing during pregnancy. It is a biochemical manifestation rather than a disease.

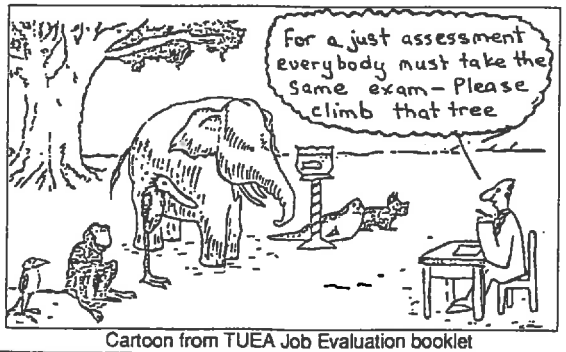
The concept of prediabetes, which held that much of the pathology associated with overt diabetes develops before the appearance of insulin dependency, evolved through the 1940s and 1950s. The glucose tolerance test became the mainstay of this diagnosis, as it was believed to uncover a defect in glucose homeostasis that could only be demonstrated after a glucose challenge. It was not until 1973 that an attempt was made to link an abnormal glucose tolerance test to perinatal outcome.

2 Risks of 'gestational diabetes'

From the evidence available, the small increase in perinatal mortality associated with abnormal glucose tolerance appears to be predicted as much by the indication for glucose tolerance testing (such as obesity, large fetus, previous stillbirth, or malformation) as by the test result. The glucose intolerance thus is simply a marker for other underlying conditions that adversely influence perinatal outcome.

Even as only a marker for increased perinatal mortality, the glucose tolerance test could still be a useful indicator of risk. The question remains as to whether or not identification and treatment of women with gestational diabetes can prevent some of the associated perinatal deaths.

At present there is no convincing evidence that insulin treatment of women with an abnormal glucose tolerance test will reduce perina-



Cartoon from TUEA Job Evaluation booklet

[11] NZ ASSOCIATION OF NATURAL FAMILY PLANNING NATIONAL CONFERENCE

24-26 August 1990
Lincoln University
Canterbury

Theme: Breast Feeding

Contact : National Secretary
NZ Association of Natural Family Planning
P O Box 38-406
Howick
Auckland

[12] INTERNATIONAL CONFEDERATION OF MIDWIVES 22ND INTERNATIONAL CONGRESS

07-12 October 1990
Kobe
Japan

Theme : A Midwife's Gift - Love, Skill and Knowledge

Full Papers : Deadline 30 June 1990

Registration Fee : Y50,000 (NZ$581.00) - before 15 June 1990
Y55,000 (NZ$640.00) - after 15 June 1990

Estimated Total Cost to attend Conference including registration, all fares, accommodation and food : NZ$3,600.00

Information and Enquiries : Regional Chairperson or
Board of Management
P O Box 21-106
Christchurch

[13] FOURTH INTERNATIONAL CONGRESS ON WOMEN'S HEALTH ISSUES

08-10 November 1990
Massey University
Palmerston North

Theme : Women as Health Providers within a Context of Culture, Society and Health Policy

Contact : Fourth International Congress
on Women's Health Issues
Department of Nursing Studies
Massey University
Palmerston North

[14] AUSTRALIAN COLLEGE OF MIDWIVES 7TH BIENNIAL CONFERENCE

16-18 September 1991
Perth
Western Australia

Theme : Birthdays, Birthdays

[15] 2ND INTERNATIONAL HOMEBIRTH CONFERENCE 1992

Sydney
Australia

Calling for ideas and input

Contact : Jane Thompson
12 Thornton Street
Fairlight
NSW Australia

Future maternity care will be a team effort

NZ Doctor MAY 7 1990

BY LYNNE LARACY

Consumers will be included in a team set up to monitor maternity care standards if Auckland Area Health Board proposals are adopted.

Part of the plan to revamp maternity services includes proposals to change the makeup of the Obstetrics Standards Review Committee and its service standards. The recommended Maternity Services Standards Review Committee could include specialists, GPs, midwives and consumers.

Dr Ray Naden, chairman of the Maternity Services Task Force said lack of consumer representation in the past has been a major deficiency.

"If the service is to respond to the changing needs of the community and be more accessible, personal and culturally appropriate, then we need this input. We also hope to see GPs far more involved than they have been."

The task force was set up by commissioner Harold Titter last year to produce a plan for maternity services in Auckland.

The review committee will continue to monitor all medical practitioners working in the public health system and will approve their contracts. A similar contract system for midwives with defined training and experience standards will be formulated when changes to the Nurses Act are passed.

"Midwives will have to meet those standards to work under a similar contract system now operating for medical practitioners," he said.

If we look ahead we will see maternity care being provided by teams, with GPs and midwives working together. But if maternity services are to have coherence, there must be common standards of practice that reflect the overall service, not just the individuals within it, said Dr Naden.

"If a woman receives conflicting advice from different health professionals she becomes confused and anxious. While each practitioner's advice may be entirely appropriate, the overall service is poor because there is no consistency and no clear communication between contributing parties," he said.

Maternity service managers will be appointed to each of the four health board areas to oversee all maternity care in those regions.

They will consult with primary care givers to formulate common standards of practice.

"We can develop standards by edict but I see this as unsatisfactory. It is the board's responsibility to ensure women receive quality care but we would rather achieve that by enlisting the cooperation of health professionals and by getting them interested in providing quality care," he said.

Lynne Laracy is a staff writer.

feedings can take longer using these other methods until a baby becomes practiced at them. I encouraged her to express her milk and use it as a supplement in this way so that her baby would continue to receive breast milk's benefits.

Then came the hard work: convincing Kim's reluctant baby to take the breast again. When Kim first tried putting her baby to breast, he quickly became unhappy and frustrated. It took lots of patience to get him started. I told Kim it might take some time before he was nursing well again. For many babies it takes as long to get back to the breast as it took to become confused. I also suggested that whenever he became upset that she stop and comfort him. Nursing should not become associated with unhappiness.

Kim devoted lots of time to their practice sessions, encouraging her baby to stay at the breast by filling a sterile eyedropper with her milk and dripping it down the side of her breast or in the corner of her baby's mouth to keep him interested. Her husband often helped with this, as an extra hand made the process easier. And she would switch her baby often from breast to breast, to stimulate his interest and encourage him to suck strongly. She gave her baby lots of praise when he did well, and when he just couldn't seem to get the idea, she offered him her milk by eyedropper, cup, or spoon.

Kim also found that her baby was more receptive to nursing when he was sleepy and not too hungry. Increased skin-to-skin contact—rocking, cuddling, and stroking—helped, too.

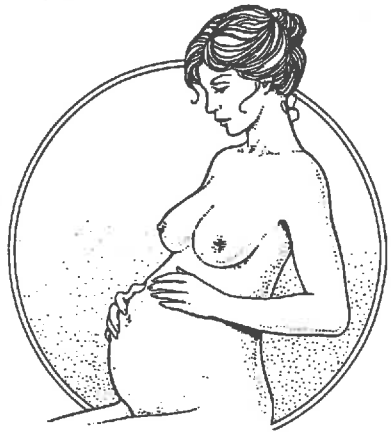
These ideas could be helpful to any mother working to get her nipple-confused baby back to the breast. For nipple confusion caused by a nipple shield, a mother could try other approaches as well. For example, some mothers have successfully weaned their babies from the nipple shield using the gradual approach, by cutting away a small portion from the tip of the shield each day until it is gone. Another successful, but more sudden, approach is to quickly slip the shield off the breast once the baby is comfortably nursing.

Within a couple of days, Kim and her baby were back to total breastfeeding again. It was a lot of work for both of them, but Kim was committed to giving her baby the best and she knew breastfeeding would be worth the effort.

I encouraged Kim to write to the staff of the hospital where her baby was born and let them know how bottles had affected her baby and how hard she had to work to get her baby back to breastfeeding. Although bottles, nipple shields, and pacifiers are routinely given to newborn babies in some hospitals, many health-care professionals are unaware of their possible side effects. Positive communication between parents and health-care professionals can often help change policies that are unsupportive of breastfeeding.

Although nipple confusion can be overcome by a persistent and dedicated mother, prevention is by far the best course. The mother planning to give birth in a hospital would be wise to find out in advance her hospital's policy on artificial nipples. If pacifiers and bottles are routinely given to all babies (sometimes their use is dependent on which staff members are on duty), a mother can ask her baby's doctor to give her written orders that her baby not be given artificial nipples. If the mother photocopies these orders and brings them with her when she has her baby, she can give a copy to each hospital staff member she meets, greatly improving her chances that her baby will not be given artificial nipples. Rooming-in and early discharge are other options that give a mother more control over what her baby is given.

Although a small percentage of newborns can switch back and forth from breast to artificial nipple without ever becoming confused, the vast majority of babies will develop problems, either immediately or over time. Unfortunately—as Kittie Frantz points out—babies are not born with labels to tell us which are easily confused and which are not. So—as Kim belatedly learned—it makes sense, for both mother and baby's sake, to give only the breast during baby's first month. Why take a chance?



by Joan Andrea

NIPPLE CONFUSION

Kim began to panic. She couldn't imagine what was wrong. Her five-day-old son, who had breastfed just fine after birth, was mouthing her breast strangely as if he no longer knew what to do, pulling away, and crying each time she tried to breastfeed him.

While still in the hospital, Kim had followed the nurses' instructions to the letter, giving her baby bottles of glucose water after every nursing. By the third day after birth, Kim noticed that her baby was more reluctant to start nursing, pushed the breast from his mouth, and frequently fussed during feedings. Now, on his fifth day, he completely refused to breastfeed. Kim felt rejected and scared. In desperation, she tried to pump milk from her painfully engorged breasts and give it to her baby in a bottle. Then she called me, her local LLL Leader. Her panic began to subside when I gave her problem a name: "nipple confusion."

After she told me her story, I explained to Kim that nipple confusion is a common problem for many mothers and babies during the early weeks. Most babies, I told her, find it confusing to switch back and forth between the breast and an artificial nipple while they are just learning to breastfeed. Some babies, like Kim's, become fussy and eventually refuse the breast. Others continue to nurse but try to nurse at the breast as they do at the bottle, giving them less milk for their efforts and causing their mothers to develop sore nipples.

Mothers are told to use artificial nipples during their babies' early weeks for a variety of reasons. Giving breastfed babies bottles of water or formula is standard practice in many hospitals, as Kim found. Sometimes well-meaning friends or health-care professionals will advise getting the baby "used to" a bottle in case of an emergency. Fathers may be told to give bottles so that they can "bond" with their babies or to help with feedings so mothers can catch up on their rest. Some mothers are told to make sure their babies are familiar with a bottle from the beginning if they plan to go back to work or to make it easier to go out without their babies.

But giving bottles is only one way to cause nipple confusion. Babies who receive other artificial nipples can develop this problem, too. For example, nipple shields—rubber or silicone nipples worn over the breasts during breastfeeding—can also confuse babies. Many mothers who are given nipple shields while in the hospital find, once they get home, that their babies won't nurse without them. Even pacifiers can confuse some babies.

Bottles and artificial nipples seem to be such an integral part of infancy in Western societies that many mothers are surprised to learn that they can interfere with breastfeeding. However, Kittie Frantz, a retired LLL Leader who is now a pediatric nurse practitioner and Director of the Breastfeeding Infant Clinic for Los Angeles County USC Medical Center, estimates that 95% of all babies will become confused if given an artificial nipple during the first three to four weeks after birth. For some babies it may take a week of bottles before they become nipple confused, for others only one or two bottles—or other artificial nipples—will cause the problem to occur. Once a baby has been breastfeeding well for three to four weeks, nipple confusion is much less likely to develop. So if a mother plans to give her baby bottles—for example, one who will be working outside the home—it would be wise to wait until after her baby's first month to introduce them.

A newborn becomes confused because his tongue, jaw, and mouth move differently during breastfeeding than while using a bottle, pacifier, or nipple shield. During breastfeeding, baby's jaws and tongue must work together in a coordinated rhythm. Once baby latches on to the breast, baby's tongue cups around the breast in a rhythmic motion, pressing his mother's breast up against his palate. This flattens and elongates the flesh around his mother's nipple. Then the back of his tongue drops to form a grooved passageway for the milk to flow from her nipple. Then baby swallows and takes a breath. Baby's lips are flanged out and rest against the breast to make a seal.

When a breastfed baby tries to nurse from a bottle the way he nurses at the breast, he is immediately met with a flood of liquid. This forces him to block the milk with his tongue to prevent him from choking. His lips purse tightly against the unyielding artificial nipple and his jaws have nothing to do. Milk flows immediately with no waiting for the milk-ejection (or let-down), reflex, giving instant gratification with no effort from baby.

I explained to Kim that switching back and forth from bottle to breast had confused her baby to such an extent that he no longer remembered how to milk the breast. Then we discussed some ways to get her baby back to breastfeeding. The first step was to stop using all artificial nipples, including pacifiers. Naturally Kim was concerned about how her baby would get enough milk until he was nursing well again. I assured her that there are other ways besides bottles to give supplements. Newborns can also drink from eyedroppers, cups, spoons, and peridontal syringes, although, I told her,

BOOKS AND VIDEOS

BOOK REVIEW

A GUIDE TO HEALTHY PREGNANCY AND CHILDBIRTH

- by The Auckland Home Birth Association 1990
COST : $12.00 + $1.00 (postage and packaging)

This is a wonderful, comprehensive 80-page, A4 size, soft covered book of value to all pregnant women, not just those considering home birth. It provides women with the information required to understand their changing bodies and therefore meet their individual needs during their pregnancy.

Contents include:-

1] Home Birth - A Safe Alternative
2] Nutrition and Pregnancy - basic information to understand the changing requirements plus the benefits of non-allopathic additions.
3] Health During Pregnancy - discussing common health problems and the use of naturopathic and homeopathic remedies in assisting the body return to a healthy state.
4] Threats to the Foetal health - medical and recreational drugs, STDs, Toxoplasmosis, Ultrasound, VDUs, etc.
5] Preparation for Birth - exercise, perineal massage, general care, turning a breech.
6] Guidelines for Labour and Birth - excellent section on coping skills for labour, complementary medicines.
7] After the Birth - breast feeding, healing and complimentary non-allopathic medicines, exercising.
8] Sexuality and Contraception - a very sensitive chapter on the alterations in sexuality during and after pregnancy. Contraception in detail discussing side effects not seen on the drug company information leaflet.

I highly recommend this book and it is a credit to the Auckland Home Birth Association.

- Julie Hasson

Available from Auckland Home Birth Association, P O Box 7093 Wellesley Street, Auckland.

SAFER CHILDBIRTH?

A critical history of maternity care by Marjorie Tew, University of Nottingham, UK. Chapman & Hall, London

In all developed countries the last fifty years have seen a dramatic decline in the deaths of mothers and babies in childbirth. What is it that has made birth safer? The medical profession has propogated the belief that the increased safety is due to the increased management of birth in hospital by obstetricians. This is a hypothesis which can be tested against actual experience.

Marjorie Tew has brought together this evidence which discredits the obstetricians' case but supports the alternative hypothesis, that safety in childbirth depends primarily on the good health of mothers which rising standards of living and nutrition have increasingly made possible. This well-researched book provides material of vital concern, not only to all professionals involved in organising and developing maternity care and to all women who use it, but also to the wider public, Britain and abroad, who ought to know how policies for this basic community service have evolved.

Contents : Preface. The revolution in maternity care: the diverse strands of a complicated tapestry. Birth attendants and their places of practice. The practices of attendants before birth. The practices of attendants during and after birth. Maternity care - a public concern. Evaluating the results of maternity care - statistical instruments. Mortality of the mother. Mortality of the child. Epilogue - drawing fair conclusions from factual evidence. Index.

This book will be available from your usual bookseller/supplier. In case of difficulty, order from : STM Promotion Department, 11 New fetter Lane. London, EC4P 4EE or telephone the Order Department 0264-332424

ACTIVE BIRTH

- by Karen Guilliland Cost : $50.00 + $3.00 P&P

A 30-minute video in which Caroline gives birth to her second baby.

It is a planned hospital birth and shows Caroline labouring at home, arriving and labouring in hospital, and choosing to deliver on her hands and knees. Caroline and Andrew's 3-year old daughter, Helen, is present. A great parent education video.

Available from : Karen Guilliland
136 Springfield Road
Christchurch 1

Our society is one in which it is believed that there is 'a pill for every ill'. Pain is viewed as negative and bad and thus is to be preferably avoided or at least reduced. This includes the pain of labour. The medical approach is 'to take it all away', reinforcing the belief that professionals are the experts and that they have the pharmacology and the technology that are needed in order for women to be able to cope with the pain of labour.

The best childbirth education is that which aims to help women and their partners gain the knowledge and develop the skills that will enable them to make informed decisions about their pregnancy and birth. There is in depth examination and discussion about cultural perceptions of pain and the causes and role of pain in childbirth. This pain is seen as a positive force, the result of the cervix dilating so that the baby may be expelled from the uterus.

When couples are knowledgeable, they suffer less anxiety and fear, both of which greatly heighten the experience of pain. They are encouraged to visualise and understand the forces within that cause the pain and to see it as a challenge that they themselves can overcome, with appropriate emotional and physical support and with the use of various comfort measures.

Because T.E.N.S. must be used as early as possible in labour and then only after pre-labour training, the message is that the woman will be unable to cope with the pain of labour, that she is incapable of meeting and overcoming the challenge. It is in effect, a massive vote of no confidence in the ability of women to labour and birth naturally. When a woman has used the T.E.N.S. machine, will she be left with the nagging question 'I wonder if I really needed it?'

I think T.E.N.S. machines have a place, particularly for primiparas who need a medical induction, for posterior and other presentations that usually mean long and difficult labours, for those with back problems and for those women with a morbid fear of pain. However, I would hate to see them added to the arsenal of those whose philosophical approach to childbirth is the rather condescending and misleading belief that pain in childbirth is bad, that women cannot or should not have to cope with it and they need something 'to take it all away!'

Sharron Cole
March 1990

childbirth became less of a factor at our births. I was constantly amazed at the courage and beauty of the women, and I couldn't help but notice that my admiration of them seemed to help sustain them. Together we knew that pregnancy and birth were not medical emergencies.

In 1971, when I began my work as a midwife, the national cesarean rate was about 7%. Today it is 24% nationally. Then as now, the mother was not permitted to eat or drink once she was in labor. Our way was entirely different. I remembered the hunger and weakness I had felt during my own long labor, and I couldn't imagine denying my friends food and drink while they were working so hard. In my eighteen years of practice, no woman has had any problems related to eating or drinking in labor. The women in my community knew that we were doing something right. I tried to treat everyone the way I wished I had been treated when I had Sydney—like the most important being in the universe. The rule was that if anyone were to be around the laboring mother, she deserved their absolute attention, love and respect.

The men in the community had to stay away from birth, except when their own children were being born. My husband provided a positive example to the rest of the men by insisting that it was right for women to decide how they should be treated in childbirth. Once everyone saw how well this system worked, there were few arguments as to its essential rightness.

Some of my most important lessons in helping women give birth centered around showing their mates what kind of support to give during pregnancy, labor, and birth. Although my experience with birthing has involved male partners, the following experience should apply to the many women who have female labor and delivery coaches, such as female relatives and lovers.

When a woman's partner knew how to touch the mother during labor, the partner could alleviate a lot of her pain, and couples who cuddled and kissed during contractions were nice to be around: their babies seemed to slide out easily; they were in good condition, even when the labor was long. Many of the mothers seemed to experience very little pain, and it was not unusual to hear a woman say afterwards, "That was so nice! Let's have another one."

We midwives kept careful records on pregnancy and birth. We studied obstetrical texts and gathered all the knowledge we could about birth. I couldn't help but notice that we weren't experiencing the number of complications that were reported in most texts. One hundred and eighty-six babies were born before we needed a cesarean section. Another one hundred thirty-seven babies were born before we needed another cesarean.

I feel that we have unlocked the great riddle of birth and in doing so, we have found a way that women can live with men without being exploited. It seemed most relevant that someone figure out how this might be done, since half the babies being born are male, and we need to know how to raise them so we can live with them, too.

Breastfeeding worked as well as birthing. Every mother who gave birth was able to breastfeed, even those whose babies had been born prematurely. (Friends brought their babies by to help these mothers keep their milk supply up, and husbands drank the mother's milk to stimulate milk production until the premature baby was able to suckle.) Most of the women wanted to work at least part time outside the home, so in our community, babies got to go to work with their mothers. Baby beds and playpens were considered office furniture; as essential as desks.

To date, my partners and I have attended some 1,706 births, with a low mortality rate (the neonatality rate is 8.8/1000 births including all transfers, uterine deaths during pregnancy and congenital abnormalities), no babies permanently damaged by our way of childbirth, and a cesarean rate of 1.4%. I lecture regularly at medical schools and have recently begun to do Grand Rounds for family practice physicians and obstetricians. I show them videotapes of how birth should look. One of my basic tenets is that laboring women should look beautiful and powerful. If they don't, they're probably not being treated as well as they should be.

In the community where I live, we live with the knowledge that birth works. If it works for us, it can work for the rest of our species—provided that men move over and let women make the decisions about how we go about caring for women in childbirth. Obstetricians ought to be taught about birth by midwives who are independent of modern obstetrics, midwives who are versed in the true motherwit. Motherwit, or mother wisdom, includes knowing that every woman has the knowledge within her about how to give birth, and that for her to have access to this knowledge, she must be protected from fear, distraction, and abusive treatment. Obstetricians are taught to fear childbirth; all through their training, what can go wrong with childbirth is constantly before them. Obviously, since obstetricians necessarily must deal with the problems of childbirth, they must be trained in pathology, but before they are exposed to what is frightening about birth, they need a thorough grounding in what normal childbirth is and how to keep it normal.

I know that if we can bring about this change in how we treat women during pregnancy and birth, we can make important and far-reaching changes in society and how we relate with our environment. However, according to my calculations, the U.S. is about 250,000 midwives short of the number we truly need. We need to respect different educational routes to midwifery. While some midwives may enter the profession through nursing, we need to know that ultimately, nursing and midwifery are distinct professions. In many states, the laws permit only nurse-midwives to practice legally. The U.S., along with Canada, produces fewer (nurse) midwives per capita than the other industrialized countries, and this rate of production will not significantly increase until midwifery is viewed as its own self-regulating, independent profession. Only in this way can we have enough midwives with sufficient freedom of practice that all women who need and want midwifery care during labor and birth can enjoy this privilege. ∞

ARTICLES OF INTEREST

Midwifery and Women's Power

by Ina May Gaskin

***Ina May Gaskin** is a midwife and founder and director of the Farm Midwifery Center. She is the author of* Spiritual Midwifery, Revised Edition *(1978) and* Babies, Breastfeeding and Bonding *(1988). She edits and publishes the quarterly journal,* The Birth Gazette. *She also produces video programs on childbirth issues. Ina May is one of the founding mothers of the Midwives Alliance of North America and lectures frequently throughout the world. She teaches English at the Farm High School in the Farm community. She can be reached at 41, The Farm, Summertown, TN, 38483.*

I am a midwife, storyteller, writer, teacher, and pathfinder. Perhaps in another time I would have learned my midwifery from one of my grandmothers, but that chain was broken the generation before that of my grandmothers, and I had to essentially re-discover what a midwife does and why she is so necessary a part of any society.

Because that chain of women's knowledge had already been interrupted by the time I came of age, I had to learn from bitter experience why pregnant and laboring women need protection around the time of birth. I don't mean the kind of protection symbolized by the high technology so many of my sisters have come to accept as necessary at birthing time, but rather the protection of other women, wise to the ways of birth, who understand that birth is a time of transformation and empowerment in women's lives. Birth is a rite of passage, and we need compassionate and wise guides to help us during this peak experience.

Candace Whitridge, a midwife friend of mine, tells about an African myth that illustrates that no matter what we do, we women are still essentially alone when we give birth. In the myth, a woman is on a narrow log in a shallow but very rapidly moving stream. Giving birth means getting from one shore line to the other. Villagers and loved ones can be on both sides of the log and accompany her downstream. They can pick her up if she falls off the log. People can cheer her on, and they can help her keep her balance and give her an idea of how close the other shore is, but they can't get on the log with her. Birth is like that.

At least from the time of the birth of my first child in 1966, I have been obsessed with the relation of women's power to the act of giving birth. Having come to that first birth with a faith that I was perfectly made to flow with its biological necessities, I was surprised when my obstetrician said there was a very real danger that my baby's brain could be damaged "by pounding against my perineum," as he put it, unless he intervened by giving me a spinal anesthetic and pulling my baby out with forceps. He advocated this approach for all first births.

Having spent much of my childhood around farmers, I knew that the female of the species was supposed to be protected from intrusions around the time of birth in order for the process to work well. My aunt, who raised animals all her life, kept me away from a mother dog and her newborn puppies lest I obliterate the scent cues on the pups that prompted her to know they were hers and to give them expert care.

Besides not believing that all first births had to be by forceps, I was afraid of being anesthetized and helpless among strangers. I could not believe that my own body could injure my baby. Despite my arguments, general stubbornness and my strategy of being unobtrusive while in labor so that they would leave me alone, I was surrounded by several nurses and the obstetrician when I was near full dilation, and they gave me the spinal. Straps were placed around my wrists and ankles, and the forceps were inserted. I felt as if I was in a medieval torture chamber. My daughter was carried away before I had a chance to look at her (I think the doctor didn't want me to see the forceps marks on her head). I was stitched up and told that I shouldn't try to raise my head for at least twelve hours if I didn't want a headache that might last for a month. I didn't get to have a real look at her until she was almost a day old. I wasn't sure she was mine.

Although by outward appearances I was an adequate mother, inside I knew that something very important was missing. I was full of fears that I had not known before; I didn't really feel like a mother, and, most importantly, I didn't know that my daughter was Somebody. It took me the rest of her life to catch up, but we finally did. She died of brain cancer at the age of twenty.

The story of how I became a midwife has been told in my book, *Spiritual Midwifery*,* excerpts of which are reproduced with this article. Suffice it to say that most of what I learned, I learned from other women. There were a few male doctors who provided me with instruction and reinforcement at critical times in my early midwifery training.

My husband and I and two hundred seventy other people began a community in 1971. Virtually everyone who was not a child was of childbearing age, and babies started happening fast, including my last three children. I trained midwives to help me, since none of the women in my community opted for birth inside the hospital. Some of the first babies to arrive were born to mothers who had had hospital births much like mine; their enthusiasm about a style of birth that put midwives at their service was contagious. The women who were having first babies also wanted to birth at home. The confidence of the women grew with each birth, and fear of

**Spiritual Midwifery*, rev. ed., by Ina May Gaskin (Summertown, TN: The Book Publishing Co., 1977).*

Midwives teach MPs the facts of life

NZ Doctor April 4 1990

BY OUR WELLINGTON CORRESPONDENT

MPs learned a few rudimentary facts of life when they considered the first submissions on the Nurses Amendment Bill which restores the right of midwives to deliver babies without a doctor present.

Social Services select committee members **Judy Keall, Jenny Kirk,** (Labour) and **Don McKinnon** and **Kathy O'Regan** (National) were obviously surprised when domiciliary midwives explained how they get access to the drugs they need to carry if anything unexpected goes wrong in a home birth.

And they were concerned to learn that even in a hospital situation the midwives have to act as quickly as they can and get authority for their actions retrospectively if no doctor is present.

Judy Keall, the committee chairperson, took witnesses slowly through these parts of their evidence, and is obviously keen to see that the bill, when it is reported back to Parliament, contains some provisions giving midwives the right to prescribe and be responsible for any drugs necessary during an unexpectedly difficult birth.

Midwives from both domiciliary and hospital background told the committee they offered a low intervention, low cost alternative for maternity care.

When midwives are able to practice autonomously, then only one payment for the birth will be necessary, **Jackie Anderson** from the New Zealand College of Midwives told the MPs.

Midwives are prepared to accept responsibility for their actions, but they also made it clear if any problems arose during a pregnancy they would refer the patient onto the appropriate expert.

Professor Richard Seddon, president of the Royal New Zealand College of Obstetricians and Gynaecologists, prefaced his submission with the comment that the college was not there as an adversary to the bill.

However, while the college was in favour of the mother having a choice of health attendants available, it emphasised the need for all choices to involve access to a satisfactory minimum standard of care.

The college has four main concerns about the bill as introduced.

They are:

- provision for adequate assessment to exclude underlying maternal disease
- adequate and prompt diagnosis and treatment of disease intercurrent with the pregnancy and with safeguards for the foetus
- provision of adequate pain relief in labour
- ready access to the technical skills required to safely manage complications in labour and delivery.

Professor Seddon agreed that whoever accepted responsibility for the care of the mother and child should also be accountable.

The college promoted the development of an improved team concept, including the mother, midwife and registered medical practitioner. Each member of the team would have responsibility appropriate to the knowledge and skills they contribute to the team and the needs of each individual situation.

Minister of Health **Helen Clark** added her weight to the argument last week at the Taranaki Polytechnic nurses graduation. She said changes in the health system gave opportunities for nurses to increase their range of clients and professional duties.

"For many years I have been particularly interested in the status of midwives. The profession is an ancient and honourable one and it is unfortunate that it ever lost its autonomy," she said.

Midwives support home births

4.4.90

Southland midwives have expressed their disappointment at comments made by a Winton doctor advising against home births.

Dr Terry Wilson, of the Winton Medical Centre, said on Monday there had been a marked increase in the number of Southland women inquiring about home births since the closure of the maternity hospital.

But he said he was unhappy about home births which he felt could put the patient at risk.

Margaret McDonald, Southland regional chairman of the New Zealand College of Midwives, said yesterday she was disappointed Winton doctors were advising women against home births.

There appeared to be a general misconception regarding the safety of planned home birth, she said.

"Before a planned home birth the woman and her family are similarly prepared as for a hospital birth," she said.

"The choice of a home birth is made by the family being fully aware of the commitment and responsibilities of themselves, the midwife and the doctor involved.

"Domiciliary midwives carry equipment necessary for a normal birth and for emergencies that may occur. They attend the women before the birth, at the birth and for up to two weeks after the baby is born," she said.

There was a national trend with the closure of smaller maternity units that more women wanted home births.

"The New Zealand College of Midwives' Southland region supports women who are making informed choices for their birthing options but feel concerned that with the closure of smaller units these choices are being limited," she said.

Mrs McDonald said a woman was screened before being accepted for a home birth.

Patients had to meet a certain criteria.

The midwives' first concern was for the mother and baby therefore not all women would be suitable, she said.

Women need to 'know options' in childbirth

By ASTRID SMEELE

It is important for women to be confident and comfortable in pregnancy and childbirth and have some of the decision- making in their own control, a Christchurch doctor told a public meeting on birthing options in Christchurch recently.

Dr Jenny Keightley said choosing a family doctor or a doctor for the pregnancy and delivery, choosing a hospital or midwifery system, and deciding on an early discharge or maternity leave were some of the decisions faced by parents-to-be.

Dr Keightley said it was important to know the options but to keep them open as what happened during pregnancy and birth was often unpredictable.

About seventy women and men attended the meeting, organised by the Christchurch Parents Centre, to hear the panel discussion on options available in antenatal and postnatal care, and in where to give birth.

The centre had been concerned for some time that women were attending antenatal classes quite late in pregnancy without knowing what the different choices were.

Ms Carol Bartle and Ms Barbra Pullar, of the Independant Midwives Practice, spoke about the importance of continuity of care which is the main focus of their work. The practice was started to fill a need for postnatal home support. The service enables a mother to leave the hospital as early as six hours after the birth and still receive support and care in the home.

Ms Pullar also discussed the proposed amendment to the Nurse Act which will allow midwife to be responsible for a birth. At the moment only a doctor ha that responsibility. Th amendment will giv women an enormous choice in childbirth, sai Ms Pullar.

The home birth optio was discussed by Ms Ur sula Helem, of the Hom Birth Association. Sh estimated there had bee about 500 home births i Christchurch since 197 The service include three antenatal visits an visits for two weeks afte the birth.

Doctors 'should be accountable'

CH-CH PRESS 18th May

PA Wellington

Calls for an independent body to hold the medical profession accountable were made yesterday in the wake of the Medical Council's decision not to proceed with charges against Professor Herbert Green.

The council said on Thursday that charges of disgraceful professional misconduct against Professor Green would not go ahead because of his medical condition.

"By virtue of his heart disease and pathological state of anxiety he would be susceptible to mental or physical breakdown if the hearing were to proceed," the council said.

The Medical Council's chairman, Dr Stewart Alexander, yesterday gave an assurance there had been no cover-up.

Ms Claire Matheson, a former patient of Professor Green, said it was "poetic injustice" that he had "skipped out" through ill health.

Ms Matheson featured in the "Metro" article which sparked the 1988 inquiry into the treatment of cervical cancer at Auckland's National Women's Hospital.

"I don't know how ill he is. If he is as sick as they say I have to accept it is the right decision."

Ms Matheson said she understood the only lay member on the council, an Auckland Justice of the Peace Ms Trish Judd, was the only person to oppose the decision.

"It seems strange that all the medical people supported it and she was the only one against. I think it shows the need for an independent body to ensure that we can have confidence in such decisions."

Ms Phillida Bunkle, the co-author of the "Metro" article with Sandra Coney, backed Ms Matheson's call.

The council's decision was "predictable." The fate of Professor Green, however, was secondary to the real issue of the need for medical institutions to be accountable to their patients.

Ms Bunkle said the delays in formulating charges and making decisions showed inadequacies in the council's dealing with charges against members of their own profession.

Dr Alexander said he would be extremely disappointed if there was any loss of public confidence in the council as a result of the decision.

"I'm quite sure there will be those who regard this as a cover-up or a whitewash but I can assure you it is not."

Asked if he thought an independent body should have made the decision, Dr Alexander said Professor Green's fitness to stand trial was a medical issue and the council was the appropriate body to deal with a medical issue.

Dr Alexander said charges of professional misconduct against Dr Dennis Bonham would go ahead. The council would meet on May 22 to decide on the format and timing of the hearing.

Electronic fetal monitoring criticised

NEW YORK

A WIDELY used electronic technique that monitors the fetal heart during delivery is no more effective than a stethoscope in detecting fetal distress, according to a study published in the New England Journal of Medicine yesterday.

The study also says the technique may increase the risk of cerebral palsy in premature babies.

Electronic monitoring became common in the United States after studies in the 70s suggested a link between fetal heart rate and signs of oxygen deprivation during delivery that could lead to brain damage.

Early development of 93 premature babies, who had been monitored with wire electrodes during delivery, was assessed. It was compared with that of 96 similar children who had been monitored by stethoscope.

The study recorded a 2.9-fold increase in cerebral palsy among babies weighing up to 1.8 kilograms who were electronically monitored. — NZPA-Reuter

Doctors, midwives argue over births

CH CH PRESS APRIL 2 1990

PA Wellington

Doctors and midwives are arguing over who should attend normal births as a parliamentary select committee considers the Nurses Amendment Bill which gives midwives more autonomy.

Last Wednesday the Medical Association told the committee that midwifery training in New Zealand offered "insufficent clinical experience for safe independent practice to be undertaken," and they were concerned patient safety would be compromised.

The College of Midwives president, Ms Karen Guilliland, reacted angrily to the claim, saying midwives had more training in dealing with normal births than doctors.

"In the public health system midwives teach doctors everything they know about normal births.

"Midwives spend the entire labour with a woman as well as being there for delivery — doctors could not manage without them."

Although acknowledging the bill's emphasis on pregnancy being a state of wellness rather than illness, the chairman of the Medical Association, Dr Lew King, said the safety of the patient was the paramount consideration.

Even in low-risk births, complications such as haemorrhages o babies being born with the umbilical cord around the neck could arise, demanding expert care by a doctor/nurse team, he said.

Dr King said it was important to consider complete systems of care offered in other countries, such as the "flying squads" which backed up British midwives.

He suggested evaluation of the support systems that existed, training, the need for peer review and quality assurance before greater autonomy was granted to midwives.

The National Council of Women also expressed some concerns about the bill in its submission to the committee, suggesting the proposed change was motivated by a desire to cut costs, rather than a concern for the safety of mothers and babies.

The council said women should be able to choose the care they preferred, provided they knew all the possible consequences and could still have the service of a doctor at no cost.

MS GUILLILAND

MEDIA WATCH

Midwives

Sir,—With regard to the comments of Dr Lewis King, chairman of the Medical Association (April 2), in the case of complications occurring during birth, the doctor/nurse team he refers to is actually a doctor/midwife team. There is a considerable difference between the two. In most cases where the cord is around the baby's neck it can be slipped over the baby's head or shoulder. If this is not possible it is a simple matter to clamp and cut the cord. This does not require the presence of a doctor, but is a minor disorder that midwives deal with on a regular basis. In a significant proportion of births the doctor does not arrive until after the birth. Midwives are qualified to deal with complications such as haemorrhage and often have done so prior to the doctor's arrival. Haemorrhage is uncommon unless there has been some form of medical intervention, such as induction, augmentation or forceps delivery. — Yours, etc.,

G. E. WARWICK,
Midwife.
April 4, 1990.

Midwives

Sir,—Having just returned from a tour of the Netherlands Sweden and Denmark to study their systems of childbirth, I am interested in the debate ove autonomy for midwives. In his submission on the Nurses Amendment Bill, Dr King mentioned the importance of considering complete systems of care. I agree with him. Each of the countries I visited has better statistics than ours, and all o them have midwives as the primary professionals caring for women during pregnancy, child birth and the post-natal period. None of these countries has a "flying squad," even in the Netherlands, where 37 per cent of women give birth at home. In these countries, G.P.s play a minimal role in childbirth. If there are complications, a specialists is called. G.P.s have very limited training in obstetrics and even less in the field of normal childbirth. This raises questions about the motives of the Medical Association in objecting to midwives' autonomy. The specialists and health administrators I spoke with in each country I visited were happy with the midwife's role. There was no question that safety was being compromised in any way. The statistics confirm this. I believe midwife autonomy will provide a real choice for New Zealand women.—Yours, etc.,

CELIA GRIGG SOWMAN.
April 2, 1990.