From: NEW ZEALAND COLLEGE OF MIDWIVES (INC)
P O Box 21-106
Christchurch New Zealand

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NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

NATIONAL NEWSLETTER

February/March 1995

Diabetes Screening in Pregnancy

Vaginal Birth After Caesarean

Homoeopathy

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

906-908 Colombo Street P O Box 21-106 Christchurch Tel/Fax 03-377-2732

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NATIONAL INFORMATION 01 May 1994 - 30 April 1995 **REGION** _____

Name _____

Address _____ Area Code _____

Phone _____ Home _____ Work _____ Extn

Workplace _____

Date of Birth _____ ARE YOU A MEMBER OF NZNO? YES/NO

TYPE OF MEMBERSHIP

☐ Self Employed	$225.00 }	Includes
☐ Waged	$155.00 }	Indemnity
☐ Unwaged/Students	$ 50.00 }	Insurance
☐ Associate with Indemnity	$155.00 }	Cover
☐ Associate / Affiliate	$ 30.00	

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Date of Joining _____

Membership Number Allocated

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☐ Subscription payable to College Treasurer (cheque enclosed)
☐ Subscription from Salary (please arrange with your pay office)
☐ Automatic Payment (contact Treasurer)

NEW	
RENEWAL	
CHANGE	

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NEW	
RENEWAL	
CHANGE	

PLEASE RETURN COMPLETED FORM TOGETHER WITH MONEY (IF APPLICABLE)
TO YOUR LOCAL REGIONAL TREASURER

Sunday Star Times - 12/02/95

Little chance of compensation for baby deaths

By SANDRA CONEY

PARENTS of babies who died following physiotherapy treatment at a hospital neonatal intensive care unit are unlikely to receive any compensation.

Thirteen babies have been found to have suffered an unusual form of brain damage at National Women's Hospital in Auckland between May 1993 and December 1994 after a form of physiotherapy used on premature babies. Five of them died. The treatment involved tapping their chests with a soft latex cup to clear secretions.

Lynda Angus, the manager of the Accident Compensation Corporation Medical Misadventure Unit, said she had already encouraged a parent of one of the babies to put in a claim.

But current ACC coverage may have little to offer some parents, said medico-legal experts. Without the availability of lump sum entitlements, the parents of the five babies who died would be ineligible for compensation, while the parents of the eight living but damaged babies might receive help with "social rehabilitation".

Cases would have to meet ACC's test for rarity, whereby the injury must occur in only one in 100 cases or less. As 13 of the 200 babies whose cases were reviewed had been affected, it is not clear whether they would qualify.

One medico-legal expert said a "strict interpretation of the provisions might disentitle them from cover", but parents should be encouraged to apply because recently the corporation "has bent over backwards" to try to assist parents of brain-damaged babies. Nurses at National Women's Hospital were "devastated" and "in various states of shock", said Andrew Norton, area manager of the Nurses' Organisation. Some nurses had had misgivings about the new physiotherapy regime "from the outset", he said. These related to "taking work away from physiotherapists" and fears that the treatment was "overly aggressive for the stage of the babies".

But worries about the treatment were not "formally expressed", said Mr Norton. "It is a classic National Women's case, there not being any formal channels for those concerns to be expressed."

Low staff morale and the regular public revelations of errors at the hospital led to the announcement last month of a review of the hospital. At that time Dennis Pickup, chief executive of Auckland Healthcare, took over direct management of the hospital.

Audit

The problems arising from the physiotherapy treatment became apparent after Dr Jane Harding, a specialist in Newborn Services at the hospital, conducted an audit of the files of all babies who had gone through the unit in the past two years. She had been alerted to the problem when, in mid-1994, three or four babies showed unusual brain damage on routine scans. Dr Harding's audit showed that the babies who had been brain-damaged had had two to three times the number of physiotherapy treatments compared with babies not damaged.

The cases of injury coincided with the introduction of a more rigorous regimen of physiotherapy using the cupping device. Whereas previously the technique had largely been used within working hours, nurses were trained in the technique so it could be offered 24 hours a day. This resulted in an increase in the number of treatments given to individual babies.

The technique was used to clear sticky secretions from the babies' chests after they were removed from ventilators.

All the babies were very small, under 1500g, and had low blood pressure. The damage is thought to have been caused by an alteration in the blood flow to the brain, causing areas of the brain to die.

All physiotherapy on babies weighing under 1500g has now been stopped for the first four weeks of their lives.

The treatment, widely used in New Zealand and overseas, was "regarded as standard without a good basis — it's never been thoroughly tested", Dr Harding said.

She said there was no protocol at National Women's, and the development of treatment protocols was not widespread in New Zealand.

Doctors at other units around New Zealand have reacted cautiously to the bad news. Dr Phil Weston, the neonatal paediatrician at Waikato Hospital, said although his unit had been employing the same technique on the 100 or so small babies it cares for each year, it has not had any problems, and until Dr Harding's research was published and exposed to scientific scrutiny "it's inappropriate to assume it's the truth".

National Women's Hospital has set up an information line for parents wanting information. It is available daily, from 9am to 2pm and 4pm to 9pm, on 0800-227-228.

CONTENTS

ADVERTISING

Advertising in the National Newsletter is FREE to affiliated non-profit making organisations with maternity related issues, i.e. NZCOMI Regions, Home Birth Association, etc. For advertising rates and more information, please contact:

Julie Richards
NZCOMI
P O Box 21-106
Christchurch
Phone/Fax (03) 377-2732

NATIONAL COMMITTEE MEETING CALENDAR 1995

3rd, 4th, 5th March
19th and 20th May
25th and 26th August
(and AGM)
17th and 18th November

DEADLINE

for the next Newsletter is
1st April 1995
Posted
24 April 1995

Any contributions to the National Newsletter should be addressed to:
Julie Richards
P O Box 21-106
Christchurch

PUBLISHING DETAILS

Editor - Julie Richards
Typesetting - Margaret Stacey
Printing & Collating by
Marau Enterprises, Chch

EDITORIAL

Hi from gloriously sunny Christchurch. I hope you are all enjoying the summer with liberal amounts of sunblock.

Welcome to the first newsletter of 1995.

Once again it is packed with news, views and information. One of the frustrations of preparing the newsletter is that I have an overabundance of material to share which results in many 'reading worthy' articles being left out.

This month's publication explores many current issues including Diabetes Screening, Homoeopathy, Ultrasound, VBAC and the perennial holiday assualt by the medical profession.

Congratulations to Juliette Lewis for a most superbly written letter to the Editor.

Don't miss the Situations Vacant and recently published midwifery books.

Enjoy!

Julie Richards

Otago Daily Times - Monday January 16, 1995

Experts warn parents of cerebral palsy babies

Sydney (AAP). — Most babies born with cerebral palsy probably are not injured during childbirth, a transtasman group of experts has warned parents.

Parents should recognise that a baby could develop the condition during pregnancy and that Caesarean delivery would not necessarily have improved the baby's chances, the group said in the latest *Medical Journal of Australia*.

However, the Australian and New Zealand Perinatal Societies called for better free care for children with cerebral palsy and said there was a great need for more research into causes and prevention of the condition.

"Parents of children with cerebral palsy should not have to risk expensive litigation to obtain financial help," they wrote in the journal published by the Australian Medical Association.

The group said parents and expert witnesses called to give evidence in cases seeking to prove health-care workers were responsible for a child's condition needed to be educated about cerebral palsy.

"There is no evidence that current obstetric practices can reduce the risk of cerebral palsy," they wrote in their report from a consensus meeting held last year to review medical research on the condition.

"All expert witnesses and the public should recognise that the belief that the Caesarean section will prevent many cases of cerebral palsy is incorrect."

Parents today still had the same chance of having a baby with cerebral palsy as they did 40 years ago despite many advances in care which had reduced the chances of baby or mother dying by three-quarters.

These advances might have given parents unrealistic expectations about their chance for a healthy baby, the group wrote.

Many parents did not know that cerebral palsy was the most common physical disability in children, affecting two babies in every 1000.

Parents should also know that more than 15 percent of pregnancies ended in miscarriage, up to one in 12 babies were born early, one in 100 babies died near the time of birth and one in 20 had a significant birth defect.

Cerebral palsy is a term used to describe lack of control of movement or posture caused by brain or nerve damage or malformation resulting from a variety of factors, including genetic damage, infection and poisoning.

Ashburton Guardian - 6th January 1995

Midwives hit back at obstetricians' criticism

WELLINGTON, NZPA - Midwives have hit back at criticism by obstetricians who this week claimed that maternity care was going backwards.

Royal New Zealand College of Obstetrics and Gynaecology president, Tony Baird, an Auckland consultant who works part-time at National Women's Hospital, said he was called out at least once a day when on duty to take over a case that had needlessly become dangerous.

And Allan Sutherland, a member of the Medical Practitioners Disciplinary Committee and a GP who has delivered more than 3000 babies, says babies are dying or being injured through lack of proper medical care during birth.

College of Midwives national co-ordinator Karen Guilliland said today that obstetricians' views were distorted by the fact that they only saw cases where there were problems, rather than the 80 per cent of women who had their babies normally.

"They only see it when it goes wrong ... and all mostly we deal with is when it goes right," she said.

"What they're doing now is they're watching every woman that comes in that's got a midwife attached to them and ... every time a woman falls into their 20 per cent that needs assistance, that somehow or other that's the fault of the midwife," Mrs Guilliland said.

It had always been the case that a small percentage of women had problems with childbirth and needed specialist care.

She said if an an obstetrician spent all their time working in a hospital with the 20 per cent of women who needed help, "then it's very hard to hang onto the idea that the other 80 per cent out there that you never see can do it very straightforwardly and normally."

Dr Sutherland had given no evidence to back the assertion that babies were dying or being injured through lack of proper care.

"They've got absolutely no evidence of this. None of them have quoted any case, any individual, nothing," she said.

Midwives have been allowed to assist in births without a doctor present since 1990.

About 1700 registered midwives were practicing in New Zealand.

Dr Sutherland has blamed the "active inactivity" lobby for denying women and babies treatment they need.

He said he had seen many examples of babies being brain-damaged when use of proper medical equipment and techniques could have prevented the injuries.

But Mrs Guilliland said the impetus for parental involvement in decision making had come from parents, and it was not a matter of the midwife directing parents.

"No midwife ever "lobbies" against the use of medical advances to do so would deny the advantages of living in this century," she said.

"No woman, midwife or parent wants anything but the safest birthing care available but being interfered with unnecessarily with painful and often disastrous results is not safe maternity care."

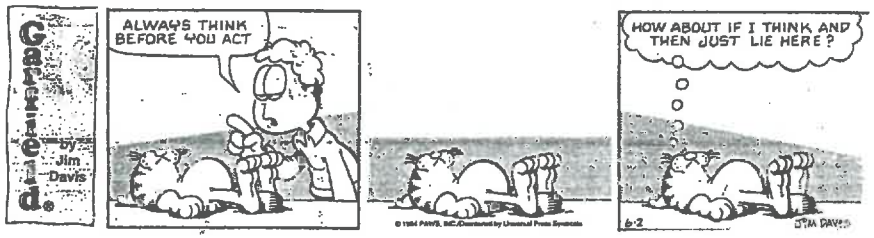
She said many studies showed homebirth care was safe, and midwives had better results.

The British Medical Journal had reported studies by Louden in 1986 and 1992, which "showed that improvements in pregnancy outcome since 1900 cannot be due to increased obstetric intervention nor hospitals, and that these technologies are more closely correlated with bad outcomes than good."

She questioned why Dr Sutherland was convinced his opinions were right regardless of evidence to the contrary.

"Is it that same reason that medicine mistakenly believed X-rays were safe, ultrasound was risk-free, and thalidomide improved pregnancy outcomes.

"Neither the medical nor the midwifery professions are suggesting, as Dr Sutherland would have us believe, that all clinical assessments should stop, only that the reliance on machines and routine procedures should be seriously questioned in the light of current scientific research."



NATIONAL CO-ORDIANTOR'S FORUM

- Karen Guilliland

TAKING A LONG HARD LOOK

Why are we doctors and midwives in conflict? Why do we doubt each others intentions? Fail to see each others strengths and reduce our efforts to ridicule? Why is the essence of our work invisible through each others eyes?

Each discipline enters the profession wanting to do their best, be respected for their work, make a difference in the world. Each of us will do this differently, some of us more or less successfully than others. Success is however not always the outcome of pregnancy or professional practice. Like any major life challenge pregnancy and birth contain elements of achievement and loss, not only for the woman and her family but also for the caregivers. Losses such as miscarriage, stillbirth, pregnancy termination, the birth of a compromised or disabled baby, clinical misjudgments and responsibility for outcomes are powerfully affecting experiences in which many of us receive little acknowledgment or support. In general we have poorly developed networks or mechanisms for the debriefing and grieving necessary to keep us well and happy and able to continue emotionally secure and professionally robust. Why is it then when we share so much that we often treat each other with so little respect and understanding.

In any caregiving role where the work can be difficult and emotions intense people develop a range of defences which make their work bearable.

I believe doctors and midwives develop different defence mechanisms which have the effect of separating themselves from each other. It also allows transference or projection of guilt or blame onto the other.

Midwives with their professional education founded in the generally obedient hierarchies of hospital life often experience a learned helplessness and powerlessness which reduces their sense of responsibility to any given situation.

The largely non verbal socialisation process of a bureaucratic and subordinate hospital system which historically is the everyday grounding of both the doctor but particularly the midwifes education divides then not only from the doctors (the authority in this system) but from other midwives. Divide and rule is the methodology. It is a poor foundation for the encouragement of healthy relationships which produce equally valued team members.

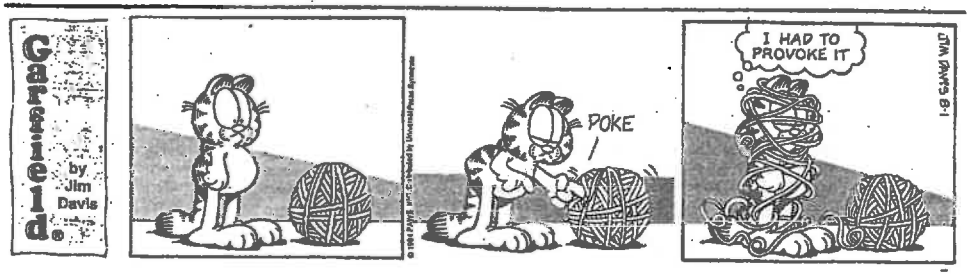
Defending a position is not restricted to one group of practitioners. The education of doctors can be equally traumatic. As the authority in the health system they are taught to view themselves as the final arbitrator and the focus of accountability for client/patient outcomes. This responsibility often is perceived as overriding that of the client themselves, eg, The Cartwright Enquiry. The weight of this assumed responsibility can be an onerous one.

In a recent NZ Doctor article (17/2/95), psychologist Evelyn Baker-Sander expands this argument to include the gender differences in communication and response which will ring bells for many women and midwives. She explains the male conversation style as commonly one of challenge and authority, whereas the female style is more co-operative. She believes the current changes in doctor/patient relationships may well be because the feminine style of co-operative, consultative decision making is challenging the former doctor as sole responsibility or authoritarian male style of society in general.

This is particularly applicable in the area of childbirth where women and midwives have reversed the dominant ideology of medicalisation (or authority) with the concept of partnership between women and midwife as Baker-Sander says:

"It is thus possible that between men and women in the workplace and in their personal lives, as individuals and in groups, blame and the attribution of the worst possible motives to the other party occurs unnecessarily, obscuring and preventing the resolution of the genuine issues at hand."

It seems to me that there is room for all styles if there is acceptance that the partnerships are individually negotiated. This applies between woman and midwife, doctor and midwife, and midwife to midwife. Perhaps it is just a matter of growing up and also taking our place in the sunshine side by side.



MEDIA WATCH

LETTERS TO THE EDITOR

'A' for effort

Sir,—Dr Allan Sutherland has fired a remarkable broadside at midwives in his recent article. NZM 11·1·95

No one would deny him "A" for effort as he positioned himself to fire. He presented the flank of his experience, signalled with the bunting of his qualifications, ran up the flag of his appointments, and shouted the strength of his convictions before he discharged his guns.

Perhaps he meant to use blanks, and was more intent on sound and fury than on a load of shot for which he could be held accountable. Certainly nothing solid passed between himself and his target beyond the smoke of anecdote, and hot air of hearsay, and some flashes of allegations.

His cannon lacked balls.

Juliette Lewis,
Charge midwife,
Middlemore Hospital.

Joint role

Sir,—While she makes some valid points, Karen Guilliland, of the College of Midwives, is selective with her information and she misrepresents what I have been saying about intervention during pregnancy and childbirth.

There has never been any intention on my part to pour insults on midwifery as she states in her article. The issue is not a contest between doctors and midwives nor between home births and hospital births.

For the record, the vast majority of midwives do a wonderful job. There is no way that I would attempt to provide care for a pregnant woman without a midwife as a partner in the team.

I support home births when the progress is normal and when there are both midwives and doctors taking part in the care.

Women's choice is important, as Karen Guilliland says, but nature often has a different plan from the one chosen by a woman, so it is imperative in the interests of the safety of mother and baby that doctors and midwives act as responsible professional people, that they are aware of abnormalities, that they are looking for the earliest signs of problems, being honest about their limitations and intervening appropriately.

M. A. H. Baird.
Grafton.
NZ Herald 16/2/95

Sir,—The holiday season brings with it many things but something new has been added. We are now into our second year of medical practitioners' attacks on midwives.

These attacks are not supported by evidence, facts, data or anything else objective. They are the yearly temper tantrums of (mostly) male doctors whose pockets are hurting as more and more women choose to have the months-long attention of trained midwives in whom they put their well-deserved trust.

The days when the attending doctor was called for the last half hour of delivery but received all the payment are gone.

So also are the days when the same attending doctor induced many patients so they would have 9-to-5 labour thereby assuring few broken nights.

I have seen my daughter, an independent midwife, come in from staying alongside a labouring woman for several straight hours, before and after birth, exhausted and exhilarated.

And the next day she may spend another eight hours with the new mother helping her with the joys of easy breastfeeding.

Not for her the quick dash, the half-hour stay and then the hand out for the money.

Gaynor J. Tuidraki.
Mt Albert.

The cascade of intervention, over-diagnosis and defensive medicine is discussed intelligently and informatively.

Clean water, a diet which provides the right vitamins and minerals, a healthy immune system, cleansing the body of metallic and chemical toxins, avoiding nonessential medicines and so on are promoted as effective ways to ensure the optimum likelihood of a healthy mother and baby.

This book has marvellous intelligent advice on everything from antenatal testing to food and healthy lifestyle. It is particularly interesting that the author comments on the dubious value and doubtful safety of ultrasound scans.

A fascinating comment on radiation: "Fluorescent lighting emits low levels of microwave radiation. Australian reports suggest that the number of miscarriages in women working in offices lit by fluorescent lighting is higher than average."

ASTHMA MAY BE LINKED TO DIET

- Christchurch Press 9/2/95 -
by Naomi Gilling

"The reason for a dramatic increase in the number of people with asthma may be as simple as a lack of fresh fruit and vegetables in the diet, according to a British expert.

A British study found that 25 years ago 5 per cent of children had asthma, said Anthony Seaton, the Trust Bank Canterbury visiting professor. Six years ago about 15 per cent of 12-year-olds had asthma. The latest results of the study, as yet unpublished, showed this had now risen to 20 per cent. Some scientists linked the increase to air pollution but he did not agree with this theory.

"My rather provocative idea is that the change has not been due to the increase in harmful elements in the environment but the susceptibility of the population to what is in the air."

Western diets had changed substantially over the last 10 years. The average Briton's intake of fresh fruit and vegetables had decreased by one-third to one-half. If during pregnancy a woman ate a diet relatively deficient in fresh fruit and vegetables her child had a greater chance of developing asthma.

"While the main determinant of asthma is genetic, maybe our diet has changed in such a way that we don't have the protective factors we used to." Professor Seaton said his interest was in preventive medicine. If his theory did prove to be correct there was tremendous hope for reversing the increase in the number of people with asthma.

Professor Seaton is professor of environmental and occupational medicine at the University of Aberdeen, Scotland. He will give a public lecture at the Rolleston Lecture Theatre at the Christchurch School of Medicine, on February 13 at 7pm. The topic is the health effects of air pollution.

UPCOMING EVENTS

Supporting Breastfeeding by Excellence in Practice

17th - 19th March 1995
Waipuna Lodge, Auckland

Key note speaker: Chloe Fisher (Midwife and Lactation Clinical Specialist)

Infant Massage Instructor Certification Training

03rd - 06th March 1995	-	Auckland
23rd - 26th March 1995	-	Wellington

Training will include videos, overheads and hands-on training, and effective methods of working with:

- Well Babies - Pre-term Babies - Teen Parents -
- Drug-exposed Babies - Special Need Babies -

Cost : $550.00

Contact : Peggy Dawson Phone 09-489-8796
P O Box 33-997
Takapuna

International Symposium : The Vaccination Dilemma II

1st and 2nd April 1995
The Aotea Centre, Auckland

Cost : $150.00

[See later advertisement for registration details]

International Conference on Water Births

1st and 2nd April 1995
Wembley Conference Centre, London, England

Aim of the conference is to increase knowledge and understanding of water birth.

Cost : 180 Pounds for waged
90 Pounds for unwaged/students

Contact : International Conference on Water Births
Administrator
Parkside Communications Ltd
St Charles Hospital
Exmoor Street, London W10 6D2, England

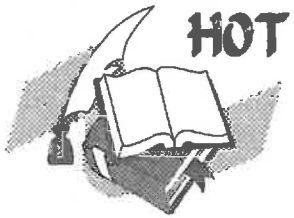
National Sexual Health Education Workshop

20-22 April 1995
Lincoln University Conference Centre, Canterbury

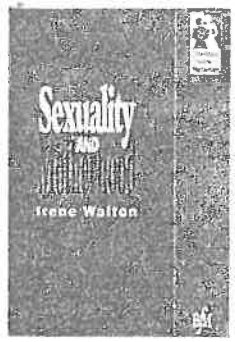
This Workshop is for educators working in any area of sexual health.

For further information contact:

Diane Shannon
Public Health Service
Healthlink South
P O Box 1475 Christchurch
Ph 03-379-9480 extn 2214 Fax 03-379-6125



HOT OFF THE PRESS



Sexuality and Motherhood

Irene Walton

£9.95

176 pages

1-898507-07-4

This book examines comprehensively the concept of sexuality in its many different social, psychological and physical manifestations. It explores the patterns of emotions, experiences and practices surrounding sex and sexuality at various stages of life; likewise it explores the various meanings commonly attached, whether rightly or wrongly, to sexuality and motherhood. One of the aims of this book is to heighten the midwife's awareness of the relevance to their practice of understanding the perception of sex and sexuality in the everyday life of her clients and their families.

Chapters include:

- Sexual behaviour from medieval to modern times.
- Major theories, including Freud, Havelock Ellis and Kinsey.
- Problems faced by people with mental and physical disabilities.
- The midwife's own feelings about her sexuality.
- Pregnancy and sexual activity. Rape victims, abusive partners.
- Labour as a sexual and erotic experience.
- Some myths and old wives' tales surrounding the postnatal period.
- 'Having a baby' for survivors of sexual abuse.
- Alternative ways of expressing sexuality.
- Sexual health and ill health, including HIV and AIDS, safe practice and contraception.

Published September 1994

The Midwifery Research Database

NPEU

£14.95

400 pages 1- 898507-18-X

The new, 1994 edition of the Midwifery Research Database, MIRIAD, is a unique reference work now enlarged to 400 pages. It details some 300 completed and ongoing research studies, itemizing the research methods used; the results of the studies; the names and addresses of the researchers themselves; and the centres at which they work. The information in this well-indexed source book has been compiled by the Midwifery Research Programme at the National Perinatal Epidemiology Unit, Oxford. The book will be updated every year, and electronic publication is likely.

Published July 1994

BOOK REVIEW

By Susan Perry

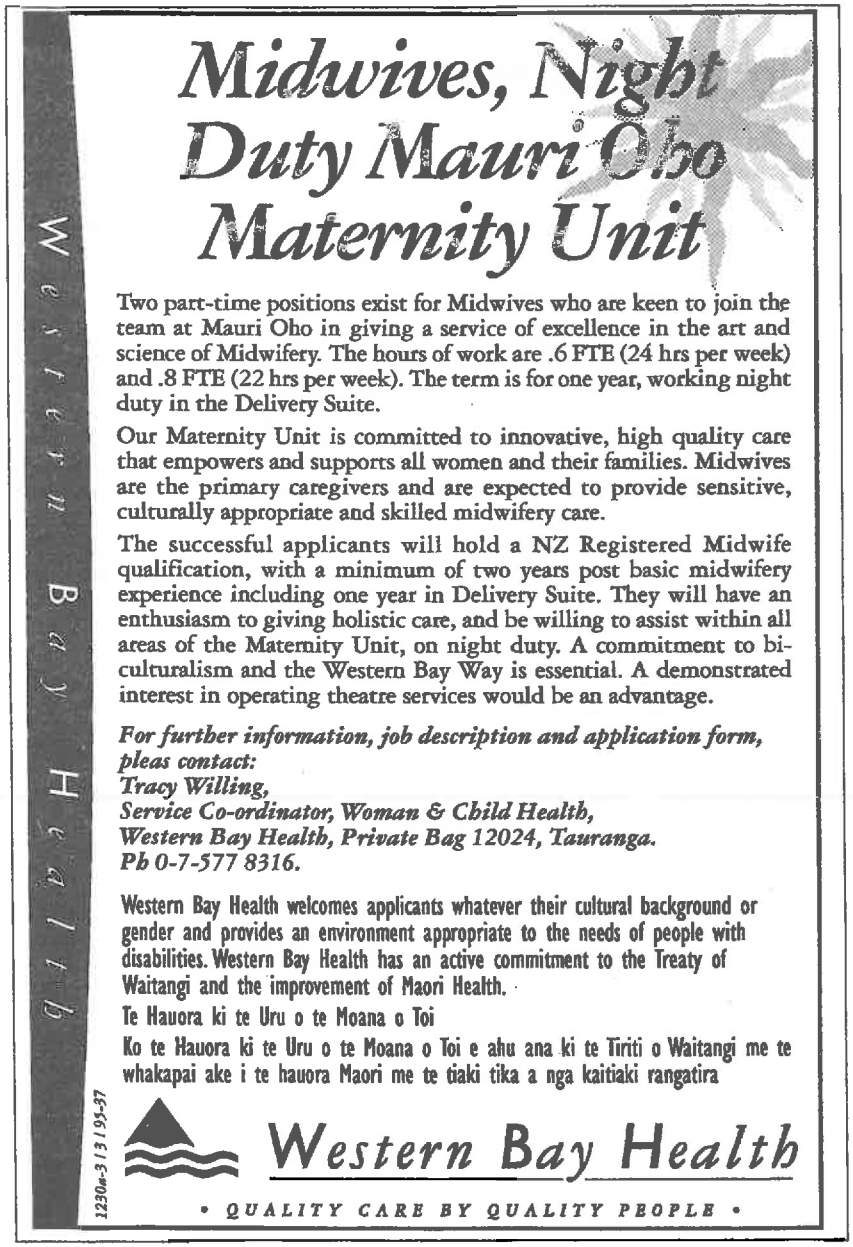
GREEN BABIES

By Dr Penny Stanway (Random Century)

What is a 'green baby'? A 'green baby' is one whose parents are concerned to protect its ecological environment from preconception to adulthood.

Continued over

SITUATION VACANT



Breastfeeding - Refresh, Renew, Revitalize
Melbourne - 1st and 2nd April 1995
Brisbane - 20th and 21st May 1995

PLUS

Breastfeeding Update & IBLC Exam Preparation Seminar
Brisbane - 22nd May 1995

Seminars conducted by : Mary Lantry, Angela Smith and Ruth Worgan

Cost : $175 if paid before 15th March 1995 or 1st May 1995

Contact : CAPERS
P O Box 567 Nundah
Queensland 4012
Phone 07 266 9573 Fax 07 260 5009

Teaching Skills Courses for Childbirth Educators and Other Health Professionals

Townsville	25th - 28th February 1995
Adelaide	6th - 9th May 1995
Sydney	2nd - 6th June 1995

Workshops conducted by Ronnie Pratt

Cost : A$350 if paid 21 days prior to starting date

Enquiries : CAPERS
P O Box 567 Nundah Queensland 4012
Phone 07 266 9573 Fax 07 260 5009

MIDWIVES HOMEBIRTH WORKSHOP

A workshop for all midwives about the philosophy of Homebirth Midwifery.
Hear Midwives Joan Donley, Maggie Banks, Jenny Johnston and others.

May 27th and 28th - Thames

Organised by the Kauraki Homebirth Midwives.
Contact Jenny Johnston (Phone 07-868-2116)
or write c/- PDC Waiomu 2850.

Perinatal Conference

02 - 05 April 1995 Sheraton Hotel, Auckland

Theme : Perinatal Nutrition & Growth

Contact : Wyeth Clinical Meeting Service
P O Box 148
Parramatta NSW 2121 Australia

Paediatric Conferfence

27th to 29th September 1995 Sheraton Hotel, Auckland

Contact : Organising Committee
1995 Paediatric Conference
P O Box 12736
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September 12-15, 1995

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ACC negligence claims about doctors escalate

NZ Dr 29/9/94

BY GLENYS HOPKINSON

There has been a steady growth in complaints passed on from ACC to the Medical Practitioners Disciplinary Committee.

Committee secretary Roger Caudwell said instead of two or three complaints a decade, about three a month are now coming in and he expects the flow to increase.

If the increase in the committee's workload continues, the Medical Council which funds the committee will need more resources. This could mean an increase in the disciplinary levy the profession has to pay, he said.

Mr Caudwell said the new requirement for ACC to draw attention to possible negligence is something the profession has pushed for some time.

"Certainly the profession is aware that behind a number of ACC claims there may be negligence or incompetence and clearly that should be looked at by the profession in the patient's, as well as in the doctor's interests."

By law ACC is required to report instances of medical misadventure, which may be attributable to negligence or inappropriate action, to the appropriate body, with a view to instituting disciplinary proceedings.

Before referring a case on, it is required to first give the health professional a reasonable opportunity to comment and be satisfied there may have been negligence or inappropriate action.

Mr Caudwell said when the committee gets a complaint from ACC, the doctor involved is invited to present a written report.

This report is sent to complainants for consideration, asking if they accept the doctor's explanation.

About one third accept the doctor's explanation, he said. Others reject either all or part of the doctors report.

If the explanation is not accepted, the committee's chairperson, Dean Williams, decides whether there is sufficient substance to warrant an inquiry by the committee's tribunal.

The ACC's principal case manager in the medical misadventure unit Helen Booth said only a small proportion of total claims are passed through to a disciplinary committee.

She said costing of premiums to be payable by doctors into a new ACC medical misadventure account have not been done.

The report by the panel reviewing ACC regulations, which recommended activating the medical misadventure account, is still with the Minister of Health.

Meanwhile ACC's medical misadventure unit has cut back the backlog of claims from 2500 in February this year to 1824.

In the 12 months from July 1993 to June 1994, 476 claims were accepted and 646 declined.

Vertical delivery position is superior, but Europeans lead the change

GP Weekly - 30/11/94

By Kate Johnson

The horizontal delivery position is 'a medical invention that we should forget' in favour of a sitting or squatting position, says Dr Tom Eskes, a Dutch obstetrician and gynaecologist and editor of the *European Journal of Obstetrics and Gynaecology*.

Dr Eskes, who chaired a recent Session on 'The Delivery Environment' at the 14th FIGO World Congress of Obstetricians and Gynaecologists, says the supine position should be actively discouraged by doctors because it results in 50 percent more forceps deliveries. And, he says, given free choice most women prefer to give birth in the vertical position.

'The free choice of position is not associated with any danger,' said Dr Frank Schneider-Affeld, head of obstetrics and gynaecology at Frauenklinik Friedrich-Ebert-Krankenhaus, Neumunster, Germany.

'Most obstetricians believed that the vertical position might lead to complications in perinatal mortality and acidosis of the fetus, and we found out that this is not true.'

He says the vertical position does put the fetus under slightly more stress, but this is off-set by the major maternal advantage of pain control. He recommends ambulation until the cervix is dilated to 10cm and then the use of birth cushions or birthing chairs.

But North American obstetricians are slow to adopt less interventional approaches to labour and delivery. That's largely the result of physician preference, says Dr Kenneth Petersen of Goshen General Hospital in Indiana (a horizontal position permits the physician easier visual contact). But he says women have also driven this trend by requiring sedating anaesthetics or epidurals that are not suited to ambulation.

Dr Jelte de Haan says there's a more pressing concern.

'North American has a tremendous problem in terms of litigation. I think that's probably the most important reason why so many interventions take place in obstetrics in North America,' says Dr De Hasan, chairman of the Department of Obstetrics and Gynaecology of the Academic hospital in Maastrich, The Netherlands, and also medical director of the Midwifery School.

The Netherlands has a Caesarean section rate of seven percent compared to 25 percent in the US.

Dr de Haan says North American obstetricians and gynaecologists are caught in a difficult position with growing public demand for less intervention, but a high rate of litigation when things go wrong. Nevertheless, he says non-intervention is a risk they must take.

'Women are already asking their obstetricians about their rate of C-sections, their perinatal mortality rate, how they deal with breeches. In my opinion, one of the reasons for the movement toward home deliveries in the US and Canada is the tremendous rise of intervention in hospital deliveries – I see that even in Holland,' he said.

Dr de Haan says there must be a return to basics, and it must begin with today's obstetricians and gynaecologists.

'Obstetricians have lost the skill of just observing and waiting,' he said. 'We have the obligation to teach our residents those kinds of skills again. The best thing is to observe, and wait and see, and only interfere when there is a clear indication.'

Dr Schneider-Affeld agrees that doctors must take a step back – literally – and make way for a more natural approach.

'We should emphasise that the midwives should lead the labour, and the medical staff should be in the background,' he said.

Dutch teaching hospitals are required by law to publish their figures on delivery interventions. It's an idea that Dr Eskes would like to see expanded into a kind of service directory for patients.

'There are aggressive and non-aggressive groups. If you have a high C-section rate you will have a high forceps rate, you will have a high rate of induction of labour, and patients should know this,' he said.

'If you open a restaurant you are forced to serve good food without bacteria, and you are inspected to make sure the place is hygienic. If you are in the medical profession it's quite logical you should do the same.'

Kate Johnson is a freelance writer based in Montreal, Canada.

GP Weekly

Fourth United Nations World Conference on Women

September 1995 Beijing, China

The Conference will be attended by government delegations and by non-governmental organisations which have official status within the United Nations. The Conference will be approving a Platform of Action to remove obstacles to women's full and equal participation in all speres of life.

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CALL FOR ABSTRACTS

Deadline 31st March 1995. Completed papers due 4th June 1995

For more information, contact: MIDWIFERY RESOURCE CENTRE
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DEREK BRIGGS – HOMOEOPATH (NZ)	Immunisation in the light of homoeopathic philosophy.
GERHARD BUCHWALD – GP (GERMANY)	Smallpox and smallpox vaccination in central Europe.
KEVIN DEW – SOCIOLOGIST (NZ)	Questioning the unquestionable: can we open the black box of vaccination?
GILLIAN DURHAM – PUBLIC HEALTH COMMISSION (NZ)	Reducing vaccine preventable diseases in New Zealand.
SHAREE COLLINS – PARENT (NZ)	Brittany, a precious gift.
KRIS GAUBLOMME – GP HOMOEOPATH (BELGIUM)	The international movement for honesty about vaccination.
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DAVID RITCHIE – GP (NZ)	Immunisation: a help or a hindrance to your child's development.
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NEW ZEALAND DOCTOR *NEWS*

Midwives up in arms about patient handover

BY OUR WAIKATO CORRESPONDENT

Health Waikato's attempt to develop maternity services policies has left GPs unfazed but, for the second time in a year, has sparked protests from independent midwives.

The CHE wants Waikato Hospital maternity staff to feel they can take over a pregnant woman's care the moment they believe there is a crisis or the need for intervention, without having to argue with the woman's lead practitioner, usually a GP or an independent midwife.

The resulting "handover" policy, believed to be a test case for other CHEs around the country, has been released as a discussion paper. Health Waikato has said it will not rush into formalising the draft, but a final decision is expected by next year.

Its controversial clauses give hospital staff the power to take over from the lead practitioner immediately if this is seen to be warranted. The rationale is the CHE's conviction that once a woman is admitted to hospital for childbirth, the outcome is the hospital's responsibility.

The woman and her practitioner would have to agree to this in advance as a condition of admission, and practitioners withholding this consent could have their hospital access agreements revoked.

GP obstetricians are not expected to resist the new policy. RNZCGP chairperson Tessa Turnbull said GPs have a tradition of handing over care when required.

"Long experience has taught them to know their limitations," she said.

Rather than opposing the policy, GPs see value in having all the respective roles defined and codified, she said.

Independent midwives, however, see the move as a direct attack on them. They believe it is a response to competition they have provided for the CHE over the past four years. This has already forced Health Waikato to close birthing units in Huntly and Waihi and to set up its own caseload birthing team offering home care and one-to-one continuity.

The CHE's general manager for women's and children's health Bev Adlam confirms that the need for a policy has increased with the growing involvement of midwives in maternity services.

She said the existing system for takeover action by hospital staff is difficult to enforce.

"When a situation arises, we can't afford to stand around arguing when decisions have to be made quickly. The safety of women and their babies is too important," she said.

College of Midwives Waikato coordinator Lynne McCroskery said the policy will deny women the right to choose their practitioner, and implies that midwives are professionally incapable of assessing risk.

Midwives have vowed to oppose the policy, mainly on grounds that the civil rights of women would be violated.

"No independent midwife is going to risk the death of a baby or mother because of irresponsible actions," Ms McCroskery said.

She is also concerned that the policy would be underpinned by a "risk list" which would effectively categorise women without taking into account their individual histories or circumstances.

"This list will highlight differences between hospital attachment to technology and intervention, and the practice of midwives to weigh up the medical, social and individual circumstances of each client," she said.

More births may be handed over to hospital staff

When 'natural' does not always mean best

NZ Dr 9/6/94

BY TONY HELMAN

One of the things which patients like about alternative remedies is that they are natural and therefore generally regarded as being safe.

However, this rosy picture of natural remedies hides an underside. Some herbal remedies do have significant side effects, and some are downright dangerous.

Awareness of the possible dangers of some herbal medication has been increasing and drug regulatory authorities are beginning to take this issue seriously.

In Australia, concern has recently led to the establishment of a Traditional Medicines Evaluation Committee within the federal government's health department.

Some herbal remedies have a tendency to recur on the idiopathic illness list, like relapsing criminal offenders!

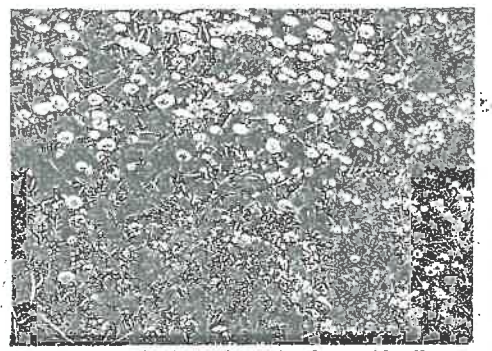
Aconitum (Monk's Hood) is normally given only in tiny, homoeopathic doses for treatment of such conditions as shock, headache and flu. However, in pharmacological concentrations it is a potent poison causing cardiovascular and CNS disturbance.

In fact this is the very reason that this substance is employed homoeopathically; homoeopathy uses a lot of remedies in minute doses which in normal doses are poisonous.

Bad incidents with aconite are invariably due to it being given in normal rather than homoeopathic doses.

All this is not to suggest that serious illness from herbal preparations is a particularly common or serious health problem.

In some cases, an initial suspicion that a particular remedy is harmful turns out to be misleading, for example because the problem is identified as being due only to a contamination of supply.



Some herbal remedies do have significant side effects, and some are downright dangerous

The most notorious example of this in recent times has been the development of eosinophilic myalgia in patients taking tryptophan for insomnia or depression.

This serious side effect led to the sale of tryptophan supplements being restricted or banned in many countries, a curious situation since tryptophan is an amino acid consumed in food.

However, further studies identified the problem as being due to a chemical which had contaminated tablets made in a particular plant in Japan, rather than anything in tryptophan itself.

Comfrey is another example which has been highly controversial. Used for countless years as a remedy for broken bones (one of its traditional names is "boneknit"), problems were encountered because of its tendency to be contaminated with arsenic.

The herb was banned from public sale in Australia and elsewhere, despite the fact that this herb has been widely grown and used both as a culinary and medical herb for centuries and despite lack of any good data on the incidence of poisoning.

More reasonable suspicion has been cast on the entire arena of Chinese herbal medicine.

There have been many reports of serious, sometimes drastic, side effects from use of these medicines, including bone marrow suppression, hepatitis and nephrotoxicity. Unfortunately there is once again no data on the prevalence of these problems in relation to the overall usage of these remedies.

The Chinese pharmacopoeia is extensive, and its proper use is based on centuries of experience. Unfortunately, many professing to practise Chinese medicine nowadays do not draw on such extensive experience.

Another reason for problems with Chinese herbal preparations is that the Asian tradition in the last 20 years has been to mix freely the wisdom of traditional medicine with the advances of 20th century. In practice some Chinese "herbal" remedies turn out to contain potent orthodox drugs whose formulation dose would be totally unacceptable in modern Western practice. Adding to this problem is the fact that these pharmacological substances are almost never declared on the packaging.

To help deal with this situation, a computer database of toxicity problems in Chinese foods and medicines has recently been set up by the Chinese Medicinal Material Research Centre in Hong Kong. In some countries, moves are underfoot to ensure all medicines contain proper lists of contents.

In the meanwhile, doctors may like to recommend some sensible measures to any patients who are planning to use Chinese herbs. Obviously these medicines should not be used by lactating or potentially pregnant women, nor by young children.

Patients should avoid bottles which do not have proper content labels; fewer rather than more substances in a given mixture are desirable, as is shorter rather than long term treatment.

CURRENT ISSUES

Diabetes Screening in Pregnancy - another opinion

SOUTH AUCKLAND HEALTH

C/o Middlemore Hospital

Private Bag 93311, Otahuhu, Auckland 6, NZ

TELEPHONE 0-9-276 0000

Address reply to officer whose official title appears below sign

The September/October 1994 newsletter included a clearly considered and detailed letter sent to Lakeland Health CHE on 13/9/94 by Sharron Cole, President, Parents Centre New Zealand. We are clinicians working in South Auckland, a poorly resourced health district within New Zealand and an area with a high proportion of those with a low socioeconomic status and of ethnic groups at high risk of non-insulin dependent diabetes.

We, like Sharron, have been increasingly concerned by the confusion associated with diabetes in pregnancy. This was recently aggravated by a visit from a British epidemiologist. We feel that this confusion has resulted in the failure to screen even high risk women for diabetes in pregnancy (internal audit 1994) and in the failure to provide proper emphasis on the diagnosis of diabetes in pregnancy even in those women with a high risk of stillbirth and obstetric complications. We have published one episode that resulted in the delivery of a stillborn baby weighing 6.7 kg at 38 weeks gestation (1). While one stillbirth does not validate our clinical approach, we would like to indicate that the cost of inappropriate care can be high to the individual mother and the community. However, we also agree that the medicalisation of childbirth should be minimised and that the costs of screening for diabetes in pregnancy should be justified.

We are a participating centre in the (New Zealand) nationwide study investigating the criteria for gestational diabetes. There are further studies underway in Australia and internationally observing the outcome in pregnancies at various levels of glucose intolerance depending on the result to the 2 hour glucose tolerance test. We are members of the Australasian Diabetes in Pregnancy Society and invite as many of your members as possible to join ADIPS in order for us all to develop the approach that will be of maximum benefit to women with diabetes in pregnancy.

The questions that have been posed omit a number of important issues and we feel that the best way to answer Sharron's points is in a manner that relates to the whole life of a given woman and her offspring, and not just the short time within which obstetric issues are at the fore.

Firstly, it is important to use the same definitions. There are 3 main forms of diabetes as they impact on pregnancy: insulin dependent diabetes (IDDM), non-insulin dependent diabetes (NIDDM) and gestational diabetes (GDM). Diabetes can either be previously diagnosed or previously undiagnosed. Known diabetes has a prevalence of 0.2-0.4% in those aged 20-29 years (2). In those aged 30-39 years, the prevalence is 0.7% (Europeans), 2.6% (Maori), 1.0% (Pacific Islands people) and in those aged 40-49 years the prevalences are 2.0%, 7.7%, 5.0% respectively (2). All other non-European groups (eg Indians, Asians,

except Eskimos) would be expected to be have a prevalence of diabetes in the Maori-Pacific Islands range (3). The proportion with undiagnosed diabetes is unknown in New Zealand, but is likely to be around 50% (4) and possibly up to 65% (eg Asians (4)). At National Womens Hospital, over 40% of women who have had diabetes diagnosed in pregnancy have been found to have permanent diabetes afterwards (5). Most of these were non-European women. It is important to realise that the arguments against screening in pregnancy proposed within largely European populations are not relevant in non-European populations where the rate of undiagnosed NIDDM is so high (5).

In pregnancy, the metabolic changes that occur result in increased insulin sensitivity and lower fasting glucose concentrations than outside of pregnancy (Q15). While the normal fasting glucose in pregnancy continues to drop throughout pregnancy (down to over 20% less than pre-pregnancy levels), increasing production of human placental lactogen and other hormones result in increasing resistance to insulin action and increasing insulin need (6). In addition, glucose absorption following meals is slowed. However, the glucose concentration should be back to normal within 2 hours of a meal (in a normal woman). Thus, the response to a 50g glucose load in a normal pregnant woman is less than that from a can of any carbonated sugar drink and normal women will be able to direct such glucose into the liver (for storage as glycogen), muscle and energy (Q16).

In view of the slower absorption of glucose, and at a time when there was no standard way to test for diabetes, O'Sullivan introduced a 3 hour glucose tolerance test using 100g of oral glucose. On following up women with higher values, he found that diabetes diagnosed using his criteria predicted future diabetes (mainly NIDDM) (7) (Q11).

These criteria are still used in the USA (Q2,Q6a). It has since been found that after 23 years, permanent diabetes develops in 70% Europeans with past GDM (vs 10% in those without past GDM) (8). A similar proportion of Indians develop NIDDM within 6 years (9). Thus, the initial screening for diabetes in pregnancy was actually developed to assist with the provision of lifelong care for an individual and was not related to obstetric outcomes in any way. With quality care, women with known past gestational diabetes should be screened 1-3 yearly for the onset of NIDDM and should receive appropriate advice regarding weight control and exercise. Recent studies suggest that such life style approaches can lead to a reduction in the incidence of NIDDM (10,11). The USA has just embarked upon a large, definitive study demonstrating the ability to prevent NIDDM (DPT2). The problem is always that individuals find lifestyle change very difficult and usually unsustainable without a great deal of support.

Up until 1979, there were a variety of tests for diabetes both within and outside of pregnancy. In that year, the WHO (and the NDDG, the American group) standardised the test for diabetes outside of pregnancy to a 75g glucose load within a 2 hour test. This is probably where the confusion for pregnancy started. The Americans decided to continue with the O' Sullivan criteria, although many centres adapted them for obstetric reasons (Q2,Q6b(12)). The WHO decided to arbitrarily define GDM using the same criteria as for NIDDM (developed to predict diabetes related eye and kidney damage) (Q2,Q6c (13)). They also introduced a category called gestational impaired glucose tolerance (IGT) where the 2 hour glucose is higher than normal, but not considered to be frankly diabetic (identical to non-gestatational IGT) (13). The Europeans and the Australians decided to group gestational IGT and GDM together with a glucose concentration 2 hours after a 75g glucose load of ≥8.0 mmol/l to mean GDM (Q2,Q6d(14)).

Until recently, the 3 hour test was used in New Zealand as it was clearly validated (see above and below). However, as a 100g drink is not a small amount of sugar to drink and 3 hours

NZ DOCTOR IN PRACTICE - NZ Doctor 17/02/94

Medical research finds homoeopathic proofs

This month DR TONY HELMAN looks further at the question of scientific research into alternative medicine and reports advances on several fronts

Does alternative medicine have the scientific guts to stand its ground in an academic, university medical school environment?

The answer to this intriguing question is supplied by an "experiment" conducted at Glasgow University.

A research Fellowship in Complementary Medicine was funded and housed within the medical school at the university for three years. During that time, the Fellow explored new avenues in alternative medical research, evaluated existing work and taught GPs at a postgraduate level.

The fellowship has been such a success that the university is now looking at ways to continue such work on an ongoing basis.

Research projects initiated during the fellowship include a descriptive study of the attitudes of doctors and medical students to alternative medicine.

There was a follow up survey on the integration of homoeopathy studies by GPs into their clinical practice.

Also, two multidisciplinary, randomised, placebo controlled trials studied the effectiveness of alternative remedies in asthma and perennial rhinitis (see box at right).

As a result of this work, a doctoral degree proposal on placebo response and homoeopathic medicine has been accepted by the university, the first based on research into alternative medicine.

One of the most basic issues which the fellowship tackled was the meaning of "scientific research" in relation to alternative medicine, and particularly its relationship to placebo.

"Placebo and alternative medicine are often mentioned in the same breath," the research fellow said.

Yet this is misleading, because it implies that the placebo response is outside the therapeutic effect. In fact, alternative practitioners can perhaps teach doctors a lot about the successful mobilisation of placebo in the patient's own interests.

"In encouraging review of this area, we have found that a lot of confusion can be resolved if the placebo response is renamed self healing response."

As a result of the initiatives started during the fellowship in Glasgow University, a Homoeopathy Medical Research Council has recently been set up to address the particular needs and methodological problems of that discipline.

A computerised library service has also been established in this area.

All told, the fellowship is an excellent start and answers my opening question with a firm "yes".

When it is approached with intelligence and proper resources, alternative medicine can hold its academic ground.

Herbal remedy study

Chelidonium is a herb which has long been used in natural therapy and in homoeopathy as a remedy for liver and gall bladder problems.

A multidisciplinary team in Germany, including a physician and naturopaths, recently reported on the results of placebo controlled, double blind trial of the herb.

The researchers looked at 60 patients with complaints such as nausea, flatulence and sensation of fullness, for which no specific diagnosis had been made.

Patients were reviewed at 14 days, four and six weeks.

In view of the non-specific nature of the symptoms, the measures of treatment outcome were ratings of symptom severity, made by the patient themselves on a standardised questionnaire, and by a treating physician.

At six weeks of treatment, liver function tests and full blood counts were performed on all subjects, with no abnormalities being found.

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ALTERNATIVE TREATMENTS

Homoeopathic asthma trial

An asthma trial conducted at the instigation of the Glasgow Medical School fellow in complementary medicine showed significant support for homoeopathic diagnosis.

- PURPOSE: to see if previously suggestive positive results in the use of homoeopathic allergy desensitisation could be reproduced in a sceptical university medical school environment.
- POPULATION: 28 patients attending the Department of Respiratory Medicine attached to Glasgow Medical School for treatment of atopic asthma with daily symptoms requiring bronchodilator therapy. Most were also on inhaled steroids.
- METHOD: based on results of skin tests and allergic history, a physician experienced in this field of work determined the single most likely allergen. The subject received either a single dose of 30C homoeopathic dilution or a placebo.

(In homoeopathic terms 30C means a solution at dilution of 10^{30}, which in orthodox terms means that less than one molecule of the original allergen would be present in the entire bottle.)

Using a visual analogue scale, patients had been asked to rate their overall symptom severity for a period of four weeks before treatment. This was compared with the rating for the four weeks after treatment.

- RESULTS: a drop in symptoms was seen from the first week after treatment in the homoeopathically treated group, but not in the placebo treated. This difference remained significant throughout the follow up period.

This trial is a good example of how proper clinical research is able to confirm a long used traditional naturopathic remedy.

- **GI TRIAL RESULTS**

Medical assessment after six weeks

	Chelidonium n=30	Placebo n=30
Symptom free	13 per cent	0 per cent
Improved	47 per cent	27 per cent
Same	37 per cent	60 per cent
Worse	3 per cent	13 per cent
Patients self-reporting freedom from GI symptoms		
Week 4	30 per cent	10 per cent
Week 6	45 per cent	10 per cent

NZ DOCTOR IN PRACTICE - NZ Doctor 12/05/94

Needles and Herbs can alleviate depression

BY TONY HELMAN

This month features two clinical studies on the use of alternative remedies in psychiatry, specifically in the treatment of depression. They also illustrate good and not so good research designs.

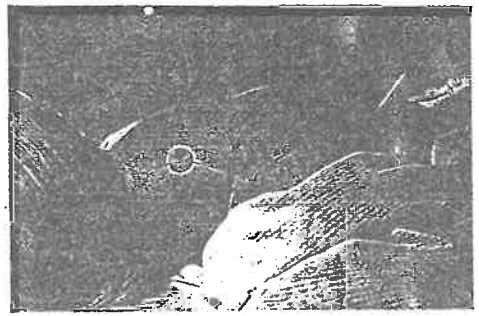
The first study, recently published in the *American Journal of Acupuncture*, evaluated the use of acupuncture treatment based on traditional Chinese diagnosis.

A sample of 68 patients from the Guangxi province of China were diagnosed as having anxiety, depression or both, using the Hospital Anxiety and Depression (HAD) Scale. Those who wished to receive acupuncture were then selected, provided they had not recently had other acupuncture treatment.

Although the study is described as single blind, the report does not indicate who or what was blinded. Certainly there appears to have been no blinding of the patients, and the results were measured purely in terms of changes in the self-reported HAD scale, comparing patient's ratings before treatment with that after.

The study did show a significant improvement in HAD rating after treatment at p values of <0.001 for both anxiety and depression after one month of treatment. Nearly three quarters of the anxiety patients reported improvement, as did 90 per cent of the depressed patients.

Unfortunately, however, it is hard to give this study much clinical importance.



Studies have been assessing the relative value of acupuncture in treating anxiety and depression

Firstly the self-selection of patients as those keen to have acupuncture treatment introduces a substantial selection bias from the outset. The absence of patient blinding or of any controls makes the reported effect impossible to distinguish from placebo.

Patients likely to feel better

There was no long term follow up to identify "effect decay". About all we can say from this study is that patients who choose acupuncture treatment for anxiety or depression are likely to feel better after one month. In case you have not guessed, this study is the not so good example.

The second study of "herbal medicine" could not be more different.

Conducted in Germany, it was a randomised, double-blind, placebo controlled trial of 60 depressed patients. The patients were recruited at a general practice from those being treated for depression, and in addition had a positive score on the Depression Status Inventory (DSI).

This is an observer rating scale, completed by the doctor. In addition, the patients completed a self-rating depression scale (DS).

Patients were then given on a randomised basis either a herbal combination or placebo.

The herbal treatment was a combination herbal multiplex. This method of combining multiple remedies in one formulation is very popular in Europe, particularly Germany and France. The herbs included hypericum (often prescribed for nervous shock), valerian (well established in herbal practice as a sedative/hypnotic) and passiflora (known in naturopathic practice as a nerve tonic) all of which are in common use here.

Treatment with active preparation or placebo was continued for eight weeks, after which the CGI, DSI and DS scores were reassessed.

The physician (blinded to the treatment) then made an assessment of whether the patient was better, worse or the same as before treatment, using on a Clinical Global Impression (CGI) scale.

The main results from this trial show that both active (herbal) and placebo treatment are obviously associated with a tendency for improvement over time.

Herbal mixtures help depression

However, the herbal medicine has a significantly greater effectiveness in reducing depression, both as rated by the patient and doctor. The DS scale followed a similar trend.

This trial was far more impressive than the first in suggesting an active pharmacological role for traditional natural herbal remedies. The randomisation of the entry group, use of both patient and physician rated scales to assess progress, and the double blinding, all make it clear that, for this trial at least, the effect observed was real and relevant to patients with depression.

It is also important to note that clinically and statistically significant improvements in

is a long time, it was felt that the 2 hour drink would be less unpleasant for the women concerned. The New Zealand Society for the Study of Diabetes (NZSSD) therefore reviewed the data and decided that a fasting glucose ≥5.5 mmol/l or a 2 hour glucose of ≥9.0 mmol/l should be taken to diagnose GDM. This is now standardised throughout New Zealand (Q1).

The WHO level for a fasting glucose concentration is the same as it is out of pregnancy 7.8 mmol/l. In the US they use either 5.8 mmol/l (7) or 5.3 mmol/l (Q2,Q6e(12)). The Australasian levels are ≥ 5.5 mmol/l (14) and again, these are used throughout New Zealand (Q2,Q6f). Thus, the 2 hour criteria have been adopted to minimise the inconvenience to prospective mothers, even though they have not been validated in the same prospective way as the 3 hour criteria. The above answers questions 1,2 and 11. In addition, as the WHO category of gestational IGT is considered GDM, question 14 is redundant.

After the increasing use of the O'Sullivan criteria for diabetes in pregnancy, it became clear that perinatal and obstetric outcomes were also associated with GDM (15). More recently, there has been increasing evidence that the offspring of women who had diabetes in pregnancy are at increased risk of obesity and NIDDM (16,17).

The next questions are (1) should women attend the OGTT immediately, or should their inconvenience be minimised by having some sort of screening test and (2) who should have an OGTT? In a pure sense, and as the OGTT is the predictor of outcome, referral for OGTT should be direct as soon as it is decided that a test for diabetes is warranted. However, as the OGTT is inconvenient, and, just as it was decided to have a 2 hour, rather than a 3 hour test, it was decided that a one off 50g Polycose screening test should be used to decide who should go for an OGTT. However, in reality, women with past GDM are often referred directly to the 2 hour OGTT. So, how should we screen for diabetes in pregnancy, to minimise the numbers having the 2 hour test and minimise the number of women with GDM missed by the screening test? It is important to realise that as the sensitivity (ie proportion of people with the condition found) of any screening test increases, the positive predictive value (ie proportion of those with a positive screen who actually have the condition) goes down. There were a number of ways to decide who should have an OGTT including history (eg past big baby, overweight, family history), urine screening, random glucose test, fasting glucose test and 1 hour polycose test.

The proportion of women with babies ≥4000g in the past is 3.2% overall but 13.8% in those with GDM (Q5(18)). However, these figures (and the following data) vary within and between ethnic groups and the mean birthweight is increasing. Glycosuria occurs in 8.9% of the general population (Q12(18)). There is no evidence that glycosuria is harmful (Q18). Overall, 85.5% of all European pregnant women have at least one major or minor risk factor (100% of other ethnic groups have a risk factor) (18). If only the major risk factors are taken (eg ethnicity, family history, obesity, age) then 50% have at least one risk factor (19). One assumes therefore that about 50% of those with GDM were left undiagnosed (Q3). Recently, it has been shown that women with no risk factors but GDM by screening and OGTT have a three fold greater risk of shoulder dystocia (Q4(20)). It must however be remembered, that those not having GDM diagnosed will miss out on the life-long follow up and may be at greater risk of the long term sequelae of diabetes if it is diagnosed late. The 1 hour glucose test has a sensitivity of 79% (Q10(19)) ie 21% of women with GDM are missed by the 1 hour Polycose (Q13).

The incidence of GDM in Europeans is 4.3-5.2%, in non-Europeans it ranges from 5.7-15.0% (Q9(21)). The incidence is increasing (21)), although this is not surprising as the age adjusted prevalence of NIDDM is increasing exponentially (22).

The proportion of women requiring insulin will of course vary with the population (Q7). The higher the prevalence of undiagnosed NIDDM, the higher the proportion requiring insulin. In addition, the degree of glycaemic control varies between centres. However, reports range around 40-50% (eg 23). The use of insulin among such women has clearly been shown to reduce the risk of macrosomia, perinatal mortality, neonatal hypoglycaemia, shoulder dystocia and emergency cesarian section (Q8(24)).

The overall acceptability of glucose tolerance tests has been investigated (Q19(25)). In general, women were pleased with the availability of such a test and did not find it too stressful. There is no evidence that testing for GDM has any significant negative impact on the pregnant woman or her baby. As the lives of all people (men and women) are fraught with a variety of "stresses" such as financial, family, work, societal and so on, it would be surprising if the blood tests were of comparable significance to these. There have been no randomised controlled studies of the use of the polycose as a screening tool (Q20). The reason it is used, is to minimise the use of the OGTT for the convenience of the women and to minimise costs.

As clinicians in the public health service, we would prefer to minimise our work load. Unlike those in private practice, we are unable to increase either fees or resources available to us to complete our work. The reason we advocate universal screening for GDM is because of our commitment to the women we see and their families, which is holistic, and applies to the whole of their lives. There is clear, scientifically valid evidence for universal screening and for treating GDM. We agree that there is currently inadequate obstetric information with regards screening for GDM in European women with no risk factors for GDM aged below 25 years. However, in view of the predictive nature of the test for future NIDDM, it remains a useful service to such women. We also agree that our treatments, and indeed, our screening methods can be improved upon. Howevér, it is essential that we do as well as we can with the available information while trying to improve this data. We are committed to this path.

Yours sincerely

Dr David Simmons
Diabetes Specialist

Caroline Conroy
Midwifery Diabetes Educator

Dr Jackie Smalldridge
Obstetrician

Joan Dixon
Charge midwife

PS We are unaware of a glucose tolerance factor (Q17).

REFERENCES AVAILABLE ON REQUEST

Postnatal X-Ray Pelvimentry after Caesarean Section and Management of Subsequent Delivery

AIMS Quarterly Journal - Vol 4 No 3

The obstetric records of 331 women who had a primary caesarean section at Glasgow Royal Maternity Hospital, had a postnatal x-ray pelvimetry during the period 1977-1982 and subsequently delivered their second baby at the same obstetric unit, were examined. The purpose of this study was to investigate the influence of postnatal x-ray pelvimetry after caesarean section on the management of the subsequent pregnancy.

Of the 331 women, the pelvis was considered "inadequate" in 248 (75%) and adequate in 83 (25%) of them *. However, of the 76 women with "inadequate" pelves who nevertheless attempted vaginal delivery, 51 delivered vaginally. Of the 83 women with radiologically adequate pelvis, 61 achieved vaginal delivery. In addition, the three cases of uterine rupture *all* occurred in women with a radiologically adequate pelvis.

The authors conclude: "This study suggests that x-ray pelvimetry is not a good predictor of the outcome of a trial of vaginal delivery. We conclude that the practice of routine postnatal pelvimetry should be abandoned.
*Using standard radiological criteria.

Chlamydia could be root of infertility

NZ Doctor 1994.

Undetected infections with chlamydia may be one cause of unexplained failure in couples who try IVF.

"If a woman either previously had a chlamydia infection or is harbouring one, then her chances for achieving pregnancy or maintaining a pregnancy are reduced compared to a woman free of chlamydia," said lead researcher Steven Witkin, director of the division of immunology and infectious diseases at Cornell University Medical College in New York.

The researchers believe that when a woman is infected with chlamydia, her immune system makes antibodies to attack a component of the infection known as the heat-shock protein.

When the woman later becomes pregnant and her uterus makes a natural version of the heat-shock protein, "her immune system thinks she has a chlamydia infection, and it induces an inflammatory response that could lead to a rejection of the embryo," said Dr Witkin.

He studied 198 women whose eggs were successfully fertilised using IVF, then transferred to the uterus.

"It's important to note that all of these women were negative for chlamydia in tests by culture or DNA probe," Dr Witkin said.

Of the 68 women who had successful pregnancies, only one had antibodies to chlamydia, and five had antibodies to heat-shock protein.

"In contrast, among the 130 women whose embryo transfers did not result in a successful outcome, 24, or 18.5 per cent, had antibodies to chlamydia; and 36, or 27.7 per cent, had antibodies to heat-shock protein," he said.

GARLIC — NZ Dr. 17/3/94

Garlic as medicine

Good evidence
- Antithrombotic
- Antimicrobial, antibiotic and anti-fungal
- Cancer preventive, especially GIT cancer

Suggestive evidence
- Hypotensive agent
- Corrects hyperlipidaemia
- Hypoglycaemic agent

Possibilities
- Anti-allergic (asthma)
- Protective against some toxic chemicals, eg, heavy metals

NEEDLES AND HERBS

Results support use of herbs

Clinical Global Impression scale	Herbal medicine	Placebo	p
Improvement (1 = very much better 8 = very much worse)	3.33	3.93	<0.02
Depression Status Inventory scale			
before treatment	55	56	<0.02
after treatment	38	43	

SEE NEXT PAGE

PSYCHIATRY

Post-natal depression is also often overlooked

NZ Doc 24/11/94

Australian physicians offer advice on improving detection and management of postnatal depression. At least 10 per cent of women are affected after delivery, so inquiring about a woman's psychological state in the follow-up visits should be routine.

There are also risk factors for postnatal depression, including a prior history of depression or premenstrual syndrome, a vulnerable personality, poor social support, disturbed relationship with the partner or parent, and the need for obstetric intervention.

There are three distinct varieties of mood disturbance following delivery, and differing treatments makes it important to distinguish between them. Mild transient depressed mood occurring a few days after delivery ("the blues") affects about two-thirds of women. Much more serious is puerperal psychosis affecting 2 in 1000 women and occurring up to three weeks after delivery. Confusion and indecisiveness are the main manifestations, and risk of recurrence is very high with subsequent deliveries; lithium prophylaxis is useful in this regard.

Postnatal depression lies between these two conditions, occurring within three-six months of delivery.

It is necessary to distinguish between the stresses and strains of coping with the constant needs of the baby and depression as an illness, characterised by ongoing depressed mood and features like sleep and appetite disturbance. Otherwise, the former may be treated unnecessarily, or the latter trivialised.

Early studies suggested postnatal depression was a unique form of depression but more recent findings suggest otherwise. The only real difference is the virtual universality of irritability and anxiety among women with postnatal depression.

Similarly, prevalence figures of about 10 per cent are not much different to figures for depression prevalence at other times in life. Thus, there is no justification for treating postnatal depression as a separate form of depression.

However, there are several reasons why it should receive special attention. It is often overlooked but should not be since about 10 per cent suffer from postnatal depression within six months of delivery. Screening with instruments like the Edinburgh Postnatal Depression Scale is therefore valuable. So too is being aware of risk factors for postnatal depression.

The consequences of maternal depression on the child are possible cognitive impairment, difficulty forming relationships with others, and behavioural disturbances. The risk of child abuse may be increased.

Treating postnatal depression at the time it develops may reduce the likelihood of recurrence of depression in later life.

Boyce PM, et al. Med Jnl Aust 161:471-2. 17 Oct 1994

PAEDIATRICS

Foetal alcohol syndrome often goes unrecognised

NZ Doc 8/12/94

The tragedy of foetal alcohol syndrome, the greatest cause of mental retardation in the Western world, "should not be underestimated". The solution lies in the detection and treatment of female alcohol abusers.

It is astonishing that the teratogenic effects of alcohol were not recognised until as late as 1968. Foetal alcohol syndrome affects 1-2 per 1000 live births but often seems to be mistaken for other conditions.

Features are variable and include growth deficiency, both pre- and post-delivery, facial anomalies and CNS problems including microcephaly, mental retardation, spasticity, seizures and squint. Congenital heart disease and cleft palate are frequent coexisting abnormalities.

It is important to determine the mother's drinking habits since foetal alcohol syndrome can mimic Noonan syndrome and foetal anticonvulsant syndrome, among others.

Alcohol itself appears to be the teratogenic agent rather than acetaldehyde. However, very high blood alcohol levels are required to cause foetal damage.

Malformations depend on the gestational age at the time of exposure. Damage is known to occur as early as the third week of pregnancy.

Epidemiological studies have failed to reveal the level of alcohol ingestion in pregnancy that is safe, and some authorities have recommended no drinking in pregnancy.

It appears, however, when daily amounts are quantified, that damage to the offspring occurs in mothers with a high daily alcohol intake, ie, the alcohol-tolerant women or abusers. Recognising the abuser and therefore the affected baby can be difficult since such women can function in society with blood alcohol levels as high as 200 mg/dL.

Genuine light drinkers are probably not at risk of having an affected infant and labelling on alcoholic beverages that drinking in pregnancy is dangerous may be overstating the case. Labelling that states the number of standard drinks within a bottle is considered more helpful.

Alcohol abuse remains the biggest legal drug problem in Western countries and its use is increasing among young women. Detection and treatment of those at risk of producing infants with foetal alcohol syndrome is critical for prevention of this problem.

Lipson T. Med Journ Aust 161:461-2, 17 Oct 1994

ACCESS AGREEMENT

Based on RHA "Principles for Access" Format on which NZCOM and NZMA Concur

Responsibilities of Midwives and Doctors Holding Access to Facility Agreements.

1. Have full registration with either the Nursing Council of NZ or NZ Medical Council.

2. Doctors to have a diploma in obstetrics (or equivalent) or specialist qualification in obstetrics recognised by the NZ Medical Council.

3. Hold a current annual practising certificate.

4. Provide evidence of current indemnity insurance.

5. Be a member of a relevant professional body.

6. Participate annually in a peer/standards review process approved by their professional bodies and show evidence of continuing education in the field of midwifery and/or obstetrics during the time the agreement is in force.

7. Provide referees who can testify to the identity of the practitioner.

8. Treat the CHE facility and its staff with dignity and respect. Any issue an access agreement holder has with the CHE, will first be raised with the personnel concerned.

9. Participate in an orientation to the clinical area they intend accessing.

10. Comply with General Managers directions in matters relating to administration and management of the CHEs facilities and relevant to the independent practitioner.

11. Where an independent provider is acting in the capacity of lead professional, or is acting under the direction of a lead professional, there shall be no requirement to transfer care to the CHE excepting that the lead professional will be guided by the Transfer Criteria established by the RHAs.

12. Until such time as transfer to secondary/tertiary care is required, the independent provider is solely responsible for the proper clinical conduct of labour and delivery.

Responsibilities of CHEs

1. CHEs must enter into access agreements with any provider who fills the criteria as outlined in 1-10 of this document. Access agreements are protocols as opposed to contracts and as such no fees are payable by independent practitioners.

2. CHEs will treat access agreement holders and their clients with dignity and respect.

3. The CHE may stipulate all reasonable administrative requirements that independent providers must comply with, in particular, all documentation requirements, prior booking requirements and requirements relating to the use of CHE resources.

4. The CHE shall not be entitled to enquire into or specify matters relating to the operation or administration of an independent providers practice excepting to the extent that it is necessary for the CHE to run an efficient booking system.

5. CHEs will make orientation to clinical areas available for access agreement holders.

6. The CHEs liability is limited to meeting its statutory and contractual responsibilities.

Note: New practitioners and practitioners returning to the workforce after a 5 year absence will be granted a one year provisional agreement. The practitioner will, during this provisional year, identify to the CHE an available clinical mentor who can provide advice and support for the practitioner. A full access agreement will be granted following a satisfactory standards review of the preceding years cases.

Requirements of both Parties

1. In any situation where either party believes the other does not or has not fulfilled agreed criteria the process will be open to review by an independent arbitrator appointed by the RHA. In the first instance it is expected the actual parties involved will attempt to resolve the dispute.

2. Independent providers and CHEs shall make themselves available at any reasonable time to participate in any enquiry initiated by either an independent provider or a CHE concerning any apparent inappropriate clinical outcome in which the independent provider was involved.

Midwifery care : attitudes vs practice

Reproductive Health Matters, No 4, November 1994

A study into the counselling role of midwives in a large Melbourne, Australia obstetric and midwifery teaching hospital found that the midwives had positive attitudes towards and high intentions about counselling of child-bearing women. However, in practice, they engaged in minimal communication with the women and demonstrated few counselling behaviours. In fact, the focus of their care was physical and task-orientated, with emphasis on practical advice and a lack of attention to the emotional needs of their clients. The author argues that midwives are actually uncertain about what to do as regards counselling and affective support, that their education and training is inadequate to helping them learn this and that the socialisation of midwives within the work culture is a powerful determinant of the model of care they adopt, as opposed to the one they think they should adopt.[1]

1. Cutts, DE 1993. Affective care: rhetoric vs reality. Australian College of Midwives Journal 6(4):21-25

Midwifery (1994) 10, 232–237
© Longman Group Ltd 1994

Midwifery

A cross-national analysis of midwifery politics: six lessons for midwives

Eugene R. Declercq

Research based on interviews and analysis of documentary sources on the politics of midwifery in Canada, Denmark, the Netherlands, the UK and the US, suggests six political lessons for midwives and the organisations that represent them. The lessons are: general health reforms represent both an opportunity and a threat to midwives' status, and midwives must learn to communicate in ways policy makers understand; research matters; coalition building is essential; the media cares (a little); it is much easier to defend the status quo than create new policy; it is essential to clarify who is to be considered a midwife. A constant grass roots awareness of and involvement in a country's political and policy making process is seen as a necessity if midwives are to prosper as a profession.

complications arise. Efforts are concentrated on providing every woman with a basic standard of primary care, with emphasis on the third trimester of pregnancy and delivery.

Until recently, there were notable gaps in secondary level care, due to limited availability of medications, x-ray, laboratory facilities, and operating theatre space. Nevertheless, relatively good maternal survival had been achieved in Grenada even before these recent improvements, making it apparent that the system of maternity care is not only humane but also effective. Further effort is needed to increase the coverage and acceptability of routine postpartum care. The government continues to seek to reduce maternal mortality, stillbirths and perinatal death rates to a minimum.

Obstacles to applying this system in other countries can be substantial. In a number of countries, such as Uganda, Ghana, Malawi, and Zimbabwe, the midwifery system established under the British continues, and midwives enjoy professional recognition, respect and social status in their communities. However, there are not enough of them and the infrastructure, referral networks and resources for providing the same level of care as in Grenada are less developed.

In other countries, midwifery has never attained a high status and the professionalism encouraged by the British system is lacking. In India, for example, this may be due to cultural and religious prohibitions that limit contact with body fluids considered to be unclean, such as those during childbirth, to people with low status. In still other countries, maternity care in the formal sector is firmly under the parvenu of physicians, as in much of Latin America. In many poorer countries, traditional birth attendants have been kept largely outside the formal sector and relatively or totally untrained.

With or without an extensive primary health care system, there may be interest in developing community-based midwifery care. Such a system is currently under development in Indonesia on a massive scale, where 18,000 of an intended 34,000 community midwives are being trained over a five-year period, as part of a major government commitment to improving maternity care.[5]

Access to trained midwives at the primary care level is one way to achieve the early diagnosis of maternal complications, together with an effectively functioning system for secondary care. Provision of emergency obstetrical services, the intervention that has been most attractive to many countries, without attention to primary care services and essential linkages for referrals, has not always been effective in preventing maternal deaths, since patients often arrive too late to be treated successfully. Integrated planning strategies, based around well-trained nurse-midwives, can simultaneously strengthen emergency care and the primary care systems that enable emergency services to be effective.

Acknowledgements

The field research in Grenada was supported by the Population Council through USAID contract DPE-5966-Z-00-8083-00, project number 936-5966. The cooperation of the Ministry of Health of Grenada, and particularly the midwives, is gratefully acknowledged, as is the editorial assistance of C Jared Coffin.

- References Available on Request -

The foregoing is not the full article. Copy of complete article available from NZCOMI.

3. Any dispute concerning the application of any access agreement shall, if not resolved by any reasonable internal CHE processes, be determined by an independent arbitrator nominated by the RHA.

4. Where an independent provider does not comply with the reasonable administrative and procedural requirements of the CHE, the CHE may terminate an access agreement provided that any such determination shall be subject to review by an independent arbitrator nominated by the RHA.

5. Where a CHE wishes to terminate an access agreement based on an independent providers apparent inability to meet commonly accepted clinical standards the matter shall be referred to the Advisory Committee of the applicable RHA which will recommend to the CHE whether or not such access agreement shall be terminated and no termination may take effect prior to the Board of the CHE considering such recommendation.

FORCEPS

I pushed and pushed with all my might
and still I could not move you
I wanted you born that very night
but did not want to lose you
He said I had tried my very best
be proud how far I had come
I wasn't ready to give you up
and then they came and took you
With all his might he pulled you out
wrenched you from inside me
Stole part of me and called it you
I feel cheated of your birth.

- Sal

STOP PRESS

PRESCRIBING RIGHTS

Some Midwives in the Waikato and Central Regions have had their prescriptions for contraceptives and antibiotics declined by pharmacists.

All Midwives have the right to prescribe during pregnancy, labour, birth and the postnatal period up to six weeks. They should be guided by their scope of practice and professional standards and should ensure their prescribing is reasoned by and appropriate to both.

There is no list defining medicines a midwife can or cannot prescribe and it is therefore not acceptable for pharmacists or any other discipline to attempt to do so.

The College is currently working with Pharmac to make this clearer for pharmacists and midwives in the next issue of the Pharmaceutical Schedule.

The Select Committee on Health called before it the Royal College of Obstetricians & Gynaecologists and questioned them about their role in maternity care.

During the Committee's questioning of the RCOG the members suggested that doctors had been denying or discouraging women from giving birth at home and not telling them of the risks of hospital birth.

Audrey Wise MP said "I can't help but feel that in your own mind you are thinking all these women who want a home birth are awkward."

To which Mr Simmons, President of the RCOG replied, "There are constraints of choice on all of us..." "Where there is scope for choice we have no argument with women being able to give birth at home."

The obstetricians have changed their tactics from recommending that all births should take place in hospital, to one in which they advise a home birth only in areas where there are facilities to deal with emergencies" (A neat change of tactic now that they have withdrawn the flying squad service from so many areas).

QUOTE OF THE YEAR

Mr Simmons went on to say that "there are risks with home births - there is no denying that", and said the RCOG wanted women to have an informed choice and it was a doctor's responsibility to make them aware of all the risks involved in home birth. The MPs then asked if women were similarly advised of the risks of hospital birth, for example infection.

Mr Simmons said they were not because to do so "would unnecessarily alarm the patients."

He did not elaborate on whether he meant that the risks of hospital births were so great women would be terrified or whether it was merely acceptable to alarm them about home birth.

Beverley Beech
AIMS QUARTERLY JOURNAL VOL 4 NO 3

woman, are indications for referral. These include: severe oedema, hypertension, albumin or glucose in urine, severe anaemia, bleeding, small-for-dates abdomen, large-for-dates abdomen, malpresentation, or suspected multiple pregnancy. When these or other signs of possible complications are detected by the nurse-midwife in the antenatal clinic, the woman is referred to the obstetrical clinic for evaluation.

There is one exception. Women with more than five previous births are encouraged to deliver in hospital because of the increased risk of complications.

Potential cases of obstructed labour are referred to hospital on an urgent basis.

The actual prevalence of obstructed labour is hard to determine because cephalopelvic disproportion is rarely diagnosed in Grenada. X-ray pelvimetry is not used to diagnose it and every woman is given a trial of labour.

Postpartum women are observed carefully for excessive blood loss and most bleeding complications are managed without blood replacement. The only routine medication used for births attended by a midwife is 5 IUs of oxytocin.

In 1987-88 there were 246 women at the General Hospital with postpartum haemorrhage, a rate of 7.7 per cent. Only 17 units of blood were used in the year for which data were available.

Grenadian women with a normal recovery and healthy newborns are discharged from hospital approximately 12 hours postpartum. Since the signs of postpartum infection are likely to show up only after discharge, women are referred to their local health centre or station for postpartum care and are instructed to report there in case of fever, foul discharge, pain, or problems with the neonate.

POSTPARTUM CARE

Health centre staff are meant to visit in the first few days postpartum to examine both mother and baby and to encourage them to seek care early if needed. At these visits, care of the infant and breastfeeding advice are given and an assessment is made of the risk of problems occurring. If there are existing or potential problems, one or more additional home visits are made. However, not all health centres and stations in Grenada have sufficient staff to make these home visits on a regular basis and staff do not always find out when patients have delivered.

The protocol for postpartum care also calls for a physical examination of the mother at six weeks postpartum, at which time family planning is offered. As in other developing countries, the actual coverage is very low. The reason for this poor coverage, in this particular context, was reported as reluctance on the part of Grenadian women to obtain such check-ups since they wish to avoid pelvic examinations, and particularly pap smears, which are considered to be painful.

Infant survival in Grenada compares favourably with other Caribbean nations. All healthy babies room-in with their mothers and are breastfed. Infant formula is available only with special orders and premature babies are given expressed breastmilk. High risk neonatal care was limited by lack of incubators and other equipment, but recently a special care nursery has been established for low birth weight and sick babies.

CONCLUSIONS

Grenada provides an illustration of a maternity care system with virtually all births attended by qualified midwives, who maintain a complex, reliable, and well regarded primary care system and who keep the load on the secondary system and the few obstetricians at a low and workable level.

A good functioning referral system makes this possible. The essential features of the referral system are the use of a maternity record card that is kept by the woman, effective communication among primary care providers and between the primary and secondary care levels, an efficient emergency transport system, and referral back to primary level as soon as possible.

The Grenadian system makes no effort to use social criteria to predict risk status to modify the antenatal care package. Midwives refer women for secondary care only when the indications of

Most deliveries attended by nurse-midwives

Maternity care in Grenada makes very sparing use of physician services, supplies or equipment. Thus, general physicians who have no obstetrical training rarely attend deliveries. Forceps deliveries were rarely used (7 per 1,000 General Hospital deliveries), caesareans were performed in only 3.9 percent of General Hospital deliveries, and vacuum extraction was not used at all during the study period.

All normal deliveries and most other vaginal deliveries are attended by nurse-midwives. These involve limited use of medications, interventions or diagnostic tests. Hospital protocols require that the progress of the first stage of labour is monitored every four hours by vaginal examination, and vital signs and any other symptoms are also monitored. In practice, there are an average of 19 women on the maternity ward at any one time and two midwives and an assistant are responsible for their care. On many occasions, adhering to the protocols may be difficult. Student midwives rotate on and off the ward. Nurse-midwives monitor fetal condition with a fetoscope, a traditional adapted short stethoscope for use on the enlarged abdomen, and by checking for meconium staining of the amniotic fluid.

During the second stage, the woman is transferred to the delivery room where she is attended by qualified midwives or student midwives on rotation. Most women receive no intravenous drip, no episiotomy, and no routine analgesics or anaesthesia. Episiotomies were carried out for only 1.5 percent of births; yet the proportion of women with second degree lacerations was only 5.6 percent and third degree lacerations only 0.06 percent. Although normal deliveries are allowed to progress without intervention, midwives are trained to recognise early signs of intrapartum complications and to notify specialist obstetricians, who serve as consultants, for guidance.

Limited use of physicians and technology

The management of labour and delivery makes minimal use of expensive technology in Grenada. This limits costs and foreign exchange expenditures, minimises the allocation of scarce skilled personnel, and reduces maintenance and monitoring of equipment at the expense of patient care.

In contrast, many developing countries rely heavily upon physicians to attend uncomplicated deliveries, which is likely to increase costs. Even where the supply of physicians is high, there is often a lack of qualified personnel in low income and rural areas. Often, the driving force in limiting the use of midwives is the oversupply of physicians in higher income, urban areas. Countries faced with such problems may wish to consider increasing the utilisation of midwives for uncomplicated deliveries in regions or areas where physicians are scarce and incomes are relatively low. This would imply changes in training, credentialing, legal aspects of service delivery, and development of locally appropriate protocols for care.

Another benefit of such a strategy might be to decrease reliance on more costly hospital deliveries, since normal deliveries could be performed by nurse-midwives in out-of-hospital centres or at home, depending on the setting, provided that the necessary infrastructure for transfer and backup are established. This redirection of resources is likely to result in savings and other benefits, since the same transport and referral systems can be used for all types of emergency medical care, not just for maternity cases.

Clear protocols for managing serious complications

The effectiveness of the referral and treatment system for pre-eclampsia, antepartum haemorrhage, gestational diabetes and malpresentation seems to be essential to the attainment and maintenance of low maternal mortality in Grenada. While Grenadian nurse-midwives take considerable responsibility, there are clear protocols for the management of major life-threatening complications, which are known, understood, and utilised by the great majority of them. Their commitment to following this process was demonstrated in practice and in interviews.

One of the unique features of the referral and treatment system in Grenada is that women who are referred for diagnosis of a suspected complication, for example, gestational diabetes, do not continue to receive care at the higher level to which they are referred unless the severity of the condition or unresponsiveness to treatment require continuation of secondary level care. Whenever possible, the patient is sent back to the referring midwife with instructions for follow-up at the lower level as needed. When necessary, the District Nurse-Midwife visited the home of the patient to provide follow-up care.

The return of the patient to the lower level of care is necessary in order to ration the consulting obstetrician's services. This also permits access for those in need of urgent care rather than overloading the consultant's roster with routine follow-up. The chart review of pregnancy complications revealed that most cases were detected early enough to be treated successfully and avert maternal deaths.

MINISTRY OF HEALTH
MANATU HAUORA

22 DEC 1994

19 December 1994

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Ref. No _____

Karen Guilliland
NZ College of Midwives (Inc)
P O Box 21 106
CHRISTCHURCH

Dear Karen Guilliland

DRAFT HEALTH (RETENTION OF INFORMATION) REGULATIONS 1994

Thank you for your submission on the above regulations. The Ministry sent these draft regulations to over 500 interested and affected parties for reply and has received more than 100 replies. The comments received have been extremely useful and have raised a number of complex issues which need further time to be properly addressed.

As a result of these comments, the Government has asked the Ministry to consult further with groups and individuals to explain the intent and the effect of the proposed regulations in greater detail.

In order to allow for more time for consultation, the Health Amendment (No. 2) Act 1994 has been passed. The effect of the amendment is to postpone the expiry of section 22I of the Health Act. It will, therefore, continue to be an offence to fail to retain health information until 31 December 1996 or at an earlier date that may be given by Order in Council.

The Ministry of Health is seeking to introduce the regulations by Order in Council as soon as practicable and plans to circulate a further discussion paper to you in late January 1995. This will set out the major issues raised from the consultation to date and options for addressing these issues.

Thank you again for your submission.

Yours sincerely

Peter Cole
Manager
Health Sector Provider Policy

NATIONAL CERVICAL SCREENING PROGRAMME

-January 1995

Teenah Handiside is the newly appointed National Co-ordinator of the National Cervical Secreening Programme. Teenah was a NCSP Policy Analyst before becoming Acting Co-ordinator when Sue Dahl resigned. She says she has a long-term interest in cervical screening. "it is a result of a passion for women's health."

In 1988, with three other women, Teenah was involved in an early pilot project in Nelson aimed at encouraging low income women to have cervical smears.

At that time she was Acting Chair of the Nelson-Marlborough Area Health Board having been elected to the Old Nelson Hospital Board in 1983.

Teenah cam to health politics through involvement in Play Centre. She says she realised the health system was not meeting the needs of many of the mothers who came to Play Centre. She decided she 'wanted to be where the decisions are made'. Eventually Teenah served on the now disbanded Board of Health.

A registered nurse, she also tutored at Nelson Polytechnic until joining the then Department of Health in 1989 as Principle Nursing Officer. Whilst Acting Chief Nurse, Teenah saw through the Nurses Amendment Act, which allowed midwives to practice independently. It's a reform Teenah is particularly proud of - other pieces of legislation had to be amended to enable the change.

Teenah then transferred to the Department's then Women's Health section and later the National Cervical Screening Programme.

She sees her new position as steering through the 'last stage of implementation of the programme' with Maria Rangiawha, the new maori National Co-ordinator. "It is now time to use the data from the Register to produce effective evaluation and monitoring." says Teenah. "Overall, 50 percent of eligible women are on the register and many regions are close to 70 percent. It is predicted 80 percent of eligible women will be on the register within two years."

Teenah has three sons. She lives in Wellington with her husband and youngest son.

The Main Report
BUSINESS LETTER

Best Way to Get New Business

Personal contact is the most effective way to chase up new business, especially if you're in a service sector. That's according to a recent overseas survey of home sellers. For choosing an agent, 13% mentioned advertising...But 87% said they had had prior contact with the agent or had been given a referral by a person who had previous experience of the agent.

Sign of the Times - A Warning for Employers

For the first time, the Human Rights Commission has found an employer guilty of discriminating against an employee for his political opinions. The employer was the Yellow Bus Company, Auckland...The discrimination was against bus driver Kevin O'Dea. Mr O'Dea distributed a socialist leaflet to fellow workers that criticised the company for "low wages, bad conditions and lack of human rights". Mr O'Dea received "verbal counselling" as discipline.

For less severe conditions, that do not represent a clear risk of maternal death but may predispose to poorer maternal or fetal outcome, however, there was less agreement among different midwives on what the protocols for treatment were. Conditions that received attention but were considered to have lower priority were: moderate or mild anaemia, previous low birth weight in the infant, previous premature labour, previous fetal loss, stillbirth or poor obstetrical history, fetal distress in labour, prolonged gestation or prolonged first stage of labour. Efforts to reduce the stillbirth rate were underway during the study period.

Antenatal record card retained by the woman

The antenatal record card is also essential to communication, since it summarises all clinical and laboratory findings, any treatment or conclusions, and recommended follow-up, which a woman then keeps and carries with her between primary and secondary level clinics.

Patient-retained record cards have been used not only in Grenada but also in other countries. This system of record keeping can be valuable in empowering women to take control of their own care. When handing over the card, they can take the opportunity to communicate their own needs and can feel they are providing the background information the professionals need to diagnose and treat them.

Good communication

Communication between nurse-midwives at the primary care clinics and the referral centres is essential to the smooth functioning of the system. Such communication was facilitated by the existence of strong informal networks among the nurse-midwives, who have their training and social background in common. Maintenance of this informal social network in Grenada was judged to be an important aspect of the success of the maternity care.

Face-to-face meetings among midwives are usually formal and take place once monthly at the parish level. They are mainly for the purpose of administrative coordination and supervision, rather than for communication of clinical information. Parish supervisors, who are public health nurses, attend a similar monthly meeting at the Ministry of Health. These face-to-face meetings were not thought to be essential to the maintenance of communication or of social networks. It was judged to be more important to have radio or telephone communication for emergency use.

In a larger system, where there are many more staff and less opportunity to meet informally, such meetings may be deemed to be more important. At the same time, providing midwives with field radios might be considered to permit both the communication of necessary information and the maintenance of a functional, professional network.

Empowering nurse-midwives empowers pregnant women

Several features of the Grenadian system are empowering for nurse-midwives and their clients. Well trained nurse-midwives in local settings provide a tangible role model for the benefits of higher education. Nurse-midwives represent their women clients from positions of responsibility, are able to help to maintain life, and have the authority to get the health care system to respond to the women's needs and desires.

The service empowers pregnant women by letting them make their own choices as they take advantage of health care. In order to see a nurse-midwife, women need not rely on expensive transport nor on the permission or acquiescence of others.

Finally, communication among the midwives is empowering because it provides a structured forum in which a cadre of professional women can share their problems and needs.

Other countries wishing to empower nurse-midwives would need to consider the development of strong training and credentialing programmes, clear norms and job descriptions, adequate salary and benefits, and standards to permit the development of a high level of professional practice.

CLINICAL MANAGEMENT OF OBSTETRIC COMPLICATIONS

Throughout the world there has been much interest in the use of social indicators such as age, parity, and socioeconomic status to identify high risk pregnancy, in order to focus antenatal care toward those who meet specific risk criteria. However, the sensitivity and specificity of such indicators is limited.[3] Although the strategy outlined by the Pan American Health Organisation for maternal and child health in the Caribbean suggests that the utilisation of a risk-based approach may be advisable, no effort is made in Grenada to identify high risk pregnancies according to social criteria.[4]

meters. The per capita income was US$ 960 in 1987 and the infant mortality was 18.1 per 1,000 live births. The birth rate was over 30 per 1,000 population and 37 per cent of the population were under 15 years of age. There are seven primary health care centres, one in each of the parishes of the island of Grenada and one on the island of Carriacou, plus 29 satellite health stations that provide more limited health services. The road system and telephone service are well developed. Both geography and infrastructure provide the foundation for an effective primary health care system.

In the first six months of 1990, we conducted a study of Grenada's maternity care system. Details of study methods and findings are available from the project report.[1] Study methods included direct observation, interviews with midwives, data collection from records at all levels of services, including information on transfer of patients, management of complications in the parishes, and a hospital chart review of complicated cases from 1987 and 1988 to obtain information on treatment of complications and specifics of care.

The great majority of antenatal and intrapartum complications are referred to St George's General Hospital for treatment. The smaller district hospital is not equipped to handle obstetrical emergencies or perform caesarean sections.

Data on maternal deaths were obtained from hospital registry books, ward and medical staff, District Nurse Midwives, and the Registrar General's Office. A search was made of the registry list of all deaths in 1987-88 among women and girls 12-48 years of age and death certificates were examined for any that mentioned pregnancy or might plausibly relate to reproductive causes.

In 1987 and 1988 there were six maternal deaths among 5,803 hospital deliveries. Two of these were due to eclampsia; the other four were due to a ruptured ectopic pregnancy, septic shock, antepartum haemorrhage, and postpartum haemorrhage complicated by sickle cell disease.

Based on hospital records, the frequency of breech presentation was 2.2 per cent, though uneventful breech deliveries were not always recorded. No cases of obstructed labour occurred. Prolonged labour occurred in an estimated 2.5 per cent of deliveries, postpartum haemorrhage in 7.7 per cent, and diabetes in just under 1 per cent. There were caesarean sections in 3.9 per cent of General Hospital deliveries. Thus, the maternal death rate is relatively low, indicating a successful maternity care system.[2]

Organisation and delivery of maternity care

Comprehensive antenatal care is accessible to all women in Grenada free of charge through nurse-midwives, with referral to an obstetrician in an emergency. The quality of care can be attributed to the training programme at the General Hospital and the qualifications of the midwives, which permit them to apply their knowledge in individual cases and to make sophisticated judgements.

The success of the system rests in part on the early diagnosis of key conditions at a point when they can still be treated successfully. Easy access to antenatal care is made possible by the network of health stations, which are usually within walking distance of most villages, and by the presence of a qualified nurse-midwife in each of these.

The dispersal of the primary health care centres allows women greater access to care, keeps the care provider in the community; and encourages greater understanding of local needs. This in turn encourages greater trust in the relationship between provider and client and facilitates successful compliance with medical recommendations, follow through on referrals, and comprehension on the part of the care provider of individual needs.

Programmes seeking to replicate this access would have to redirect resources to rural health facilities. Provision of midwifery services in rural areas should be less costly than physician services and easier to achieve.

Emphasis on third trimester coverage

In Grenada, as in other places, many women do not initiate antenatal care until mid-pregnancy. However, most life-threatening complications – eclampsia and pre-eclampsia, haemorrhage, obstructed labour, sepsis – are more likely to occur in the third trimester and around birth.

ULTRASOUND STUDIES AND THEIR CONCLUSIONS

Doreen Liebeskind et al. Diagnostic Ultrasound: Effects on the DNA and Growth Patterns of Animal Cells. *Radiology* **131:177-184, April 1979.**
Ultrasound in the diagnostic range appears to cause detectable effects on DNA and growth patterns of animal cells. Apparently ultrasound affects DNA within the living cell so that antibody binding sites which are normally inaccessible become available to anti-guanosine. The immuno-reactivity data suggested that DNA strand damage might be responsible. These results clearly indicate that ultrasound was responsible for a readily detectable disturbance in cell growth pattern. Further studies on the effects of low doses of ultrasound are now needed, especially in view of its extremely wide use and the meagre experimental and epidemiological data on its effects.

J P Newnham et al. A Randomised Controlled Trial of the Effects on Pregnancy Outcome of Frequent Prenatal Ultrasound Examinations. *Lancet* **1993;342:887-891.**
We conclude that a policy of frequent ultrasound examination does not improve perinatal morbidity and in this controlled trial was associated with an increased frequency of IUGR (Inter-uterine growth retardation). Long term assessment of these children is in progress.

James D Campbell et al. Case-control Study of Prenatal Ultrasonography Exposure in Children With Delayed Speech. *Can Med Assoc J* **1993:149(10).**
An association between prenatal ultrasonography exposure and delayed speech was found. If there is no obvious clinical indication for diagnostic in-utero ultrasonography, physicians might be wise to caution their patients about the vulnerability of the foetus to noxious agents.

Taskinen H et al. Effects of Ultra, Short Waves and Physical Exertion on Pregnancy Outcome in Physiotherapists. *Journal of Epidemiology and Community Health*, **1990 Vol 44, pp196-201.**
The findings that high exposure to ultrasound increased the risk for late spontaneous abortion, raises the question of the potential hazards of diagnostic ultrasound commonly used during pregnancy.

Kjell Å Salvesen et al. Routine Ultrasonography in Utero and Subsequent Handedness and Neurological Development. *Brit Med Journal* **1993;307:159.**
Our data suggests a possible association between routine ultrasonography in utero and subsequent non-right handedness.

Bernard G Ewigman et al. Effect of Prenatal Ultrasound Screening on Perinatal Outcome. *The New England Journal of Medicine*, **Vol 329, No 12, Sept 16, 1993.**
Screening ultrasonography did not improve perinatal outcome as compared with the selective use of ultrasonography on the basis of clinician judgement.

POSSIBLE RISKS - REFERENCES

IUGR
(Inter-uterine growth retardation)
Newnham 1993

DELAYED SPEECH
Campbell 1993

PREMATURE OVULATION
Testart 1982

DAMAGE TO CENTRAL NERVOUS SYSTEM
Ellisman 1987

DNA AND CELL GROWTH
Liebeskind DE et al 1979

DYSLEXIA
Stark et al 1984

LOSS OF NEURONS
Mole 1986

LOW BIRTH WEIGHT
Evans 1988

LOWER AGPAR SCORES
Thacker 1985
Newnham 1991

MISCARRIAGE
Taskinen 1990
Lorenz 1990

MISDIAGNOSIS
False Positive/False Negative
Saari-Kemppainen 1990
Fyro and Bodegard 1988
Chitty et al 1991
Roberts et al 1983
Atkins and Hey 1991
Scott et al 1993

NEUROLOGICAL DAMAGE
Scheidt et al 1978

For a full list of references contact
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Vaginal Birth After Cesarean (VBAC) Fact Sheet

Evidence confirming the safety of vaginal birth after cesarean (VBAC) within proper guidelines has been available for more than ten years. However, wide variations in VBAC rates, unjustified by medical factors, still exist between hospitals and physicians. These facts are presented with the hope that more women will be encouraged to avoid an unnecessary cesarean section and supported in their wish to labor and have a VBAC.

- VBAC with appropriate informed consent is the standard of care for women with one prior low transverse uterine incision. Studies indicate that overall at least 50% and as many as 90% of women who plan a VBAC can delivery vaginally (*ICEA VBAC Review* 1990).
- The rate of reported uterine rupture in planned VBAC with a low transverse scar has ranged from .09% to .22%. This risk is thirty times lower than any other unpredictable childbirth emergency such as acute fetal distress, premature separation of the placenta and prolapsed umbilical cord. A 1994 study based on 5733 planned labors after one or more cesareans reported a rupture rate of .8% with no maternal deaths related to uterine rupture (*Guide to Effective Care in Pregnancy and Childbirth* 1992; *Obstetric Gynecology* 1994).
- Maternal morbidity rates are consistently and substantially lower for women who plan a VBAC — 2%-23% — than for women who have an elective repeat cesarean — 11%-38% (*Guide to Effective Care in Pregnancy and Childbirth* 1992).
- Any hospital that provides standard obstetric care can also provide care for women who wish to plan a VBAC. A recent study concluded that family physicians can play a major role in promoting VBAC (*American Family Physician* 1993).
- The National Association of Childbearing Centers of the United States (NACC) indicates that birth centers may encourage VBAC clients to labor and deliver in their facilities provided that emergency care can be initiated within thirty minutes of recognition of a problem (NACC Committee Opinion 1989).
- In the United States, 22.6% of all births in 1992 were by cesarean section. Thirty-eight percent of all cesareans performed were elective repeat operations. The VBAC rate in 1991 was 24.2%. A national health objective for the year 2000 is a cesarean rate of 15% and a VBAC rate of 35% (*Unnecessary Cesarean Sections: Curing a National Epidemic* 1994).
- In 1988-89, the cesarean rate in Canada was 19.5%. Thirty-eight percent of all cesareans were repeat operations. The VBAC rate for this same period was 15.6%, a fivefold increase since 1979-80. In the province of Manitoba, the VBAC rate for women younger than twenty was 55.2% (*Canada Health Reports* 1991).
- A review of twenty-five medical reports concluded that women with two prior low transverse uterine scars who wish to plan a VBAC are not at any greater risk for a uterine rupture. The literature indicates that 60% to 75% of women with two or three prior cesareans gave birth vaginally (*British Journal of Obstetrics and Gynecology* 1991; *American Journal of Obstetrics and Gynecology* 1988 and 1989; *Obstetrics and Gynecology* 1990).
- A low segment vertical uterine incision does not appear to increase the risk of uterine rupture for women who plan a VBAC (*American Journal of Obstetrics and Gynecology* 1988; *Obstetrics and Gynecology* 1987 and 1988).
- VBAC is safe for non-diabetic women who are expected to give birth to infants that weigh more than 4000 grams (*Obstetrics and Gynecology* 1989; *Journal of Reproductive Medicine* 1984).

continued on page 42

ARTICLES OF INTEREST

Features

Reproductive Health Matters, No 4, November 1994

Delivering Women-Centred Maternity Care with Limited Resources: Grenada

Virginia Hight Laukaran, Adity Bhattacharyya and Beverly Winikoff

Maternity care in the Caribbean island nation of Grenada is organised and provided largely by trained nurse-midwives and maternal mortality is relatively low. This paper discusses how the various elements of this care – emphasis on third trimester coverage, health education for women, clear protocols for managing serious complications, round-the-clock coverage, effective referral, good communication and record-keeping, and limited use of physicians and technology – can be used as a model by other countries to reduce maternal deaths.

THE maternity care system in Grenada can be described as a success in achieving and maintaining a low level of maternal mortality in spite of a limited use of technology. Most maternity care is provided by nurse-midwives, who are trained at government expense on the British model in a three-year, hospital-based nursing programme, with an additional nine-month programme in midwifery.

Antenatal care is provided through a network of multi-purpose health centres and smaller health stations throughout the country. Although midwives are employed in all of these as district nurse-midwives, the majority of births take place in the general hospital. About ninety percent of births are attended by nurse-midwives, as there are 1.5 obstetricians per 100,000 population.

Just over ten per cent of women deliver at home, usually attended by district nurse-midwives, with the remainder of births occurring in medical facilities. Attendance at home deliveries on request of the family is guaranteed by the government and this entitlement is understood by the population. Grenada has no untrained midwives, presumably because there is good access to qualified ones.

Private maternity care seems to be rare. In 1988, less than one percent of nurse-midwives who attend births were in private practice and less than one percent of normal hospital births were performed by general practitioners in private practice. Nine percent of vaginal deliveries at the general hospital were performed by obstetricians in 1988, of which many, perhaps most, would have been done on a private basis.

The backbone of the early detection and referral system that controls maternal mortality is in the hands of women who are trained to serve their women clients with professionalism and compassion. The system of primary health care and midwifery in which they work is part of the British colonial legacy in Grenada. In Britain, as in most developed countries, maternity care has changed considerably. In Grenada, maternity care still follows an older pattern, using only limited technology. This is mainly because of the cost of technology, the need for highly trained personnel to use it and the cost and difficulty of maintaining it.

The Grenadian maternity system is very small in scale and part of a health care system whose basic infrastructure is already in place. Because of its successes, its applicability as a model for other countries is worthy of consideration, though many of its features may not easily be replicable elsewhere. This paper attempts to identify the operational features and the most essential factors that contribute to safe pregnancy for women in this setting, and give some indication of what would be required for these to succeed in other settings.

Background

Grenada is located in the southern Caribbean, 90 miles from the mainland of Latin America. It is a very small country, less than 650 square kilo-

Birthing: danger in 'mindless activity'

NZ HERALD 26/01/95

By KAREN GUILLILAND, national co-ordinator and immediate past president of the College of Midwives

When I read Dr Allan Sutherland's article on his impressions and conclusions gained during his 30-year career in medicine I was reminded of author Simone de Beauvoir's famous quote:

"Representation of the world, like the world itself, is the work of men. They describe it from their own point of view which they confuse with absolute truth."

Dr Sutherland's and Dr Tony Baird's claims that more babies are dying and maternity care is somehow regressing with the advent of independent midwifery is simply not supported by the evidence.

The Auckland National Women's annual reports of 1992 and 1993, which is the area of practice for both these doctors, quite clearly illustrate the continued decline in baby deaths.

Furthermore, the reasons those newborn babies do die remain consistent and are largely out of human control.

Over the past 10 years the midwifery profession has consistently called for and written submissions to the Government for hospitals to establish a national perinatal database in order to be able to make informed judgments on the outcome of maternity care.

The Auckland Homebirth Association has been the only organisation to collect comprehensive national data in that time. The Homebirth Association statistics over these years clearly illustrate the safety of homebirth and midwifery care.

Many international studies support these findings.

The British Medical Journal reports studies by Louden (1986-1992) which showed that improvements in pregnancy outcome since 1900 cannot be due to increased obstetric intervention or hospitals and that these technologies are more closely correlated with bad outcomes than good.

So why is it that Drs Sutherland and Baird are so convinced that their opinions are right regardless of the evidence to the contrary? Is it that same reason that medicine mistakenly believed that x-rays were safe, that ultrasound was risk-free, that stilboestrol and thalidomide improved pregnancy outcomes, that the routine cutting of the birth canal open was an improvement of nature's method, that routine foetal monitoring improves the outcome for the baby?

That is the belief that always doing something must be better than doing nothing regardless of the activity itself having never been evaluated for its risks and benefits. It is these sometimes mindless activities that Dr Sutherland appears loath to see reassessed.

Medicine itself concludes in several respected publications that the routine use of technology is not recommended because at best it makes no difference to the outcome yet escalates the costs of maternity services; and at worst it may increase the risk of the outcome in either, or both, the woman or baby.

Obstetrics has always relied on parents and midwives working together in the normal birth process to recognise when the birth process has, or is likely, to deviate from normal and require medical input.

Midwives are the check and balance on that process as obstetricians are on the midwives' observations and diagnosis. It must be a co-operative system to work. For as long as obstetrics has been a discipline, it has in the main trusted midwives to call them in as necessary.

Why is it that medicine is, no longer able to do that? The only change has been that midwives' statutory recognition was lost in 1971 and regained in 1990.

Consequently midwives now expect acknowledgment and respect for their professional judgment which has been previously taken for granted or often not even viewed as a skill at all with midwifery care and assessment invisible until the medical "expert" arrives.

There is nothing in today's maternity services which denies the woman the right to choose a doctor. There is no compulsion to choose a midwife; in fact quite the opposite. Women choose a midwife in spite of media hype and hostility.

Modern obstetrics and modern midwifery offer a range of choices which suit today's society where individual values, beliefs and health needs are varied and valued.

All women need to have made their choices on all the information available to them. All women are entitled to the full range of maternity services they need in order to remain safe and satisfied but ultimately the decision should be theirs.

The Cartwright report outlines many of the experiments and attitudes associated with medical advances. Dr Sutherland was a doctor during this time. Does he not remember the days before patients had rights, and informed consent was a requirement? Has he forgotten the "near disasters" of yesteryear?

"Obstetrics keeps you humble" was and is a favourite expression to console medicine about its lack of control over nature. The same "near disaster" (or is it really a legitimate referral for secondary care) is now almost always seen as a failure on the part of the midwives and is a symptom of the same arrogance which has afflicted medicine for years.

Midwifery has taken the criticisms of the Cartwright report seriously and is no longer able to stand and watch practices which jeopardise women and their babies.

The midwifery profession is well educated in its specialist area of the normal childbirth experience. The New Zealand curriculums have the same number of hours and experience as other western countries such as Holland, Denmark and Britain where midwives also have autonomy.

The standards of practice and codes of ethics are consistent worldwide. In New Zealand the Nursing Council operates in the same way as the Medical Council.

Midwifery is an old, well-established and respected profession which has autonomy in New Zealand exclusively except between 1971 and 1990.

It does not deserve the insults that medicine is pouring on it. Midwifery takes its role of advocate seriously and is well educated to do so. Midwives and women throughout the world, including New Zealand, are challenging the medical profession's claims to absolute truth.

Medicine's response is to use its social standing to undermine these challenges as dangerous to a point where even the word "natural" has achieved radical or dangerous status while medical intervention becomes the norm.

Judge Cartwright underestimated the bravery it takes to speak out in the face of such organised opposition. Midwives are, however, unable to watch silently any more when they know there are alternatives which are safer.

Many doctors have responded positively and with concern and are working collaboratively with midwives and women in an effort to improve maternity care.

Combined scholarly activity, critical and constructive analysis and active listening to other viewpoints are essential.

It is this approach, where doctors, midwives and parents respect each other's role and knowledge, which will eventually make the maternity experience all it is capable of being.

In spite of Dr Sutherland's personal opinion and the continuing negativity of the stories the media choose to portray, midwives and doctors are working towards a deeper understanding and the majority of their clients are benefiting from the change.

- A review of forty-two studies concluded that within appropriate guidelines, VBAC with a breech presentation is a safe and reasonable option (*Journal of Reproductive Medicine* 1989; *Clinical Perinatology* 1989; *American Journal of Obstetrics and Gynecology* 1989).
- External cephalic version (a method of rotating a breech presentation) is a reasonable option for women with a prior low transverse scar who wish to plan a VBAC (*American Journal of Obstetrics and Gynecology* 1991).
- Prostaglandin E_2 in gel can safely be used for cervical ripening for women who plan a VBAC. Its use can lower the risk of a cesarean for failed induction with oxytocin (*Acta Obstetrics and Gynecology of Scandinavia; American Journal of Perinatology* 1992).
- Although uterine rupture in planned labor after cesarean is a rare event, when it does occur, it is often seen as an acute emergency. The most common indicators of uterine rupture are an abnormal fetal heart rate pattern or prolonged decelerations with an arrest of progress in labor. Abdominal pain or vaginal bleeding are not reliable indications (*American Journal of Obstetrics and Gynecology* 1991, 1993 and 1992; *Journal of Clinical Anesthesiology* 1991).
- A vertical incision (classical/midline) in the upper segment of the uterus is a contraindication for labor (*Canadian Medical Association Journal* 1993).
- A Canadian study of sixteen community hospitals revealed that physicians are more likely to offer a trial of labor—38.2%—if an educationally influential opinion leader initiated practice guideline recommendations, than if the hospital audited charts of women with a prior cesarean, held departmental meetings and discussed the audit results—21.4% (*Journal of the American Medical Association* 1991).
- Data from North American studies indicate that 30% to 50% of women who are offered a trial of labor based on the medical benefits versus risks approach choose to have a repeat operation. A significant number of women who elect another cesarean had their initial surgery for non-progressive labor (*Culture, Medicine and Psychiatry* 1987; *Journal of Reproductive Medicine* 1993; *Women and Health* 1989; *American Family Physician* 1993).
- A European study of over 1000 women with a prior cesarean section concluded that routine examination of the prior scar to detect dehiscence after vaginal delivery is of doubtful value (*ACTA Obstetrics and Gynecology of Scandinavia*; Enkin, Kerise and Chalmers 1992).
- X-ray pelvimetry is an unreliable indicator of the outcome of planned labor after cesarean and should be abandoned (*British Journal of Obstetrics and Gynaecology* 1993; 1991).
- A five-year American study concluded that nurse midwives attending women in labor with a prior cesarean had an 83% rate of vaginal delivery (*Journal of Nurse Midwifery* 1989).
- Data from a National Birth Center VBAC Study in progress indicate that 86% of 189 women had a vaginal birth and 93% of these took place in the birth center setting. Forty-nine infants were "macrosomic" —more than 4000 grams; 82% of them were delivered vaginally (NACC 1994).
- VBAC is a valid option in developing countries. Maternal and fetal outcomes are not compromised when women are attended by midwives in hospitals that do not have the use of electronic fetal monitors and availability of a blood bank. However, an attending physician and a surgical team must be available as needed (*International Journal of Gynaecology and Obstetrics* 1991; *Journal of Reproductive Medicine* 1992; *Australian and New Zealand Journal of Obstetrics and Gynecology* 1988).

■ *Fact Sheet author Nicette Jukelevics, MA, ICCE is past chair of the ICEA Cesarean Options Committee.*

SPECIAL FEATURE

Birthing : danger in 'active inactivity'

NZ HERALD 03/01/95

Concerned at an increasing toll of birth injuries, family general practitioner, obstetrician and member of the medical practitioners' disciplinary committee DR ALLAN SUTHERLAND, of Milford, writes that "parents should be on guard against a lobby that preaches 'active inactivity' at birth."

In a letter accompanying this article, Dr Sutherland (MB, ChB, DHBM, D Obs RCOG, FRNZCGP) says: "As a result of this article being published I will be retiring from active obstetric practice and may be placing my membership of the medical practitioners' disciplinary committee in jeopardy.

"I therefore ask you to make it clear that these observations are made [as a result of my experience] as a previously active general practitioner-obstetrician, as an obstetric representative and, to a lesser degree, as a member of the disciplinary committee."

Working as a general practitioner-obstetrician I have, like many of my colleagues, become increasingly concerned at trends in birth practice over recent years.

These concerns have been reinforced by my observations as a member of the medical practitioners' disciplinary committee.

I have now seen several recent cases where a baby has been left brain-damaged as a result of a birth that has gone wrong. In some cases the baby dies, and in others babies are left blind, unable to move limbs, intellectually handicapped, or subject to epileptic fits.

Had the birth injury not occurred, these children would in all probability have been born healthy.

For their parents, of course, such an outcome is catastrophic. But perhaps the most disturbing aspect of these cases has been the expert opinion that disaster could have been avoided.

Until now, it has been left to parents of injured children to speak out publicly. While medical organisations are discussing and producing protocols, most doctors privately express concern about the increasing frequency of obstetric problems and near disasters.

Because of my interest in this topic and knowledge of these events, I feel a responsibility to speak out before more families are harmed.

Thirty years ago when I began in family medicine many conditions such as cot death, asthma and heart disease were occurring in epidemic numbers and caused many deaths.

With medical, scientific and educational advances, these mortality and morbidity rates have been much reduced and the benefits of progress are now almost routine.

Yet when it comes to obstetrics, I increasingly have a sense of having seen safety standards go full circle.

Developments in foetal monitoring, blood sampling and ultra-sonography in the 1960s and early 70s were all greeted enthusiastically because they reduced risk.

Now we have a new birth lobby whom I characterise as preaching a sort of "active inactivity" who argue against the use of such advances because they somehow render a birth "not normal" or "unnatural."

Unfortunately, as the parents who have appeared as complainants before the disciplinary committee can attest, the consequences of this approach can be severe.

Near-disaster births happen more often

New Zealanders not close to this debate would probably be surprised to find just how politicised it has become.

Some, of course, will be familiar with what has been portrayed as a doctors versus midwives dispute, but to see this as an old-fashioned turf fight over money and power is to grossly underestimate the health issues at stake.

First let me say I have a high regard for the professionalism and competence of the vast majority of midwives I have worked with in hospitals as part of the obstetric team.

Equally, there are a few medical practitioners who can be counted among the active inactivity group.

That said, the fact remains that most of the new lobbyists are midwives and the role of this increasingly widespread lobby is, in my view, undermining traditional safeguards of careful investigation and close monitoring, particularly during the potentially hazardous process of delivery.

My obstetric colleagues tell me they are being called on more and more often to try to rescue near-disaster births.

A former Wellington Hospital obstetrician, Dr Henry Murray, has been reported as saying that staff there dealt with some sort of obstetric near-disaster every night.

The shift in standards can be more subtle as well, for there are numerous occasions when medical instructions have either been ignored or undermined, with serious consequences.

For example, a small group of independent midwives attached at North Shore Hospital (where I was involved in setting up a roster of medical practitioners to assist as junior staff with more complicated deliveries), are proposing that the hospital do without this medical assistance.

For a Level II obstetric hospital to conduct complicated deliveries without junior staff would be extremely unwise and is against the advice of obstetric specialists.

As to why this trend of active inactivity has emerged will be for epidemiologists and historians to decide. I believe that one of the factors is a simple lack of understanding of the scientific process by people who have comparatively brief training and a less professionally critical approach.

For example, recent academic publications have suggested that cerebral palsy is a rare result of birth asphyxia, and that foetal heart monitoring is difficult to interpret and not bringing the benefits previously expected.

While it is appropriate that such propositions are carefully examined and debated by scientific professionals, it is not appropriate that they have been seized by others as a simple justification for disregarding careful investigation, monitoring and obstetric safeguards.

The result is that some patients are being exposed to unacceptable risk.

The major change in New Zealand dates from the legislation of former Labour Minister of Health, Helen Clark, who in 1990 had passed the Nurses' Amendment Act allowing midwives to deliver babies and to prescribe narcotic drugs without the participation of a medical practitioner.

By my observations, not all midwives have sufficient skills and expertise to dispense this responsibility safely.

For example, I am particularly concerned to hear of frequent reports of mothers who have had a previous caesarean section having a planned home delivery well away from a hospital with caesarean section facilities.

This same legislation has prompted a blow-out in maternity funding, reflecting other areas in which it was poorly thought through.

From a health point of view, the most serious issues arise when obstetric providers show little insight into the boundaries of their expertise and experience.

This is demonstrated by the repeat story of active inactivity providers promising a safe delivery, but being late in the recognition of a deteriorating clinical situation, with poor communication and late transfer to the providers who have the responsibility to effect delivery.

It is often the obstetrician who has inherited the problems who receives any complaint.

While all providers, administrators, midwives and doctors have responsibility, there is no mechanism to call administrators to account and midwives do not appear to have the same standard of audit as doctors.

In several cases heard before the disciplinary committee it has been clear to me that midwives behaved in such a way that, had they been doctors, they would have had considerable difficulty defending themselves against a charge of professional misconduct.

Yet while parents did lay complaints against these midwives, it was stated that these complaints did not proceed to the parents' satisfaction.

It is to be hoped that these inequities in responsibility will be arrested by the recently appointed Health Commissioner.

In this context, it is hardly comforting to see an Associate Minister of Health, Catherine O'Regan, comment publicly that she has been concerned by this development, but is powerless to effect any change.

Nor is there any reassurance to be had from the College of Midwives national co-ordinator, Karen Guilliland, who is reported as saying that the point of having an independent midwife or general practitioner was not to follow standing orders which may have been laid down by an obstetrician.

Of course mothers want a birth that is as natural and untroubled as possible. This goal is shared by scientific obstetrics.

Mainstream obstetrics has become less interventionist and more user-friendly over the years, but the one real difference between it and the new active inactivity lobby remains its more keenly self-critical approach.

Expectant parents should be warned that when things do go wrong with the delivery process, if they are unrecognised or not responded to, the consequences can be devastating.

All babies deserve the safest birthing care available.

Mindless Activity vs Active Inactivity

The new year began with yet another unfounded attack on the midwifery profession.

The public are bored with it, the midwives wonder when the professional jealousy will come to an end but the media want it to continue because they believe it sells papers.

Despite Karen Guilliland's immediate response to Allan Sutherland's article on 03/01/95, neither the Press Association, television or radio would enable her to respond in a way that would refute his claims. The NZ Herald eventually printed an edited article at the end of January.