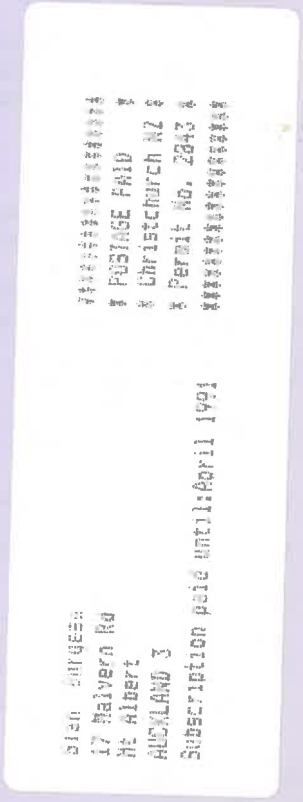
TO:

from:

New Zealand College
of Midwives
P O Box 7063
Wellington



New Zealand College of Midwives [Inc]

NEWSLETTER

Volume 3, Number 2 : December 1990

Changes to the Constitution

Contracts with Area Health Boards

Pharmacists Oppose Midwives Prescribing

NEW ZEALAND COLLEGE OF MIDWIVES INC.

PRESIDENT

KAREN GUILLILAND

136 Springfield Road
Christchurch 1

BOARD OF MANAGEMENT

LYNLEY DAVIDSON
BERYL DAVIES
JEANNIE DOUCHE
CHRISTINE GRIFFITHS
CHRIS HANNAH
JENNIFER SAGE

Address for correspondence:

P.O. Box 7063
Wellington South

NATIONAL COMMITTEE

NORTHLAND
Lynley McFarland
16 Russel Road
Whangarei

AUCKLAND
Glenda Stimpson
P.O. Box 24-403
Royal Oak, Auckland

WAIKATO/BAY OF PLENTY
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12 East Street
Hamilton

EASTERN/CENTRAL DISTRICTS
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76 Charles Street
Westmore, Napier

WANGANUI/TARANAKI
Kathy Glass
P.O. Box 5074
West Town, New Plymouth

WELLINGTON
Marion Lovell
P.O. Box 9600
Wellington

NELSON
Angela Kennedy
32 Tamaki Street
Nelson

CANTERBURY/WEST COAST
Anne O'Connor
P.O. Box 21-106
Christchurch

OTAGO
Suzanne Johnston
P.O. Box 6243
Dunedin North

SOUTHLAND
Lesley Watson
390 Dee Street
Invercargill

PARENTS CENTRE
Wendy Browne
31 Chester Road
Tawa, Wellington

LA LECHE LEAGUE
Marcia Annandale
16 Shannon Place
Christchurch 5

HOMEBIRTH
Madeliene Gooda
92 Ellice Street
Mount Victoria, Wellington

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 eg. 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 your local Treasurer

good evidence that when there is too much contact between obstetricians and normal pregnancy and birth, there is a unnecessary increase in interventions and considerable iatrogenesis. Creating a distance between obstetricians and women experiencing normal pregnancy and birth is essential.

There is also a need to change the nature of the profession of obstetrics. First it is necessary to separate the field of gynaecology from that of obstetrics. Gynaecology is a surgical discipline focusing on pathology while obstetrics deals with a normal part of the life cycle. These two fields demand totally different approaches and it is unreasonable to expect that the same individual will be comfortable to function appropriately in both areas. For those doctors who choose obstetrics it is important to change their training so they are, for example, given an opportunity to observe a large number of home births and an opportunity to become thoroughly familiar with the social literature concerning birth. If obstetricians were no longer gynaecologists and were given this kind of experience it would be much more likely that they would find a willingness to collaborate on an equal footing with midwives and pregnant and birthing women.

These are some of the ways in which the two major movements in maternity care can be brought together. The promotion of this amalgamation between these two approaches is vital in providing the best maternity care for women today.

FROM THE BOARD OF MANAGEMENT

Meet the sixth member of the B.O.M.

My name is Chris Hannah. I have been a midwife since 1982 and am mother to 2 boys, Quinn aged 7 years and Dan aged 3 years.

I have a background in politics and industrial relations and have been involved in midwifery politics since I trained.

My commitment as a midwife comes from my belief that affordable, appropriate and accessible health care is a universal right, although the experience of this seems firmly rooted within a social class structure that addresses the needs of the vocal and empowered first and foremost.

My work as a midwife is a chance to make a difference here, to even out the odds a little for women who, by and large, don't have a voice within our health care system.

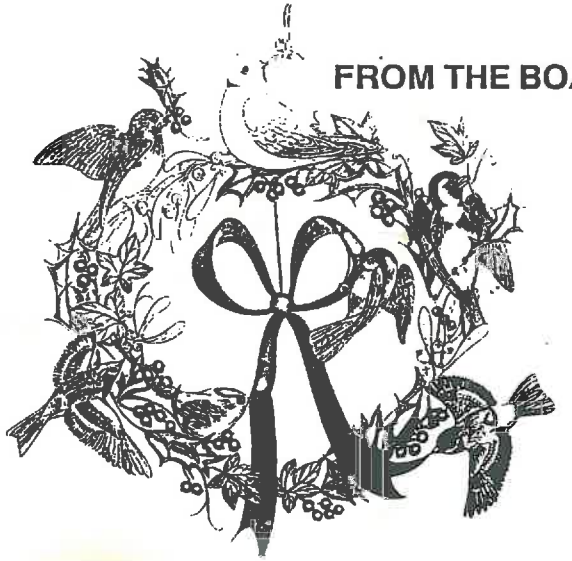
For me, midwifery is health care work that is based upon the development of a personal relationship. This relationship exists primarily between the mother and the midwife, and generally involves a family of some sort or other. I believe this relationship is only useful, only health promoting and enhancing, when it occurs within an environment of mutual respect with the midwife clearly aware of her power and prejudices. It is only possible when there is a sharing of self, knowledge, resources, experience, and power. It is from here that the work of midwifery begins for me with its goal of supporting the normalcy in the maternity experience.

Since October, and since the Amendment, I have worked full-time as midwife for the Newtown Union Health Service in Wellington. N.U.H.S. is a free health service for union members and beneficiaries living within South Wellington.

I work as part of a primary health care team comprising a woman G.P., myself, and a nurse specialising in young families. My role is to provide continuity through the maternity cycle, attending the births, and providing ante-natal and post-partum care for five women a month.

When I'm not doing this, I put some energy into my family, the garden, swimming, the cinema, embroidery and poetry - my favourite poets being Audre Lorde and Adrienne Rich.

FROM THE BOARD OF MANAGEMENT



Season's Greetings
and all good wishes for
the New Year

NEWS & VIEWS

1990

What a year for midwifery in New Zealand. The Law was changed, midwives now have the right to care for women without a doctor.
The NZCOM had its first National Conference.

Queens Service Medals

Joan Donley and Karen Guilliland were honoured with the commemorative Queens Service Medal.

Congratulations!

National Committee Meeting

The National Executive had its first committee meeting in Wellington on 2nd and 3rd November.
Karen reported back from Japan.
The developments within New Zealand have caused great international excitement.
Our consumer involvement has caught the imagination of the midwifery community.
Position Statements were discussed further.
We were reminded that Position Statements reflect the times and our context - these will change frequently, and individuals may feel less than completely satisfied with final results. This leaves work to be done!
Marcia reported that the breastfeeding protocol is going well in the main.

Contracts with Area Health Boards

Discussion at the National Committee meeting suggested that Contracts would not be easy in any region.

Some Area Health Boards are frankly obstructive.
In Wellington the Domino midwives have been allowed to change the conditions of their Contract. Another midwife working with a GP has been granted temporary access.

The Maternity Services Standards Review Committee is operational.

There are no consumers on the committee so far; consumer groups need to be alerted.
What is happening in other areas?

Another way in which science can be used to bring together the separate movements in maternity care is through the so-called consensus conference. I this approach, attention is focused on one particular obstetrical practice which is felt to be contentious. This might be, for example, the routine use of the electronic foetal monitor during labour, the routine use of ultrasound scanning during pregnancy, or the use of caesarean section. One such intervention is chosen and a committee is formed which includes all relevant interested parties including obstetricians, neonatologists, epidemiologists, social scientists and consumer groups. This committee then carefully reviews the world literature on the subject, and also reviews the local situation with regard to this intervention. The committee then drafts a list of recommendations regarding the appropriate local use of this intervention, based on their study and discussion. This draft list must have the consensus of all the people on the committee. Then a large public meeting is organized at which the recommendations are presented to the general public and discussed, and a consensus reached with regard to the final recommendations. These recommendations are then widely distributed to the public and practitioners. Such consensus conferences have been held in a number of countries on a number of subjects such as caesarean section and ultrasound and have been very important in bringing together the wide variety of opinions on individual technologies and gradually reaching a consensus. Essential to this approach is the full consideration of all the scientific evidence, pro and con.

A final strategy to be mentioned with regard to bringing together the medical and social approaches to maternity care is to change the pattern of providers of this care. First it is absolutely essential to increase the role of midwives in maternity care. Unfortunately in most countries the essential role of midwifery in preserving the normality of pregnancy and birth has been eroded. It is only when there is a strong independent obstetrical profession and an equally strong and independent midwifery profession that the proper balance is reached which leads to the very best kind of maternity care. So midwives need to be strengthened and given roles of leadership and decision-making in hospitals and in the community. There must also be an increase in the contact and responsibility of midwives for low-risk pregnant and birthing women. At the same time there needs to be a reduction in the role of obstetrics with regard to normal pregnancy and normal birth. There is

effective strategy developed in the United Kingdom is to produce a "Good Birth Guide" which is like a Michelin Guide for restaurants except it gives stars for all hospitals and clearly states what is available in each hospital for birth care. The information includes what the woman's choices are in the hospital, as well as rating the quality of the services. This "Good Birth Guide" has been a best-seller in the United Kingdom.

Another important strategy in combining the best of the social and medical approaches is the proper use of science. As stated above, science has clearly demonstrated the validity of at least some aspects of the social approach to pregnancy and birth. For example, it has been clearly shown that adequate social and emotional support during pregnancy can improve the biological outcome of the pregnancy both with regard to better birth weight and less need for interventions and this fact needs to receive more widespread attention. The scientific approach has proven that a close contact between the mother and baby at birth is essential. For example a study in Denmark of post-natal depression demonstrated that the factor most commonly associated with such depression was a separation of the mother and her baby, for whatever reason, at the time of birth and in the first few days following birth. Likewise scientific research has demonstrated that breastmilk is far superior to any man-made milk. These are all examples of the use of science in support of the social approach to pregnancy and birth. The medical profession needs greater exposure to this aspect of the scientific literature.

Another approach which can be highly effective in altering birth services is study of regional variations in obstetrical interventions. At the present time the World Health Organization Regional Office for Europe is conducting a survey of regional variations in obstetrical interventions (caesarean section, forceps or vacuum extraction, episiotomy, induction, anaesthesia) in a number of countries. It is clear from the data that there are enormous variations in all these interventions among hospitals even within the same country or region of a country. By gathering detailed data on these variations and then feeding it back to the practitioners involved, it is hoped to influence practice and reduce intervention rates. This is a simple strategy which can be developed in any local region by any group.

Planned National Forum 1991 on Nursing and Midwifery Education

Proposed dates: 14-16 March in Auckland.

There is to be a National Forum on Nursing and Midwifery Education. We were asked to send a College representative to the planning committee.

The purpose of this forum is to get practitioners, managers and educators to address the issues of attracting, preparing and developing practitioners to meet service needs and provide professional development.

ISSUES TO BE ADDRESSED

ENTRY TO NURSING + Midwifery

- How to recruit Maori/Pacific Islanders and Males.
- Financial support for students.
- Cross credit of previous schooling/criteria for entry.
- Image of nursing.
- Context of nursing service.

PREPARATION OF PRACTITIONERS

- Core curricula across all Schools of Nursing.
- Completion of course i.e. hours (clinical and theory).
- Clinical teaching aspects (ratios and availability).
- Funding formula and affects.
- Siting and number of Comprehensive courses.
- Teacher qualifications.
- Award for entry to practice - diplomas versus degrees.
- Profile of Graduate and requirements for registration.

Note Midwifery/Direct Entry same as above
Enrolled courses/where/type and siting of preparation.

PREPARATION AT POST BASIC LEVEL

- Recognition/credit of previous nursing/education.
- What is appropriate post basic preparation?
- Need an incentive for post basic education.
- Funding of post basic nursing education.

Ongoing education and Career programme

New Zealand has its first lactation consultants.
Marcia Annandale, our consumer representative from La Leche among them.

Certified Smear Taker

Jeannie Douché from the BOM recently completed her training and is now fully certified.

Well done!

STOP PRESS

There is a bogus letter in circulation. It expresses views that are bizarre and extremist. The envelope it is sent in is marked confidential and suggests the sender (the letter is not signed) a number of individuals with a high profile, from a number of professions have been implicated. Our concern is that it could be suggested the letter is a midwife's view - the letter is anti midwife and anti choice.

OPPOSITION TO MIDWIVES PRESCRIBING

The Pharmological Society and Dr Millar from the University of Otago have both written to Members of Parliament suggesting midwives have neither the knowledge or expertise to write prescriptions.

Copies of these letters have been sent to your Regional Chairperson. You must lobby your own MP.

NOTE

It is important to point out we promote drug free childbirth. A large proportion of the drugs we use are 'over the counter' items which the public can buy themselves, e.g. panadol, laxatives, anti acids. The use of some drugs is specific to childbirth and we are very knowledgeable about them (e.g. ergometrine and syntocinan). We administer them currently through delegated prescription.

Controlled drugs are just that controlled. We can only prescribe it in midwifery cases and only twice for any one client.

Please send dates of courses and conferences so we can share the information and

maximize the opportunities.

doctor or other health professional will visit with the group only on invitation. Likewise the partners of the women may be invited to group meetings if the women so wish. The women will also determine for themselves what kind of training they want in physical exercise or other psychoprophylactic techniques. Ideally these group meetings would take place in a local neighbourhood women's house where there would be not only prenatal group meetings but also postnatal group meetings as the same group could continue to meet after they all have given birth to share their experiences with their new babies and help each other with breastfeeding and other aspects of baby care. This mutual aid approach is perhaps the most powerful strategy for reducing any tendency toward the medicalization of pregnancy and birth. The use of the mutual aid approach after birth is most effective in reducing tendencies toward the professionalization of parenthood. There is a serious tendency in most countries today for the nature of the services given during pregnancy to convince the woman that her body is inadequate to bear a child without the help of experts and technologies. The birth experience in the hospital in almost all cases reinforces this feeling of inadequacy on the part of the woman. The tendency to professionalize parenthood through having health experts assist the woman with breastfeeding, bathing of the infant and other aspects of baby care again reinforces the woman's feeling of inadequacy as a parent. All of this leads to the woman becoming dependent on the health care system to which she turns at frequent intervals. It is true that in modern urban society with the nuclear family, the young mother has lost the opportunity to learn about pregnancy and child care through the extended family. Unfortunately this function has been taken over by the professionalized health sector but the mutual aid approach will move it back into the lay sector. Too much of prenatal education today is attempting to train women and their partners how to behave when they go into the hospital for a birth, when in fact it is not these people who need to be trained how to behave at birth, but rather the doctors.

Closely allied to the strategy of mutual-aid is the important strategy of giving all possible support to user groups who are working for the improvement of maternity services. In the United Kingdom and northern Italy these groups have clearly demonstrated their essential role in improving maternity services. As stated in "Having a baby in Europe" it can be a very effective strategy for these user groups to combine with midwives in this effort. An

One of the fundamental necessities of combining the social and medical approaches to maternity services is to put the pregnant and birthing woman back in control of her own body and her own pregnancy and birth. How can this be done? First there must be informed choice for all women with regard to their own pregnancy and birth. As discussed above, it is essential that the woman be given all information so she can make an intelligent and informed choice. Furthermore she should have true choice with regard to all options. As a simple example, the woman should be able to choose the place of birth whether it is her own home, a neighbourhood birth clinic or a hospital. To make such a choice she needs accurate information including the fact that for a woman who has had a normal pregnancy without medical complications, a home birth is just as safe for both her and her baby as a hospital birth. In nearly all countries the doctors continue to insist that home birth is not safe for the baby. This misinformation must be changed so women can make true informed choices.

Another important strategy in putting the woman back in control is the use of the mutual aid approach to services. This approach relies on people helping each other and themselves in their own particular situation. This approach was pioneered by the organization "Alcoholics Anonymous" and there are now in every country many organizations of people who share some particular health situation. There is an urgent need to show the validity of this approach both for prenatal and postnatal care, With regard to prenatal care this would involve gathering from a local district five or six pregnant women at more or less the same stage of pregnancy. These women would meet together as a group throughout their pregnancy. They would decide for themselves what kind of education and information they wanted and there would be a consultant midwife to the group. The midwife is not the leader of the group but simply a resource person to help the group provide themselves with the best possible care during pregnancy. The midwife would teach the women to take each other's blood pressure, test each other's urine and measure each other's uterine size. All these are very simple procedures with no magic involved and can be taught very simply and quickly. The women would then examine each other during their group meetings and keep their own records of their own pregnancy. Prior to joining the group these women will have been screened at the beginning of pregnancy and be considered at low risk. A

NEW ZEALAND NURSES' ASSOCIATION

Address all correspondence to the Executive Director

WESTBROOK HOUSE 181-183 WILLIS STREET, WELLINGTON 1.
PO BOX 2128, WELLINGTON 1.
TELEGRAPHIC ADDRESS 'REGNURSE' WELLINGTON 1
TELEPHONE: (04) 850-847
FAX No: (04) 829 993

OUR REFERENCE: 25-6-1

YOUR REFERENCE:

21 November 1990

National President
New Zealand College of Midwives
PO Box 7063
WELLINGTON SOUTH

Dear Karen

The Professional Services Committee of the New Zealand Nurses' Association would like to congratulate the members of the New Zealand College of Midwives for their initiative and drive that resulted in the passage of the Nurses' Act Amendment 1990. The College's political effectiveness sets a precedent for other organisations.

The Professional Services Committee also appreciates that the Amendment will benefit the nursing profession as well as the midwifery profession.

Please thank the college members for their hard work and demonstrated professional commitment.

Yours sincerely

Joy Bickley
for Elizabeth Sturch, Chairperson
Professional Services Committee
New Zealand Nurses' Association

[LMK\JB\LETTER]

* *

Position Vacant

Organiser Educator

The New Zealand College of Midwives has funding for an Organiser Educator to be employed for 1 year to run a series of seminars throughout New Zealand for groups interested in developing midwifery knowledge and standards.

The aims and objectives for the Educator will be:

(a) To increase awareness amongst health professionals of the midwifery model for childbirth services.
(b) To promote midwifery as a profession and to attract nurses and midwives back to midwifery.
(c) To educate health professionals about legislative changes to the Nurses Act.
(d) To promote the New Zealand College of Midwives Standards for Practice.

Job Description

The Educator will be employed by the College to run a series of seminars based on the aims and objectives throughout New Zealand.

The applicant will need to be a proven educator, have extremely wide knowledge of the issues and current developments within the profession.

This position is for 1 year only. Salary $37,000. Hours 40 (no penal rates).

Applicant must be free to travel within New Zealand.

Closing Date: 7th January 1991.

* *

Application with CV should be made to:

Beryl Davies
Board of Management
P O Box 7063
South Wellington
WELLINGTON

The last excuse I will mention is quite extraordinary but nevertheless I have heard it from time to time. This is the statement that the women in the local area are different from women elsewhere and therefore the experience elsewhere is not relevant to the local situation. For example I have heard Scottish obstetricians say that the reason there can be home birth in the Netherlands is because Dutch women are different from Scottish women. Likewise at a birth conference in Greece, when the Greek obstetricians were asked why 50% of women in Greece are given a general anaesthetic and put sound asleep during labour and birth, the answer was that Greek women are not able to tolerate pain in the way that women elsewhere can. All such excuses need to be dealt with if we are ever going to be able to promote change in our maternity care systems.

An important strategy to promote the combining of social and medical care in maternity services is the sharing of all information. Information is power and control and the medical profession has been closely guarding its information on pregnancy and birth. The idea is that only we doctors can understand all this highly complicated business, that the women and the public cannot be expected to understand and therefore we will not try to explain. The sharing of information must take place on several levels. With regard to the individual pregnant and birthing woman, it must be her right to see her own medical record whenever she wishes. On the community level it means that all hospital data should be public domaine and available to the general public. It also means that the medical profession has a duty to explain carefully both to individuals and to groups in the community everything they do and the reasons behind it. This is because all this information belongs to the people.

Another strategy to promote bringing the medical and social movements together is to involve all interested parties in any discussions of maternity services. This is why organizing birth conferences is so important and why such conferences should include doctors, midwives, nurses, social scientists, epidemiologists, health authorities, politicians and the general public. Furthermore the mass media have an essential role to play and should be involved not only in birth conferences but in all aspects of discussions on birth care.

Another common reason given for unwillingness to change maternity services is danger of infection. It is extraordinary to me that this excuse is still so widespread since for a number of years the scientific literature has made it very clear that hospitals are full of dangerous germs. The problem with outsiders coming into the hospital is not that they will bring in dangerous germs but just the opposite: the outsiders are likely to pick up the dangerous germs from the hospital. Careful scientific study has shown that allowing partners and other people into the labour and birthing rooms in a hospital does not increase infection rates in the hospital. Infection is also very commonly used as an excuse against introducing rooming-in in a hospital. This is ironic in that the centralized nursery for healthy newborn infants in the hospital is in fact a serious source of infectious epidemics and is far more dangerous with regard to infections than rooming-in. Indeed I am convinced that when we look back on the twentieth century and the care of the newborn infant, we will conclude that the most serious mistake of this century was to put all healthy newborn infants in the hospital into a common nursery. This is a disaster not only because of the danger of infectious epidemics but also because it separates the infant from the mother.

Sometimes I hear that change is not possible because of inadequate funds. Most of the changes that would come if there were to be a combining of the medical and social approaches would cost little or no money and indeed might save money. It is the high technology care that is expensive, not the humanized care. It costs nothing to close a centralized nursery in a hospital and give the babies back to the mothers. It costs nothing to allow fathers to be present during labour and birth. It costs nothing to allow women to walk around during labour and assume a vertical position at birth. In the Netherlands there are only half as many hospital beds for children as in other countries in Europe because they do not need hospital beds for many of their newborn infants and the Dutch thereby save very large sums of money. The French spend more money doing ultrasound scans of normal pregnant women than on all the rest of their pre-natal care for pregnant women, in spite of the fact that the scientific evidence shows that routine scanning of all pregnant women is of no value.

NEW ZEALAND COLLEGE OF MIDWIVES INC.

The following amendments/additions to the Constitution of the New Zealand College of Midwives Inc. were adopted at the Annual General Meeting on 17 August 1990.

4. Philosophy

Delete: "Midwifery Policy Statement N.Z.N.A. 1988".

7. Membership

7.2 Add: "Overseas individuals' membership is to the National Committee."

7.6.2 Delete: "except on issues concerning the midwifery profession."

7.8.2 Change to: "The member has paid no subscription for 3 months after membership has expired."

9. Board of Management

9.1.13 That BOM call for remits 3 months prior to the AGM.

New section to be added as follows:

9. National President

9.1 The National President shall be a Full Member and is elected for a term of 2 years with a right of renewal.

9.1.1 Regions shall submit nominations to the Board of Management 3 months prior to the AGM or SGM.

9.1.2 The Board of Management shall forward nominations to each region.

9.1.3 Voting shall be at regional level and results sent to National Committee 14 days prior to the AGM.

9.2 *Functions of the President*

9.2.1 The President shall be the national spokesperson for the NZCOMI.

9.2.2 The President shall attend the National Committee meetings, AGM and National SGM.

9.2.3 The President has the right to attend Regional and BOM meetings.*

9.2.4 In the absence of the President, a BOM member will deputise.*

17. Alteration of Rules

17.3 Change "not less than 21 days prior to the General Meeting" to read: "not less than 3 months prior to the AGM."

As a result of the new section being added (Section 9 - National President) all sections from there on will have to be renumbered, i.e. Board of Management becomes Section 10 etc.

NEW ZEALAND COLLEGE OF MIDWIVES INC.

The following Standards and Position Statements were adopted at the Annual General Meeting on 17 August 1990.

Standards

That the NZCOMI Standards of Practice, Service and Education be formally adopted.

Position Statements

... *Infant Feeding*. The NZCOM protects, promotes and supports breastfeeding.

... *Immunisation*. The NZCOM believes that immunisation is inappropriate in the first six weeks of a baby's life unless specific risk factors are present.

... *Staffing in Maternity Units*. The NZCOM believes that women in maternity units should be cared for by midwives.

... *Endorsement and Advertising of Products*. It is not the policy of the NZCOM to endorse any commercial products. Sponsorship or advertising which contravenes the objectives of the NZCOM is not acceptable. The NZCOM upholds the WHO International Code of Marketing of Breast Milk Substitutes.

... *Circumcision*. The NZCOMI does not support circumcision. The College acknowledges that circumcision may be performed for religious, cultural or medical reasons.

In accordance with our belief, parents should be given all available current information, including risk factors, to make an informed decision.

By Laws

7. Membership fees to be increased to $74.00 for waged membership and $37.00 for other membership groups and that the National Committee investigate a fee structure for midwives who choose indemnity insurance.

8. (a) That membership fee includes subscription to the NZCOMI Journal.
   (b) That separate subscriptions be available for the purchase of the Journal for non-members.

9. Overseas members' subscriptions shall be retained in their entirety by the National Committee.

10. The NZCOMI AGM is to be held in August of each year.

11. The National Conference is to be held biennially in August in conjunction with the AGM.

12. Capitation fees to be divided between National Committee and region as 60% to National Committee and 40% to Regional Committee:

$29.60 Region }
$36.40 National } Full Membership fees
$8.00 Journal

One of the most common alibies given for leaving the services unchanged is that of safety. All too often the medical profession insists that the fall in perinatal mortality in the last 20 years is the result of high technology obstetrics, despite the fact that there is no good evidence to support such a contention. The modern obstetrical profession has to a great extent decided that it is their duty to protect the foetus and the newborn child. The modern notion in obstetrics is not "women and children first" but "children first, and women maybe". Underlying this stance of the medical profession is first of all the separating of the woman and her own child and the implication that the mother is not always as concerned for the safety of her baby as the doctor might be. This of course is a very dangerous notion. Also underlying this attitude is the assumption that technology equals safety while nature equals danger. Behind the arguments about safety is also the belief that the social approach to pregnancy and birth is a nice "frill" to be brought in only after the safety aspect has been guaranteed through proper medical attention. If one looks carefully at the scientific literature, however, one discovers that technology is very often not safe and that there is rapidly increasing scientific evidence that attention to the social and emotional status of the pregnant and birthing woman is highly correlated with the biological outcome of the pregnancy and birth. Thus safety has been used as a bludgeon to force women to go along with the unpleasantness of the high technology obstetrical approach.

Another alibi given by the medical doctors to excuse no change is that the physical facilities in the hospital will not permit changes. In my own experience in visiting hundreds of hospitals in many countries, this excuse is just that - an excuse. For example, the excuse is made that the woman's partner cannot be present during labour because there is inadequate space, yet when one enters the labour room in these hospitals one finds a midwife, a doctor, a medical student, a nursing student, etc. but no room for the father. Likewise very often I am told that rooming-in is a nice idea but impossible because of the physical facilities despite the fact that rooming-in requires absolutely no change in the physical facility: indeed, the newborn infant can simply stay in the mother's bed.

A third excuse that I hear frequently is that the local situation is different from anywhere else and therefore one must understand that the services in this local setting are designed to fit the local situation and thus there is no possibility of learning from experience elsewhere. This alibi is frequently brought forward when there are discussions on maternity services in the Netherlands. In an attempt to explain why the local medical profession is opposed to any possibility of home birth, it is stated that in the Netherlands they have a transport system that will allow women to have their baby at home because they can very quickly be brought to the local hospital. The reality is that in the Netherlands the standard is that the woman choosing home birth should be within 30 minutes of the nearest hospital. In most countries the vast majority of people live within 30 minutes of a hospital, so this argument for a different local situation is not valid. Clearly maternity services in any local area must be tailored to the needs of that area but equally clearly there are important principles with regard to maternity care to be learned from evaluating maternity systems elsewhere.

A fourth excuse for leaving maternity services unchanged is that the women are demanding that services be the way they are. This is an excellent example of what is called "blaming the victim". Why do some women want to have their baby in the hospital surrounded by high technology? Clearly the medical profession has succeeded in convincing women that if they come to the hospital and have the expertise of the obstetrician and the assistance of all the technology, they can be guaranteed a healthy baby. Unfortunately at the present time the general public has lost the important basic understanding that, regardless of the quality of medical attention, there will always be some babies who die. This is a fact of life which has been lost and which is indeed underlying many of the serious problems in maternity care today. Regrettably the doctors have played God and stated that they can guarantee perfect babies. If one plays God, one will be blamed for natural disasters. Consequently the doctors are blamed when a baby dies, even though in the majority of cases when a baby dies no-one is truly to blame. This problem must be solved by the medical profession helping to bring back the basic understanding that there will always be some babies who die and furthermore, that doctors will always from time to time make mistakes. Women very badly need to have more honest information from the medical profession with regard to the realities of pregnancy and birth.

The Domino Option

NORTHLAND AREA HEALTH BOARD

AUGUST 1989 - JULY 1990

The Domino option is a new service that believes that women who get to know their Midwife before they go into labour will need less ante natal admissions, feel more in control of the labouring experience, need less narcotic analgesia, and less medical intervention in the labour and birthing experience. The continuity of the midwifery support into the post natal period, decreases the multiplicity of advice and increases successful breastfeeding patterns. The National Home Birth Statistics of New Zealand reflect the benefits of continuity of care, commitment to support of natural childbirth, where appropriate, and education to increase healthy living styles, and the rejection of unnecessary intervention. The challenge for the Domino Option is to try and reflect some of those statistics. The Domino Option also acknowledges that the majority of New Zealand women have been socialized to view hospital birthing as a safer option than home birth. The Domino Option is committed to ensuring that women return to their own home environment as soon as it is practical after the birth. We believe that a women's own home is a more appropriate place to develop parenting skills and problem solving, for low risk women, and that the hospital setting is only appropriate for women needing high risk post natal support.

The following statistics represent the first 70 Domino Births

Normal deliveries - 65

Ventouse assisted - 3

Caesarian Sections - 2

- 1 - failure to progress, meconium liquor, feotal distress
- 1 - premature twins

Primipara - 20 = 29%
Multipara - 50 = 71% similar to the balance of primigravida in usual system

Positions for giving birth in order of most common use:

- kneeling
- birthing stool
- sitting
- hands and knees
- squatting
- standing
- dorsal, lithotomy, lateral

Pain relief - sublimaze 7
- pethidine 5
- epidurals 2

total narcotics combined = 17%

Intervention - Prostin inductions 4 = 6%
- 3 for post dates more than 42 weeks gestation
- 1 for increasing antibody litres

Augmentation of labour with syntocinon - 2

Perineal repair Episiotomy - 2
Sutured lacerations 30%

Complications pph 5
Neonatal death 1 complications of a breech birth

Numbers not able to go home within the prescribed time

Complications with the baby - 4
- 1 early onset jaundice
- 1 prem
- 1 jaundice from antibodies
- 1 birth asphixia

Reason to do with the mother - 9
- 4 pph
- 2 C/S
- 3 Social pressure

Breastfeeding - 2 decided to artificially feed
- 68 fully breast feeing by the end of 2 weeks
Of those, - 4 gave a single milk comp
- 3 gave small amounts of boiled water of a teaspoon

COST JUSTIFICATION

The Domino Midwife has a contract with the Minister of Health which pays for all services occuring in a women's home . i.e. ante natal care, home birth and Post Natal care.

For women electing to give birth in Hospital under the Domino Option the Northland Area Health Board pays the Domino Midwife the equivalent rate due to a Domiciliary Midwife for the labour and birthing care, even if the early part of the labour is supported at home.

At the moment the Domino Midwives (2), are paid as well as Delivery Suite maintaining the same midwife cover. As more midwives work on the Domino scheme and as the demand increases, it will be possible to decrease the rostered cover for delivery suite and have a greater pool of Domino midwives and 'On Call' staff to provide the same cover for no extra cost.

Cost savings are made from the non use of Post natal services at a cost saving at $200.00 per day.

Lynley McFarland

The first excuse for leaving things as they are is to say "Be realistic, not idealistic.". This statement implies that the medical movement is realistic and practical while the social movement is idealistic and impractical. It needs to be pointed out that in those areas where there has been some combining of the two approaches, this has been done realistically and without loss of the quality of care so it is clear that the social approach is not idealistic nonsense but just as practical and realistic as the medical approach.

A second excuse that is frequently heard is "Be scientific". Behind this statement is the notion that we in medicine are objective scientists while the pregnant and birthing women are subjective and therefore not qualified to be involved in decision-making. There is an interesting double standard here in that it is clear from discussions with obstetricians that in general they trust technology but do not trust women and their bodies. Thus if a paper is given at a meeting discussing alternative approaches such as acupuncture, there is an immediate demand by the medical profession that these approaches be subject to careful scientific scrutiny to assure their value. But if a technology like ultrasound scanning is introduced, it is immediately taken up by the obstetrical profession without equal insistence on scientific scrutiny. It is also important with regard to discussions of science in maternity care to point out that present obstetrical care is no more than 10% scientific. A study of the international literature* with regard to routine obstetrical procedures, which was carried out under contract by the World Health Organization, demonstrated than no more than 10% of all routine obstetrical procedures have been subjected to adequate scientific evaluation. Furthermore it is important to point out, as is stated in "Having a baby in Europe"**, that our present level of scientific knowledge with regard to pregnancy and birth is quite inadequate. For example, we still do not know such a basic fact as what initiates labour. Thus the scientists, the medical people and the general public need to be humble with regard to our need for much more scientific knowledge of maternity care.

*Fraser, Cynthia M. Selected Perinatal Procedures Scientific basis for use and psycho-social effects Supplement 117 to Acta Obstetricia et Gynecologica Scandinavica Umea, 1983

**World Health Organization Having a baby in Europe World Health Organization, Copenhagen, 1985 (Public Health in Europe 26)

Conference papers not yet available

2010j This paper included for holiday reading

PROMOTING CHANGE IN MATERNITY CARE*

by
Marsden G. Wagner

At the present time there are two separate major movements within maternity care. The first is based on the medical model of pregnancy and birth and is promoted by the medical profession, most especially the obstetrical profession. This movement focuses on care in hospitals and on the use of technologies and tends both to the medicalization of pregnancy and birth and to the professionalization of parenthood. The second major movement found in countries is based on a social model of pregnancy and birth and is promoted by a disparate group of people including midwives, social scientists, epidemiologists and women's organizations. This movement focuses on the humanization of birth both within hospitals and outside, and on bringing technology under control. We in the World Health Organization are convinced that the best maternity care systems will evolve if the most important approaches of these two movements are combined. However, it is very difficult to promote the combining of these two different movements. In the rest of this presentation there will be a discussion of how to facilitate such a process.

There is a great deal of resistance to change in maternity services and there is a rather long list of excuses made for leaving things as they are. At the present time the maternity care systems are essentially completely under the control of the medical profession and consequently this profession is not likely voluntarily to give up this power and control. Yet if a combining of the medical and social movements is to take place, there must be a sharing of the power and control. This will require that all the excuses or alibies given for leaving things as they are be debated. In my travels to many countries I have heard many of these excuses which I will summarize briefly here.

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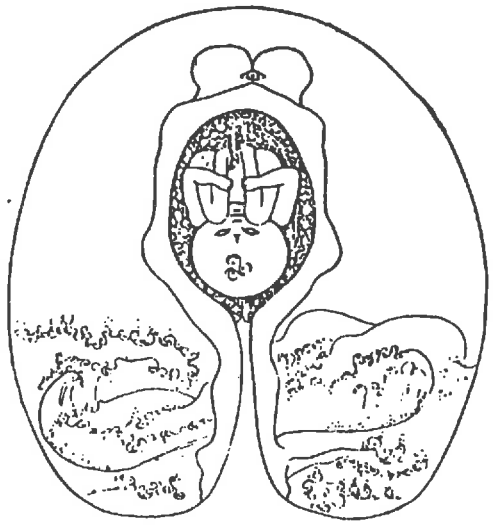
*Speech given at International Conference "Women and children first: birth and delivery, what has to be changed", Milan, Italy, 19-20 November 1988

SPIRITUAL MIDWIFERY



Liz Brunton,
24 Farnham Drive,
Richmond,
Nelson.

Board Of Management
NZCOM INC.
C/O Mrs. J Sage,
P.O. Box 7063
Welington

30-10-90

A SEMINAR SERIES WITH SHIVAM RACHANA

Dear Jenny,

Greetings. I am writing to make enquiries regarding a midwifery workshop we plan to have next year in February. It is similar to one we had here in Nelson last April and have invited Rachana, the workshop leader, to run the course again.

We plan it to run near the end of February for five days, the first two days being the basis and the remaining three being optional. The venue would have live in facilities and hopefully the local group would give back up transport cover. The cost for the five days was about $400.00 but I am not sure what the actual cost would be and how much accommodation would add to this.

I have enclosed some information on Rashana and the siminar. For those of us who attended the April seminar our comments included statements such as "a journey to get in touch with feelings, development and awareness of self, acceptance, knowing, trusting and loving, not only a focus with birth but a personal move so as to really "be with others" and a development of believing and trusting that birth is a natural process".

Apart from opening the seminar here in Nelson to everyone we were wondering if anyone in Wellington would like to organise Rashana to run one up there, taking advantage of the fact that she will be in the country.

I have written to others through out N.Z. sharing the some information and hopefully another workshop will eventuate outside Nelson.

I would be grateful if you could let me know if there is any interest in your area and I would be happy to provide any further information if required.

I am not sure if you have followed up with Rashana Jenny, and thus you may already be organising something. We were keen to have some co-ordination of workshops hence our enquiry. We would like to advertise the Nelson workshop in the College newsletter, could you let us know the details for doing so.

regards,

THE AIMS

1. To awaken the spirit of midwifery and recover its art.
2. To provide the opportunity for the midwife/birth attendant to explore herself and her relationship with birth.
3. To teach techniques which equip the midwife/birth attendant with skills to enrich her own experience and enable her to become a more valuable resource for the birthing woman.
4. To introduce the latest neuroscience technology and its place in birth and birth preparation.
5. To train teachers of Spiritual Midwifery.

WHO ARE THESE SEMINARS FOR?

This work is for any person who wishes to understand more fully the birth process and its impact on all concerned.

It is for people ready to expand their understanding and explore realms of experience which open up to us during this most crucial time.

It is particularly suited to people working with others during pregnancy, birth and post partum and for those who wish to explore their own mysteries.

The following practitioners can specifically benefit:

Bodyworkers
Childbirth Educators
Counsellors
General Practitioners
Gynaecologists
Healers
Masseurs
Midwives
Obstetricians
Physiotherapists
Rebirthers

THE SEMINARS

There are two and five day introductory seminars, as well as intermediate and advanced courses.

The subject matter includes:

- Where has the spirit of midwifery flown?
- Why are only 25% of registered midwives practising?
- Recovering the art of midwifery.
- Seeing with new eyes:
  a. Routine procedures
  b. Conditions of pregnancy
  c. Abnormal labour.
- The importance of "The Breathing" — changing states of awareness.
- Breath therapy.
- Rebirthing.
- Pre birthing.
- How the birth experience is influenced by past birthing trauma, miscarriages, abortions, the individual's own birth, sexual experiences, menstruation experiences.
- Bodywork — its role in birth preparation.
- Processes for deepening — meditations and transpersonal techniques.
- Birth and sexuality.
- Obstetric myths and their influence on the birthing process.
- Wholistic birth preparation.
- New technology available — the contribution of neuro-science.
- Water birth.
- Lotus birth.

THE FORMAT

The material will be presented in seminar, workshop, lecture and experiential sessions. Individual consultations are also available.

THE OUTCOMES

"The Spiritual Midwifery course provided me with a means to enhance further, my knowledge as a midwife, to explore new areas unknown in my experience and to re-contact ones that I have discovered for myself. Even more than this, it has bee a vehicle to touch the woman inside me: to bring her to the surface, to realise she is whole in her youthfulness and innocence and yet ancient in her knowing and wisdom."

Sally Davies — Midwife

"The course in Spiritual Midwifery shows the way to spiritual growth and healing which is present at each birth. Being able to recognise it and use it for your own and others' expansion."

Vivienne Wall — Midwife — Founder of "Birth Link Fremantle

"It has helped me realize many things about my life, but most importantly it has given me an integrity and faith in my own body and process."

Robyn Varpins — Physiotherapist — Rebirther and Reiki practitione

"As women we have a most delicate, shimmering connection that for me has become more manifest during this workshop. I have not felt judged (nor judged myself) for my most private longings or hurts. I have seen that I am the same, and felt the oneness."

Ratna — Mother of 2

"My breathing is deeper and I feel I'm moving more of the time from a place inside me."

Karyn Patterson — Childbirth Educato

"It has renewed and repatterned my biological contract with my parents and through that, with my children."

Yuthika Robin Junipa — Bodyworker and Psychic Healer

Epidural anaesthesia during labour can result in chronic back pain

Chronic backache occurs almost twice as often in women who have epidural blocks during labour than those not undergoing the procedure. The back pain is probably associated with abnormal posture during labour rather than a result of the procedure itself.

Serious side effects associated with epidural anaesthesia are uncommon. Minor symptoms include shivering and mild hypotension. Headache, backache and bladder problems sometimes occur in the days following delivery. Staff from the University of Birmingham decided to investigate whether longer term problems resulted from epidural anaesthesia.

The study population consisted of almost 12,000 women who had delivered their most recent baby at Birmingham Maternity Hospital between 1978 and 1985 and filled in a questionnaire asking about health problems after delivery. An association between epidural anaesthesia and backache was discovered.

Approximately one-quarter of women complained of backache after delivery which lasted for more than six weeks. In approximately one-half of these the backache had been present prior to delivery so these people were excluded. Sixteen hundred and thirty-four women (14%) with new backache constituted the study group. Around two-thirds had experienced back pain for more than one year and a similar proportion still had backache at the time of the investigation.

Significantly more women with backache had undergone epidural anaesthesia compared with those who had not (19 versus 11 per cent; relative risk 1.8). Multivariate analysis indicated epidural anaesthesia was by far the most important factor predicting backache, regardless of whether the delivery was normal or not.

Backache rates among women who had an epidural did not differ between those who delivered vaginally and those who underwent emergency caesarean section. However, this was not true for those undergoing elective caesarean section, indicating that a period of time in labour was important in the aetiology of backache.

The origin of the backache is probably postural. New backache occurred in one in 10 patients following delivery without epidural anaesthesia. Muscular relaxation and total relief of pain with epidural anaesthesia may exacerbate the effect of the postural component. Labour seems to be the other important factor since back pain is uncommon following epidural anaesthesia for surgical procedures. The mechanisms resulting in backache need to be defined so this cause of chronic pain can be prevented.

MacArthur C, et al. BMJ 301:9 12, 7 Jul 1990

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23/10/90 Vol 2 No 18

women, have succumbed to the fear engendered by the medical model of childbirth, and been oppressed by the hierarchical structure which makes them the handmaidens of doctors. In struggling to free themselves from this fear and conditioning they also have to contend with those trying to prevent them from breaking free.

The only place a midwife can work with any real independence is in the community. However, there is a strong lobby to require midwives to work for two years in a hospital first. This is completely counter-productive! Those midwives competent to practice, as the Report of the Social Services Committee concluded, are those registered by the Nursing Council. This was endorsed at the conference.

Since 1988 training has been a post-graduate year for nurses. A midwifery option within the Advanced Diploma of Nursing still exists at Waikato and Christchurch Polytechnics, in spite of efforts to have this discontinued. The other contentious midwifery training issue is that of "direct entry" which allows women with no previous nursing experience tot rain as midwives. At present a possible three-year direct entry midwifery course at Carrington Polytech is blocked by lack of approval from the Nursing Council. The legal impediments have been removed, but the Nursing Council still has "philosphical problems" arising from its "misconception" that midwifery is a post-graduate course of nursing rather than a profession in its own right.

An amendment to the Nurses Act 1977 would allow direct entry midwives to practice midwifery on the same basis as other registered midwives. Also, they can now register as domiciliary midwives. But the National Council of Women also opposes direct entry as it has been suggested to them by "some people" (guess who?) that three years comprehensive nursing education are necessary to guarantee familiarity with all complications and abnormalities. Direct entry would ease our serious shortage of midwives and make midwifery training more available to Maori and Pacific Island women would can then provide culturally sensitive care for their own people.

With independence, midwives will be directly accountable for their practice, especially on the domiciliary scene. In view of the medical opposition to this independence we can expect a few "witch hunts" in an attempt to show that the only "safe" practice is medical practice.

As Wagner pointed out in several lectures "babies do die" regardless of the quality of attention. This is a fact of life. It is also a social problem. Although New Zealand has a "no fault" medical misadventure system embodied in the Accident Compensation Act, this term is not precisely defined. As independent practitioners midwives will be subject to actions to sue by parents who feel a child has been damaged due, as they see it, to mismanagement of the birth, and will need indemnity insurance.

Re-education of midwives, birthing women and their partners is also needed in recognising that pregnancy and birth are normal functions. Wagner pointed out that when women are "delivered" rather than "giving birth" they become dependent on doctors – both in the short and long term. For over 50 years New Zealand women have been conditioned to believe, and have also experienced, birth as a medical crisis. Therefore, many will see midwifery care as either dangerous or a second-best option.

However, for the first time since 1927, the Department of Health has officially claimed that birth is normal. In Policy Recommendations for Pregnancy and Childbirth (about to be published) it states that "pregnancy and childbirth are part of the life experience of women. The majority of women have the ability to conceive, undergo pregnancy and give birth without problems..." This official endorsement of birth as normal should help change the present attitude towards childbirth: midwifery independence will

BOOK REVIEW

" Breastfeeding" third edition 1989 by Ruth A. Lawrence, the C.V.Mosby Company

"Breastfeeding" (the main referenced text for the breastfeeding consultants exam) is a comprehensively written book detailing social, political, emotional, physical, anatomical and biochemical issues involved in the art of breast feeding.

Ruth Lawerence through a very strong commitment to breast feeding as both a mother and health professional has used her own experiences, a host of nursing mothers experiences and extensively bibliographed research to base her very soundly based book.

I have found this book easy to read with numerous interesting topics covered. Amongst them the areas of anatomy and physiology of the lactating breast, the biochemistry and immunologic make-up of breast milk, maternal diet , the topic on weaning and what it truly means and the extensive list of drugs in breast milk and what effects they have on baby - all have proved to be of immense value and interest.

Lynley Davidson (27/11/90)

QUOTES

"I AM NOT YOUNG ENOUGH TO KNOW EVERYTHING" James M Barrie

"The truth is more important than the facts" Frank Lloyd Wright

"In time of war the first casualty is truth" Boake Carter

"Virtue is it's own reward" John Dryden

"An honest man's word is as good as his bond" Cervantes

"I was a freethinker before I knew how to think" George Bernard Shaw

"In love there is but little rest" Chauncer

"Though this be madness, yet there is method in it" Shakespeare (Hamlet)

"One generation cannot bind another" Thomas Jefferson

"Your ignorance cramps my conversation" Anthony Hope

"I never think of the future. It comes soon enough" Albert Einstein

"The cruellest lies are often told in silence" Robert Louis Stevenson

Midwives set up own clinic

Three Christchurch midwives are about to set up a clinic for women wanting homebirths.

Ursula Helem, Julie Hasson and Maria Ware are currently the only Christchurch midwives offering homebirths and say the opportunity to open a clinic has come from recent legislation giving their profession greater autonomy.

The clinic in the Cranmer Centre will offer physical assessment as well as somewhere women can come to talk about any aspect of their pregnancy, says Ms Ware.

It will also link women with ante natal classes and post natal care, as part of their continuity of care.

Ms Ware said the women she had talked to about the clinic were "absolutely enthusiastic and wanted us to start tommorrow".

She sees the opportunity for women to come and talk about general aspects of their pregnancy as one of the greatest things the new clinic has to offer.

"Some women find it annoying to sit in a doctor's waiting room for half an hour, being with the GP for five minutes and not having an opportunity to ask general questions." she said.

Often questions are of a non-medical nature and doctors may not be able to help anyway, she said.

"However, even in a normal pregnancy women want to talk about it."

While the number of homebirths is increasing slowly, Ms Ware said the impact of the legislation removing doctors from necessarily being involved in pregnancy, birth and post natal care, has still to be felt by most women and midwifes.

Among the advantages Ms Ware sees for increasing use of midwives is in clinics for women going into hospital. Allowing these women somewhere to go to talk about their pregnancy..

How much midwives' salaries increase and how many want to take on a 24-hour, seven day a week job will be two of the factors determining whether more midwives become involved in home births.

"As yet we have been told nothing concrete about our salaries only that they will go up," said Ms Ware.

Like doctors' visits for pregnant women, visits to the midwives' clinic will be paid for by the government.

As far as home births versus hospital births are concerned, Ms Ware said, "Women should be able to give birth where they feel safe."

"While some feel very happy in hospital, a growing number of women don't feel safe there and want to know the people who are going to attend them and give care," she said.

"I personally feel the joy of the occasion is heightened at home."

Ch d f12

The New Zealand College of Midwives

NATIONAL CONFERENCE

WOMEN IN PARTNERSHIP

Joan Donley reports on the First National Conference of the New Zealand College of Midwives Inc (NZCOMI) held in Dunedin in August.

The theme "Women in Partnership" reflected the unity between midwives and the women we support during the pregnancy cycle. In fact the NZCOMI is the first professional body to include consumers, not only in its membership, but also in a decision-making capacity.

The conference was opened by Minister of Health, Helen Clark, who was made an honorary midwife in appreciation of her efforts in midwifing the Nurses Amendment Bill, which would restore autonomy to New Zealand midwives, through parliament.

Guest speaker Dr Marsden Wagner, World Health Organisation Regional Officer for Maternal and Child Health for the European region, made an impact on both the conference and the obstetricians he met with in Auckland, Wellington and Christchurch. The latter found him hard to handle, especially when he said, "You have far more interference in pregnancy than is necessary in this country."

He made reference to New Zealand's 14 percent rate of forceps deliveries, compared to 5.7 percent in European countries, excluding the UK. "Not only are you using forceps twice as often as you should, you are using the wrong instrument," he said. He pointed out that ventouse (vacuum) extraction is preferable as research shows that this method does less damage to the baby's head and to women.

Wagner was also critical of our 30-40 percent epidural rate. "Nowhere else in the world do I know of such extensive use of epidurals," he said, adding they "made women dead from the waist down" and contributed to out high rate of operative deliveries, which result in 25 percent of our babies being "either pulled out or cut out of their mothers". He also detailed the side effects of epidurals and pointed out that they are the second most common cause of women dying during child-birth in the UK.

Wagner does not support the routine use of ultrasound in pregnancy. Waiting for someone to discover harm rather than actively pursuing the issue of safety is not satisfactory, he said. He also felt there was a conflict of interest when the safety monitoring was done by the same clinicians who use it as part of pregnancy care. There is evidence that the intensity of ultra-sound pulses is extremely variable and the dose absorbed in one place is not predictable. There are no agreed standards for the equipment.

His outspoken criticisms were not designed to enhance Wagner's popularity with obstetricians. However, they were appreciated by those concerned about the high level of medicalisation of child-birth in New Zealand.

Each day of the conference was devoted to a specific topic: consumerism, midwifery and feminism – "the three greatest threats to modern obstetrics!" With midwifery autonomy in the pipeline, there was much discussion on how midwives would meet this challenge. Having been trained in hospitals, midwives, like